AUSTRALIAN
Anaesthetist
THE MAGAZINE OF THE AUSTRALIAN SOCIETY OF ANAESTHETISTS • DECEMBER 2019

ASA 78th NSC 2019

MEDICO-LEGAL FEATURE

- The changing medico-legal landscape for anaesthetists
- Take care when setting fees
- Informed consent and the death of paternalism

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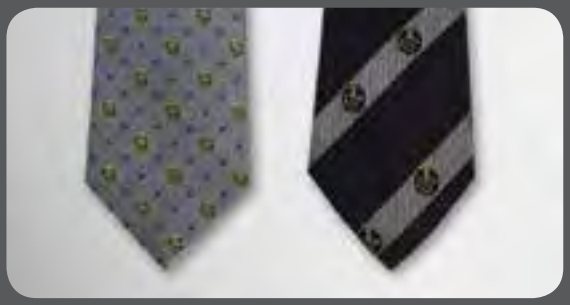

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Letters are welcomed and will be considered for publication on individual merit. The Medical Editor reserves the right to change the style or to shorten any letter and to delete any material that is, in his or her opinion, discourteous or potentially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

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INSIDE YOUR SOCIETY

WOULD YOU LIKE TO CONTRIBUTE TO THE NEXT ISSUE?

The March issue of *Australian Anaesthetist* will focus on volunteer work. If you would like to contribute with a feature or a lifestyle piece, the following deadlines apply:

- Intention to contribute must be emailed by 6 January 2020.
- Final article is due no later than 16 January 2020.

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

REGULAR

LETTERS TO AUSTRALIAN ANAESTHETIST

DIGITAL AGE

I read the September issue feature on the Digital Age with great interest.

I could not help noticing reference to 'irrelevant information'[1] – this is imprecise. Our problem is that we are being buried by data which hides the information. Good digital systems have efficient data entry and present us with information (what we need to know, when we need it). Information is by its nature not irrelevant.

The digital age will be embraced if it improves productivity and interoperability. Productivity will improve as we move to data entry once and check often. Interoperability is another term for 'handover' and if well managed, reduces clinical risk.

Thank you to all the authors for an interesting and thought provoking magazine.

Andrew Walpole
Melbourne, Victoria

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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 shorten any letter and delete any material that is, in his or her opinion, discourteous or potentially defamatory. Any major revisions required will be referred back to the author for approval.

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

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

DAY CARE ANAESTHESIA SIG, NSC 2019

Thank you very much Ken, Martin, and Jui for your contribution to the ASA 2019 conference in Sydney. Big thanks to Tomoko for travelling all the way from New Zealand to be here for the meeting. It was quite an insightful session. Dr Jui Tham from the AHSA shed some light on the issues and functioning of private health insurance in Daycare anaesthesia. Ken gave us a rundown on how the DayCOR registry has been going; we need more hospitals to join in and use the survey. Dr Culwick spoke about day case incidents reported through webAIRS.

A big thank you to Maxine for standing by us and helping us through.

We also went out for brunch so we could catch up socially too. It was a lovely day indeed.

Dr Shravani Gupta

L-R: Martin Culwick, Jui Tham, Ken Sleeman and Shravani Gupta

ASA EDITORIAL FROM THE PRESIDENT

DR SUZI NOU
ASA PRESIDENT

This issue covers some highs and potential lows for Australian anaesthetists. Firstly the highs. A huge congratulations to Dr Anne Jaumees, Convenor of this year's NSC, Dr Alwin Chuan, Scientific Convenor and the entire organising committee. There is a saying that the more you put in, the more you get out and that couldn't be more true of the NSC. Years of meetings by teleconference, the anticipation the day before it all commences, the relief as things come together and then revelling as we all enjoy the fruits of their hard work. I cannot express enough how much of a pleasure it was to be part of this and I encourage members to enjoy Jaumees'[1] wrap of the NSC and be inspired to get involved with future events.

At the other end of the spectrum is perhaps being involved in medicolegal proceedings. Being the source of a complaint or investigation whether it be unfounded, vexatious or not can be one of the most stressful moments in one's career. Throughout any type of investigation, whether it be at a local, hospital level or with a statutory body, the ASA is able to offer confidential peer to peer support. Please do not feel that you have to go it alone.

The ASA also receives complaints and enquiries from patients, particularly when it comes to fees and consent. In this issue, Bird outlines that one of the best strategies in preventing medico-legal claims is keeping 'up-to-date with professional standards and behaviours'.[2] For this reason, I direct you to Leaver and Kumar's[3] outline of the requirements for informed consent whilst Egan[4] navigates the Competition and Consumer Act and its impact on determining one's fees.

In my brief role as President so far, I have been in contact with a number of anaesthetists who have been subject to an investigation or complaint regarding an adverse patient outcome. I have learnt that this happens far more commonly than we might think and perhaps it is only luck that determines whether our many near misses don't progress into something more significant. An adverse event can result in a 'second victim' as the anaesthetist involved experiences considerable distress which is often long lasting.[5] Nearly 20 years since this term has been coined, we perhaps have made some progress in the processes around the reporting and investigation of adverse incidents but have we progressed as individuals or do we still become an 'incredulous jury of peers who return a summary judgment of incompetence'?[5] I particularly thank those who have been in these situations who have been kind to each other and shown emotional leadership. We live in a complex world and there is often more than two sides to the same story.

Finally, a Past President provided some sage advice to thank family at every opportunity. I tried to follow it as best I could during the NSC. I wish to particularly thank the family members of the NSC organising committee for their support and contribution to a highly successful meeting. I also invite you to keep in contact with us, whether it is to get involved or because of concerns in your workplace. Like family, we are here to support you and be with you during the highs and the lows. This is your ASA.

Wishing you a very Merry Festive season.

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5. Wu AW. 'Medical error: the second victim', *BMJ* 2000; 320 (7237):726-727.

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

REGULAR

ASA UPDATE FROM THE CEO

MARK CARMICHAEL, ASA CEO

Much has happened in recent months with the 2019 Sydney National Scientific Congress (NSC) undoubtedly being the highlight. There is a great summary of the NSC within this edition so I won't say anything more, other than to thank and congratulate the Convenor Dr Anne Jaumees, Scientific Convenor Associate Professor Alwin Chuan and all of the committee members who put together such a wonderful event.

Among my personal highlights, and there were many, was indeed the ferry ride from Darling Harbour to Luna Park and return, as part of the family night, where our guests saw Sydney's famous landmarks of the Opera House and Harbour Bridge from the best vantage point possible, on Sydney Harbour. The oohs and aahs from those on the ferry as it rounded Millers Point along with the many photographs taken certainly made everyone feel good.

During the NSC a number of special events occurred. Among those was the awarding to Dr Martin Culwick of the ASA Medal for his outstanding contribution to the profession through ANZTADC and the awarding of Honorary Membership to Associate Professor Lis Evered. I am sure that all members will join me in congratulating both of these worthy award recipients.

At the same time congratulations go to Dr Suzi Nou (Victoria) who was, at the Annual General Meeting (AGM), elected President. Suzi as we know, stepped into the role during the year in an acting capacity, until the AGM. Suzi becomes the 46th President of the Society. At the same time Dr Andrew Miller (Western Australia) was elected Vice President. Members should be pleased that the Society has such dedicated and committed leaders.

We look ahead in 2020 to Wellington New Zealand for the Combined Meeting which I am sure will be a special event. Hopefully the dates of October 16-20 are already in your diaries.

In the three days immediately preceding the NSC, the ASA hosted the Common Issues Group (CIG) meeting in our North Sydney head office. The CIG brings together the senior office bearers and CEOs of the Australian, American, English, Canadian, South African and New Zealand

Common Issues Group (CIG) meeting 2019

L-r: Renu Borst, Debra Thomson, Karen Pappenheim, Mark Carmichael, Natalie Zimmelman, Paul Pomerantz

Societies. The primary purpose of the meeting is to share ideas and discuss common issues shaping the specialty in the various countries.

Members may be interested to learn that four themes dominated this year's meeting:

- Wellness of Anaesthetists;
- Drug Shortages;
- Diversity, Equity and Inclusion within the Specialty;
- Workforce.

Across all six countries these key issues were consistent. While it is not possible to report in detail on the discussions of each matter, it is pleasing to note that the meeting agreed to share resources among each other in order to assist each Society address these issues. Of note in relation to Wellness, was the interest expressed by the other Societies, in particular the Association of Anaesthetists (AA), previously the AAGBI, in our Long Lives Healthy Workplaces toolkit. It is anticipated that this resource will be adopted widely by the AA in order to help address the issue in England.

