AUSTRALIAN

Anaesthetist

THE MAGAZINE OF THE AUSTRALIAN SOCIETY OF ANAESTHETISTS • SEPTEMBER 2018

- Anaesthetist or anaesthesiologist?
- ASA Strategy 2018-2020
- 2018 ASA Member Workforce Survey
- ASURA 2019

ASA
Australian Society of Anaesthetists

8 - 10
NOVEMBER
2018

NZ Anaesthesia ASM
Face the Future

Cordis Hotel, Auckland, New Zealand

KEY DATES:

Abstract submission open 20 March

Earlybird registration open 26 April

ANZCA
AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS

New Zealand SOCIETY OF Anaesthetists

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REFERENCES: 1. PALEXIA IR Approved Product Information, 27 March 2017. **2.** Hartrick C *et al. Clin Ther* 2009; 31(2):260–71.

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THE MAGAZINE OF THE AUSTRALIAN SOCIETY OF ANAESTHETISTS

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

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

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A MEMBER SOCIETY OF THE WFSA

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INSIDE YOUR SOCIETY

WOULD YOU LIKE TO CONTRIBUTE TO THE NEXT ISSUE?

The December issue features of *Australian Anaesthetist* will focus on the History of Military Anaesthesia. If you would like to contribute with a feature or a lifestyle piece, the following deadlines apply:

- Intention to contribute must be emailed by 4 October 2017.
- Final article is due no later than 16 October 2017.

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

REGULAR

ASA EDITORIAL FROM THE PRESIDENT

A/PROF. DAVID M. SCOTT
ASA PRESIDENT

Welcome to my last editorial as President of the ASA. It certainly has been a busy two years, below is a list of some of the activities that have occupied much of my time representing our members and the speciality during this time.

1. Governance Restructure – implementation of a new Board/ Council model including the establishment of terms for all elected positions.
2. Engagement of Credit Suisse – which has led to better and safer management of the ASA's investments.
3. MBS Review – active involvement working directly with the Health Minister and the Federal Department of Health. This is ongoing and has represented one of the greatest external threats to the speciality in the last decade.
4. Branding Refresh – professional appearance of the ASA productions has been updated and made more consistent.
5. *Anaesthesia & Intensive Care* Journal – production is to be outsourced as part of improved risk management and improved value to members and the Society.
6. Website Refresh – currently under way this will lead to greater functionality, and interaction with members and the public through enhanced services.
7. Adoption of an Equity and Diversity Policy – applicable to all aspects of ASA.
8. Engagement with RANZCOG working on how to improve value for private obstetric services.
9. Working with the Health Minister and Chief Medical Officer on how to deal with medical out of pocket expenses.
10. Worked with the College and other agencies to address rural anaesthesia workforce issues, including meeting the Rural Health Minister and The Rural Health Commissioner.
11. Worked with Wellbeing of Anaesthetists Special Interest Group and Everymind on a comprehensive package for the mental wellbeing of anaesthetists.
12. Represented the ASA at the CIG meetings in Canada and London ensuring the ASA is up-to-date with our colleagues in the English-speaking world.
13. Engaged with the European Society of Anaesthesiologists and signed a MOU to enable closer cooperation between our societies.
14. Appointment of our CEO – including development and institution of CEO assessment and appointment process.

This is not an exhaustive list but does cover most of the major issues. Going into the future the importance of active advocacy with Government and fund payers is one of the key roles the ASA will be undertaking.

One of the most persistent negative comments we have had to deal with during this time has been the almost constant pessimistic flow of fake news from the private health insurance industry. They are very well resourced and have actively lobbied the Government and Health Minister that the Australian Health System is in crisis, is unsustainable and is vectoring toward complete collapse, unless major overhaul and change is made.

It has been repeatedly stated that insurers have been struggling and premiums have to be increased above CPI to ensure the viability of the industry. Despite this we see that profits for the sector have increased above CPI, executives receive seven figure remuneration packages, they sent numerous executives to Portugal this year at a cost of $100,000, a 'conscious decision' by HBF CEO John van der Wielen, saying if you want global input you have to travel! (Sue Dunleavy, *Adelaide Advertiser*, July 14).

However, considering Australia's performance in the cost and delivery of healthcare, this is unsupported: when we look at our performance compared to 11 leading OECD countries it's a very different story. 'Mirror, Mirror 2017: International Comparison Reflects Flaws and Opportunities for Better US Health Care' by Eric C. Schneider, Dana O. Sarnak, David Squires, Arnav Shah, and Michelle M. Doty (https://interactives.commonwealthfund.org/2017/july/mirror-

Exhibit 2. Health Care System Performance Rankings

	AUS	CAN	FRA	GER	NETH	NZ	NOR	SWE	SWIZ	UK	US
OVERALL RANKING	**2**	**9**	**10**	**8**	**3**	**4**	**4**	**6**	**6**	**1**	**11**
Care Process +	2	6	9	8	4	3	10	11	7	1	5
Access +	4	10	9	2	1	7	5	6	8	3	11
Administrative Efficiency +	1	6	11	6	9	2	4	5	8	3	10
Equity +	7	9	10	6	2	8	5	3	4	1	11
Health Care Outcomes +	1	9	5	8	6	7	3	2	4	10	11

mirror/) it can be seen that Australia is a world leader, and at the lowest cost (as a percentage of GDP).

As you can see if it weren't for equity, Australia would be the leader. Equity is a measure which reflects access to healthcare, and number of patients who choose to forego filling prescriptions etc due to cost. However Health Care Outcomes shows Australia as the leader. Interestingly the overall leader is the UK NHS, however they rank second last in health care outcomes, and it's only factors like equity and process where the universal coverage of the NHS provides the best ranking.

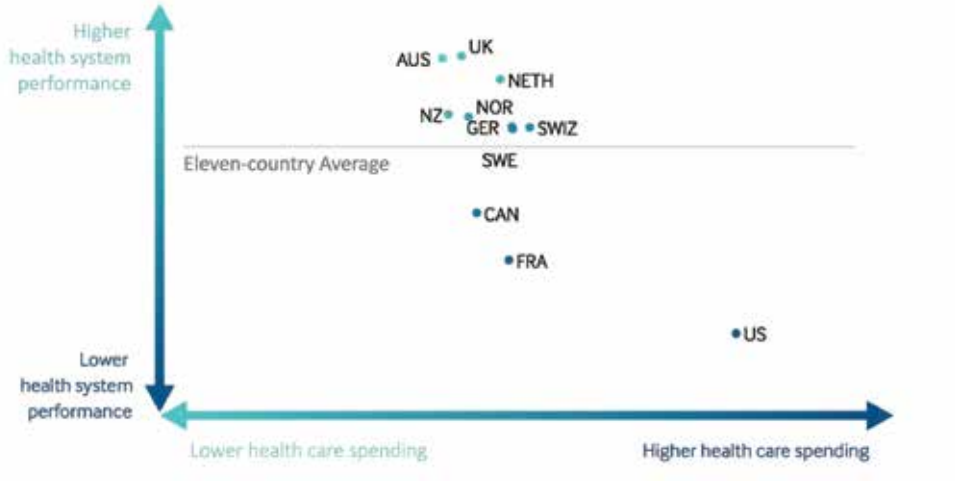
When we compare performance against cost (%GDP) a graph is generated which has Australia as almost the best outcomes, and the lowest cost, and as such the best value healthcare system in this group of 11 leading countries. See below.

Admittedly these numbers are a few years out of date, but demonstrate that we are far from being in crisis and unsustainable. I encourage you all to look at this website, and inform yourselves of the good work we are doing.

In these days of twitter democracy and fake news it's been easy for people and organisations to promulgate views which are false or misleading. Trump makes statements such as "everybody knows…" and some people believe him. Many of the decisions that were taken by the MBS Review Anaesthesia Clinical Committee (ACC) fell into this category. As an example the Chair of the ACC stated that "everybody knows people who insert arterial lines inappropriately", and the committee acted on that. The ASA lobbied to have this and other assertions reviewed and tested rather than accept fake news. Working with the Department of Health we examined the data and it turns out that while there may be some questionable instances of arterial line insertion, the number is tiny, and certainly not systematic. In fact, the data suggest that we as a speciality are placing arterial lines appropriately, and in line with the evidence of tight blood pressure control in the elderly having major surgery. A reason to insert arterial lines and support good practice.

This edition of *Australian Anaesthetist* has some interesting reading. We continue

Exhibit 5. Health Care System Performance Compared to Spending



Note: Health care spending as a percent of GDP.

Sources: Spending data are from OECD for the year 2014, and exclude spending on capital formation of health care providers; Commonwealth Fund analysis.

2018 ASA ANNUAL GENERAL MEETING

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

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

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

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the discussion on the future name of the speciality. Respected academic anaesthetist, Prof Paul Myles and our Trainee Members Group Chair Dr Richard Seglenieks give us their views on the debate. Our Speciality Affairs Advisor Dr Jim Bradley provides some interesting insights into our ongoing member survey on workforce, which is in its 3rd biennial iteration and some interesting trends appear.

Reports from our principal committees Professional Issues, Economic Advisory and Public Practice will inform you of the work completed by your Society this year.

I also take this opportunity to thank and congratulate Dr 'Harry' Harris for his work in the Thai cave rescue in July, and acknowledge his awards along with the team of Bravery awards and Orders of Australia. Well done to all concerned. His work has done much to elevate the profile of the speciality.

As I reflect on my time as President I must say it has been a constant and busy time. I would like to thank the outstanding support I have received from so many people. In particular the support from my wife Rachel, in allowing me to take on this task and supporting my too frequent absences. To the ASA HQ, CEO Mark Carmichael, and EA Sue Donovan, and Digital Marketing Coordinator Emilia Podetti, thank you so much for your guidance, advice and support. Thanks also to the ASA Board and Council for their support and patience working through an enormous series of issues – many of which are ongoing, especially Guy Christie-Taylor, and Peter Seal. I also want to thank the Lismore Anaesthetists, who have been incredibly supportive of me. They have covered my work when I have been called to meetings at the last minute, they have generously excused me from the weekend call roster for the past two years, and been very understanding of my reduced contribution to the Anaesthesia Department. Finally thank you to all the Members who have provided feedback and support to me, it's all appreciated.

I wish the new President Dr Peter Seal all the best for his time in the role.

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

Dr Richard Harris with his Medal of the Order of Australia and a Star of Courage. Photo: Sahlan Hayes, Official Photographer to the Prime Minister.

ANAESTHETIST PRESENTED WITH AUSTRALIAN BRAVERY DECORATION

Australian anaesthetist Dr Richard 'Harry' Harris was presented with a Medal of the Order of Australia and a Star of Courage, the second-highest Australian bravery decoration for "acts of conspicuous courage in circumstances of great peril".

Dr Harris, an expert cave diver, assisted an international team in the rescue of 12 young Thai boys and their soccer coach who were trapped in a flooded cave system in Thailand.

The Adelaide-based doctor conducted initial medical assessments on the boys and their coach. Dr Harris also managed sedation of the boys before they were retrieved from the cave.

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ASA UPDATE FROM THE CEO

MARK CARMICHAEL, ASA CEO

September is always an exciting time of year for the ASA. Not because it means the various football code grand finals are upon us (although that can be exciting), it means the National Scientific Congress is almost here.

The 2018 Congress in Adelaide is shaping as a wonderful event. Convenor Dr Simon Macklin, Scientific Convenor Dr Kate Drummond and the enthusiastic committee, have prepared a program which I am sure members will find both stimulating and challenging. Our invited International Speakers include Professor Joyce Wahr from Minnesota, USA, Canadian A/Professor Duminda Wijeysundera and Professor Lars Erikson from the Karolinska Institute in Stockhom, who along with our Australasian Speaker, Professor Lorimer Moseley from the University of South Australia, will no doubt set the scene for a tremendous congress.

The Kester Brown Lecture this year will be delivered by Air Vice-Marshall Dr Tracy Smart, Surgeon General of the Australian Defence Force. As Australia recognises the centenary of the end of The Great War, it is fitting that we will be welcoming to Dr Smart to our Congress.

I, along with Drs Macklin and Drummond look forward to seeing you in Adelaide from October 6-9.

External relations are most important for the ASA, and in recent months some valuable opportunities have been presented and taken.

During May ASA supported and promoted the AMA (NSW) webinar series highlighting the changes being proposed by the Private Health Insurance company Bupa. AMA (NSW) were most appreciative of our support. Thank you to all those members who took part in the webinars, I trust you found it a valuable opportunity.

The relationship with the AMA is an important one from the ASA's perspective, and opportunities to partner with them on important issues, are valued.

Two international opportunities also presented themselves. May/June saw the ASA represented at two important meetings. The first being the Common Issues Group Meeting (CIG) held in London at the AAGBI. The second, being the European Society of Anaesthesiology (ESA) meeting held in Copenhagen.

The 2018 CIG Meeting was hosted by the AAGBI and was attended by representatives of the Canadian Society, American Society, South African and New Zealand Societies along with ASA. The ASA was represented by Dr Guy Christie-Taylor Immediate Past President, President Associate Professor David M. Scott, Vice President Dr Peter Seal and myself.

While many topics were covered during the three days, the key outcomes were as follows:

- Joint statement on drug shortage to be prepared and circulated by all CIG members to their relevant authorities. USA to provide draft template.
- Anaesthetist Wellbeing members looking to share resources they produce in relation to this issue. This is particularly relevant when we consider the ASA funded resource 'Long Lives Healthy Workplace' developed by the Everymind Centre based in Newcastle.
- Controlled Drug Guidelines CAS agreed to circulate the revised Controlled Drugs Guideline as a way of promoting this issue more broadly.
- Drug Labelling remains a discussion point in all members countries and the AAGBI agreed to take the initiative to contact members re leads for this initiative
- Workforce Situation provided much discussion and members agreed to share information re workforce and trainee numbers ongoing.

Such sharing of resources and information is invaluable in helping address these issues both from the Australian and global perspective. Importantly all of this is done with the full knowledge of the World Federation, who were represented at the meeting by its CEO Mr Julian Gore Booth.

Following the CIG meeting was the European Society Meeting (ESA) in Copenhagen from June 2-4. This meeting attracted approximately 5,000 delegates from across Europe and the rest of the world. Both the President and CEO attended this meeting as ASA representatives. Vice President Dr Peter Seal, Specialty Affairs Advisor Dr Jim

Bradley along with a number of other ASA members were also in attendance.

This meeting saw the signing of a Memorandum of Understanding (MoU) between ASA, ANZCA and ESA. This concept was initially discussed at the 2016 World Congress in Hong Kong and was further developed during the 2017 ASA National Scientific Congress in Perth. With all three organisations happy with the progress of the discussions, the ESA meeting provided the perfect opportunity to sign off on the MoU.

While the MoU sets out a number of things the key considerations could be summarised as:

- Clarifying the roles and responsibilities of the organisations in the establishment of international exchange.
- The further development in scientific and educational collaboration between the organisations.
- Defines the extent of participation in each organisation's annual scientific meeting.

This is a pleasing outcome for all concerned and will ideally add significantly to the work and resources for all three organisations.

I would also like to take this opportunity to congratulate Professional Issues Chair Dr Antonio Grossi (Vic) who was recently elected to fill one of the two Council elected vacancies on the Board. Dr Grossi replaces Dr David Borshoff (WA) who stepped down from the Council when his term as the Chair of the Western Australian Committee of Management concluded.

Finally I would like to acknowledge the over 90% of members who had already renewed their ASA membership at the time of writing. I have no doubt this figure will have increased in recent weeks and I look forward to the remainder having renewed before year's end.

See you in Adelaide!

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

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LETTERS TO AUSTRALIAN ANAESTHETIST

WITH THANKS

Just wanted to acknowledge the articles on the RVG in the last issue of *Australian Anaesthetist* (June 2018).

Thank you A/Profs Dennis and Scott, Drs Deacon and Story. An excellent summary of the huge contribution by the ASA to the RVG. The range of issues that that work covers is also broad: equity, common sense and independent anaesthesia practice. That is a testament to the need for an organisation that thoughtfully approaches industrial issues for anaesthetists.

Thank you to the authors of the articles and the ASA members who contributed to the RVG and liaison with government.

Dr Vida Viliunas
Deakin, ACT

I just want to say thank you very much for the great opportunity for me to attach in Darwin, it is really a good time to attach and observe the work and learning new things from this observation. This would not have happened without ASA support and the hard work done by Dr Chris, Dr Meg and Dr Brian, and the ASA team… really appreciate it.

Thank you very much. I try my best to apply all that I am learning and I know that with your support we always can provide a safe and great anaesthesia in East Timor.

Regards

Dr Ming da Costa Herculano
Dili, East Timor

* Dr Ming da Costa Herculano spent two weeks at Royal Darwin Hospital as part of the ASA Pacific observership program. Read about her experience on page 45 of this issue.

ANAESTHETIST VS ANAESTHESIOLOGIST – WHAT'S IN A NAME?

I'm taking up your offer to voice my view on the possibility of changing the name of our speciality in Australia and New Zealand. I have taken the opportunity to discuss it with many of our peers. Most of those supporting the status quo do so on the basis of preserving the history of the speciality in the Commonwealth countries, although I note Canada has long used anesthesiologist, and my other country of nationality, Ireland, has recently voted overwhelmingly to follow the majority of their European colleagues. There is also a widespread revulsion towards the US spelling without the diphthong (an aversion I share), coupled with a fear that eventually the American spelling will win out. There is widespread emotional attachment to this aspect of the history of our speciality in Australia.

All of this I think is probably all well and good, and can be rationalised against.

I find the argument that the adoption of the 'ologist' suffix improves our standing with the public, indicates our level of education and training, and differentiates us from nurses and technicians a less compelling argument. Many of my colleagues introduce themselves as 'Dr X' for just this reason – while arguing it isn't needed! I'm a first name sort of guy, so I do actually need this even though I have just argued against it.

For me there are two main reasons why we should adopt the change. The first is it brings us into line with Europe, where practice standards are excellent and often less OTT when compared to those in the US. I have found that more and more I am adopting the ESA guidelines into my clinical practice.