A second area of interest was that expressed by other CIG attendees was the relatively new governance model established by the ASA in having a Board of Directors responsible for the business aspects of the Society and Council to direct the policy direction. This model is seen as efficient and quite nimble by comparison to some of the larger governance structures where, for example, the US has a 104 person Council. This attracted significant discussion among the CEOs in particular. The Common Issues Group is an excellent forum, that continues to provide valuable information and resource sharing amongst the members. Ideally this will continue well into the future.

My update would not be complete without a reference to the ongoing MBS Review. Drs Andrew Mulcahy and Mark Sinclair along with Professor David A. Scott continue to represent the specialty on the Anaesthesia Information Liaison Group (AILG). Members would be aware that the first tranche of changes came into effect on November 1. Dr Sinclair presented a comprehensive overview of the current position at the NSC and again to the Victorian members at their October 10 meeting. His presentation at the NSC was filmed and members may view it on the ASA website.

Suffice to say the MBS issue has not yet been fully resolved. The ASA, courtesy of Dr Mulcahy, along with Dr Sinclair will continue to engage on behalf of members in order to secure the best possible result.

OPPORTUNITY TO DONATE

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

HARRY DALY MUSEUM AND RICHARD BAILEY LIBRARY: The ASA is pleased announce that both the Harry Daly Museum (HDM) and the Richard Bailey Library (RBL) have been granted deductible gift recipient status by the Australian Taxation Office (ATO). By receiving this endorsement from the ATO it means that any cash donations to the HDM and RBL are now tax deductible.

BENEVOLENT FUND: The purpose of the fund is to assist anaesthetists, their families and dependents or any other person the ASA feels is in dire necessitous circumstances during a time of serious personal hardship.

LIFEBOX CHARITY: The Lifebox project aims to address the need for more robust safety measures by bringing low-cost, good quality pulse oximeters to low-income countries.

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AIRWAY LEADS AUSTRALIA – GET INVOLVED

In 2012, the Australian and New Zealand College of Anaesthetists (ANZCA) released 'Guidelines on Equipment to Manage a Difficult Airway During Anaesthesia' (PS56).

These guidelines are currently being reviewed and major changes have been suggested which will impact on the guideline. Several devices are likely to be withdrawn and new technology introduced. As the Chief Airway Lead for Australia and Chairman of the PS56 review committee, I will be seeking input from the Airway Leads throughout Australia during the review process. The Airway Leads will have a significant role during the review process as well as advising on difficult airway equipment procurement within their health care centre after the new guidelines have been accepted.

The review will encompass adult, paediatric and obstetric difficult airway management trolleys. In addition, both public and private anaesthesia areas including small stand-alone single procedural rooms are being considered. Finally, the PS56 review will consider the diverse requirements encountered from very remote areas to tertiary level hospitals (RA1 – major cities, RA2 – inner regional, RA3 – outer regional, RA4 – remote, RA5 – very remote).

The PS56 review will be breaking new ground by liaising closely with Intensive Care and Emergency Medicine to identify key elements of the difficult airway trolley common to all these specialities. The hope is to establish a 'universal difficult airway trolley' which will then be modified to meet the unique features required in the specific department. The Airway Leads network will be important for the co-ordination of difficult airway management throughout critical care areas and ongoing liaison with other specialists to ensure quality care of patients and support of personnel.

Please consider becoming an Australian Airway Lead for your hospital. Applications are through the following web site: http://www.anzca.edu.au/fellows/safety-and-quality/airway-leads

For further information, contact Keith Greenland, via sq@anzca.edu.au.

Professor Keith Greenland
Chief Airway Lead for Australia
Chairman of the PS56 review committee

WEBAIRS NEWS

EUGLYCAEMIC DIABETIC KETOACIDOSIS ASSOCIATED WITH SODIUM GLUCOSE CO-TRANSPORTER 2 INHIBITORS (SGLT2 INHIBITORS)

WebAIRS has received three reports over the last 18 months where Sodium glucose co-transporter 2 inhibitors (SGLT2), also known as Flozins, have led to euglycaemic diabetic ketoacidosis (EuDKA). In the webAIRS cases, the patients presented for emergency surgery and the SGLT2 inhibitors had not been ceased beforehand. Fortunately, all three patients were managed appropriately, and it was possible to mitigate the degree of harm. The blood glucose levels were 3.4, 5.7 and 14 mmol/L and the plasma ketones were 1.4, 1.0 and 6.9 mmol/L respectively (Normal < 0.6 mmol/L). Two cases were managed in intensive care and one case by an endocrinologist on the ward. All three cases in this series ultimately had a satisfactory outcome but experienced ketoacidosis of varying severity. However, poorly treated DKA can be associated with significant risk of severe harm or death.

SGLT2 inhibitors act by reducing the renal uptake of glucose and thereby increasing glucose excretion in the urine. This mode of action has the potential for diabetic ketoacidosis to develop associated with normal or with moderately raised blood glucose levels. This is known as EuDKA, although it should be noted that the definition includes blood glucose levels up to 14 mmol/L which is above the normal range. There have been several articles and safety alerts relating to the issue of EuDKA published since 2015.[1-4] Perioperative management can be divided into the risk factors, methods for prevention and if DKA occurs then escalating the management.

Risk factors

- Patient factors – Management of diabetes with SGLT2 inhibitors, dehydration, low carbohydrate diet, acute illness, sepsis and the stress response to injury or surgery.
- Task factors – Fasting for a procedure, bowel preparation for a procedure, emergency case and medical or surgical procedures especially major surgery.
- Caregiver factors – Knowledge of the risks of SGLT2i, following an accepted management plan and communication between team members.
- System factors – Adequacy of protocols and adequacy of preoperative instructions.

Prevention

- Assessment – Identify the use of SGLT2i at least 3 days before admission and on the day of admission. If taking SGLT2i, check both plasma blood glucose and plasma ketones by fingerprick or laboratory test.
- Planning – Ensure that management protocols are in place for the perioperative management of patients taking SGLT2i. This should include protocols for elective cases, emergency cases, and where DKA is identified on admission. It is normally recommended that SGLT2i should be ceased 3 days prior to a procedure and not recommenced until dietary intake has completely returned to normal. If dieting is recommended prior to a procedure, for instance, in morbidly obese patients, then the SGLT2i should also be ceased.

Escalate

- Where DKA is detected, enact protocols for management, including a specialist physician, endocrinologist or intensive care specialist. Consider management in a high dependency (HDU) or intensive care unit (IDU). Where emergency surgery must proceed, stabilise as much as possible before the procedure.

This article is intended to raise the level of awareness of the problem with SGLT2 inhibitors and DKA, especially euDKA where blood glucose levels are either normal, or mild to moderately elevated. However, it is beyond the scope of this article to provide a detailed summary of the issues involved and the management of DKA. It is strongly advised that the following references are read[1-4] and that all institutions develop their own customised protocols and management plans.

Dr Martin Culwick
ANZTADC Medical Director and the webAIRS Case Report Writing Group

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FEATURE

THE CHANGING MEDICO-LEGAL LANDSCAPE FOR ANAESTHETISTS

This article is based on an analysis of MDA National's claims data and discussion with the anaesthetists on our claims committees who provide advice in relation to anaesthetic claims.

What are the most common causes of claims against anaesthetists?

Have there been any changes in the medico-legal landscape in anaesthesia over the past decade?

And what are the emerging medico-legal risks faced by anaesthetists?

ANAESTHETIC CLAIMS

Dental injury remains the most common reason as to why claims are made against anaesthetists, comprising around 45% of anaesthetic claims. There has been little change in the frequency of dental claims over the past 10 years. While the average cost of these claims has increased over the past decade with advances in dentistry, such as implants, the cost of dental claims remains modest compared to other causes of anaesthetic claims.

The highest value anaesthetic claims involve the central nervous system. Long-term neurological problems comprise approximately 15% of the claims against anaesthetists. A recent judgment against an anaesthetist involved a 24-year-old patient who suffered paraplegia during spinal surgery. The Court found that the paraplegia was caused by an ischaemic injury to his spinal cord following an avoidable episode of profound cardiovascular collapse during a general anaesthetic[1]. It is worth noting that if 24 hour care is required for a young patient, the potential award of damages in a medical negligence claim could well exceed $10 million.

The highest value anaesthetic claims involve the central nervous system. Long-term neurological problems comprise approximately 15% of the claims against anaesthetists.