However, I think the main reason is that we are facing the inevitable appearance of the nurse anaesthetist in Australian and New Zealand practice. I am aware that many will go to the barricades to prevent this. They may even be successful for a while, but in the end I suspect simple economics will defeat us. There was a session at the Copenhagen meeting on the growing role of nurse anaesthetists in Europe, unfortunately I couldn't get to it; it would have been interesting to hear their perspective. Already we have seen the introduction of nurse sedationists in many Australilan major hospitals, this is the typical Sir Humphrey Applebey 'thin end of the wedge'. They are there now and now that they are, the move to nurse anaesthetists is probably inevitable. I have heard colleagues say "well we won't train them, so there, that'll fix 'em". This is a very short-sighted view. Thirty years in the ADF has taught me that once the change wagon starts rolling you have only three choices, jump on board and steer it in a direction you at worst can live with or perhaps even prefer, stand in front of

it in the vain hope of halting it and watch it crush you, or stand aside and become irrelevant as it rolls off into the distance. Only the first option is acceptable, when change is inevitable – you must drive the change yourself! If we don't train nurse anaesthetists then the answer for those driving the change is obvious: import someone from the US or Europe to do it instead, and then we lose all control. We adopt this course at our peril.

So we need this change to buttress our position as the premier anaesthesia providers in Australia and New Zealand and to steer the change in a direction that causes us the least harm, and possibly the most benefit. Anaesthesiologist becomes the reserved name for specialist physician anaesthesia providers. It indicates to all that the anaesthesiologist is at the top of the professional tree. Anaesthetist is reserved for those GPs who still provide anaesthesia, particularly in rural areas, and nurse anaesthetist is reserved for our nursing colleagues who will in my view inevitably join us at some stage (be it either in years or in decades) in the future as anaesthesia providers. There may be some who are so wedded to the name anaesthetist that they perhaps should be offered a compromise. Grandfather the term, allow them to keep it and allow those of us who wish to to effect the change for ourselves to do so, and have it mandatory for all new graduates of the training programme from a set date. And the spelling is set in stone.

In closing I've actually been running a little trial of my own in public acceptance. I've been labelling myself as an anaesthesiologist since the change was mooted. I have had no adverse comment from patients or nursing colleagues whatsoever. Patients appear entirely comfortable with the name, and they appear to have a clear understanding that it indicates a professional physician anaesthesia provider (which actually supports the argument I dissed earlier, although I still think it is less critical an argument than my main one). One or two have even said "oh so you are a doctor", even when I have introduced myself by first name. All my emails over that time (and going forward) have the anaesthesiologist moniker in my signature block. Again I have had absolutely no adverse comment whatsoever. A few of the surgeons I work with regularly have also adopted it seeing me use it, with only one aghast at the term (a very conservative older surgeon who sees it as 'American' and therefore somewhat distasteful).

The time has come. The time is now. We need to make this change, and grab the wheel of the change bus and take charge of it.

Jackson Harding
Bendigo, Victoria

HAVE YOUR SAY

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

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

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

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WEBAIRS NEWS

ANTI-REFLUX VALVE FAILURE

An alert in the June ANZCA e-News informed of a V-set malfunction involving the cracking of an anti-reflux valve and subsequent leakage of intravenous infusions. The webAIRS incident report detailed a propofol infusion running into a Go Medical Industries V-set via a faulty white anti-reflux valve resulting in reduced delivery during a TIVA infusion.

Following the e-News article, an analysis of the webAIRS database was undertaken to identify similar cases. A total of nine reports detailed a problem with a V-set or anti-reflux valve. Seven webAIRS reports were suitable for analysis; a further notification was received via email and included.

A cracked anti-reflux valve.

V-sets are a variant of a multiway connection devices where two, three, or more lumens converge to one large bore connector with minimal common space.

It is not clear whether the problems encountered are unique to one brand of device or a problem with V-sets in general. The table below summarises the malfunctions reported:

These problems may arise due to a variety of reasons: insufficient tightening, device damage through forceful connection, debris related line blockages, kinking or, ultimately, faulty device. The ANZTADC Medical Director has contacted Go Medical who report they are aware of the potential for cracks to develop in the anti-reflux valve. In response, Go Medical informed that rates of reported product fault are fairly low. "We have reviewed our customer complaint log and found that there are 1 or 2 complaints each year for the white valve, representing approximately 0.001% (2/200,000) of the V-sets distributed per year." There are 3

	Incident	Device
1.	Proven air embolus with possible entrainment of air from an injection port, burette or V-Set	Go Medical
2.	Spontaneous disconnection of Remifentanil infusion	Go Medical
3.	The anti-reflux valve attached to a V-set leaked when a pressure infuser was used but not during normal use	Go Medical
4.	The anti-reflux valve (white connector) of device cracked and leaked after connection of an extension line to the valve for a vasopressor infusion	Go Medical
5.	Propofol refluxed into the intravenous infusion bag as there was no anti-reflux valve connected	–
6.	A cracked anti-reflux valve led to the leak of propofol infusion	Go Medical
7.	Two cases described on one webAIRS report: • Remifentanil infusion alarmed due to high pressure. The small bore connector of the V-set had become blocked and could not be flushed with saline • Leak of propofol from a cracked anti-reflux valve on the V-Set	Go Medical
8.	A cracked anti-reflux valve led to the leak of propofol infusion	Go Medical, Model V3 3V R

valves per V-set and therefore the rate of cracked valves is 0.00033% (2/600,000). The Models that have cracked have the product code V3 3V R, however an alternate model V3 GISS R, has not been reported to crack in this way. Go Medical have investigated the ability of the anti-reflux valve to expand and development of prototypes with a greater capacity to expand are underway.

The analysis of these incidents provides some important learning points. Firstly, V-set devices do have a failure rate due to cracking, disconnection or blockage potentially leading to under dosage of infused drug. This, in turn, might bring about a risk of various incidents including awareness, hypotension or severe cardiovascular event. In order to immediately manage these risks, anaesthetists should consider a routine cross check of connections before surgery commences. While Go Medical works on a permanent solution they also encourage anaesthetists to contact them directly with any issues (info@gomedical.com.au).

Please continue to report any similar cases to webAIRS so that ANZTADC can continue to contribute to the improvement of safety and quality in anaesthesia.

A V-Set Device.

For more information, please contact:

Adjunct Professor Martin Culwick, Medical Director, ANZTADC

Email: mculwick@bigpond.net.au

Administration support: anztadc@anzca.edu.au

To register, visit www.anztadc.net and click the registration link on the top right-hand side.

A demo can be viewed at: http://www.anztadc.net/Demo/IncidentTabbed.aspx.

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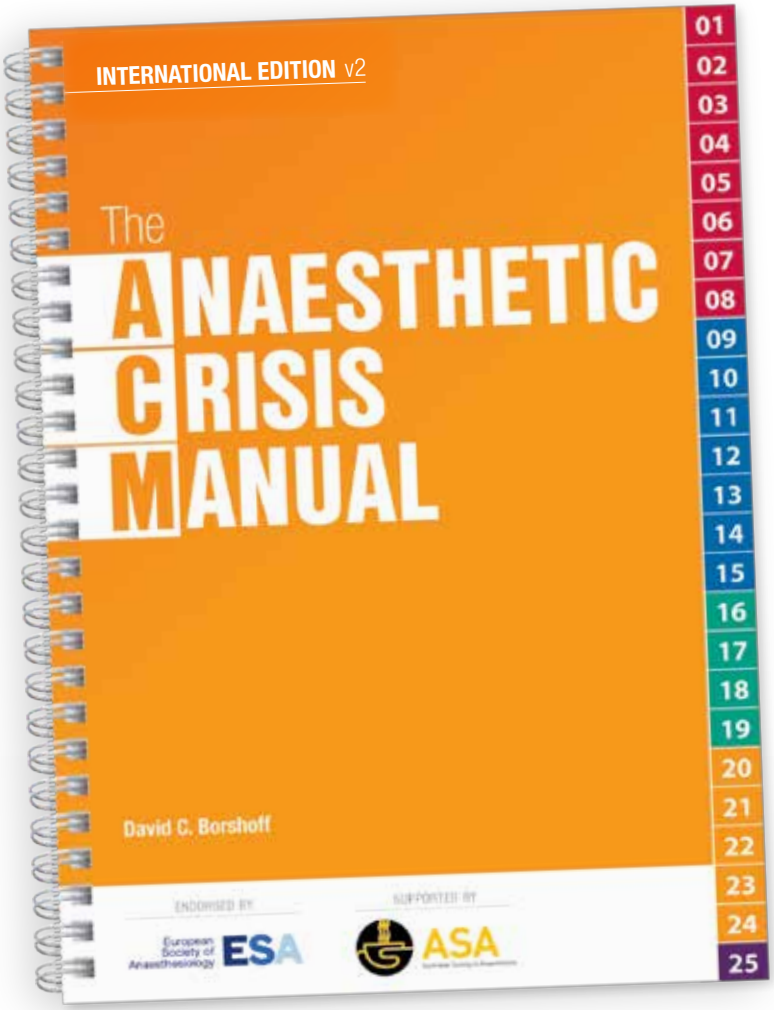

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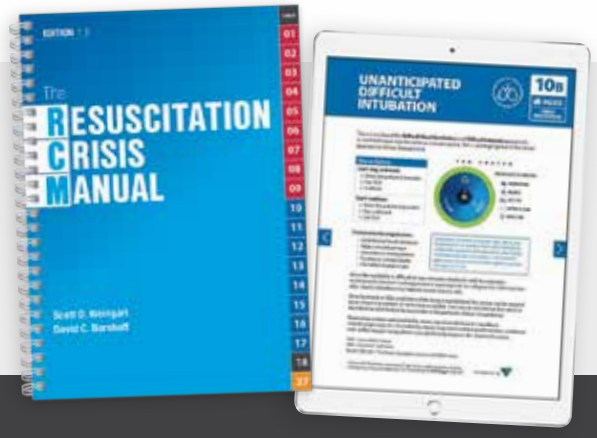

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NEWS

ASA PARTNERS WITH ESA AND ANZCA

Front row, l to r: Dr Stefan De Hert, President of the European Society, Immediate Past President of ANZCA Professor David A. Scott, President of the ASA Associate Professor David M. Scott and Vice-President of the European Society Dr Zeev Goldik.
Back row, l to r: Nicole Phillips, Stephen Ma, Ann De Groot, Chris Cokis, CEO of the ASA Mark Carmichael and Executive Manager of the ESA Marc Gheeraert.

The recent European Society of Anaesthesiology Meeting held in Copenhagen, was a resounding success on many levels.

From the ASA's perspective it provided the backdrop for the signing of a momentous Memorandum of Understanding (MoU) between the ASA, our colleagues from the ANZCA and the ESA. The MoU brings to fruition a dialogue that began at the World Congress in Hong Kong in 2016.

Encapsulated in the MoU is the agreement to establish an international linkage program between the three organisations to develop cultural understanding, international cooperation and the exchange of scientific progress in the field of anaesthesiology.

The ASA, ANZCA and ESA have agreed to develop and support the scientific exchange between its members and support joint programs such as, the co-operative development of quality and safety guidelines joint clinical research, presentation of joint scientific papers and statements and invitations to agreed educational events.

ASA President Associate Professor David M. Scott commented that this MoU signifies a strengthening of relations between all three bodies and confirms the importance of international engagement across the specialty.

With the final document being agreed to at the end of 2017 the signatories were current ASA President Associate Professor David M. Scott, and the Immediate Past Presidents of both ANZCA Professor David A. Scott and the European Society Dr Zeev Goldik and Dr Stefan De Hert, President of the European Society.

Mark Carmichael

ANZCA | ASA | NZSA

#CommSIG18

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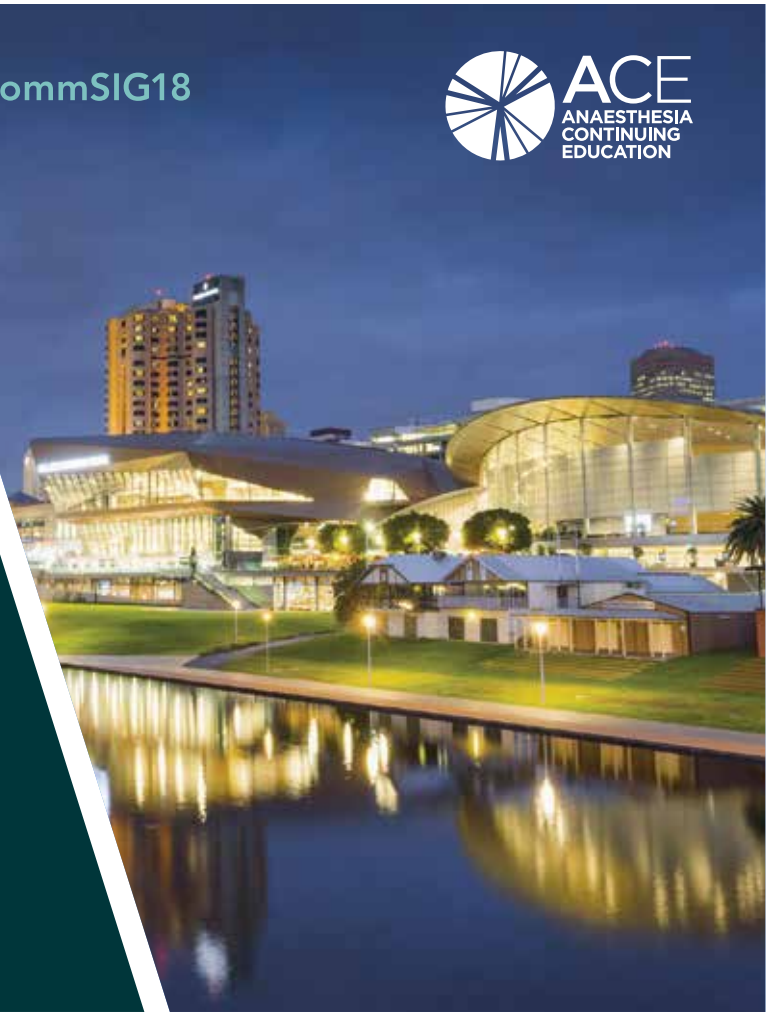

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NEWS

DR DAVID FENWICK'S PRESENTATION TO AMA SA
3 MAY 2018

On 3rd May 2018, at the AMA (SA) Annual General Meeting, the Chairman of the AMA (SA)'s Historical Committee, Dr David Fenwick, presented a bronze sculpture 'The Doctor', pictured, as a gesture of gratitude and appreciation of the Association's guidance and support during his career in South Australia.

Over the past 10 years, he has presented seven other sculptures to the ASA, ANZCA, the Royal Adelaide Hospital (RAH) and the University of Adelaide Medical School.

David was born and educated in South Africa and after graduation from the University of the Witwatersrand, Medical School in 1967, he was conscripted by the South African Army as a military medical officer for 10 years. He commenced training in anaesthesia in 1970 and passed his primary examination in 1971. Because of the apartheid situation and army politics he emigrated to South Australia in 1972 and completed his FFARACS in Adelaide, where, subsequently, he was a consultant and VMO at the RAH, Flinders Medical Centre and leading private hospitals until 2007 when he retired from clinical practice.

Over some 40 years David has been a most active contributor to training and examination of registrars, ambulance officers, and medical students, and an advisor to many private hospitals in SA. He was convenor of the ASA's NSC in Adelaide in 2002, and a recipient of the ASA President's medal, among many other honours. In retirement, he remains an active member of the Retired Anaesthetists' Group, medical history and heritage groups in SA, and enjoys his hobbies of sculpting and boat building.

Dr David Fenwick, and the AMA (SA) President, A/Prof. William Tam with the presented sculpture.

'The Doctor' embodies the ethos of the AMA in the confident, well-stanced figure, in academic dress and surrounded by books indicating that his ongoing learning and knowledge has been subjected to peer-review and found to be acceptable. His right foot is on a sea chest to remind us of the origins of early doctors in South Australia. The open book in his right hand cites the AMA motto on the right page: *Pro genere humano concordes*; whilst the left page bears the Hippocratic dictum: *Primum non nocere*. The Pinard fetal stethoscope indicates the importance of obstetric ability in the early doctors, and the spine of the upright book cites Ethics. The book on end has a set of scales denoting the advocacy role of the AMA for doctors and their patients.

Further details of this and all David's sculptures are available on request.

Dr John A. Crowhurst
Chairman,
History of Anaesthesia SIG

FEATURE

TRAINEE PERSPECTIVE: WILL WE BE ANAESTHESIOLOGISTS?

Many trainees seem to have little interest in the current debate surrounding the future name of our profession. I find this surprising, given that most of us are likely to work with the title for longer than currently established specialists.

Perhaps this lack of interest stems from a lack of exposure and engagement of trainees in the discussion, from a limited understanding of the reasons for and against renaming and its potential impacts, or from genuine apathy towards the matter. I hope not the latter. This article aims to present some of the arguments and, in doing so, clarify why this issue may be more important than it first seems.

Of note, this isn't the first time this topic has raised its head. If you're keen to read more about the history of this discussion in Australia and New Zealand, an interesting overview was published in the March 2018 issue of *Australian Anaesthetist* by the then presidents of ANZCA, ASA and NZSA[1].

ETYMOLOGY & PERIOPERATIVE MEDICINE

The etymological arguments are reasonably straightforward. Most of you will remember that anaesthesia is derived from the Ancient Greek *an* (without) and *aísthēsis* (sensation). What you may not realise is that the term wasn't used in its modern context until 1846, when Oliver Wendell Holmes Sr wrote the following in a letter to dentist William T.G. Morton:

"Everybody wants to have a hand in a great discovery. All I will do is to give you a hint or two as to names, or the name, to be applied to the state produced and the agent. The state should, I think, be called 'anæsthesia.' This signifies insensibility—more particularly... to objects of touch. The adjective will be 'anæsthetic'[2]."

Labelling as an -ology is consistent with many other medical specialties – radiologists, cardiologists, urologists…

Prior to this, the word had been used to describe pathological (rather than drug-induced) loss of sensation, such as that associated with a nerve palsy[3].

The current debate revolves around the most appropriate suffix to attach to the end of anaesthesia in order to best label ourselves as medical practitioners specialising in anaesthesia. To highlight the academic nature of our discipline, it has been argued that we should adopt a suffix derived from the Ancient Greek *logía*, denoting the study of something, in place of ist, indicating 'one who does or makes'. An -ology can be considered a "discipline based on scientific rigour and research"[1] – features that are important to highlight in anaesthesia, though we're certainly also a practical specialty with a focus on doing.

Anaesthesiology has been defined to include the science and practice of anaesthesia, along with pain medicine, perioperative medicine, resuscitation and intensive care medicine.