Other anaesthetic claims of relatively high value arise from nerve and musculoskeletal injuries. Injuries may be

caused during regional, local or general anaesthesia. They may be the direct result of local infiltration or neurological blockade. Malpositioning and pressure effects, such as from a tourniquet, may be involved. These claims comprise approximately 10% of anaesthetic claims. An increase in the use of regional and local blocks, with or without general anaesthesia or sedation, has led to an increase in the frequency of these claims. Spinal and epidural anaesthesia feature prominently in this group, along with interscalene brachial plexus blocks and femoral nerve blocks. Most of the claims involve allegations of neurological injury suffered during the procedure, leading to persistent symptoms such as paraesthesia, pain and weakness. Some of the common themes are:

- failure to obtain appropriate consent, which may also involve an allegation of inadequate indications for the block;
- failure to use either a nerve stimulator or ultrasound guidance during performance of the block;
- inadequate medical records and documentation.

The latter inevitably reduces the defensibility of any medical negligence claim. Accurate and clear documentation is of enormous assistance in the defence of all claims, especially as this information may need to be relied upon many years after the event when the anaesthetist has no specific recollection of the patient or procedure.

Approximately 5% of claims against anaesthetists arise from allegations of inadequate pain relief, especially in obstetric anaesthesia and awareness under general anaesthesia, usually involving the use of neuromuscular blocking agents.

Drug related events are responsible for around 5% of anaesthetic claims. In 2010, a tragic medication error resulted in a high value claim when a 32-year-old patient who was in labour received an epidural where chlorhexidine 0.5% solution was inadvertently injected instead of local anaesthetic[2]. Two solutions had been placed on the epidural trolley and the anaesthetist chose the wrong container from which to draw up and inject into the epidural space[3].

Other events which feature in moderate to high value anaesthetic claims are:

- failure to adequately protect the eyes, such as during anaesthesia in the prone position or when antiseptic solution is being used on the head during neurosurgical procedures;
- retained throat packs causing airway obstruction following extubation.

COMPLAINTS AND INVESTIGATIONS

Over the past decade, there has been an increase in the number of complaints and medico-legal investigations against all doctors, including anaesthetists. This represents a major and ongoing change in the medico-legal environment.

These complaints and investigations can be very confronting, distressing and, at times, career limiting. The importance of obtaining personalised advice and support during these processes cannot be over-emphasised.

Over the past decade, there has been an increase in the number of complaints and medico-legal investigations against all doctors, including anaesthetists. This represents a major and ongoing change in the medico-legal environment.

MDA National's data reveals that the types of investigations involving anaesthetists are:

- coronial investigations – 40%;
- Australian Health Practitioner Regulation Agency (AHPRA) and Medical Board notifications and investigations – 40%;
- other investigations e.g. hospital – 19%;
- Medicare audits and reviews – 1%.

CORONIAL INQUIRIES

Some of the common underlying causes and themes in coronial investigations and inquests include:

- anaphylaxis, especially where only a single clinical feature (such as hypotension, tachycardia or bronchospasm) is dominant;
- aspiration during induction of general anaesthesia or under intravenous sedation;
- delayed or failed intubation;
- failure or disconnection of anaesthetic equipment;
- unrecognised deterioration in the post-operative period.

AHPRA AND THE MEDICAL BOARD

It is important to be aware that AHPRA and Medical Board investigations can arise not only out of clinical performance and skills issues, but may also occur as a result of health concerns or inappropriate behaviour, such as bullying and harassment.

Complaints and other medico-legal investigations can have a significant impact on the health and wellbeing of doctors. A 2015 survey of almost 8,000 doctors revealed that 17% of doctors with a current or recent complaint reported moderate or severe depression compared to 9.5% of doctors with no complaints, and 15% reported moderate or severe anxiety compared to 7.3% of doctors with no complaints. Doctors with a current or recent complaint were twice as likely to report thoughts of self harm or suicidal ideation[4].

In relation to health, some of the unique risk factors faced by anaesthetists include irregular work hours, on-call stress, not feeling a sense of belonging to a particular team, and the availability and easy access to opioids and other drugs which can contribute to substance abuse. The past decade has seen a much greater awareness of the need to promote good

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FEATURE

mental health amongst the medical profession. Considerable work has been undertaken to try to improve the health and wellbeing of anaesthetists, including supportive workplaces[5].

With the introduction in 2010 of the national registration scheme for health practitioners, all practitioners (and employers) now have a mandatory obligation to report to AHPRA a colleague who has engaged in 'notifiable conduct'. The definition of notifiable conduct includes a colleague who is practising while intoxicated by drugs or alcohol, or practising with an 'impairment' which is placing the public at risk of substantial harm[6]. Impairment is defined as a physical or mental impairment, disability, condition or disorder (including substance abuse or dependence) that detrimentally affects or is likely to detrimentally affect the person's capacity to practise the profession.

With the introduction in 2010 of the national registration scheme for health practitioners, all practitioners (and employers) now have a mandatory obligation to report to AHPRA a colleague who has engaged in 'notifiable conduct'.

In any Medical Board investigations, an anaesthetist's actions will be assessed against the Medical Board of Australia's Good medical practice: a code of conduct for doctors in Australia (the Code)[7]. The Code includes guidance on doctors' obligations in relation to:

- informed consent;
- adverse events and open disclosure;
- working with other healthcare professionals;
- maintaining professional performance;
- ensuring doctors' health;
- professional behaviour.

The Code is 24 pages of essential reading for every doctor who is practising in Australia.

EMERGING MEDICO-LEGAL RISKS

There is not only increased regulatory scrutiny of doctors by AHPRA and the Medical Board – hospitals where anaesthetists are employed and accredited now have a much greater role in monitoring their conduct. Hospitals are increasingly reviewing patient feedback metrics, including complaints, to detect problems with individual practitioners. Adverse publicity, including on social media, can result in damage to the hospital's reputation and business. Importantly, the by-laws of many hospitals require their accredited doctors to report any medico-legal issues, such as a complaint or coronial investigation which may have occurred in another hospital or health facility. This can then lead to a cascade of investigations which may impact on the anaesthetist's ability to work.

Another area of increased scrutiny is anaesthetic billing practices. Anaesthetists have an obligation to ensure that informed financial consent has been obtained from a patient in relation to the anaesthetic costs prior to the procedure wherever possible. This can be quite challenging to achieve, especially in emergency and semi-urgent procedures.

A much greater scrutiny of Medicare billing practices by anaesthetists is also on the horizon.

WHAT TO DO?

Despite these changes, the strategies to minimise medico-legal risks are largely unchanged: keep up-to-date clinically, keep up-to-date with professional standards and behaviours, keep good clinical records and keep good professional relationships with your patients and colleagues.

Dr Sara Bird
Executive Manager, Professional Services
MDA National

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FEATURE

TAKE CARE WHEN SETTING FEES

The Competition and Consumer Act 2010 (Cth) ('the Act') prohibits competitors entering into contracts, arrangements or understandings to fix prices. These provisions apply to medical practitioners who are competing with one another.

Medical practitioners do not have to enter into a written agreement to be found to have breached the Act. An understanding or arrangement will be sufficient, a 'meeting of the minds' to act in a particular way.

Actions that may be in breach of the Act include decisions to:

- Charge the same fees;
- Charge different fees;
- Increase or decrease fees.

Actions that are unlikely to breach the Act include:

- Being aware of the fees other doctors charge;
- Doctors practising through separate entities discussing economic factors, information or formulae that have been used or will be used to determine fees;
- The fact that two or more doctors charge the same fee.

WHO ARE COMPETITORS FOR THE PURPOSES OF THE ACT?

Medical practitioners who practise within one legal entity are not in competition with one another. For example, medical practitioners who are partners in a partnership (where there is no corporate partner) or medical practitioners who are employees of a company. In these instances, the legal entity may set fees for all those within the one legal entity and will not be in breach of the Act. Such arrangements are understood to be internal management decisions about fees made by the entity.

Most medical practitioners do not practise in partnerships any longer and are not often employees. This is particularly so for anaesthetists, many of whom practise either as a sole traders or through a medical practice company of which they are the director and shareholder.

Medical practitioners do not have to enter into a written agreement to be found to have breached the Act.

Anaesthetists may enter into an arrangement with a service entity that provides the anaesthetists with

administrative services. Under these arrangements the anaesthetist enters into a service agreement with the service entity. They are not employees of the service entity. The anaesthetist is acquiring services and is a competitor with other anaesthetists who also have service agreements with the same service entity for the purposes of the Act.

WHEN ARE DECISIONS ABOUT FEES LIKELY TO CONTRAVENE THE ACT?