Labelling as an -ology is consistent with many other medical specialties – radiologists, cardiologists, urologists, etc – but is far from a universal naming system. Many specialties deviate from this convention, such as general practitioners, emergency physicians and obstetricians[4]. Consistency with other specialties is thus not a convincing argument.

Some claim that becoming -ologists will reinforce our roles beyond the technical provision of anaesthesia in the operating theatre. Anaesthesiology has been defined to include the science and practice of anaesthesia, along with pain medicine, perioperative medicine, resuscitation and intensive care medicine[5]. Particularly, our increasing involvement in perioperative medicine has been highlighted as favouring a change to anaesthesiologists. It's not entirely clear that this is something inherent in the name that could not be encompassed in the term anaesthetist – as I would suggest it already is. It would, however, be advantageous for a name change to coincide with a transition in scope of practice. This would facilitate simultaneous negotiations with government and other stakeholders on both the model of care for perioperative medicine and our name, which could be closely linked.

Given that the work of anaesthetists already involves far more than merely rendering patients sensationless, we probably shouldn't place too much emphasis on etymology alone.

On the other hand, it's reasonable to question whether such a change would actually alter public perceptions. It's far from universal that -ologists are the most educated or expert in a given field. The difference between astronomers and astrologists is understood because the terms are well-established and understood, not due to any conscious etymological considerations. The same applies to psychiatrists and psychologists, pharmacists and pharmacologists, scientists and scientologists. Scientists are considered educated academics despite being identified as physicists, chemists, biologists, and so forth.

Given that the work of anaesthetists already involves far more than merely rendering patients sensationless, we probably shouldn't place too much emphasis on etymology alone. I think it's overly hopeful to believe that any significant proportion of the general population would realise the difference in meaning between these suffixes. Especially in younger generations as classical languages are rarely taught today.

CONSISTENCY

Internationally, anaesthesiologist (or anesthesiologist) is the most widely used term denoting doctors specialising in anaesthesia. Becoming anaesthesiologists would bring us into line with naming conventions across most of the international anaesthesia community (even if the spelling of anes/anaesthesiologist can't be agreed on). The European Society of Anaesthesiology (ESA) and World Federation of Societies of Anaesthesiologists (WFSA) use the term, along with most of the WFSA member societies – including the USA, China, Russia, India, Malaysia and South Africa.

With the College of Anaesthetists of Ireland recently voting 58.1% to 41.95% in favour of rebranding as anaesthesiologists[6], only Australia, New Zealand and Great Britain continue to use the term anaesthetist for medically-trained anaesthesia specialists. This same discussion is occurring in Great Britain and it may not be long before anaesthesiologist is the universally accepted term – possibly with Australia and New Zealand remaining the only exceptions.

…only Australia, New Zealand and Great Britain continue to use the term anaesthetist for medically-trained anaesthesia specialists.

Even within Australia and New Zealand, anaesthesiology is not a completely foreign word. A number of departments, disciplines and groups use the term. For example, the Department of Anaesthesiology at the University of Auckland[7]; the Discipline of Anaesthesiology and Critical Care at the University of Queensland[8]; and the Pharmacology, Pharmacy and Anaesthesiology Unit at the University of Western Australia[9]. The Queen's Birthday Honours List also tends to refer to recipients who are specialist anaesthetists as anaesthesiologists[10].

DIFFERENTIATION

One of the strongest arguments in favour of changing our name is to differentiate ourselves from anaesthetic

FEATURE

practitioners who are not specialist anaesthetists (e.g. GP anaesthetists) or not doctors (e.g. nurse anaesthetists). Many areas of the world rely heavily on anaesthetic technicians and nurses to provide anaesthesia services. In those areas, the standard nomenclature is 'anaesthesiologist' for physician anaesthesia providers and 'anaesthetist' for non-physician anaesthesia providers.

One of the strongest arguments in favour of changing our name is to differentiate ourselves from anaesthetic practitioners who are not specialists…

The WFSA, representing anaesthesia societies from more than 150 countries, issued a position statement last year, including the following statement: "An anaesthesiologist is a qualified physician who has completed a nationally recognized specialist training programme in anaesthesiology. In some countries, the term anaesthetist is used instead of anaesthesiologist[5]."

Anaesthesiologist is thus a clearly-defined term that specifically describes medical doctors with specialist training. In the modern globalised world, there is clearly a great potential for confusion when only a few countries use different terminology.

While it may seem that this is only relevant in the developing world, many advanced countries utilise anaesthesia providers without medical degrees. Certified Registered Nurse Anesthetists (CRNAs) are widespread in the US, with more than 50,000 practitioners providing approximately 43 million episodes of anaesthesia every year – without physician supervision in 17 states[11]. In the UK, Physicians' Assistants (Anaesthesia) have been working under the direction and supervision of anaesthetists since 2004, providing general and regional anaesthesia, sedation and non-theatre work (preoperative assessment, cardiac arrest teams, etc.)[12].

Given these trends, it's entirely possible that non-medical anaesthesia providers could occupy a growing space in Australia and New Zealand. While it may be premature to use this potential future as justification for change, the existence of such groups internationally provides a strong impetus. As Dr Paul Clyburn, President of the Association of Anaesthetists of Great Britain and Ireland, observed: "If I were to call myself an anaesthetist in the US, people would think that I am a nurse anaesthetist[13]."

Closely related to this point is the fact that many Australians are not aware that anaesthetists are doctors. For example, a 2013 ANZCA survey found that only 50% of the community thought that all anaesthetists were doctors[1]. This isn't a matter of proud self-importance; it's central to patient safety. If people understand that anaesthesia is provided by doctors then perhaps they will be more aware of the training required for safe anaesthesia and be less willing to undergo risky procedures without a properly trained anaesthetist, as in the case of Jean Huang who died last year after receiving local anaesthesia and intravenous tramadol from an unqualified individual[14].

TRADITION

I suspect the role of tradition and familiarity play a larger role in this debate than many are willing to accept. Anaesthetist is a familiar term, which many of us strongly associate with ourselves and our work. We are trainee anaesthetists. Anaesthesiologist has always been a foreign word applied to others – not to us. We are naturally inclined to stick with what we know.

One of the most frequent questions I hear when this issue is brought up is: "why would we want to be more like America?" I understand the sentiment behind this view. I felt the same way when I first heard this discussed. Most of my exposure to the word anaesthesiologist had been through popular media and I assumed it was just an Americanisation of the traditional term anaesthetist. This is hardly accurate, though, given the near-universal usage of the word – it's a global term. *The* global term.

COST

Last, but not least, is perhaps the simplest question – why bother? Is it really worth it?

Changing our name would be associated with considerable costs, in terms of money, time and effort. Professional documents would need to be altered, official materials redesigned, company registrations updated. Individual anaesthetists may need to adjust online profiles, résumés, business cards, and so on. A slight mitigating factor is that all relevant acronyms – ANZCA, FANZCA, ASA, NZSA, etc. – would not require modification.

There is also the risk that changing our name would divide the specialty and create animosity about what is seen by some as a trivial and unnecessary move.

A publicity campaign would be necessary to fully realise the goals of the name change in a reasonable timeframe. Significant resources would be required to enact these changes and it would be necessary to determine the cost-effectiveness, as well as the risk of negative media and reactions.

There is also the risk that changing our name would divide the specialty and create animosity about what is seen by some as a trivial and unnecessary move. In order to limit this possibility, involved organisations are seeking to engage all anaesthetists and trainees to arrive at a consensus opinion. Respecting both sides of the debate is vital. Everyone wants what is best for our profession, our patients and the community – all that differs are our views on what is best.

While our name is important, there are clearly other significant issues facing our specialty. Nobody wants this discussion to take our focus away from the other important matters – but we can multitask. The argument that we should not even be discussing changing our name because there are more important matters is weak. We have always discussed and worked on multiple issues simultaneously.

CONCLUSIONS

Ultimately, I think this is a timely opportunity to have this debate. Our College and Societies are keenly interested in expanding our role in perioperative care, our ties with international organisations are continuing to grow, and other similar nations have been going through the very same discussions and debates. We are yet to experience the proliferation of nurses or technicians providing anaesthesia seen overseas – which may well occur locally and which we would be wise to pre-empt.

As trainees, we have as much invested in this as anyone else. This is our future and it will affect us.

While I support changing our name, I don't necessarily want to persuade you to agree with me. I do, however, want to convince you to engage with the discussion, to carefully consider the arguments and your own preconceptions, and to reach a reasoned position. As trainees, we have as much invested in this as anyone else. This is our future and it will affect us. I hope you take the time to think about it, discuss it with your consultants and fellow trainees, and decide where you stand and why.

Dr Richard Seglenieks
Chair, Trainee Members Group

References

1. Scott DA, Scott DM, Kibblewhite D. Should we stay 'anaesthetists' or could we become 'anaesthesiologists'? *Australian Anaesthetist*. 2018 March, pp. 10-13.
2. Hart E (Ed.). The British Medical Journal – Epitome of Current Medical Literature (Vol. II). British Medical Association. 1896, p. 1140.
3. Miller A. The Origin of the Word "Anaesthesia". Anesthesia & Analgesia. 1928; 7(4):240-247.
4. Medical Board of Australia. Lists of specialties, fields of specialty practice and related specialist titles. 2018 June.
5. Mets B. WFSA Position Statement on Anaesthesiology and Universal Health Coverage Adopted by Extraordinary Resolution. 2017 September.
6. College of Anaesthetists of Ireland. Report of ballot on terminology change proposal. May 2018.
7. The University of Auckland. Department of Anaesthesiology. https://www.fmhs.auckland.ac.nz/en/som/about/our-departments/anaesthesiology.html
8. The University of Queensland. Discipline of Anaesthesiology and Critical Care. https://medicine-program.uq.edu.au/academic-disciplines/anaesthesiology-and-critical-care
9. The University of Western Australia. Pharmacology, Pharmacy and Anaesthesiology Unit. http://www.medpharm.uwa.edu.au/home/pharmacology
10. Governor-General of the Commonwealth of Australia. The Queen's Birthday 2018 Honours List. https://www.gg.gov.au/queens-birthday-2018-honours-list
11. American Association of Nurse Anesthetists. Certified Registered Nurse Anesthetists Fact Sheet. https://www.aana.com/membership/become-a-crna/crna-fact-sheet
12. Royal College of Anaesthetists. Physicians' Assistant (Anaesthesia). https://www.rcoa.ac.uk/anaesthesia-related-professionals/physicians-assistant-anaesthesia
13. Clyburn P. AAGBI President's Blog. 2018 April. https://aagbipresidentsblog.wordpress.com/2018/04/25/april-2018/
14. ABC News. Beauty clinic manager Jean Huang conscious during her fatal surgery before likely overdose, court told. http://www.abc.net.au/news/2017-10-26/womans-death-in-botched-boob-job-was-likely-due-to-overdose/9089726

In the next edition of *Australian Anaesthetist* we will feature articles focussing on why we should remain as anaesthetists.

FEATURE

ANAESTHETIST OR ANAESTHESIOLOGIST?

Progress is impossible without change, and those who cannot change their minds cannot change anything.

George Bernard Shaw

I am proud of my specialty and I am proud of its history. "Anaesthesia", derived from the Greek, is believed to have first been coined in the early 18th century[1]. That is, before Morton's demonstration and Holmes proclamation several decades later[2]. 'Anesthesiology' came later still, a new term adopted by the University of Illinois in 1912, as "the science that treats of the means and methods of producing in man or animal various degrees of insensibility with or without hypnosis"[3]. All of you will know that anesthesiologist is the term used for the medical specialists of our craft in the US, and nurse anesthetists and anesthetic assistants are the alternative anaesthesia providers. But 'anaesthesiology' is used throughout all of Europe, in Canada, Hong Kong, Uganda, India, South Africa, and most recently in Ireland. The list goes on. The World Federation of Societies of An[a]esthesiologists (WFSA) have used this name for more than 60 years.

"Anaesthesia", derived from the Greek, is believed to have first been coined in the early 18th century.

I, for one, haven't cared too much about how other countries describe our specialty. If anything, perhaps because of my university education here in Australia (a product of our colonial history), or the various specialty Colleges that oversee medical specialist training and fellowship (a product of our colonial history), I have had an aversion to our specialty being referred to as 'anesthesiology' and me as an 'anesthesiologist'. I am a victim of my upbringing and my pride. I am stubborn and have, until now, held onto the word 'anaesthesia' and my specialist title as an 'anaesthetist'. But now I've changed my mind.

So why should you change your mind? Does this make you indecisive or careless; less certain? Or are you simply adapting to changing circumstances, being more self-aware?

Our specialty is changing just as the world is changing. The broader scope of our practice, from its origins in the operating rooms around the world and including the development of recovery rooms and intensive care units, to now include pain medicine, retrieval and

prehospital medicine, patient safety, military medicine, global health, and the golden era of perioperative medicine. Medicine, medicine, medicine. Education, training, research, extensive areas of clinical practice, and healthcare policy. 'Anaesthesia' and 'anaesthetist' don't really cut it anymore.

Embracing the new name of 'anaesthesiology' offers an opportunity to enhance and promote all that we now do. The full spectrum of our specialty. Embracing changing times. It is not just a name change and it shouldn't be restricted to this alone. There is an opportunity for all of us – trainees and specialists, members of the Society and the College, young and old – to celebrate our true value. The modern face of our specialty, of anaesthesiology.

Embracing the new name of 'anaesthesiology' offers an opportunity to enhance and promote all that we now do.

'Anaesthesiology' and 'anaesthesiologist' more accurately describes my practice and what I do. It is more comprehensive and emphasises the study of anaesthesia; the science underpinning our specialty. It communicates exactly what we do and what type of doctors we are. It reinforces our professional and academic status. A name change harmonises ourselves with nearly every other part of the world, and helps the WFSA achieve its goal of universal access to safe anaesthesia by bringing all of us together with the same title globally.

'Anaesthesiology' and 'anaesthesiologist' more accurately describes my practice and what I do. It is more comprehensive and emphasises the study of anaesthesia; the science underpinning our specialty.

In May this year I sat in the audience at the ANZCA combined scientific meeting in Sydney, as leaders of our specialty debated the pros and cons of a name change. I went into the session with a firm view that we did not need to change our name, that I was proud to be an anaesthetist. But a penny dropped and I simply began to question why I had such a view. Several weeks later, at the official dinner of the annual scientific meeting of the College of Anaesthetists in Ireland, held in the wonderful Dublin Castle, I listened as the College President, Kevin Carson, announced the results of a ballot of all fellows of their College. By a majority of more than 60%, the fellows voted for a change in name of their College to the College of Anaesthesiologists of Ireland. There was pride in the room. I celebrated their bravery and open-mindedness.

I fully support a change of name of our specialty. I am an anaesthesiologist. I practice anaesthesiology.

Professor Paul Myles
Alfred Hospital and Monash University
Melbourne

References

1. Miller AH. The origin of the word anaesthesia. Boston Med Surg J (now N Engl J Med) 1927; 197:1218-22.
2. Kavanagh MF. The origin of the word "anesthesia". Cal West Med 1928; 29:10-12.
3. https://www.etymonline.com/word/anesthesiology; accessed 25th June, 2018.

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FEATURE

ASA STRATEGY 2018-2020

Through extensive consultation and engagement the ASA has revised the 2018-2020 strategic plan and the final draft is presented in this edition of *Australian Anaesthetist*.

PROCESS

ASA council and it's committees were invited to consider strategic issues and challenges towards the end of 2017. At the PIAC face-to-face meeting considerable time was allocated to considering how the ASA could add value to the membership in an authentic, unique and distinctive sustainable fashion. Hypothetical scenarios were employed to flesh out what really matters. Through their Chairs, the committees, the board and the rest of council came together for a strategy workshop in March, 2018. In preparation for this meeting councillors reviewed several interactive documents including an online survey. These results were collated and considered during deliberations.

The strategic position, options, risk and implementation were considered to develop the revised strategic priorities, strategies and key outcomes. The Chair of PIAC, Antonio Grossi and ASA CEO Mark Carmichael summarised these results to produce the final draft strategic document.

Building on the existing strategic framework, council began proceedings by reviewing the past 12 months and considering what had been achieved, what had been done well and why, and what could have been improved? This was a robust process that permitted a wide range of discussion, interviews, role-play, focus groups 'workshopping' and testing of theories from a diverse group that constitutes the current ASA leadership. Through thoughtful reflection, face-to-face interaction, logical argument, listening to feedback from grassroots membership sources and staff, collaboration and mediation, federal ASA council was able to arrive at a genuine consensus position.

VISION – RAISON D'ETRE

Support, represent, and educate our members and enable the provision of the safest and best anaesthesia, perioperative medicine and pain medicine to the community.

The vision of an organisation reflects it's 'sacred core' that should always be preserved[1]. The ASA core ideology, core values and core purpose is reflected in the vision that reflects what the ASA stands for and why it exists. Reflecting on Dr Daly's (1947) ASA presidential address[2], he spoke of:

a) collegiality;

b) the responsibility of anaesthetists to the broader community (including through a contribution to national service);

c) remembering and honouring our history;

d) reflecting on developments in anaesthesia (new drugs, techniques,

advances in preoperative and perioperative care);

e) promoting patient safety;

f) providing value for the ASA membership;

g) considerations for entry into anaesthesia with ongoing teaching and the maintenance of standards and industrial conditions including remuneration.

This constitutes core ASA business as relevant today as ever.

MISSION

To enable medical practitioners in the specialty of anaesthesia, perioperative medicine and pain medicine to achieve best practice in the following:

- *Safe, high quality patient care for all.*
- *Engagement in planning and delivering health care services.*
- *Compliance with professional obligations.*
- *Continuing Medical Education, research and publications.*
- *Personal health and welfare.*
- *Leading advocacy on economic, industrial and workplace issues.*
- *Philanthropic service and contribution to the developing world.*
- *Preservation of the history of the specialty.*

The ASA mission was considered fit for purpose. Provision of patient care in relation to anaesthesia includes multidisciplinary perioperative medicine and pain medicine as determined by one's scope of practice.

STRATEGIC PRIORITIES

1. Member Advocacy

Promote the needs of the specialty in both the public and private sector to government and other appropriate authorities.

The ASA exists to support all members. This includes those who work in public, private or both sectors. At times there may be issues that are more context specific than others, yet the need to provide quality patient centric anaesthesia care to the whole community, transcends all sectors. This includes providing the best care possible to regional, rural, indigenous and disadvantaged communities.

The ASA mission was considered fit for purpose. Provision of patient care in relation to anaesthesia includes multidisciplinary perioperative medicine and pain medicine as determined by one's scope of practice.

Given cyclical fiscal financial pressures, historically there has often been a tendency for erosion of working conditions for anaesthetists which compromises the quality and safety of patient care. Without the ASA representing anaesthetists' interest in patient safety to government, statutory and regulatory authorities, third party payers and other organisations, there would be regression to mediocrity. This requires constant vigilance by the committees supported by the team at ASA headquarters in preparing submissions, position papers, engaging stakeholders, attending meetings and collaborating with partners to increase the awareness and the anaesthetist's role in maintaining patient safety.

Supporting the wellbeing of anaesthetists has been a priority for the ASA since it's inception. Issues of job security, job satisfaction, role ambiguity, work life balance, professional autonomy, working in a healthy, happy safe environment free of bullying, harassment and discrimination are reasonable aspirations for any anaesthetist and the ASA continues to advocate for this.

2. Member Education

Provide a broad range of high quality educational services, resources and opportunities for members.

Since the formation of the ASA, providing the highest quality meetings, events, workshops and access to accredited teaching has been a focus of the society. In 1948 Dr Orton[3] described that it is only through high quality education and training that the surgeon-anaesthetist relationship would evolve from a master-servant relationship to a mature situation reflected by mutual respectful specialist recognition. In 1967, Dr Patricia Mackay[4] stressed the importance of developing academic anaesthesiology in it's own right. Today the ASA provides a number of educational opportunities including a world class National Scientific Congress, many other satellite and local meetings, access to websites and information services, production of the *Anaesthesia and Intensive Care* journal facilitating publication of much local research and a Continuing Professional Management System. The ASA further supports research through funding for awards and presentation of papers. Educating members is core ASA business.

The ASA values, recognises and supports the history of anaesthesia and the society through a number of endeavours.

3. Professional and Economic Issues

Actively address the professional and economic issues for anaesthetists in public and private practice across Australia.

Through the sufficiently resourced committees supported by the federal staff, the ASA provides peace of mind to members so they may care for their patients without being distracted by industrial and financial considerations. The production of the Relative Value Guide and the current advocacy surrounding the MBS review into anaesthesia is a clear example of the meaningful work the ASA does. Formulating considered opinions on matters, collating members' feedback through surveys, engaging

FEATURE

with Government and other bodies and developing tools such as patient information and informed financial agreement platforms, assists members promote and deliver safe anaesthesia.

Dr James Bradley's[5] oration (2004), discusses professionalism in some detail. Conceptually there is some public expectation that anaesthetists will remain up to date and fit to practice in terms of knowledge, competence, care and compassion. Patient's autonomy, privacy and vulnerabilities will be respected. There may also be an expectation of altruism or at the minimum a custodianship of the limited healthcare resources and maintenance of sustainability. With increased scrutiny, anaesthetists' integrity has recently been questioned. Perhaps some rogue practitioners have even violated this social trust? The profession's own autonomy, self-regulation, financial independence and credentialing are being challenged. The ASA believes this is worth fighting. As Maxwell[6] (1984), and others have stated, maintaining the anaesthetist-patient relationship, particularly through the preoperative and post-operative visits are key ways to maintain professionalism.

4. International and Community Service

Actively support services in the provision of indigenous and overseas development and education.

The ASA has a long tradition of supporting social justice initiatives both at home and abroad to promote equity and access to safe, effective, timely anaesthesia. This includes support for the Overseas Development and Educational Committee and initiatives such as 'Lifebox'.

Recognition of the commitment to local care providers to optimise the care of their communities is context specific, profound and integral to fulfilling the anaesthetist's professional social contract to address inequity. In the context of Indigenous Australians McKenna[7] describes listening to stories in the spirit of Makarrata – "healing and coming together after a struggle".

5. Governance

Ensure the Society is governed in such a manner that it complies with all statutory obligations while serving the interests of members.

Successive ASA presidents and their boards have worked diligently to arrive at a modern, functional, transparent constitution that promotes participation, diversity, gender equity and fairness. Any member is encouraged and supported to participate and contribute to this open, collegiate and professional member based society.

The ASA has a long tradition of supporting social justice initiatives both at home and abroad to promote equity and access to safe, effective, timely anaesthesia. This includes support for the Overseas Development and Educational Committee and initiatives such as 'Lifebox'.

The Society complies with relevant legislative requirements and utilises the members' resources in a responsible and sustainable manner that considers the financial, environmental and community implications.

WHERE TO FROM HERE

The culture of the ASA may be described as; a) purposeful (reflected by idealism, altruism, compassion and a focus on sustainability and global communities); b) caring (reflected by a collegiate atmosphere and building trustful relationships with stakeholders); c) ordered (reflected by a structured environment and modus operandi based an the ASA constitution; and d) focussed on safety (reflected by planning, caution, preparedness and risk mitigation)[8].

Inclusiveness and transparency determine how daily business is conducted. The strength of this strategic document lies in the engagement and consultation process. This process has purposefully not been rushed. The broader membership will have a further opportunity to study the details here and provide additional feedback. Council will consider this feedback at the October, 2018 meeting before ratifying the final document. Why is this important? The ASA operations and measures of success over the next two years will be determined by this document. Please ensure you read it thoroughly and provide your feedback. This is your Society. It relies on member input to be successful.

Antonio Grossi
Chair
Professional Issues Advisory Committee

References

1. Collins CJC, Porras JI. Building your company's vision. *Harvard Business Review*. September, 1996.
2. Daly HJ. (1947), ASA Presidential Address: Available at ASA website.
3. Orton RH. (1948), ASA Presidential Address: Available at ASA website.
4. Mackay P, OAM. (1967), ASA Presidential Address: Available at ASA website.
5 Bradley JD. (2004), ASA Presidential Address: Available at ASA website.
6. Maxwell DC. (1984), ASA Presidential Address: Available at ASA website.
7. McKenna M. Moment of Truth: History and Australia's future. *Quarterly Essay*. Carlton, Australia. Schwartz Publishing, 2018.
8. Groysberg B, Lee J, Price J, Cheng Y-J. The leader's guide to corporate culture. *Harvard Business Review*. January-February 2018. pp44-52.

ASA STRATEGIC PLAN 2018-2020

Mission: To enable medical practitioners in the specialty of anaesthesia, perioperative medicine and pain medicine to achieve best practice in the following:

- Safe, high quality patient care for all. Engagement in planning and delivering health care services.
- Compliance with professional obligations. Continuing Medical Education, research and publications.
- Personal health and welfare. Leading advocacy on economic, industrial and workplace issues
- Philanthropic service and contribution to the developing world. Preservation of the history of the specialty.
- Vision: Support, represent, and educate our members and enable the provision of the safest and best anaesthesia, perioperative medicine and pain medicine to the community

STRATEGIC PRIORITIES				
Priority 1 **Member Advocacy** Promote the needs of the specialty in both the public and private sector to government and other appropriate authorities.	**Priority 2** **Member Education** Provide a broad range of high quality educational services, resources and opportunities for members.	**Priority 3** **Professional and Economic Issues** Actively address the professional and economic issues for anaesthetists in public and private practice across Australia.	**Priority 4** **International and Community Service** Actively support services in the provision of indigenous and overseas development and education.	**Priority 5** **Governance** Ensure the Society is governed in such a manner that it complies with all statutory obligations while serving the interests of members.
SUPPORTING STRATEGIES				
• Prepare and circulate position papers and submissions concerning issues of relevance. • Actively engage with Government on issues that impact directly on the specialty. • Maintain active and professionally supported committees to articulate the ASA's position. • Work with like bodies and societies to promote areas of common interest.	• Provision of high quality meetings and events, including an annual National Scientific Congress, along with appropriate workshops, seminars and Special Interest Group meetings. • Production of range of suitable publications including *Anaesthesia and Intensive Care* and *Australian Anaesthetist*. • Funding of awards for research and scholarly papers. • Provision of a Continuing Professional Development (CPD) Management System. • Access to current information via ASA website and information services. • Recognition of history via historical book collection and artefacts.	• Sufficiently resourced Committees to consider issues and determine the ASA's position. • Qualified staff to support and assist in the development of the Society's position. • Active engagement with Government and other bodies to promote ASA's position. • Regular surveys of the membership to determine professional opinion on key issues. • The production and distribution of suitable publications in particular the Relative Value Guide. • Ensure suitable budget allocation to maintain and develop services. • Member access to submissions and information via ASA website.	• Allocate financial resources to support suitable initiatives in such areas. • Actively promote programs and initiatives which aid anaesthesia delivery in areas of need. • Maintain a committee structure which oversees aid/service initiatives provided outside of Australia and New Zealand in the ASA's name. • Provision of suitable administrative support to chosen initiatives.	• Ensure compliance with the ASA constitution and other legislative requirements. • Ensure governance educational opportunities are available for those members accepting positions on the Board. • Have a transparent selection and succession plan for Board, Council and Committee positions. • Allow sufficient funding for Board, Council and Committee activities and their reporting to members. • Provide appropriate resources to communicate the role of anaesthesia to the broader community. • Development of and adherence to the annual budget along with sound financial and investment management.
KEY OUTCOMES				
• Increased awareness among government and the public of the critical role of the anaesthetist in ensuring patient safety. • Support the personal welfare and health of anaesthetists. • Advocate for anaesthetists optimum work/life balance. • Support anaesthetists in providing safe anaesthetic services to the whole community. • Actively engaged in matters surrounding anaesthesia services.	• Increased take up of ASA educational opportunities, services and resources. • Publication/presentation of ASA supported research. • Increased membership. • Ongoing development of appropriate educational resources and opportunities. • Member recognition and awareness of the history of anaesthesia and the Society.	• The ASA's position is clearly articulated to Government and other regulatory bodies. • ASA is proactive in positioning itself as a leading body on matters of a professional and economic nature. • Promote the safe practice of anaesthesia. • Members are aware of current fee guidelines and IFA practices.	• Continued financial support for the Overseas Development and Education Committee initiated activities. • Ongoing support and promotion for service initiatives. • Support local care providers to optimise the health of their communities. • Appropriate governance to review/approve new and ongoing initiatives. • Recognition of the commitment to community by the profession.	• Board members are aware of their fiduciary responsibilities. • All members have an equal and fair opportunity to engage in the business of the Society. • Members interests are protected. • All matters of compliance are addressed. • Building of awareness and trust amongst ASA stakeholders. • The Society's resources are used in a responsible and sustainable manner which address financial, environmental and social considerations.

FEATURE

2018 ASA MEMBER WORKFORCE SURVEY: INITIAL ANALYSIS

The 2018 ASA Member Workforce Survey was, like the 2014 and 2016 surveys, targeted at ASA members in active specialist practice: registration with the Medical Board of Australia as Specialist Anaesthetist, Specialist Pain Medicine Physician and/or Specialist Intensive Care Physician was required for eligibility to respond. Dr James Bradley (Specialty Affairs Adviser) summarises the initial findings.

A total of 2,368 responses were received (a 40.3% response rate), and 147 responses offered comment. Candidly, the response rate could be seen to be lower than might be expected, but was in line with the response rate to the 2014 and 2016 Surveys, which were also offered without inducements. This report offers an initial assessment of responses to the 2018 survey, and draws some comparisons with 2014 and 2016.

In prefacing response analysis, the validity of the survey needs to be considered. Are the responders representative of the national specialist anaesthetist workforce? Reassuringly, the geographic, age and gender metrics captured by the initial questions do align closely with the most recent quarterly report of the Medical Board of Australia (which noted 5,069 medical practitioners registered as Specialist Anaesthetists as of 31 March 2018[1] and with the earlier AFHW – Anaesthesia Report from 2016[2]. Further, the same metrics were found to be consistent across four sequential tranches of responses during the time allowed for responses. Accordingly, the responders are considered to be representative of the specialist anaesthesia workforce, and the survey is considered to valuably inform our knowledge of the specialist anaesthesia workforce.

Demographically, there are no appreciable differences between the 2014, 2016 and 2018 surveys in relation to the gender split of the specialty, location of practice, type of registration (Specialist Anaesthetist, or Specialist Anaesthetist plus Pain Medicine and/or Intensive Care Medicine), years since beginning practice, and retirement intentions (Table 1). The age profile of members is unchanged,

Table 1

	2014	2016	2018
Gender, male	74.3%	73.8%	73.4%
Gender, female	26.7%	26.2%	26.6%
Practising in MMM1 (Modified Monash model classification)			
MMM1		81.7%	80.6%
MMM2		11.4%	10.1%
Practising anaesthesia exclusively	89.3%	88.5%	88.9%
Commenced practice within the last 5 years	16.3%	18.7%	16.2%
Planning to retire within the next 5 years	20.1%	19.3%	22.2%

and reassuringly, 90% enjoy practising anaesthesia.

…the survey is considered to valuably inform our knowledge of the specialist anaesthesia workforce.

In relation to professional workload, members (as in 2014 and 2016) most commonly worked six to eight 'sessions' (equating to 3 to 4 full days) per week, less commonly 8-10 sessions and 4-6 sessions (Figure 1).

Members are more likely to want to work more sessions than fewer, and three-quarters report being able to increase their professional workload, without difficulty or with some difficulty. These findings are considered to be measures of a capacity for an increased workload by the existing specialist workforce. There was a slight decrease in those wanting more public work compared with 2016 (from 15.7% to 12.3%) but 35.5% wanted more private work, maintaining an expressed threefold preference for an increase in private work (see Table 2). The number of responders believing that 'too many' anaesthetists were being trained has fallen from 73% to 58.4% since 2014, but less than 1% believe that an inadequate number of anaesthetists is being trained (Figure 2).

In 2016, further analysis of the responses from different geographical practice locations in respect to professional workload revealed quite differing opinions: 77% of capital city anaesthetists had reported that there were too many anaesthetists in their location, with 12% reporting an appropriate number, and 11% offering no opinion. Conversely, members in non-metropolitan and rural areas were more likely to answer in a way that suggested that the anaesthesia workforce was busier in those locations than in capital cities. Detailed analysis of responses from 2018 across various geographical areas will be reported later this year, and this analysis will be further informed by a new question that enabled responders to further define themselves as 'salaried practitioner' or 'private practitioner'.

Members are more likely to want to work more sessions than fewer, and three-quarters report being able to increase their professional workload, without difficulty or with some difficulty.

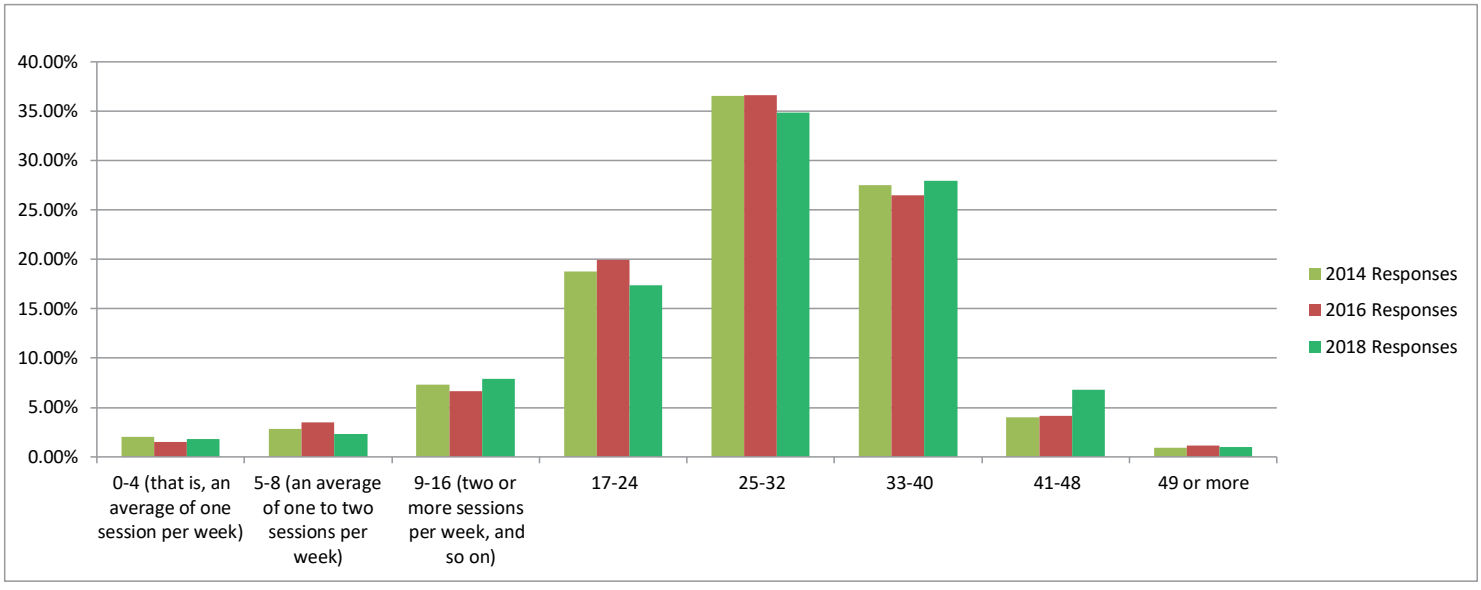

Figure 1: How many clinical 'sessions' (private and public) do you currently perform in a four week (one month) cycle? Regarding 'sessions' worked, it is acknowledged that both private and public facilities commonly use a 'monthly' theatre allocation.

FEATURE

Table 2

	2014	2016	2018
Wanting more public practice	11.5%	15.7%	12.3%
Wanting more private practice	36.8%	37.6%	35.5%
Wanting to work fewer sessions	18.4%	18.6%	19.5%
Wanting to work more sessions	30.0%	30.1%	25.9%
Able to increase professional workload without difficulty	34.9%	34.7%	36.2%
Able to increase professional workload with some difficulty	39.6%	40.0%	38.8%
Number of anaesthetists being trained			
'too many'	73.0%	70.6%	58.4%
'appropriate number'	17.9%	17.7%	26.1%

In relation to difficulties in the recruitment of anaesthetists to non-metropolitan areas, professional and social isolation continue to be identified as the most significant confounding factors.

A sizeable majority (86.6%, a slight increase from previous years) feel that their case-mix and caseload was adequate for the purposes of maintaining clinical skills; conversely, 12.3% (a slight decrease) had felt obliged to work outside their 'comfort zones' due to economic pressures, and 25% due to workforce shortage or other professional pressures. Only 3.4% had moved to, or worked in a rural region, in order to obtain an adequate workload.