An anaesthetist must make his or her own decision about the fees he or she will charge a patient.

Under certain contractual arrangements, such as contracts with public hospitals, an offer will be made to the anaesthetist (or a number of anaesthetists) by the hospital to remunerate the anaesthetist/s on a certain basis. The anaesthetist can either accept or refuse the offer made. This is not conduct that will be in breach of the Act.

Anaesthetists who exchange fee information with each other to assist in obtaining informed financial consent from patients will not breach the Act provided there is no agreement on the fees to be charged.

If anaesthetists (who are competing with one another) were to meet and determine the fee they were going to charge a hospital or patient, this would likely be in breach of the Act.

A collective agreement amongst practitioners to bulk bill, no-gap or charge a gap (be it for a fixed amount or variable amount) would likely be in breach of the Act. While it may be thought that the ACCC would be less likely to prosecute parties to enter into arrangements that lessen fees, it may do so. Persons who may engage in such conduct need to also be mindful that a competitor or other person may bring a private action for breach of the price fixing provisions of the Act.

IS THE EXCHANGE OF FEE INFORMATION FOR THE PURPOSES OF OBTAINING IFC A BREACH OF THE ACT?

Anaesthetists who exchange fee information with each other to assist in obtaining informed financial consent from patients will not breach the Act provided there is no agreement on the fees to be charged.

EXAMPLES OF MATTERS PURSUED BY THE ACCC

In 1998 the ACCC commenced enforcement proceedings against individual anaesthetists and the ASA for alleged price fixing. It was alleged that anaesthetists agreed, through their medical practice companies, to charge an on-call service fee of $25 to a number of hospitals. It was alleged that the conduct arose from a series of department meetings at a number of hospitals and that the fee had been proposed by the ASA to members. The matter was resolved based on undertakings provided by the anaesthetists and the ASA and the payment of money towards the ACCC's costs. Monetary penalties were not sought on the basis that it was the first enforcement proceedings against medical professionals following amendments to the then legislation; the then Chairman of the ACCC said that the ACCC would not hesitate to seek penalties in the future.

In 2002 an ACCC action against three obstetricians was settled by consent. The ACCC commenced proceedings against three obstetricians for a collective boycott of a no-gap billing arrangement at a private hospital.

Some other examples of price fixing where the ACCC has pursued proceedings include:

- The suppliers of products who held meetings and telephone conversations during which they agreed on the prices they would charge for certain vitamins.
- The two companies conspired to raise the prices of their products while maintaining their respective market shares. One party to the arrangement reported the conduct to the ACCC and was granted immunity from prosecution. Proceedings were pursued against the other party to the arrangement.

Penalties are considerable and may be up to $10 million for each breach by a corporation and up to $500,000 for individuals. In the case of a corporation, the Court may impose penalties based on a percentage of the annual turnover of the company in the preceding 12 months or if the Court can ascertain the benefit obtained from the conduct, a penalty of three times that value.

ARE THERE CIRCUMSTANCES IN WHICH THE ACCC WILL ALLOW PARTIES TO COLLECTIVELY NEGOTIATE FEES?

Permission may be sought from the ACCC to collectively negotiate fees. This is known as 'Authorisation'. The ACCC will grant an application for Authorisation only if it is satisfied that the likely public benefit from the proposed conduct will outweigh the likely public detriment.

An Authorisation will provide permission for competitors to engage in what would otherwise be anti-competitive conduct for a set period of time. Examples of authorisations granted to medical practitioners include the following:

- Authorisation granted to general practitioners. Under the terms of the Authorisation, medical practitioners within the one medical practice are able to set fees. In this case, the ACCC considered that the public benefit of allowing practitioners to collectively negotiate outweighed the public detriment. The identified benefits included administrative efficiencies, a greater ability in remote and regional

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areas to attract and retain locums and GPs, and the improved continuity and consistency of patient care. Under the terms of the Authorisation, fees may only be set within a medical practice and medical practices will continue to compete with each other on price and non-price terms.

- Similarly, Authorisation was granted to dental practitioners in the one practice to set fees. It was determined that this would improve the availability and continuity of patient care by providing access to additional dental practitioners within a patient's usual dental practice, greater quality of services where dentists are working as a team, greater efficiency in the provision of services with an ease of obtaining appointments, and an increased availability of part-time work for dental practitioners. Any public detriment was said to be countered (as with the general practitioners) by the fact that it was only practitioners within a practice who could agree and agreement could not be reached between practices.
- In contrast, the ACCC refused an application made by the Australian Society of Ophthalmologists to agree fees within a shared practice on the basis that there were a relatively small number of competitors for the provision of ophthalmic services in many geographic areas, a lack of substitutability for many ophthalmic services and not insubstantial barriers to entry to the market. It was decided that the effects of any agreements amongst competitors would reduce existing price competition resulting in higher prices to be paid by consumers. Further it was noted that patients already had access to group ophthalmic practices and the associated benefits of improved communication and teamwork within practices because many set up in a group practice due to the high capital costs of setting up an ophthalmic practice.

A previous Authorisation granted to the Vision Group was distinguished on the basis of consumer expectation of consistent pricing within the group – more than half of the ophthalmologists were employees, and the group was branded to create the expectation of a single business.

CONCLUSION

Medical practitioners need to take care when making decisions about the fees they charge patients or hospitals. This does not mean that they are unable to obtain information to assist them to make informed decisions such as the exchange of financial information and data to assist them to make a decision such as at an industry conference, or cannot know what others charge, however, they cannot agree (in writing, verbally or by conduct) with others what they will charge.

Dominique Egan
Principal, Meridian Lawyers

INFORMED CONSENT AND THE DEATH OF PATERNALISM

Much has been written in relation to the duties surrounding the issue of informed consent following the English case of *Montgomery v Lanarkshire Health Board* [2015] UKSC 11.[1]

In that matter a child born with cerebral palsy failed to prove that the medical treatment his mother received was negligent, but was awarded full damages due to the failure to properly consent her. The case, and a number of similar cases which have followed it, are a strong reminder that it is important to get the consenting process right.

Unfortunately, anaesthetists often stand in a difficult position when it comes to the consenting process, with considerable issues faced accessing patients to obtain consent, as the proceduralist and hospitals drive the admission process. Furthermore, the current environment of day of surgery admissions and short notice of hospital lists makes seeing patients preoperatively difficult. And anaesthetists are not assisted by hospital and procedural consent forms which do not address many aspects of the requirements for anaesthesia consent.[2]

Regardless of the type of procedure, including anaesthetic procedures, a patient's consent to undergo any treatment can only be valid once he or she has been informed of:

a. the nature of the procedure recommended,
b. the material risks associated with it,
c. the alternative treatment options available to them,
d. the material risks associated with those alternate procedures,
e. the risks associated with doing nothing,
f. the risks associated with the concerns of that particular patient.

Of course, patients are also well within their rights to inform their doctor that they do not want to know any information about the risks associated with the treatment. And doctors are entitled to withhold information on therapeutic grounds. However, the courts have indicated that they will be reluctant to accept a failure to properly inform a patient on those grounds unless it has been clearly documented and explained.

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A failure to provide your patients with information concerning treatment options and the risks associated with these, exposes you to a finding that you have failed to meet your obligations to the patient. Such a finding can result in you being the subject of a claim in negligence and a consequential order to pay monetary damages, as well as disciplinary proceedings.

If disciplinary proceedings are commenced, this can lead to findings of unsatisfactory professional conduct and/or professional misconduct. In the event that a finding of unsatisfactory professional conduct and/or professional misconduct is made, this may result in you having conditions placed on your registration or adversely affecting your entitlement to practice.

A failure to provide your patients with information concerning treatment options and the risks associated with these, exposes you to a finding that you have failed to meet your obligations to the patient.

In September 2018 a gynaecologist in NSW was found guilty of unsatisfactory professional conduct and professional misconduct. The gynaecologist was subsequently disqualified from seeking registration for a period of five years.[3] In handing down its findings the NSW Civil and Administrative Tribunal found that generally the doctor failed to fully inform his patients before undergoing surgery, including the failure to inform them of the risks associated with the surgery.

WHAT INFORMATION ARE PATIENTS TO BE PROVIDED WITH?

The court made it clear in Montgomery's case that there is no longer any room for paternalism when it comes to consenting. Patients must be treated as having the right to make their own assessment after considering all of the material information.

Rogers v Whitaker is the seminal Australian case in relation to the duty to warn of risk associated with treatment. In that case an ophthalmic surgeon failed to warn his patient that as a result of surgery on her right eye, she might develop sympathetic ophthalmia in her left eye. As a result of visual loss in the patient's right eye and the development of sympathetic ophthalmia in her left eye with the consequential loss of sight, the plaintiff was left almost totally blind. There was no suggestion that the surgery was performed negligently, but rather the claim arose as a result of the information provided to the patient by the surgeon in the context of her deciding whether to undergo the surgery or not.

The surgery carried a risk of sympathetic ophthalmia. The risk of this occurring was approximately one in 14,000 procedures, although there was evidence that the risk of occurrence may be slightly higher where there had been an earlier penetrating injury to the eye to be operated on, as was the case here.

WHAT IS A MATERIAL RISK?

The High Court concluded that a risk is material if:

a. in the circumstances of that particular procedure, a reasonable person in the patient's position would, if warned of the risk, likely attach significance to it, and

b. if the medical practitioner is, or should be, reasonably aware that the particular patient, if warned of the risk, would likely attach significance to it, then there is a duty to warn of that risk.

When it comes to identifying the risks that a reasonable person would consider material, unlike a medical procedure which may be performed in a variety of different ways according to what a wide body of peers consider competent, there is only one standard. However, in determining what information should be given to a patient, the court said that a standard which has been set by the profession for a particular procedure will usually be decisive.

A failure to undertake these enquiries will place the practitioner at risk of failing to meet his or her obligation to the patient.

The obligation also requires practitioners to undertake enquiries of their patients as to any specific concerns that they may have in relation to the proposed treatment and if they do, to provide them with advice related to those concerns and the recommended treatment. A failure to undertake these enquiries will place the practitioner at risk of failing to meet his or her obligation to the patient.

In *Rogers v Whitaker*, the trial judge found that the patient had incessantly questioned the doctor as to possible complications including the danger of the surgery affecting her 'good eye'. The court held that these enquiries from the patient should have elicited a reply from the doctor dealing with the risk of sympathetic ophthalmia. Accordingly, Dr Rogers was found to be in breach of his duty to his patient.

The duty to consent is however, subject to therapeutic privilege. This means that in some exceptional cases a doctor can withhold information from their patient in the event that they form the view that providing the information will cause harm to the patient. Such circumstances which justify the use of therapeutic privilege are rare and great caution should be exercised in utilising this to withhold information. Advice from senior colleagues and your medical indemnity insurer is advisable if you are considering adopting this course.

WHAT DOES THIS MEAN FOR ME?

It is no longer appropriate for practitioners to determine what information should and should not be given to patients in order to try and shield or protect them from the distress which may be caused by knowing the potential risks associated with treatment. If a risk is a material risk, that is one which a reasonable person or the specific patient due to factors unique to them would attach significance to, then they must be warned of it.[4]

As always, good documentation as to what information was provided to your patient is critical to your defence in the event that civil or disciplinary proceedings are commenced. In the disciplinary forum, the decision maker will also be looking at your documentation in order to ensure that you have met your record keeping obligations as set out in the Medical Board of Australia's code of conduct.

The law requires you to explore with each of your patients any specific concerns that they have, so that these can be addressed by you in deciding the treatment options available and the associated risks, and thereafter in the advice you provide to your patient.

When communicating with your patients it is important that you ensure the information is conveyed in a manner and form which they can understand. The Courts will not find that your obligation to warn your patients of material risks has been met if you provide patients with voluminous, complex and scientific information as to every possible risk. The skill is determining what information is relevant to each individual patient and communicating it in a manner that can be understood. And a good starting point is a standard of information generally agreed by your profession for the procedure.

Cameron Leaver and Karen Kumar
MedConsent

References

1. This case related to allegations that the mother should have been warned of the risk of shoulder dystocia during delivery and the option for an elective Caesarean section, which would have avoided this. The mother's labour was complicated by shoulder dystocia resulting in the child being born with cerebral palsy.
2. Presentation by Dr Kumar to the Federal Board of Australian Society of Anaesthetists on 20 September 2019.
3. *Health Care Complaints Commission v Reid* [2018] NSWCATOD 162.
4. Subject to therapeutic privilege.

FEATURE

ASA 78TH NATIONAL SCIENTIFIC CONGRESS

SYDNEY, 20-24 SEPTEMBER 2019

The conference is over and the banners and registrants are gone. The ASA Sydney's National Scientific Congress (NSC) 2019 is done and dusted and it's time to reflect on what made the conference the success that it was and what I hope you will have taken away from it.

Registrants come to the NSC from all over Australia and in some cases the world. Everyone comes with different backgrounds, interests and thoughts about what they want to get from the meeting, but we know from Australian research that three of the biggest motivators to attend conferences are to learn how to make better decisions, to assess how our practice compares with new and changing standards and for the very practical acquisition of CPD points.

The NSC has always been thought of as a very worthwhile, friendly meeting. It's a great place to get good practical updates with excellent opportunities to hear great lecturers and attend worthwhile workshops. It has always had a reputation for offering plenty of opportunities to catch up with friends old and new. We wanted to capitalise on that fantastic reputation and offer even more.

The theme of the Sydney NSC 2019 conference was 'An Eye to the Future'. Anaesthetists have a dynamic multifaceted profession in the everyday performance of our job and in the factors that influence who we are and how we practice, now and into the future. These factors include among other things: education, research, leadership, communication, multidisciplinary liaison and perioperative medicine. We also need to know how to keep ourselves working safely both professionally and personally. The NSC 2019 aimed to further our knowledge and skills in all these areas. Alwin Chuan, our incredibly able scientific convenor and the committee worked to get a selection of fantastic international, Australasian and local speakers, with workshops and small group discussions (SGDs) that added to this aim. We endeavoured to do all that in the enjoyable collegial setting that is so characteristic of these meetings.

Dr Suzi Nou, the ASA president, opened

the meeting and was immediately followed by a gorgeously evocative rendering of 'We are Australians' in the local Eora language of the Gadigal people of Sydney by Kevin Hunt and his band accompanied by a piano and a didgeridoo. This was followed by a more formal welcome by a local Aboriginal elder.

What followed were four days of stellar speakers, great forums, on and off site workshops and SGDs. Our international speakers were Professor Iain Moppett from Nottingham and Associate Professor Glenn Woodworth. Professor Moppett challenged us in his plenary on the benefits and downsides of standardising anaesthesia care. He proposed that the variability in care provided by individual doctors may be contributing to differences in patient outcomes and posed the statement that we should be concentrating on the needs of the patient rather than the particular desires of the anaesthetist, surgeon or health service.

Associate Professor Glen Woodworth from Portland, Oregon in the USA gave a fascinating overview of competency-based medical education. He used examples of e-learning and assessment milestones that can give a real-time cycle of feedback and engagement for both those being educated and those doing the educating. A/Prof Woodworth comes from long years in both private practice and academia which really informs his very practical approach to the question of how we achieve this in busy clinical settings.

Prof Pam MacIntyre from Adelaide described the history, personal experiences and insights into the current opioid epidemic. From her extensive work as a leading pain specialist in Australia, she highlighted how we have reached the crisis and the initiatives that will hopefully steer Australia away from the worst of the social, health and economic impacts of the mis-use of opioids in our community.

A/Prof Lis Evered from Melboune is a world leading expert on neurocognitive disorders and we were delighted to hear the latest updates on nomenclature and research efforts to reduce the burden of diseases such as delirium and persistent post-operative cognitive disorders. As part of the conference the ASA honoured her long-term contributions to anaesthesia by awarding her with honorary membership of the ASA at the AGM of the NSC.

Professor Colin Royse from Melbourne is a leader in peri-operative ultrasonography for anaesthetists in Australia. He spoke passionately about how all anaesthetists can and should integrate bedside ultrasound into all aspects of their clinical care, from haemodynamic diagnosis, regional anaesthesia, vascular access, pre-operative gastric volume, lung pathology diagnosis, peri-arrest assessment and for trauma surgery. Such was his impact that all the exhibitors with ultrasound machines were delighted to be swamped during the subsequent breaks.

The Pioneer Lecture was given by Professor Alan Merry in honour of Professor Ross Holland (1928-2017). Professor Holland was a giant in the world of Australasian anaesthesia. Among his enormous contributions was being instrumental in the establishment of the precursor of SCIDUA (Special Committee Investigating Deaths Under Anaesthesia) in NSW in 1960. He remained heavily involved in that committee for over 50 years. The idea of a legally protected, anonymous reporting of anaesthesia mortality was a world first and is no doubt contributory to the world class level of safety and an associated excellent worldwide reputation of anaesthesia in Australia and NZ. In his outstanding plenary Professor Merry outlined current efforts in infection control, simulation, crisis management and minimisation of drug errors that continues the tradition and emphasis on safety that Ross Holland initiated. Professor Merry also gave his medicolegal perspectives in a riveting three speaker standing room only session of Anaesthesia and the Law.