Questions which were new in 2016 in relation to periods of unemployment or underemployment in the initial years since obtaining Fellowship were repeated in 2018. Unemployment was very uncommon, but 30% of new Fellows reported being underemployed for up to two years, with both limited case numbers and case-mix. These findings are to be analysed in greater depth.

Support for vocational training in the private sector remains conditional…

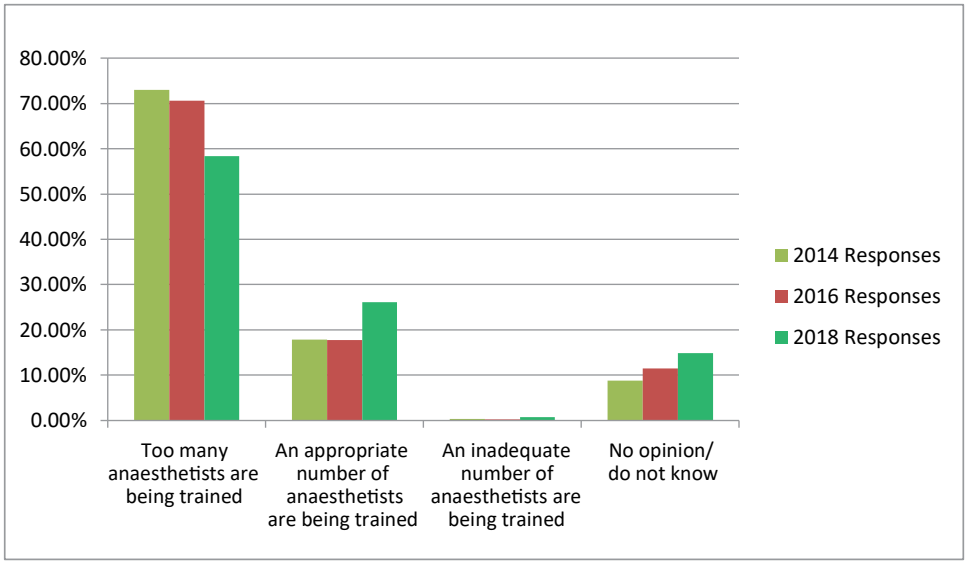

Figure 2: Response to question 27: In my opinion currently the number of anaesthetic trainees are 'too many', 'appropriate', 'inadequate' and 'no opinion'.

Seventy percent of responders, as with the previous surveys, believe that public hospitals should increase the availability of work for young specialists, and 80% believe that any increase in public workload should be met by the appointment of specialists rather than an increase in the number of vocational trainees.

Support for vocational training in the private sector remains conditional, as it was in 2014 and 2016: One-third (32.6%) believe that training should be restricted to public hospitals with 60.6% supporting a limited exposure and only 6.8% a substantial exposure to private facilities. A majority (55%) believe that productivity in the private sector is diminished by vocational training into the private sector; with only 16.7% believing there is no effect on productivity. Further analysis against type of practice may inform these findings.

More than 80% reported understanding the concept of 'material risk'. Almost 95% reported in both 2016 and 2018 that they understood what was required in obtaining the 'informed consent' of the patient, with the percentage of responders reporting 'a clear understanding' of material risk continuing to increase. Only 10% obtain written consent from the patient, and although 55% report documenting the attaining of consent in the anaesthesia record, a further 30% report the attaining of consent but do not document this consent.

In relation to obstetric anaesthesia practice in private hospitals, just over half report that the facilities with which they are most familiar have no difficulty in covering anaesthesia for epidural analgesia and Caesarean section. Payment is made for participation in obstetric anaesthesia rosters in just under half of private facilities. These findings are largely unchanged over the three surveys, but there are regional differences: initial further analysis shows that 'paid' rosters are uncommon in Queensland, but quite common in NSW.

Medical indemnity cover for private patients is provided by AVANT, MDA National, MIGA, MIPS and TEGO in decreasing order.

…80% believe that any increase in public workload should be met by the appointment of specialists rather than an increase in the number of vocational trainees.

A final series of questions surveyed a number of contemporary matters of interest:

- Members were informed that the ASA and ANZCA are canvassing a possible change of name of the specialty from 'anaesthesia' to 'anaesthesiology', and to indicate their support for such a change. Figure 3 shows the responses as of April 2018. Further initial analysis showed that younger members were no more likely to support such a change than older members.
- Member understanding of the Medical Board of Australia's proposals for 'Revalidation' had been canvassed in 2014 and 2016, with two thirds believing that they understood the concept of revalidation. The Board's current evolving proposal for a 'Professional Performance Framework' was canvassed in 2018, and in contrast to 2014 and 2016, 11% expressed an understanding of the proposals, 29.7% some understanding, and 59.2% no understanding.
- Members were asked how they identified themselves on first meeting their patients. It was most common to use 'Doctor' plus surname (40.2%), then first name plus surname (33.8%), then first name only (15.9%). Further initial analysis has shown that younger members are much more likely to introduce by first name only than older members.

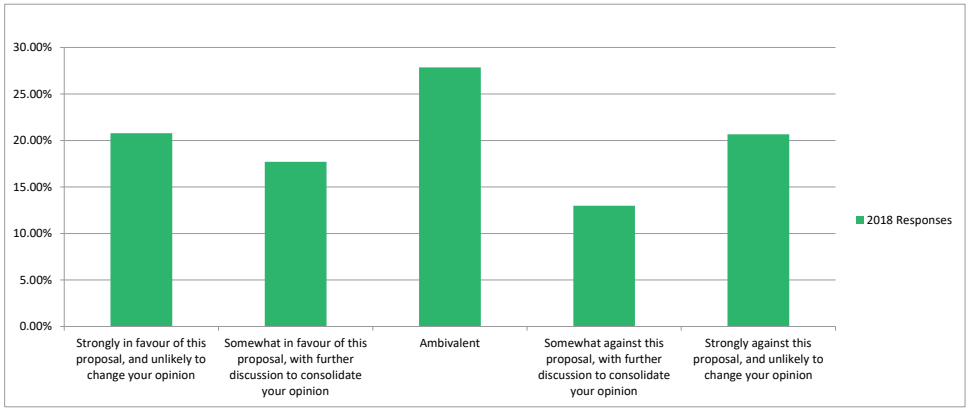

Figure 3: The ASA and ANZCA have canvassed a possible change of name for the specialty from 'anaesthesia' to 'anaesthesiology', with specialist practitioners to be 'anaesthesiologists' rather than 'anaesthetists'. At this time, are you: strongly in favour, somewhat in favour, ambivalent, somewhat against, strongly against.

- While three-quarters of responders continue to agree that anaesthetists will incorporate an increasing component of 'perioperative medicine' into their practices, only a third continue to wish to incorporate more 'perioperative medicine' into their own practices. Initial further analysis shows that those identifying as 'public practitioners' are much more likely to wish to incorporate perioperative medicine.

Given that sexual harassment of women has become a subject of national debate, a new question addressing sexual harassment was asked in 2018, and was intended to provide baseline data for the ASA.

In answer to a question in relation to 'bullying' during vocational training, a fifth reported having been bullied, a quarter responded "perhaps, depending on the definition of bullying", but more than half responded in the negative – identical findings to 2016. In relation to 'bullying' during specialist practice, a quarter, as in 2016 responded as having been bullied, a further quarter 'perhaps', and half in the negative.

Given that sexual harassment of women has become a subject of national debate, a new question addressing sexual harassment was asked in 2018, and was intended to provide baseline data for the ASA. In relation to sexual harassment during training, 5.8% of members reported 'yes', 5.7% "perhaps, depending on how sexual harassment is defined", and 88.6% 'no'. In relation to sexual harassment during specialist practice, 2.9% reported 'yes', 5.5% 'perhaps' and 91.6% 'no'.

In relation to family income, 84% reported being the major income earners in their families, with 11% 'equal earners'.

References

1. Medical Board of Australia: Statistics - accessed 18 June 2018 at http://www.medicalboard.gov.au/News/Statistics.aspx.
2. Australia's Future Health Workforce: Anaesthesia. Accessed 18 July 2018 at http://www.health.gov.au/internet/main/publishing.nsf/Content/australias-future-health-workforce-anaesthesia-repor

ANZCA | ASA | NZSA

ACE ANAESTHESIA CONTINUING EDUCATION

AUSTRALASIAN SYMPOSIUM ON ULTRASOUND AND REGIONAL ANAESTHESIA

ASURA 2019

21-23 FEBRUARY • NOOSA QLD

INTERNATIONAL INVITED SPEAKERS

Professor Sandra Kopp

Sandra L. Kopp is a Professor of Anesthesiology at Mayo Clinic, Rochester, MN. Prof Kopp is currently the Vice Chair, Integration and Convergence, Department of Anesthesiology and Perioperative Medicine and Chair, Division of Community Anesthesia and very involved in the American Society of Regional Anesthesia and Pain Medicine. Her interests include regional anesthesia and analgesia, anticoagulation, and local anesthetic toxicity.

Associate Professor Thomas Bendtsen

Thomas Bendtsen, Scandinavian pioneer in ultrasound guided regional anaesthesia and head of a research group of five PhD fellows in regional anaesthesia, affiliated to Aarhus University, Denmark. His research focus is on development of new techniques in regional anaesthesia for acute, subacute and chronic pain relief after major surgery and trauma – primarily related to the hip, knee, and ankle joints.

Professor Su Ganapathy

Su Ganapathy, trained in India and England, Su also practiced in Kenya before arriving in London, Ontario in 1994 to take up a position as Professor of Anesthesia at the University of Western Ontario. Her special interest is the management of acute post-operative pain with regional anaesthesia, and she is one of the leaders in the use of ultrasound in this field.

Associate Professor Ki Jin Chin

Ki Jinn Chin, FRCPC, is an Associate Professor in the Department of Anesthesia at the University of Toronto, and is also the Fellowship Coordinator and Regional Anesthesia Program Director at the Toronto Western Hospital, Toronto, Canada. He graduated from the University of Newcastle-upon-Tyne, UK, completed anaesthesiology training in Singapore, and completed neuroanaesthesia and regional anaesthesia fellowship training at the University of Western Ontario and Toronto Western Hospital respectively.

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

REGISTRATION OPENING SOON

FEATURE

Photo courtesy of Tourism and Events Queensland

AUSTRALASIAN SYMPOSIUM ON ULTRASOUND AND REGIONAL ANAESTHESIA

21-23 FEBRUARY 2019

ASURA Co-convenors Neil MacLennan, Liz Maxwell and Helen Lindsay detail what attendees can expect at ASURA 2019.

Since the first symposium in 2008, ASURA has established itself as the principal regional anaesthesia meeting in Australasia. Following on from the success of previous meeting, ASURA 2019 will return to Peppers resort in Noosa, QLD for the perfect mix of quality education and a relaxing resort environment.

As always, the key to ASURA is the quality of the scientific programme. To offer the best content possible, we have invited four international speakers to join us and together, they bring wealth of expertise to the fields of clinical practice, research and the teaching of regional anaesthesia.

As always, the key to ASURA is the quality of the scientific programme.

Our keynote speakers are as follows: Associate professor Thomas Bendtsen is a Scandinavian pioneer in ultrasound guided regional anaesthesia and is from Aarhus University, in Denmark. Prof Bendtsen has published on anaesthesia for knee and hip surgery, including the anatomy of the adductor canal, femoral triangle and lateral cutaneous nerve. He also researched the quadratus lumborum (QL) block for abdominal surgery.

Associate professor Ki Jinn Chin is from the University of Toronto and is the Fellowship Coordinator and Regional Anesthesia Program Director at the Toronto Western Hospital.

Prof Chin has also studied optimal techniques for hip and knee surgery. Other interests include analgesia for abdominal surgery (erector spine, retrolaminar block), ERAS pathways and regional anaesthesia for cancer surgery.

KIDS TAUGHT LIFE SUPPORT

ABOUT THE KIDS TAUGHT LIFE SUPPORT PROGRAM

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

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

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

ABOUT THE FACILITATOR


Romy Ottens - Director

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

www.kidstaughtlifesupport.com.au

FREE TO CONGRESS THIS YEAR!

FEATURE

ASURA 2016, Peppers Resort

ASURA 2016, Peppers Resort

Professor Su Ganapathy is Professor of Anesthesia at the University of Western Ontario. She established the post-graduate regional anaesthesia training programmes for the university of Western Ontario. She has researched regional anaesthesia options for shoulder surgery, LIA for joint arthroplasty and paravertebral and QL blocks for abdominal surgery.

ASURA is also about improving hands-on skills in small-group workshops.

Professor Sandra L. Kopp is from the Mayo Clinic. Prof Kopp is the Vice Chair, Department of Anesthesiology and Perioperative Medicine and Chair, Division of Community Anesthesia. Prof Kopp has contributed to several Cochrane reviews including RA for hip arthroplasty, RA versus general anaesthesia for hip fracture surgery. She is an author on the recent ASRA guidelines on RA and anticoagulation.

Our keynote speakers will make a major contribution to the plenary programme on Day 2 of ASURA, supported by our local faculty from NZ, Australia and Singapore.

ASURA is also about improving hands-on skills in small-group workshops. On Day 1 of the meeting, we are running an introductory workshop (aimed at less experienced delegates). This combines practical skills training (needle-imaging), with 'All Around the Block', a small group, scenario-based teaching session. For more experienced anaesthetists, there will be a half-day advanced anatomy and sonoanatomy workshop at the Anatomy Dept of QU, Brisbane. In addition to the Thursday workshops, we plan to offer a full day of small group workshops on Day 3 of the meeting.

ASURA 2019 is being held from Thursday 21 February to Saturday 23 February at Peppers Resort, Noosa. We are drawing on the beautiful local area for social programme activities and the conference dinner. Make sure to join us for the Conference dinner being held at the Woodfired Grill – price of attendance includes the cruise down the river to take in the gorgeous sunset. Other optional activities include yoga on the beach and a wine and cheese tasting. Make sure to keep checking www.asura2019.com.au for any changes.

Registration will open soon, and we expect workshops to fill quickly. The organising committee encourage you to join us in Noosa for an enjoyable, and educational ASURA!

The beach at Noosa. Photo courtesy of Tourism and Events Queensland

INSIDE YOUR SOCIETY

ECONOMICS ADVISORY COMMITTEE

DR MARK SINCLAIR
EAC CHAIR

MEDICARE BENEFITS SCHEDULE (MBS) REVIEW

Since the last edition of *Australian Anaesthetist*, representatives of the ASA and ANZCA, as well as an independent academic, have had a further meeting with representatives of the federal Department of Health (DoH). This all-day meeting, held in June, is likely the last such in-depth meeting to be held before the review of the Relative Value Guide (RVG) in the MBS is implemented.

The report of the original Anaesthesia Clinical Committee (ACC), engaged by the MBS Review Taskforce, was again discussed, but the emphasis was on the ASA's set of alternative recommendations, and our reasons for putting these forward as a far more sound approach to the Review. Again, it should be emphasised that the ASA's recommendations are based on input from not only EAC members, with their extensive history of dealing with all stakeholders involved in producing the MBS RVG, but also representatives from other ASA committees, from ANZCA, and from a clinical academic background.

I would like to again take the opportunity to thank the members of the anaesthesia stakeholder group, for devoting much personal time and effort in order to achieve the best possible outcome. At this stage the wider specialty does not have access to the details of the original ACC report, and therefore may not fully appreciate how much effort has been needed, in order to try to prevent what would be a very poor outcome for private patients, and for the anaesthesia specialty. It should be noted that if the suggestions of the ACC are fully implemented, this poor outcome will, in all likelihood, be with the community for decades into the future, and could impact on the availability and delivery of anaesthesia services.

The members of the group (in alphabetical order):

- Dr Guy Christie-Taylor, ASA Immediate Past President
- Assoc Prof Alicia Dennis, Chair, ASA Public Practice Advisory Committee
- Dr Antonio Grossi, Chair, ASA Professional Issues Advisory Committee
- Dr Phillipa Hore, Chair, ANZCA Quality and Safety Committee
- Dr Andrew Mulcahy, ASA Past President, Past EAC Chair, AMA Councillor
- Dr Suzi Nou, ASA Executive Councillor
- Prof David A. Scott, ANZCA President, 2016-May 2018
- Assoc Prof David M. Scott, ASA President
- Dr Peter Seal, ASA Vice President
- Dr Mark Sinclair, Chair, ASA Economics Advisory Committee
- Prof David Story, Foundation Chair of Anaesthesia, University of Melbourne

Our thanks also go to ASA CEO Mr Mark Carmichael, past ASA Policy Team members Mr Chesney O'Donnell and Dr Elaine Tieu, current ASA Policy Manager Ms Jacintha Victor John, and to the rest of the North Sydney staff for their ongoing assistance.

The final outcome of the MBS RVG review is by no means certain. Our views have however been positively received by the DoH and Ministerial representatives, particularly given the strong evidence-based and expert-backed approach we have used. At the time of writing, we are awaiting the final response from the DoH, after consultation with the Minister. By the time of publication of this edition of *Australian Anaesthetist*, more information may have already been made available to the ASA, and of course any such developments will be publicised immediately. The DoH has assured us that the stakeholder group will be given the opportunity for a final response, before any changes to the MBS are implemented.

MBS ITEM INDEXATIONS

As members are no doubt fully aware, there has been no indexation to MBS RVG items (nor to almost the entire MBS) since November 2012. Originally, this freeze in indexation was to be continued through to July 2020. However, federal government policy was recently changed, such that items for professional attendances were indexed in July 2018, and all other MBS items are to be indexed in July 2019.

From 1 July 2018, MBS items for anaesthesia attendances have been

MBS Item	Service	MBS Fee (prev)	MBS Fee July 2018
17610/17640	Pre-anaesthesia/referred attendance, ≤15 mins	$43.00	$43.65
17615/17645	16-30 minutes	$85.55	$86.85
17620/17650	31-45 minutes	$118.50	$120.30
17625/17655	>45 minutes	$150.90	$153.15
17680	For regional blockade, patient in labour	$85.55	$86.85
17690	Outpatient loading	$39.55	$40.15

indexed by 1.5%. By way of comparison, the Reserve Bank calculates that overall inflation from 2012-2017 was 10%[1]. At the time of writing, the private health insurance schedules are not available, but there are expected to be some increases in rebates, as many insurers have committed to adopting the MBS method of indexation (and as a result, of course, have frozen their rebates for the last six years).