Associate Professor Allan Cyna from Adelaide was this year's Kester Brown lecturer. Each year the opening plenary of the NSC is in honour of Dr Kester Brown and his contribution to anaesthesia. A/Prof Cyna gave an intriguing lecture on the problems associated with informed consent, and the paradox inherent in what medical professionals feel they need to inform their patients about, what their patients want to hear and what is determined by legal rulings.

Our closing main speakers were Professor Ken Hillman and Professor Charlie Corke, both intensivists with unique perspectives on futility, end of life decision and the role anaesthetists can play in meeting the needs and wishes of patients and relatives in the last years of their lives. These are areas that will increasingly be important in giving good holistic care to our patients.

In addition to our many inspirational speakers we were able to deliver a myriad of other perspectives to the scientific program including a wonderful leadership stream which included a World leadership panel moderated by journalist Sally Warhaft and including presidents from the societies of anaesthesia around the world including Dr Kathryn Hagen – NZSA; Dr Kathleen Ferguson – AAGBI/Association of Anaesthetists; Dr Linda Mason – ASA (USA) and Dr Daniel Bainbridge – CAS. Other leadership streams included one on personal leadership and management.

We were also proud to continue the trainee day stream that has developed over the last couple of years which was focused on trainees and their needs. As part of our focus on trainees, who are the future of our profession, we introduced a Trainee Audit Prize. This allows trainees, as part of their Scholar Role, to have the opportunity to present at a major meeting. The standard of these presentations was very high and the experience was valued by everyone.

Benjamin Franklin said, "Tell me and I

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forget, teach me and I may remember, involve me and I learn". We know that is what the literature shows as well. Therefore we had a large number of well-attended onsite and offsite workshops including management of obstetric crises, how to do eyeblocks, neuro anaesthesia simulation, and how to do some interesting veterinary anaesthesia at Taronga Zoo. There was excellent response to an awake fibreoptic intubation workshop which was a first for one of our Australian major meetings. This involved active participation in both doing and being the subject of an awake fibreoptic intubation. The feedback was excellent and included a greater awareness of just what it's like to be on the other end of this procedure.

To cater to everyone's need to keep current, update sometimes rarely practiced skills and to earn those valuable CPD points, there were a large number and variety of emergency response workshops including ALS, CICO, paediatric and neonatal resuscitation and management of major haemorrhage.

We had a broad range of small group discussions led by experts, offering up-to-date knowledge and practice in areas as diverse as paediatric TIVA (which sold out in the first 10 days!) to Common Obstetric Crisis Management and Planning For Your Retirement.

We were fortunate to have the Medical Education Trauma/ACCUTE SIGs onsite on the Friday before the conference. I was in the room adjacent to the Trauma SIG and it's not often you hear in the housekeeping announcements "if you hear gunshots don't worry". Both SIGs got great feedback and had speakers that were also able to contribute to the conference proper.

We trialled for the first time three practice evaluation sessions including a PONV audit run by David Elliott, which was attended by almost 100 people and allowed registrants to track PONV in a series of their own patients, thus gaining valuable insights into their own practice and very useful QA points.

Continuing in the tradition of NSCs, there were many opportunities for catching up with friends and colleagues. The International Convention Centre (ICC) is located in a wonderful spot adjacent to Sydney CBD on Darling Harbour. Darling Harbour is always humming because of its great location, wonderful restaurants and things to do. The informal welcome drinks on Friday night were a perfect way to start the weekend while enjoying delicious canapes and a selection of local wines. We elected to continue to have the gala dinner on Saturday night so that as many people as possible could come. The setting was perfect, on the fourth level of the Convention Centre overlooking the brilliant lights of the CBD, with the crowds and the harbour below. The theme was the 'Great Gatsby' and everyone looked incredibly glamorous. It's amazing what a feather boa or a fedora can do for one's looks. The Gatsby-themed decorations and cocktail bar made it all the more special. The photo booth was a hit and I only wish we had access to some of the photos that were taken there. The High Rollers dressed to the theme – they looked amazing and provided wonderful music that just kept people on the dance floor all night.

Sunday night allowed us to relax and unwind after another busy conference day with an informal cocktail event with the exhibitors. Monday took us to Luna Park for the family night. We all boarded the ferry just outside the ICC. It was a little cool to start, but as we took off into the dusk and rounded the corner to see the Sydney Harbour Bridge we all 'oohed and aahhed' as one – even locals like me. The sight of the bridge lit up was pure magic. Luna Park provided its usual magic and the night whizzed by in a blur of dodgem cars, ferris wheel rides and the old school fun rides of Coney Island, like the big slides and the mirror maze.

The other important moments of the conference include the confirming of Dr Suzi Nou as president for another two years after she so ably stepped into the role after Dr Peter Seal unfortunately had to stand down earlier than anticipated

I would also like to congratulate Gilbert Troup winner Dr Ashley Creighton, 1st Best Poster Dr Alan Bullingham, 2nd Best Poster Dr Xiao Liang, 3rd Best Poster Dr Danielle Volling-Geoghegan, Trainee Best Poster Dr Ashley Creighton and the Trainee Audit Prize winner Dr Sneha Neppalli. It was very exciting to see the diverse range of research going on.

Dr Simon Macklin gave an eulogy on Sunday morning for Dr Piers Robertson who was the National Scientific Officer for many years. Piers was awarded the President's Medal in 2018 in recognition of his enormous contribution to the ASA. He was a huge supporter of the NSC including having been the Convenor in 2015. The NSC would not be what it is without him. Piers died earlier this year after a long illness. Simon's eulogy was very moving and very evocative of the tremendous person Piers was.

We were extremely lucky in having tremendous support from our exhibitors and sponsors. Without them it would be impossible to run such a conference. We can't thank them enough.

I'm also very proud of the sustainability initiatives of this conference which included, but was not limited to, measures such as reusable gorgeous bags as satchels, our unused food going to OzHarvest and donation of unwanted toiletries to Orange Sky which is a charity committed to helping the homeless with hot showers. We also donated all pillows, blankets and sheets used in this year's workshops to the Street Level Mission.

I look forward to the Combined Scientific Meeting CSC 2020 in Wellington, New Zealand from 16-19 October 2020. I wish their convenors and committee all the best for a fantastic meeting and look forward to seeing you all there.

Finally when I think of the job of convenor I think of a quote from Sally Warhaft, "nobody does it for you but you rarely do it on your own". I have been amazed by the generosity of everyone who has given their time and effort so willingly. I would particularly like to give unending thanks to the amazing committee for the Sydney NSC 2019 which includes Alwin Chuan (Scientific Convenor), Stephanie Phillips and Andy Cluer (Workshop Convenors), Su May Koh (SGD Convenor), Ting Ting Lui (Social Convenor) with help from Lissa Buenaventura, Malcolm Bannerman (Trainee Day organiser) and Carl D'Souza. A big thanks to Martha Ghaly (anaesthetic registrar) who helped both before and during the conference. Enormous thanks also to Anthony Coorey who in his role as the National Scientific Officer nurtured this conference through like it was his own. Also, to David Elliott who takes over the role as National Scientific Officer this year from Anthony and who gave huge support in multiple ways.

The conference would also not be possible without Ms Denyse Robertson Senior Events Coordinator at the ASA and Amy Buttery and her team from our professional conference organisers ICE. Huge thanks to them for all their work.

Anne Jaumees
NSC 2019 Convenor
(with considerable help from
Alwin Chuan Scientific Convenor)

Simon Macklin gives the eulogy for Piers Robertson

Presidents from the societies of anaesthesia speak on the world leadership panel. L-r: Moderator Sally Warhaft, Kathleen Ferguson AAGBI/AA, Kathryn Hagen NZSA, Daniel Bainbridge CAS and Linda Mason ASA USA

Acknowledgements and the President's Medal were awarded to Peter Stanbury, Martin Culwick and Greg Deacon by ASA President Suzi Nou at the President's Reception

NSC 2019 organising committee: L-r: Anthony Coorey, Ting Ting Liu, David Elliott, Stephanie Phillips, Su-May Koh, Andrew Cluer, Malcolm Bannerman, Alwin Chuan and Anne Jaumees

Take a break on us!

Rural and remote anaesthetists are eligible to receive between $500 and $700 per working day for taking leave.