Note that all MBS anaesthesia attendance items have time, complexity and other requirements – see the MBS or your RVG booklet for details.

PRIVATE HEALTH INSURANCE

Anaesthetists who have utilised the 'no gap' or 'known gap' product of Bupa should all have received updates as to the new terms and conditions applying from 1 August 2018. Importantly, the above-MBS rebates available to patients under the 'no gap' or 'known gap' schemes will only apply where the hospital has a contractual arrangement with Bupa. At other facilities, the rebate for doctors' services will be limited to 100% of the MBS Fee.

The ASA has spoken out against such arrangements, and the AMA in particular has led the debate against the practice. However, it appears Bupa will push ahead with the plan, regardless. The only change to the original plan relates to public hospitals, where if doctors are currently eligible for the 'no' – or 'known gap' product, planned admissions will still be eligible for these rebates. Unplanned or emergency admissions to these hospitals will have a 'no gap' product available, but not the 'known gap' product, meaning patients will only receive a rebate of 100% of the MBS Fee should the doctor not accept the Bupa rebate as the full fee.

A number of day surgery facilities have an agreement with Bupa (so called 'members first' facilities). It is important for members to note that these centres have probably agreed, on behalf of their accredited doctors and without necessarily informing these doctors, that all Bupa patients will have a 'no gap' account for their medical fees. A full list of these centres (as well as those which have a contractual arrangement with Bupa) is available at: https://www.bupa.com.au/for-providers/bupa-medical-gap-scheme.

Members are reminded that conforming to such billing requirements takes control over financial affairs away from doctors, and places it firmly in the hands of groups who have a long history of poor or absent indexation of rebates, and whose sole aim as a funder is to make financial profit. Bupa has previously stated that it is not interested in pursuing a USA-style 'managed care' system. This may be true by the strict definition of 'managed care', but it is clear that Bupa (and others, especially for-profit insurers) wish to gain an increasing control over who receives treatment at what location and from which specific doctors. Complying with insurers' requirements merely serves to assist them with their ultimate aim of control of the system, and purely benefits the insurance companies, while disadvantaging doctors and their patients.

The ASA remains ready to assist members with all financial aspects of their practice, including the setting of fees, the rebates available from Medicare and the private health insurers, and best possible informed financial agreement (IFA) practices. Contact the Society on 1800 806 654 or policy@asa.org.au

INSIDE YOUR SOCIETY

POLICY UPDATE

A consensus framework for ethical practices in health care, developed in collaboration by a large group of Australian health leaders including the Australian Society of Anaesthetists (ASA), and endorsed by Australian federal, state and territory health ministers, was launched in Tokyo in July 2018.

The ASA is proud to be a signatory to the framework, which was developed in collaboration with a host of Australian professional health bodies, industry organisations, hospital and health services associations, regulators, patient and advocacy groups and other related organisations.

Signatories to the Australian Consensus Framework for Ethical Collaboration are committed to delivering the best outcomes for patients. Collectively they share similar challenges and hopes – including the desire to maintain and improve ethical behaviour.

Australian Federal Minister for Health, The Hon. Greg Hunt MP, praised the Australian health sector for developing the voluntary initiative.

"The Consensus Statement, and the number of signatories to it, is a clear commitment from the Australian healthcare sector to ethical behaviour, collaboration and interaction. It demonstrates how Australian healthcare is driven by the values and principles of honesty, integrity, transparency, accountability and oversight. Most importantly, the statement also gives further certainty to patients about the behaviour they should expect from providers, facilities and companies.

Chair of the Australian Consensus Framework for Ethical Collaboration and CEO of the Australian Orthopaedic Association, Adrian Cosenza, said that the framework "has been designed in an environment where society's trust in government, business and not-for-profit bodies globally, including in Australia, as measured by the respected Edelmen Trust Barometer, has been in steady decline in recent years. Unethical behaviour is one of the causes of this trust deficit."

"As the fifth largest contributor to national growth and in employing over 1.5 million Australians, it is important that the healthcare sector exhibits and practises high levels of trust to the standards expected by the community. Open collaboration, dialogue and communication across all players in the health care sector is key. The Australian Consensus Framework for ethical collaboration provides a platform for this engagement," said ACF Leadership Team member and MTAA, CEO, Ian Burgess.

"Every day in Australia, 578,000 people visit a doctor or hospital and there are 777,000 prescriptions for innovative and generic medicines filled. Australians place their trust in the entire healthcare ecosystem and need to know that they are going to be looked after from the discovery of a new medicine, right through the supply chain. Australians also want to know that their healthcare provider is acting in an honest, transparent and accountable way," said Medicines Australia CEO and ACF Leadership Team member Elizabeth de Somer.

"The Australian healthcare sector has come together in an unprecedented collective effort to develop the Australian Consensus Framework for Ethical

Collaboration, aimed at setting the standards for ethical behaviour across the sector to best serve the people of Australia," said ACF Leadership Team member and Australian Healthcare and Hospitals Association Chief Executive, Alison Verhoeven.

"Consumer organisations play an increasing leadership role in shaping policy, standards and services that take into account community expectations and trust that the best possible care is going to be delivered. This Consensus Statement sets the yardstick for the behaviours the community should expect from providers," said Consumers Health Forum of Australia CEO, Leanne Wells.

"There is much to be done, and we are only at the start. However, we are all driven by a shared objective – to do the right thing for the future of Australia's health system," said ACF Leadership Team member and Royal Australasian College of Surgeons, Councillor, Greg Witherow.

ASA was represented on the working party Vice President Dr Peter Seal and CEO Mr Mark Carmichael. The launch of the framework took place in Tokyo with an address by the Federal Minister for Health the Hon. Greg Hunt MP as part of the 2018 APEC Business Ethics for SMEs Forum.

Jacintha Victor John
Policy Manager

References

1. https://aimp2.apec.org/sites/PDB/Lists/Proposals/DispForm.aspx?ID=2038
2. https://www.ranzcog.edu.au/RANZCOG_SITE/media/RANZCOG-MEDIA/Women%27s%20Health/Statement%20and%20guidelines/Clinical%20-%20General/Australian-Consensus-Framework-for-Ethical-Collaboration-in-the-Healthcare-Sector.pdf?ext=.pdf

CONTACT US

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

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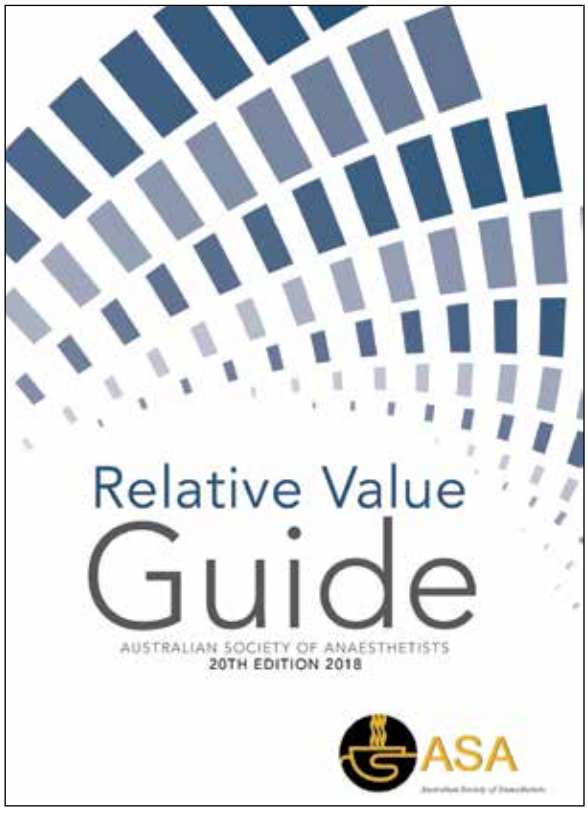

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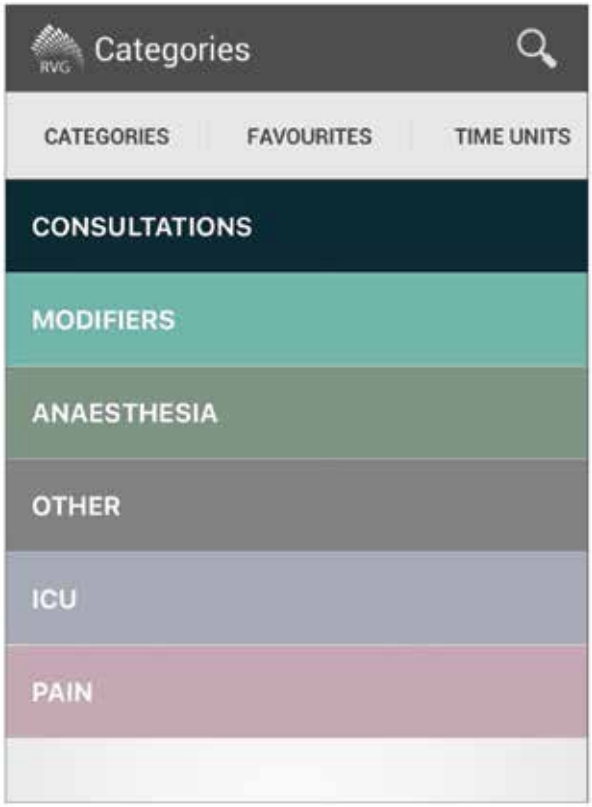

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RVG

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INSIDE YOUR SOCIETY

OVERSEAS DEVELOPMENT AND EDUCATION COMMITTEE

Globally maternal mortality remains unacceptably high; each day 830 women die from preventable causes related to pregnancy and childbirth. Ninety-nine percent of maternal deaths occur in resource poor countries.

The maternal mortality rate in developing countries in 2015 was 239 deaths per 100,000, however the Sustainable Development Goal 3 (SDG3) is to reduce the global maternal mortality ratio to less than 70 per 100,000 births, with no country having a maternal mortality rate of more than twice the global average. Currently 75% of maternal deaths are due to haemorrhage, sepsis, pre-eclampsia, complication of delivery and unsafe abortion.

Mongolia has made remarkable gains in health since 1990, achieving Millennium Development Goal (MDG) 4 with an annual rate of reduction of 5.9 in its under-five mortality rate between 1990 and 2011. Mongolia also achieved the MDG5 with the maternal mortality rate (MMR) reducing from a peak in 1993 of 259 per 100,000 to 26 in 2015. Unfortunately, despite the Sustainable Development Vision of Mongolia foreseeing the reduction of maternal mortality ratio to 15 per 100,000 live births, recent figures demonstrate a reversal in trend with a near doubling of MMR in 2016 to 48.6.

The highest rates of a maternal mortality persist in central, western and Arkhangi regions. Vast distances, absent infrastructure and harsh climatic conditions pose significant challenges in delivering reproductive health. This year the ASA and Mongolian Society of Anesthesiologists (MSA) launched a three-prong initiative to address the increase in MMR: SAFE Obs, annual scientific meeting and a feasibility study of sub-district hospitals to perform caesarean section.

Developed as a joint program by the Association of Anaesthetists of Great Britain and Ireland (AAGBI) and the World Federation of Societies of Anesthesiologists (WFSA), SAFE Obs is a three day training course aimed at both physician and non-physician anaesthesia providers in low-middle income countries (LMIC). The course equips anaesthesia

Participants, facilitators and translators at the end of the course, June 22nd Ulaanbaatar, Mongolia.

INSIDE YOUR SOCIETY

Instructors of the Mongolian SAFE obstetrics course: Debra Devonshire, Amanda Baric, Andrea Yap, Darren Lowen, Melissa Taylor, Rod Wilson and David Pescod. Absent: Terence Loughnan.

providers with the essential skills and knowledge to provide and teach anaesthesia for obstetrics in low resource environments, addressing the major causes of maternal death, important skills in obstetric anaesthesia and immediate resuscitation of the newborn. SAFE courses in obstetrics and paediatrics have now been delivered in 24 countries.

In response to the increase in MMR, the Mongolian Society of Anaesthetists (MSA) requested the SAFE Obs course precede their annual scientific meeting. The major supporters of this activity were the ASA, Interplast Australia, the World Federation of Societies of Anaesthesiologists (WFSA) and MSA. Led by A/Prof Terry and Margaret Loughnan, who had experience in providing SAFE Obs in PNG, the Safe Obs course was delivered by a faculty of Australian anaesthetists (Dr Amanda Baric, Dr Debra Devonshire, Dr Darren Lowen, A/Prof David Pescod, Dr Rodney Wilson and Dr Andrea Yap) and midwife Ms Melissa Taylor.

Forty-eight participants attended the course, including 21 participants, one from each of Mongolia's 21 aimag (province) regions. Encouragingly, many of the participants knew much of the material and the course provided them with an opportunity to refresh their knowledge and share their common experiences. There was robust discussion and problem-solving around the lack of essential medications and the challenges of retrieval and delivery of anaesthesia in resource poor areas with a low volume of practice.

In order to achieve sustainability, the SAFE Obstetric Anaesthesia course is supported by 'Train the Trainers'. At the conclusion of the Mongolian course the majority of participants were confident and enthused to commence SAFE Obs in their own aimag and sub-district hospitals. (Australian anaesthetists interested in contributing to SAFE Obs can contact the AAGBI or the ASA ODEC).

Complementing the SAFE Obs course, the MSA scientific program also concentrated on obstetric anaesthesia with presentations by the Australian faculty and members of the MSA. Presentations by the Mongolian faculty included:

- Why mothers die?
- Current status of anaesthesia services in Mongolia and international standards for safe anaesthesia practice.
- WHO strategies towards ending preventable maternal mortality Mongolian perspective SDGs.
- Early warning signs and organisation of rapid response team and its benefits.
- Pre-eclampsia and eclampsia.
- Preoperative assessment of pregnant women for CS: How we do it. APR classification (anaesthesiology and perinatal risk classification).
- Obstetric sepsis and post CS peritonitis.
- Massive obstetric haemorrhage, emergency management.
- HELLP syndrome.

In addition, Kybele, which is an international group based in the United States, was approached this year to help the MSA to address the safety of caesarean section in the countryside in Mongolia. Two doctors, Dr Melvin Seid, an obstetrician from the US and Dr Ronald George, an anesthesiologist from Canada arrived on 23 June 2018 and travelled to the Uvs province with Professor Ganbold Lundeg and Lkhagvasuren B to perform an assessment of three inter-soum (district) facilities.

The Uvs province is located 1,400 km to the west of Ulaanbaatar, divided into 19 soums and with a land area of approximately 70,000 square kilometres and a population of 80,000 there is a population density of 1.2/km^2. Inhabitants are principally nomadic herders. Total livestock (sheep, goats, camels, cows and horses) in 2015 exceeded 2.5 million.

Drs Seid and George have extensive experience in Ghana and Georgia, working to improve obstetric care and they will make recommendations regarding whether it is safe to perform emergency caesarean sections in the countryside at 2nd level hospitals versus the current system of having mothers travel large distances, for the last two weeks of confinement, to their provincial capital in case of a need for caesarean or delivery in the soum hospitals and no access to emergency caesarean section.

Dr David Pescod

Above: Dr Andrea Yap teaching with Dr Ganbold as interpreter.
Right: Using the NeoNatalie donated to Mongolia by Laerdal Australia.

SAFE OBSTETRICS MONGOLIA 2018

This course was first developed by the AAGBI and is now endorsed and supported by WFSA. At the request of the Mongolian Society of Anaesthetists, ASA members presented this course in Ulaanbaatar from 20-22 June 2018. ASA members who facilitated the course were Drs Dave Pescod, Amanda Baric, Darren Lowen and Andrea Yap from Northern Hospital, Victoria, Dr Deb Devonshire from Monash Medical Centre, Dr Rod Wilson from Bendigo Hospital and myself. They were supported by Melissa Taylor midwifery NUM from Northern Hospital and Dr Margaret Loughnan on logistics.

The course was conducted over three days at the Mongolian Medical School in a wonderful facility on the sixth floor that provided four tutorial rooms and a conference room. An absolutely ideal environment. There were 48 participants in all and we were honoured to have 21 participants from the Provincial areas representing one from each region, as well as doctors from Ulaanbaatar, both specialists and trainees. All facilitators stayed on to present a lecture at the MSA Annual Meeting on the weekend that followed the SAFE Course.

The SAFE Course is designed for practitioners involved in obstetric anaesthetic care and whilst many of the practitioners who attended are trained anaesthetists they were able to witness the course first hand and see how it could be rolled out into appropriate areas of the country. It is envisaged that this could be done by participants of this course. For us a unique situation that arose with this SAFE is that the whole course had to be delivered through interpreters. It is a testimony to the ability of these anaesthetists who fulfilled this role plus the dedication of the participants and eagerness of the facilitators that it worked so well. Special appreciation must go to Drs Lkhagvasuren and Enkhzaya who were present at all sessions and did an amazing job of translating for hour after hour.

The feedback session at the end of the course reflected that participants felt that the course content and length were appropriate. They particularly enjoyed the sessions involving a refresher on physiology, a new module of anaphylaxis and the hands-on sessions with mannequins and practicing life support. They were keen to receive instruction on labour analgesia and more basic physiology.

Thanks go to the WFSA for providing the booklets on Obstetric and Paediatric Anaesthesia for all participants. And also thanks to Laerdal Australia who donated four Neonatal resuscitation dolls, two for this trip and an additional two for PNG. They were used on this SAFE Course and were added to the simulation asset in Mongolia.

I thank the participants, facilitators and interpreters for their involvement. I thank WFSA and Laerdal and Northern Hospital for donated teaching equipment and feel confident that Mongolian anaesthetists will be able to take this program forward in their own language and with their own emphasis and flavour.

Dr Terence Loughnan
Frankston Hospital

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INSIDE YOUR SOCIETY

Brian Spain, Mingota da Costa Herculano and Meg Walmsley

ASA PACIFIC OBSERVERSHIP PROGRAM

My name is Mingota da Costa Herculano and I am an anaesthetic registrar from East Timor. I am currently working at National Hospital Guido Valadares (HNGV) in Dili.

I obtained my MBBS degree from the Latin American School of Medicine in Cuba in 2010, after seven years of medical school, which included one year of Spanish preparation. After finishing medical school I worked as general practitioner in the Soibada-Manatuto districts in East Timor.