For more information visit rurallap.com.au or freecall 1800 Rural LAP (1800 78725 527).

The ASA is updating our popular patient information pamphlets on a range of common procedures. These fact sheets can help address many of the questions your patients may have around anaesthesia.

Patient information pamphlets are available for members to download and distribute to their patients as a member service.

The pamphlets can be found on the ASA website:

asa.org.au/member-resources/

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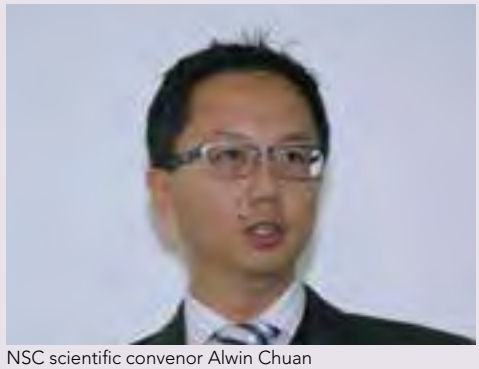
ASA President Suzi Nou officially opens NSC 2019


Anne Jaumees, convenor, NSC 2019


NSC scientific convenor Alwin Chuan


Allan Cyna gives the Kester Brown lecture


Invited Keynote Speaker Iain Moppett


Invited Keynote Speaker Colin Royse


Invited Keynote Speaker Lis Evered


Invited Keynote Speaker Glenn Woodworth


Greg Luck, Exhibition opening address


Uncle Allan Murray gives the Welcome address


Kevin Hunt, Richard Green and Matthew Doyle perform 'We are Australian' in the Eora language

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CIG AND NSC – A PRESIDENT'S PERSPECTIVE

Eighty-five years ago the ASA was formed[1] with the foundation goals to: 1) improve the status of anaesthesia, 2) facilitate the exchange of ideas between Australian anaesthetists and overseas anaesthesia organisations, 3) foster research and 4) publish the journal. I couldn't think of a better way of meeting many of these goals than through the Common Interest Group (CIG) meeting and the National Scientific Congress (NSC).

COMMON INTEREST GROUP (CIG)

The Common Interest Group (CIG) consists of the American Society of Anesthesiologists, Canadian Anesthesiologists' Society (CAS), Association of Anaesthetists (AAGBI), New Zealand Society of Anaesthetists (NZSA), South African Society of Anaesthesiology (SASA) and of course, our ASA. The Executives of each society meet twice a year and the whole CIG meets annually. Each society is represented by the presidents, vice-presidents, past presidents, and CEOs or equivalent. As this was my first CIG meeting, I found it incredibly humbling to be at the same table as these great leaders in anaesthesia and slightly intimidating chairing a meeting of chairpersons!

The first day commenced with a visit to the Mater Hospital, Sydney, whilst the executives conducted their meeting. Thank you to Dr Alastair D'Vaz and all those involved for coordinating our visit. Our time at the Mater was a great ice breaker and enabled people to ease into Australian time and recover from their long journeys.

Each society contributes items for inclusion on the agenda and all are included without editing or censorship. As items were received, it became apparent that there were themes that were common to us all and we changed the traditional country-by-country agenda to one based on these themes. Over the next two days we discussed the welfare of anaesthetists, the anaesthesia workforce, advocating for anaesthesia research, medical education, diversity and inclusion, incident reporting, drug shortages and the environment and sustainability.

How did the ASA compare? On the majority of topics, we had as much to contribute as the other societies. However, all of the other societies are doing work in the three areas of 1) physician welfare, 2) diversity, equity and inclusion and 3) environment and sustainability by way

of forming committees, working groups or having nominated representatives. These areas have been deemed important enough to have human and other resources allocated and to be incorporated into their governance structures. There is a deficit here within our ASA which will be discussed at the next Council meeting. I very much welcome your views.

One of the strengths of this group is the willingness to share resources. I particularly acknowledge the work of the tripartite ANZCA, ASA, NZSA Wellbeing SIG (formerly Welfare of Anaesthetists SIG) Long Lives Healthy Workplaces Toolkit which I presented to the group. There was much interest and a request from the Association of Anaesthetists (formerly the AAGBI) to use and adapt the toolkit to the needs of anaesthetists in the UK. I was impressed that the ANZCA-ASA Australian incident reporting system, WebAIRs has been shared and introduced to Canada. I look forward to sharing further resources from this group with Australian anaesthetists in the coming years.

ASA BOARD AND COUNCIL

Between the CIG meeting and the NSC was the ASA Board and ASA Council meeting. This Council meeting is the largest meeting of the year and the opportunity to hear from all of the working committees of the ASA. One of the important decisions made at this Board meeting which was supported at the AGM was to broaden the Pre-vocational Medical Educational and Training (PMET) category with regard to pre-vocational doctors. Now, any medical practitioner undertaking pre-vocational medical education and training with an interest in pursuing a career in anaesthesia is eligible for complimentary ASA membership. By welcoming a wider range of PMET members, the ASA hopes to represent, educate and support new talent and interest in the field through membership benefits, prizes and grants.

NATIONAL SCIENTIFIC CONGRESS

Anne Jaumees,[2] Convenor, and Alwin Chuan, Scientific Convenor of the NSC provide an excellent wrap-up of the meeting in this edition of *Australian Anaesthetist* which I invite you to read.

One of the behind-the-scenes highlights for me was the President's cocktail function which is held on the eve of the NSC. This is an opportunity to welcome the international and Australian keynote and invited guest speakers. It is also an opportunity to congratulate the ASA Life Members and the 50-year members as well as thank the Board and Council for their hard work. At this year's cocktail function, the ASA Medal was presented to Professor Martin Culwick for his significant contribution to the profession with his work on WebAIRS. Dr Peter Stanbury OAM was acknowledged for his many years of service to the ASA library and museum and we wish him well in his retirement, and the Ben Barry Award to Drs Christine Ball and Rod Westhorpe for their outstanding contribution to the Society's journal, *Anaesthesia and Intensive Care*. Dr Greg Deacon stepped down as Chair of the Communications Committee at the Council meeting and it was an honour to thank him for his 31 continuous years of service as an ASA office bearer. Awarding these prizes acknowledges the history of the ASA and the legacy of the people who have come before. I believe that these individuals who have contributed so significantly to our past and present have laid great foundations for us to build an even greater future.

Another highlight for me was the Gala Dinner. A trail of feathers from various boas led us through the convention centre to the stunning grand ballroom. Looking out from the podium, I was so impressed with how dapper everyone looked in their Great Gatsby-themed outfits. For me, Anne Jaumees won the award for best dressed and most practical (flat) shoes of the evening. After much dancing, I was very envious! Importantly, this function is the opportunity to thank the organising committee for their hard work and many hours volunteered to organise this meeting. Unlike other NSC organising committees, the bulk of the work was conducted by teleconference, which in itself is an incredible feat and deserving of a great party.

For our family, the highlight was definitely the Family Night at Luna Park. It was a refreshing break to spend time with my family during a busy week of meetings and congress. Sydney Harbour was stunning, as always, and arriving by ferry added to the excitement of the night. The looks of wonder and joy on everyone's face as they ran, drove, slid and climbed through Luna Park is something I won't ever forget. It was also wonderful to be a parent amongst other parents.

As I wrote in my editorial for this edition of *Australian Anaesthetist*, I took the opportunity whenever I could to thank our families for their support in the work that we do. Our committee members, our office bearers, our award recipients and the guest speakers are likely to have been able to achieve and contributed what they have because of the support extended to them by their families. In my case, during a busy NSC in the midst of a busy year, I am indebted to my husband Felix and our daughter for their patience, support and humour throughout this time. With that, I wish you and your families all the best over summer and the Festive Season and I look forward to seeing you in a productive and busy 2020.

Dr Suzi Nou
ASA President

References

1. Wilson G. *Fifty Years*, Australian Society of Anaesthetists, 1987.
2. Jaumees A. 'ASA 78th National Scientific Congress', *Australian Anaesthetist*, December 2019, pp. 20-25.

FEATURE

ASA WELCOME DRINKS


Peter Johnston, Kathryn Hagen, Doug Duval, Kathleen Ferguson, Patrick Cesar and Monique Duval


Lucky De Silva, Nicola Ackworth and Peta Lorraway


Time for a chat


Industry reps at Welcome Drinks


Nicole Hunt and Sanaa Ismail


Phillip Melksham and Anthony Coorey catch up with colleague


Geoff Meara, Sally and Anthony Chapman


Cheers!