I started anaesthetic training in 2012, doing a Diploma in Anaesthesia at HNGV in Dili. This diploma program is part of a scholarship offered by the Australian Aid ATLASS program administered by the Royal Australasian College of Surgeons in collaboration with East Timor National University. I then went on to study a four year Masters of Medicine in Anaesthesia at the Fiji National University in Suva, Fiji. I have spent the majority of the past four years working and studying in Fiji. I will complete my masters at the end of 2018 and return to East Timor as an anaesthetic specialist.

HNGV is the main referral hospital of East Timor, with approximately 260 beds. The ICU has six beds and two ventilators. There are three operating theatres staffed by five anesthetist specialists from Timor, Cuba, China and Nepal. There are also nine Timorese anesthetists registrars who are either working in Dili or training in Fiji.

In June of this year I spent two weeks at Royal Darwin Hospital as part of an ASA Pacific observership program. I was really impressed with the working environment, the efficiency of the theatre and the anaesthetic services at the hospital. I had the opportunity to visit the ICU, participate in preadmission clinic, pain round, CME and to spend time in the operating theatres.

I was really excited to observe how post-operative pain is managed and to attend some pain rounds. I was able to see how the use of multimodal analgesia is well established and how these interventions can have a great benefit for patient comfort and outcomes.

Overall the experience has been great and I have learned new things that I can try to incorporate into our practice in East Timor in the future.

I would like to thank Dr Meg Walmsley for organising and making this attachment possible, Dr Chris Bowden and the ASA for funding my observership and Dr Brian Spain and the anaesthesia department at Royal Darwin Hospital.

Dr Ming da Costa Herculano

INSIDE YOUR SOCIETY

ASA MEMBER'S GROUPS UPDATE

ASA TRAINEE MEMBERS UPDATE

Our TMG Committee has had a busy couple of months and we are actively working on a number of issues affecting trainees. Our membership is continuing to grow, with over 500 Australian anaesthetic trainees now ASA members. I hope this indicates an increasing awareness of the many challenges and opportunities presented to our specialty and the need for a motivated and resourced Society to represent us and advocate for our interests and the interests of our patients.

Fatigue and rest facilities

It is well-known that fatigue is common in medical practitioners, particularly those working long hours and whose practice involves shift work or overnight on-call. Anaesthetists and trainees are high risk groups for fatigue – both in terms of our risk of being fatigued at work and the risk of harm to patients when we are fatigued. Fatigue reduces cognitive and physical performance, impairs judgement and contributes to medical errors. Limiting the incidence and impact of fatigue is thus a clear patient safety issue, in addition to its importance for our own health and wellbeing.

In the UK, the British Medical Association (BMA) and Association of Anaesthetists of Great Britain and Ireland (AAGBI) have been working extensively on the issue of fatigue. This has been fuelled by devastating incidents involving junior doctors suffering fatal car accidents driving home after night shifts. This issue is receiving increasing attention across the international medical community and particularly in anaesthesia. ANZCA is in the process of reviewing its professional document on fatigue, PS43 Statement on Fatigue and the Anaesthetist, which is accessible through the College website. While the current document doesn't specifically refer to trainees, many of the points are just as applicable to us.

The TMG is working together with the ASA Professional Issues Advisory Committee (PIAC) and Public Practice Advisory Committee (PPAC) to advocate for appropriate systems to prevent and manage fatigue in anaesthetists and anaesthetic trainees. We encourage all health services to provide appropriate rest facilities for junior and senior staff, and to ensure that rosters allow for adequate time off between shifts and overnight call.

Access to courses

Funding was recently removed from the only EMAC course in Western Australia. This will inconvenience local trainees and substantially increase their costs to undertake the compulsory course – as is already the case in SA, NT, Tasmania and the ACT. With courses now limited to New Zealand and the East coast of mainland Australia, there is a clear increased financial and time burden on other trainees needing to travel for the course. The TMG is keen for the WA Government to reverse this decision and we are pushing for a timely solution to the situation.

Examination performance and feedback

Concerns have been raised by trainees in several regions about declining examination pass rates in recent sittings. While the reasons for this are likely multifactorial, particular questions have been raised about variability in access to and quality of exam preparation courses, as well as the cessation of the centralised Black Bank of MCQs with the same recall practices being continued but in isolated groups, limiting access particularly for trainees in rural areas. We are keen to help identify potential reasons for poor pass rates in some centres and determine avenues for improvement.

This issue is also being pursued by the ANZCA Trainee Committee (ATC), including concerns regarding timing and quality of feedback for trainees who have failed an examination. We are in the process of identifying causative factors and possible solutions. The ASA can help support trainees facing difficulties and advocate for improvements in systems that may be disadvantaging some trainees. As always, if you have any concerns or feedback please contact us at trainees@asa.org.au

Trainee Research Networks

There is growing interest for Trainee Research Networks (TRNs) among trainees and the wider medical community. TRNs are collaborative groups helping trainees interested in research to network, share resources, and collaborate on multicentre studies. Following a similar model to that used widely in the UK, where more than 20 regional anaesthetic trainee research groups operate, TRNs have been established in New Zealand (SATURN, saturn.ac.nz), Queensland (QARRC, qarrc.org) and Victoria (AVATAR, avatarnetwork.wordpress.com). There is strong support for this concept from experienced researchers and committee members from ANZCA and the ASA. TRNs offer a unique opportunity for trainees to be engaged in any/every step of the research process and amplify the scope of projects so that they're more impactful. I encourage you to get involved no matter what your level of training and research experience.

National Scientific Congress 2018

I want to make one last push to encourage you to register for this year's NSC in Adelaide on October 6-9. National conferences are a great opportunity to network, meet new and old friends, learn more about topical issues in anaesthesia, and gain insights into the future direction of the specialty. This year's NSC program is outstanding and features an extensive trainee stream. Adelaide is a beautiful city and you'll have the opportunity to tour one of the world's most expensive buildings – the new Royal Adelaide Hospital!

Dr Richard Seglenieks
Chair, ASA Trainee Members Committee

RETIRED ANAESTHETISTS GROUP

South Australia

Our group in SA meets for lunch on the second Monday of every odd month at the Kensington Hotel, where we have our own private dining room, and from time to time, a guest speaker. Our membership, comprised of colleagues from anaesthesia, intensive care and pain medicine, now numbers more than 80. Some 20-30 colleagues regularly attend our meetings and guests are welcome.

In early May, one of our oldest RAG members, Dr Pauline Nicholson, died peacefully in her sleep. She was 92 years old, and like many of her generation trained in Britain and, as a senior registrar, came to Australia in 1954. There were few consultant anaesthetists here at that time with the Faculty of Anaesthetists RACS being founded in 1952. She directed Anaesthesia at the Royal Adelaide Hospital for many years, and, along with Pat MacKay, Mary Burnell and Teresa O'Rourke Brophy and other women colleagues of that generation, she will be remembered in South Australia as one of the pioneers of our speciality.

At our May meeting, Dr Richard Davis presented 'Bad Blood', an account of the ineptitude and inefficiencies of the commercialisation of clinical services such as blood banks and pathology. For much of his career Richard practised in Whyalla, where such services were provided within the local district hospital and were able to be adapted to more efficient patient requirements. Today's systems are, arguably, analogous to the privatisation of other essential services such as electricity.

In July, Prof Don Moyes, former Director of Anaesthesia at The Queen Elizabeth Hospital, who trained in South Africa, presented 'Capture Myopathy', an account of how large wild animals, such as elephants, rhinos and others are 'anaesthetised' and moved to safer regions. Etorphine and carfentanil are the principal agents used and surprisingly they do not cause apnoea in such large animals. However, in some other animals such as deer, malignant hyperthermia is a not uncommon complication.

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

For further information email: jacrow@optusnet.com.au

Dr John Crowhurst

INSIDE YOUR SOCIETY

HISTORY OF ANAESTHESIA LIBRARY, MUSEUM AND ARCHIVES NEWS

Part of the audience at the recent History of Anaesthesia seminar; the Harry Daly Museum is in the background.

IN PRAISE OF LIBRARIES AND THE RICHARD BAILEY LIBRARY IN PARTICULAR

A modern library is not a silent room full of volumes of printed material. It is, or should be, an appealing, comfortable and stimulating place where one seeks and finds the thoughts and discoveries of people, past and present, with similar interests. It is a meeting place that stimulates thoughts and ideas.

Public libraries are centres of community. Libraries are places providing both human contact and physical objects, there memories revive and ideas flourish.

Libraries have an atmosphere redolent of learning and reflection; the layout usually includes exhibitions, discussion places and meeting rooms. Libraries are places of opportunity, providing a feeling of well-being. The tranquillity aids remembrance and recall, often stimulating relevant but unexpected ideas and pathways.

The difference between a library and the internet is the difference between a scholar and a student. The internet is a display of facts, mostly secondary, often opinionated. It is a frothy cornucopia of experience, whereas scholarly books are based on a bedrock of substantive knowledge and contain thoughtful discussion rarely found on the internet even behind its increasingly prevalent paywalls.

The scholar's knowledge is the result of years of collective experience. It is extensive, expansive and time-consuming to gain so cannot be skimmed from the internet like an insectivorous bat swiftly echo-locating its prey. Scholars' information is more akin to the slow, savouring, gustatory experience of dining with a hatted chef.

Writers' festivals feature reading and discussion as much as writing. It is the special attention that proper reading demands – deep, critical, transformative reading – that engenders curiosity, understanding, the desire to experience and research deeply.

Of course, the ASA's library should, and does, have access to the internet. The advantage of libraries over the internet is physical – libraries provide tangible access to in-depth material, a contemplative view of a range of titles and bindings and, in due time, a memory of how and where particular areas of information are shelved.

Perusing a volume in the Richard Bailey Library, a visitor often discovers more than the published text. Many of the

volumes contain inscriptions, bookmarks or autographs and some have associated letters, reviews or articles. Often just the sight of a spine of a book will bring one's student days strongly to mind, or the smell of a particular hospital's theatre or the character of a colleague. Such associations make the Richard Bailey Library special, important and unique. In addition, Richard, who amassed most of the books in the Library, lives in an adjacent suburb to the ASA's headquarters and may sometimes be persuaded to act as a data mine for ASA members. Such profound depth of experience is rare on the internet. Knowledge builds on knowledge and experience on experience. In a library, books build on other books, leading towards new goals, understandings and expanding insights.

A person in a library may let their gaze glide over the shelves, choosing a title not at random, but because of a name, because of what someone once said in a lecture, because of a binding pleasing to the eye or hand or because the title attracts or is big enough to read without spectacles.

Information on the internet is subject to change and disappearance while the information in books is permanent. Books from personal libraries often have so much intrinsic value – informational, aesthetic, historical and personal – that one is reluctant to lend such volumes.

Books have the leisure of space to properly explore a subject, whereas the internet, like a newspaper, is limited to a word count, peoples' desire for précised information and the time constraints of the modern world.

Some libraries are particularly fortunate to be associated with collections of objects; the Richard Bailey Library is no exception. Like the Welcome Library and Museum in UK and the Wood Library Museum in USA, the Richard Bailey Library has its adjacent museum (the Harry Daly Museum). The knowledge found in books and the knowledge embedded in objects mingle. Visiting minds come away the fuller for experiencing the combined riches.

It is not surprising that old books and old objects work well together. Where is the glamour of looking at a Kindle page of *Origin of the Species*? Who does not experience a quiver of excitement in seeing the characteristic 19th century embossed green binding of a book by Charles Darwin or the gleam of a glass anaesthetic inhaler?

ASA members who discover that the Mesmerism collection in their Library has few equals worldwide may well be astounded.

Those members who trace Dr Reginald Cammack's exhaustive Timeline of Anaesthesia in our Museum (or on our website) will ponder their place and their colleagues' contribution to the profession.

Old books, old objects connect the present with the past but also assist in understanding the changes to come in the future, for change is always with us. To paraphrase Jane Austen, 'It is a truth universally acknowledged, that the future is not what it used to be, or what we expect'.

Today everyone expects to be able to access the internet, but libraries and museums are special places for those with an enquiring mind, intelligence and imagination. They are places to linger, observe and think; the internet is a place only (using an unfortunately recently ubiquitous verb) to grab. Redolent history and the excitements of the future do not emerge like a genie from the electronic screen; whereas from a book all is possible, even probable.

Books and anaesthetic equipment have a continuing place in time; there was a predecessor and there will be a successor. Come and discover; indeed, please use your Society's library.

Office hours or by appointment: telephone 1800 806 654 or 02 8556 9700.

Peter Stanbury
Richard Bailey Librarian

Some rare items from the Library. The book on the right bears the signature of W.T.G. Morton, who in 1846 publicly demonstrated the use of ether as an anaesthetic for surgery. The book on the left is about Mesmerism; it appears to be in the process of revision and requires further research.

A sample of the material in the Richard Bailey Library. We use The American National Library of Medicine classification for cataloguing the books. To explore the collection on line visit http://ehive.com/collections/5441.

INSIDE YOUR SOCIETY

"I DECIDED THAT HE WOULD NOT DIE IN VAIN"

In 1966, after witnessing a 13-year-old boy die from hyperpyrexia (aka malignant hyperthermia) during routine surgery; Dr Frederick Richard Neason 'Dick' Stephens decided that there must be a better way to alert doctors to changes in a patient's metabolic state, rather than relying on monitoring their body temperature or pulse rate. Once the patient's temperature has spiked, hyperpyrexia is very hard to reverse and can be fatal.

For the next 13 years, Dr Stephens says he was 'hell bent' on inventing a device which would give doctors an earlier warning of the likelihood that the patient was developing shock or fever.[1] The microcirculatory system, which allows for the exchange of gases (such as oxygen and carbon dioxide) and nutrients between the blood and tissues, is very sensitive to changes in blood pressure. Therefore, monitoring tissue perfusion will show changes in a person's body temperature and blood pressure sooner than taking their skin temperature or measuring the blood pressure of the larger arteries.

When a patient is under anaesthesia, the tissue perfusion monitor (TPM) measures changes in blood pressure and pulse rate, which may be due to depth of anaesthesia, posture of the patient, blood loss or the presence of shock. Under ideal circumstances, the meter shows stable readings and the assurance of blood flow to the body's periphery. If the monitor shows a significant jump or reduction in tissue perfusion, then this can be an early indication of an impending medical crisis. Dr Stephens described the monitor as a "human fire alarm".[2]

With the assistance of Teletronics in Sydney, Dr Stephens built a proto-type machine. This light weight machine, which uses mains power and can be carried in one hand, sensitively measures and monitors a patient's heart rate (as shown through tissue perfusion) via a transducer which is attached to a finger or ear lobe. The transducer uses a laser light sensor to monitor changes in the patient's blood flow in tiny subcutaneous capillaries and convert these to electrical impulses which are shown on two gauges on the machine.[3] To quote from the abstract of 'Observations on a new non-invasive monitor of skin blood flow': "It employs photoelectric plethysmographic principles to measure changes in the nett flux of red blood cells in superficial microvasculature. The 'tissue perfusion index' (TPI) varies in proportion to SkBF [skin blood flow], provided local haemoglobin concentration does not change significantly. TPI of humans and experimental animals has been shown to indicate reliably, well established phenomena such as decreased SkBF in response to mechanical restriction, cold or Valsalva's manoeuvre, or increased SkBF in response to heat, acetylcholine, sodium nitrite or local nerve blockade".[4]

In September 1970, Dr Stephens presented his 'Calibrated tissue perfusion and heart rate monitor' (as it was then known) at the Asian Australasian Congress of Anaesthesiology in Canberra. It received a lukewarm response from his peers who were used to working without it.

When Professor G. Schimert from the University of Munich tested the device in 1973, he reported that the TPM "shows

The front panel of the Stephens Tissue Perfusion Monitor, donated to the Harry Daly Museum by Bill Stephens in 2018.

local changes of blood flow (perfusion) in relation to a standard end-value (result) with a sensitivity and reproducibility never before reached by a device".[5]

News of this ground-breaking invention travelled across the Atlantic, for in 1974, Dr Willian Kane from the Northwestern University Medical School in Chicago wrote to Dr Stephens asking: "when will that wonderful peripheral flow meter be available in this country? I had a patient yesterday who came as close to 'buying the farm' as you can come and still survive. The problem was that the anaesthesiologists just weren't aware of what was going on with her peripheral perfusion and they got behind in blood replacement. Seriously, there is a great need for that machine and device over here [. . .] so that we can maintain the surgeon's sanity and preserve the patient's vitality".[6]

Dr Stephens went on to test and perfect the monitor with colleagues from Sydney's Mater Misericordiae Hospital (where he was Director of the Clinical Research and Development Unit) and the CSIRO.[7] In 1979 he entered ABC Television's *Inventors* program and was 'stunned' when he was presented with the Inventor of the Year award by the Governor General, Sir Zelman Cowen. He won $3,500, the ABC Inventor of the Year trophy and a trip to Geneva to attend and enter the annual International Exhibition of Inventors (where he won the silver medal). While the prize money in no way compensated him for the $100,000 he had spent on the invention, it did result in him signing a contract with the Wellcome drug firm to make and market the monitor commercially.[5,8] The Stephens Tissue Perfusion Monitor is no longer used in anaesthesia practice – it has been replaced by monitoring the combination of pulse oximetry and exhaled carbon dioxide. Dr Stephens has retired from practicing medicine.

As well as assisting anaesthetists, the Stephens Tissue Perfusion Monitor has other uses. It has been used to measure the levels of stress in primary school principals as blood flow and heart rate is affected by stress.[9] It can also be used as a lie detector, to see if skin grafts have taken, to check for circulatory restitution in vascular surgery, to monitor patients undergoing major dental surgery and to help prevent cot death of babies.[10]

ABC Inventor of the year Trophy, presented to Dr F.R.N. Stephens, 1979. Donated to the Harry Daly Museum by Dr Stephens in 1997.

Dr Stephens continued to do medical research alongside his private practice. With his colleague, Prof J.R.S. Hales from the University of New South Wales, he received grants of $78,000 (in 1992) $55,000 (in 1993) and $50,000 (in 1994) from the Australian Research Council to develop a "non-invasive, easy to use instrument for continuously monitoring blood flow in skin".[11] A man with a medical and engineering mind, he had previously (in 1960) developed the Stephens Anaesthetic Apparatus – a compact portable machine which weighed a little over 15 kilograms and which anaesthetists could take with them to hospitals (and veterinary surgeries) to safely administer volatile anaesthetic agents.[12]

Alison Wishart
Curator
Harry Daly Museum

Dr F.R.N. Stephens holding the monitor which he invented. Photographer unknown.

References

1. Dr Stephens quoted in 'Doctor wins inventors award', *The Canberra Times*, 15 November 1979, 15.
2. "'Human fire alarm' vies for top idea", *The Adelaide Advertiser*, 14 November 1979.
3. 'Medical monitor', *The Canberra Times*, 31 December 1973, 3.
4. Hales JR, Stephens FR, Fawcett AA, Daniel K, Sheahan J, Westerman RA, James SB. 'Observations on a new non-invasive monitor of skin blood flow', *Clin Exp Pharmacol Physiol*. 1989; 16: 403-415.
5. Correspondence dated 16 September 1973, Harry Daly Museum.
6. Correspondence dated 10 December 1974, Harry Daly Museum.
7. 'Doctor's need convincing', *The Sun*, 15 November 1979.
8. 'Doctors win awards for inventions', *The Adelaide Advertiser*, 15 November 1979.
9. Whan L. '"It's Friday and I know it", Observations of a principal at work'. *Journal of Educational Administration*, 1989, 26(2): 141-158, https://doi.org/10.1108/eb009946
10. 'Dr Dick's up for inventor of the year', *North Shore Times*, 14 November 1979.
11. *Uniken*, University of New South Wales, no. 18(1991), 8 November 1991, 6.
12. *Stephens Anaesthetic Machine Owner's Manual*, 4th edition, November 2002.

INSIDE YOUR SOCIETY

AROUND AUSTRALIA

NEW SOUTH WALES

Ammar Ali Beck, Chair

In the last few months we had a significant change to the committee membership. I would like to welcome our new members: Drs Anne Rasmussen (Port Macquarie), Simon McLaughlin (Newcastle), Lan-Hoa Lee (Gosford), Liwei Ren (Sydney), Stephanie Philips (Sydney), Ian Stewart (Sydney), and finally our junior rep will be represented by Dr Dana Perignon Ruth. It is pleasing to see a growing interest in the ASA work particularly from the younger generation. The new committee structure will bring diverse and unique expertise enabling us to serve NSW more efficiently and be more sensitive to the need of our growing membership.

Part 3 course planning is well underway, the meeting will be hosted at the Hyatt Regency – Darling Harbour on the 3rd of November, places are filling up fast. Part zero course will be held on the same day, Dr Jeffery (Senior Trainee Rep) will be representing the ASA.

The opening date for the new Northern Beaches Hospital is fast approaching, lack of details regarding the running of the hospital is causing anxiety to our members. We will continue to support and advise our members as necessary.

It was a unique experience to visit the Harry Daly Museum in the North Sydney office. Despite the limited space, Dr Reginald Cammack and the History of Anaesthesia Committee managed to put together a great display with the addition of new cabinet. The museum highlights what is uniquely Australian advancement in the practice of anaesthesia and I encourage everyone to visit.

We would like to congratulate Dr Michael Cooper from NSW on his AM award in the recent Queen's Birthday honour list for his services to medicine, teaching and contributions to anaesthesia.

QUEENSLAND

Jim Troup, Chair

At the AGM on June 30 office bearers were elected.

- Chair: Dr Jim Troup
- Vice-chair: Dr James Hosking
- Hon Secretary: Dr Michael Steyn
- Hon Treasurer: Dr Chris Breen

Dr Steven Cook has taken up the role of ASA representative on the Combined CME Committee.

The 'Art of Mindfulness' CME event was held on Tuesday 27th March at the Art Gallery. This was fully subscribed; attendees seemed to find it interesting. Thank-you to the ASA for assisting with funding for this event.

The Queensland annual day-long CME meeting incorporating the ASA Qld AGM was held on June 30th. The theme was 'The Occasional Anaesthetist'. There were approximately 120 attendees. Despite this attendance at the College (morning tea break) and Society's (lunch break) AGMs was poor.

The Part 3 course will be held on November 10th this year. The program is almost complete. This will be followed by a social event. The Queensland committee discussed the idea of a New Fellow's evening but was uncertain of the value as many of the topics would be covered in the Part 3 course.

SOUTH AUSTRALIA

Josh Hayes, Chair

The SA Part 3 courses were held in June. Overall, excellent feedback was garnered, however attendee numbers were down due to a variety of reasons such as sickness and roster changes. Commendations to the trainee representatives for their immense effort.

The ASA/ANZCA SA CME Committee continue to provide an interesting and challenging program for Wednesday evening CME. Congratulations again to this group of individuals from our Anaesthetic community. August 22 sees our next local meeting titled "Severe Sepsis: Pathophysiology and Clinical Implications", combined with the ASA (SA) AGM.

TASMANIA

Michael Challis, Chair

Our 2018 winter meeting will be at Barnbougle again on Saturday 25th August. We are expecting another good turnout and look forward to some competitive golf the following day for those who are staying on.

We are fortunate to have one of the NSC speakers (Prof Joyce Wahr) visiting Tasmania following the NSC, and she has kindly offered to give a couple of talks while visiting us. We will be having two ASA-sponsored dinner meetings – one in Launceston on Tuesday 9th October, and one in Hobart the following evening on the 10th October.

WESTERN AUSTRALIA

Philip Soet, Chair

The SJS/ASA joint M and M meeting is provisionally scheduled for early October.

The ANZCA/ASA Country Conference will be held at the Pullman Resort in Bunker Bay on 26-28 October.

VICTORIA

Jenny King, Chair

A 'New Fellows Forum' was held on Tuesday June 12th at the Neighbourhood Bar, Fitzroy.

It was a Q and A approach from various speakers discussing private/public practice with the pros and cons, group and individual practice, billing, welfare and using locum agencies.

This was a very successful night with about 30 people in attendance. Avant very kindly partially sponsored the night and we had good feedback from the attendees.

The ANZCA/ASA yearly combined CME is to be held on Saturday 28th July at the Sofitel. The title of the meeting is 'Rising Temperatures, the Heat is on'. The Honorable Mr John Hewson is one of the guest speakers and the organisers have been able to incorporate a self-audit into the programme enabling participants to gain 20 tantalising CPD points. ANZCA have organised the meeting and the ASA will be chairing two of the sessions.

Nearly finalised is our 'ASA Night for the Mature Anaesthetist' on Thursday August 16th. Topics to be covered will include superannuation, transition to retirement, investment options if over the cap, modifying insurance needs as we mature, medical indemnity insurance as you wind down practice, and consideration of locums as a sea change/tree change option. This event was suggested by our Retired Anaesthetist Committee member and is aimed at ordinary members but particularly those members established in practice. We wait to see the response but hope that members will attend. This event is in partnership with Avant and will be held at their headquarters with drinks and snacks provided.

INSIDE YOUR SOCIETY

NEW AND PASSING MEMBERS

The ASA would like to welcome all new members from May to July 2018.

TRAINEE MEMBERS

Dr Fernando Arduini	WA
Dr Paige Ashton Bavich	WA
Dr Lisa Biggs	SA
Dr Sophie Margaret Boast	SA
Dr David Brooke	WA
Dr Ronald Cheung	NSW
Dr Diana Da Silva	QLD
Dr Ahmad Dawar	QLD
Dr Louise Dawson	WA
Dr Ilana Delroy-Buelles	NSW
Dr Alyssa Gardner	SA
Dr Raphael Grossi Rocha	WA
Dr Arghya Gupta	NSW
Dr Timothy David Hall	SA
Dr James Haslam	WA
Dr Jackson Hawkes-Sutton	VIC
Dr Anoop Jain	QLD
Dr Angus Johnston	WA
Dr Faisal Khan	QLD
Dr Joyce Leung	QLD
Dr Rebecca Madigan	SA
Dr Siaavash Maghami	WA
Dr Ricardo Nates Moron	NSW
Dr Ravindran Samuel Nathan	SA
Dr Tu Nguyen	SA
Dr Myfanwy Painter	NSW
Dr Heather Isabel Patterson	WA
Dr Simon Porter	QLD
Dr Bronwyn Posselt	TAS
Dr Amit Ramavat	VIC
Dr Ambujaan Raviendran	VIC
Dr Alexandra Reid	SA
Dr Benjamin Rose	TAS
Dr Victoria Sabbouh	NSW
Dr Melanie Schulze	QLD
Dr Joanna Patricia Simpson	VIC
Dr Jessica Taylor	QLD
Dr Satya Surya Shravan Varanasi	NSW
Dr Leigh White	QLD

ASSOCIATE MEMBERS

Dr Daniel Coric	NSW
Dr Laetitia Deknudt	SA
Dr Nicholas Lower	VIC
Dr Chrestyl Smoors	VIC

ORDINARY MEMBERS

Dr Babak Amin	VIC
Dr Preeti Ananda Krishnan	SA
Dr Danielle Isabel Crimmins	QLD
Dr James duPreez Drew	QLD
Dr Alastair D'vaz	NSW
Dr Clare Mary Farrell	NSW
Dr Mark William Hayman	VIC
Dr Anthony Oliphant Jackson	WA
Dr Lucy Rebecca Kelly	NSW
Dr George William Kennedy	QLD
Dr Dennis Lee	VIC
Dr Richard Samuel Lumb	SA
Dr Bernard Mc Clement	NSW
Dr Sarvesh Natani	QLD
Dr Sarah Elizabeth Palermo	VIC
Dr Raje Rajasekaram	VIC
Dr Vinay Rao	NSW
Dr Paul Scott	QLD
Dr Eve Shepherd	VIC
Dr Claire Heather Stewart	NSW
Dr Emily Stimson	NSW
Dr Helge Suhr	NT
Dr Kah Wei Teh	NSW
Dr Milena Marie Wilke	WA
Dr Poranee Wongprasartsuk	VIC

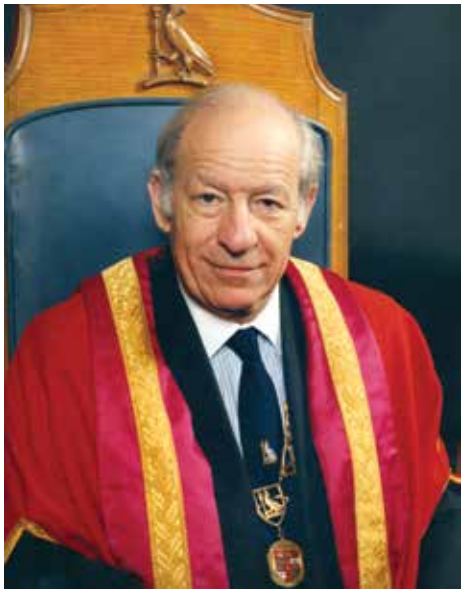
IN MEMORIAM

The ASA regrets to announce the passing of ASA members Dr William Edmond Sweetapple, NSW; Dr William Eric Mann, SA; Dr Thomas Young Anderson, Tasmania; Dr Vilim Stanisich, Victoria and Honorary member Professor Michael Rosen CBE, Wales, UK.

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

PROFESSOR MICHAEL ROSEN 1927 – 2018

CBE, MB CHB, HON LLD, FRCA, FRCOG, FRCS



Last May our speciality lost one of its most revered members when Professor Mike Rosen of Cardiff died, just two weeks after the death of his beloved wife Sally; he was 91. Arguably, Mike was one of the most famous Scottish anaesthetists of all time and will be remembered for his teaching, research, innovations and medico-political achievements, not just in the UK but throughout the world.

Born and educated in Dundee, Mike graduated from the University of St Andrews medical school and trained in Bradford, Newcastle-upon-Tyne and Cleveland, Ohio before being appointed in 1961 to a consultant post in Cardiff, where he spent the rest of his working life and retirement. At that time, the Cardiff anaesthetic department was pre-eminent, and he worked alongside such luminaries as Professor William Mushin and Professor Bill Mapleson. He was awarded a personal chair in 1983, the first non-university NHS post holder in Cardiff to be so honoured.

He quickly established the Cardiff department as one of the leading anaesthesia research centres in the world and mentored many Research Fellows from many countries. As one of those privileged trainees, I owe an enormous debt of gratitude to Mike for guiding me into a most satisfying career in Australia and the UK.

Apart from his work as Secretary, Treasurer and then President of the Association of Anaesthetists, 1986-88, Mike was a leader in 'liberating' the Faculty of Anaesthetists from the Royal College of Surgeons. As Dean of the FARCS, he pioneered the foundation of the College of Anaesthetists in 1988 and became its first President. In addition he was Treasurer and Vice-President of the World Federation of Societies of Anaesthesiologists and a co-founder of the European Society of Anaesthetists, as well as a founding member of the Obstetric Anaesthetists' Association.

His first visit to Australia was as the ASA Visiting Professor in 1974. In 1990 he was a Burnell-Jose Professor and, in association with Prof Barry Baker, then Dean of the FARACS, he met with leading clinicians and researchers throughout Australia and New Zealand.

Undoubtedly though, he will be remembered internationally as the 'Father of Patient Controlled Analgesia' (PCA) following his research, invention and introduction of the Cardiff Palliator the world's first commercially available PCA device in 1976. During his career in Cardiff, Mike published over 170 research papers, and edited and/or wrote seven books.

Cardiff Palliator (1976). First commercially available PCA device. Image courtesy of the Geoffrey Kaye Museum of Anaesthetic History

There are few anaesthetists alive today who have not been influenced in some way by the works, teaching and inspiration of this great man.

Dr John Crowhurst
Chairman
History of Anaesthesia SIG

A more comprehensive obituary to Professor Rosen was published in *The Times*, London, on 6th June. The link is: https://www.thetimes.co.uk/article/professor-michael-rosen-obituary-xtlkzznhr?shareToken=116b01cb94c39d1d17018d4e34815ee4]

INSIDE YOUR SOCIETY

UPCOMING EVENTS

SEPTEMBER 2018

History Week 2018: Life and Death. Anaesthesia and Resuscitation

Date: 6 September 2018, 2-3pm

Venue: Level 7, 121 Walker Street, North Sydney 2060

RSVP: By Friday 31 August to Alison Wishart, awishart@asa.org.au or 02 8556 9708

OCTOBER 2018

ASA NSC 2018

Date: 6-9 October 2018

Venue: Adelaide Convention Centre

Contact: events@asa.org.au

Event website: http://asa2018.com.au/

ACT Thomas Lo Registrars Prize Evening

Date: October 2018

Venue: Canberra, ACT

Applications are now open for the ACT Thomas Lo Registrars Prize evening.

The evening is a great opportunity to showcase and discuss your work, honour our late colleague and enjoy light refreshments with the possibility of walking away with the 1st place prize of $500.

All registrars should consider presenting on this night and we encourage you to start thinking about your presentation early. Please discuss with your supervisor

Expressions of interest to Kym Buckley by Friday 7 September, 2018

Contact: kbuckley@anzca.edu.au

JANUARY 2019

Mindful Practice Workshop 2019

Date: 26-27 January, 2019

Venue: The Playford Hotel, Adelaide

Contact: events@asa.org.au

FEBRUARY 2019

ASURA 2019

Date: 21-23 February 2019

Venue: Peppers Noosa, Queensland

Contact: jmelville@asa.org.au

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

THE ASA NSC *future dates*

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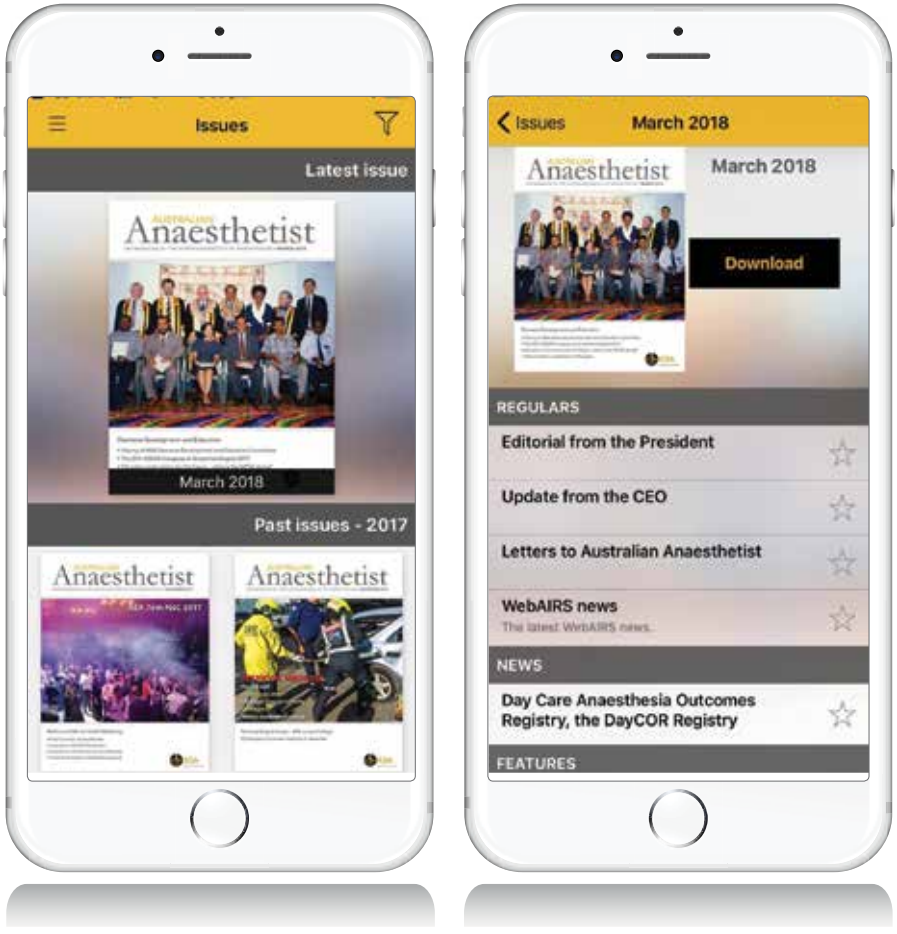

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ASA

Australian Society of Anaesthetists

SAVE THE DATE 6 – 9 OCTOBER 2018

ADELAIDE NATIONAL SCIENTIFIC CONGRESS

AUSTRALIAN SOCIETY OF ANAESTHETISTS | 6-9 OCTOBER 2018

INTERNATIONAL INVITED SPEAKERS

A/Professor Duminda Wijeysundera

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

Professor Joyce Wahr

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

Professor Lars Eriksson

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

AUSTRALASIAN SPEAKER

Professor Lorimer Moseley

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

www.asa2018.com.au

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

THE ASA NSC *future dates*