Simon Macklin and Jan Davies


Marie and Andrew Walpole, James Bradley and Antonio Grossi


Enjoying the evening


Catching up with friends

PRESIDENT'S COCKTAIL RECEPTION

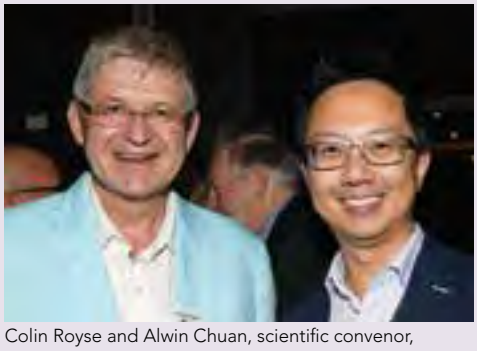

ASA President Suzi Nou and Stephanie Phillips


Traian Cojocaru, Mary Peterson, James Grant and President of the ASA USA Linda Mason


Wayne Braganza, Renu Borst, Raylee and John Ilot


Guy Christie-Taylor, David Kibblewhite and Daniel Bainbridge


Anne Jaumees, convenor, NSC 2019 and Millie Coorey


Colin Royse and Alwin Chuan, scientific convenor, NSC 2019


Monique Duval, Sue Christie-Taylor and Lynaire Kibblewhite


David M. Scott and Brigid Brown


Malcolm Bannerman, Milita Zaheed and Ammar Ali Beck


Phil Morrissey, David Elliott and Michael Ellis


Michael Levitt, Sue Jappy and Murray Selig


Phil Soet and Jim Bradley

FEATURE

ASA GALA DINNER

Delegates having fun

Ava and Andrew Miller and Shannon Dry

Renu Borst and Sereima Bale

Paul Stewart and Ashley Creighton

Guy Ludbrook chats to a colleague

David M. Scott, Antonio Grossi and Colin Royse

Millie and Anthony Coorey with Nicole Fairweather

L-R: Rod Mitchell, Suzi Nou,Traian Cojocaru, Linda Mason, Peter Johnston and Kathleen Ferguson

Sereima Bale with Chris and Cheryl Bowden

Mark Colson and Suzi Nou

Gail and Jim Bradley

President of the ASA USA Linda Mason with David M. Scott, past president ASA

Arun Ratnavadavel, Anne Jaumees and Ammar Ali Beck

Raylee and John Ilot

Phil Soet, Brigid Brown and Greg Luck

Kathleen Ferguson and Peter Johnston

High Rollers entertain the crowd

FEATURE


Dressed to the nines


Iain Moppett and Mark Featherston are all ears


All smiles


Jayanthi Shresta Dhaubhadel and Amir Babu Shrestha


Monique and Doug Duval showing how to charleston


Rosa Hou and Alwin Chuan


Guy and Sue Christie-Taylor


Catching up with friends


Tripping the light fantastic


Rebecca King and John Robertson


Roberta Deam and Richard Bailey


High Rollers entertain the delegates

FAMILY NIGHT AT LUNA PARK


Family fun on the Tango Train


Ting Ting Liu, David Elliott, Anthony Coorey, Anne Jaumees and Su-May Koh


Jenny King, Richard Bailey, Roberta Deam and friend


Alwin Chuan, Lis Everard, Colin Royse, Rosa Hou and friends enjoying the snacks


Families having fun


Etuini Fifita, Selesia Fifita, Millie Coorey, Flavio Brandao and colleague


Who will be thrown off the Joy Wheel?


Izzy, Felix and Suzi


Enjoying the dodgems


Hope we win!


Thrills on the Wild Mouse


Fun for all ages

FEATURE

SESSIONS & WORKSHOPS


Anaesthesia for lower limb orthopaedics conducted by Ajay Kumar, David Auyong and Yean Chin Lim


Simulator workshop TOE


Heather Gunter speaks about Matt's story – a patient's perspective


Robert Barnett, Guy Ludbrook and Simon Macklin, The Deteriorating Patient


Iain Moppett speaks on standardising anaesthesia care


Special Interest Group: ODEC disaster preparedness and response in our region


Peri-operative Point of Care Ultrasound (POCUS) workshop


Masterclass refresher: Pre-operative optimisation


Danielle Ni Chroinin, Masterclass refresher: Hip fracture management


Sally Warhaft, Patsy Tremayne and Lis Evered


David A. Scott, Perioperative Medicine SIG


Day 3 Workshop


Audience at Pioneer Lecture


Mark Sinclair speaks on the MBS Review


Lunchtime Educational: Long Lives Healthy Workplaces


Scott Ma advises on using social media in medical education


CICO workshop


Allan Cyna conducts SGD16: Little words BIG impact: hypnosis and communication in anaesthesia care


Catherine Traill, SGD 16: post-dural puncture headache: what's the current evidence


Workshop 33: nasendoscopy


John Loadsman, Chief Editor of the AIC Journal at the AIC Editor's Session


David Elliott, Clinical Practice Audit: post-operative nausea and vomiting


Panel, Anatomy of the specialty: the ASA member surveys


Charlie Corke speaks at the closing ceremony

FEATURE

EXHIBITION & EXHIBITORS' DRINKS


Getting hands on


Jim Bradley, Anton Booth, Anthony Coorey and Peta Lorraway


Glenn Woodworth and colleague try out the latest equipment


Stephanie Phillips with colleague


Jessica Walker, James Turnbull, Samantha Tong and Min-Qui Lee


Time for a catch-up


Catching up with friends


Industry rep demonstrates new product


Martha Ghaly and Alwin Chuan


Su-May Koh and Iain Moppett


Flavio Brandao, Selesia Fifita, Suzi Nou, Amir Babu Shrestha and Jayanthi Shresta Dhaubhadel


Chatting with industry rep

On behalf of the ASA NSC 2019 Organising Committee, we would like to thank all the sponsors and exhibitors who supported this year's NSC. We look forward to welcoming you all to Wellington in 2020.

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AUSTRALIAN SOCIETY OF ANAESTHETISTS | 20-24 SEPTEMBER 2019

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Teleflex

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AFT Pharmaceuticals
AMBU Australia
ACE
Anaesthetic Private Practice
ANZCA
Avant Insurance/Mutual
BD
B. Braun
bongiorno national network
BTC Health
Charterhouse Medical
Department of Defence Recruiting
Diagnostica Stago ANZ
Doctors' Health Fund
Dräger Australia
Experien Insurance Services
Fisher & Paykel Healthcare
Fujifilm SonoSite
GE Healthcare Australia
Getinge
Getz Healthcare
Global Medics
HALMA
Haemoview Diagnostics
HosPortal
ICU Medical
InterPharma
Intersurgical Australia
Jacq Hats
Juno Pharmaceuticals
Karl Storz Endoscopy
Lateral Medical
Lexus Australia
Masimo
Medical Business Systems
Medistar
MediTrust
Medtronic
MIGA
MSD
Mundipharma
Murray Medical Solutions
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Surgical Specialties
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Vyaire Medical
Westpac
WiZDOM
WSFA
Zeep Medical

For 2020 sponsorship enquiries please contact Denyse Robertson E: drobertson@asa.org.au

2019 AWARDS, PRIZES & RESEARCH GRANTS

WINNERS ANNOUNCED

The awards were presented by Dr Stephanie Phillips

PhD Support

Dr Zoe Keon-Cohen

End of life care and the role of Advance Care Planning for surgery in Australian Healthcare

PhD Support

Dr Rochelle Ryan

Does cefazolin and metronidazole prophylaxis during elective colorectal surgery achieve therapeutic concentrations in plasma and adipose tissue?

ASA Best Poster Prize 1

Dr Allan Bullingham

Ketamine only patient controlled analgesia – audit of outcomes in complex acute pain setting

ASA Best Poster Prize 2

Dr Xiao Liang

Cardiac surgery patient audit

ASA Best Poster Prize 3

Dr Danielle Volling-Geoghegan

Observational analysis of the departmental educational and transfusion practice impact of the TEG6s versus rotem sigma Viscoelastic Haemostatic Assay (VHA) pilot study – Princess Alexandra (PA) Hospital Brisbane

ASA Trainee Best Poster Prize

Dr Ashley Creighton

Comparison of two muscles using a novel electromyographic device to assess recovery from muscle relaxants in patients undergoing general anaesthesia

Gilbert Troup Prize

Dr Ashley Creighton

Comparison of two muscles using a novel electromyographic device to assess recovery from muscle relaxants in patients undergoing general anaesthesia

Kevin McCaul Prize

Dr Gloria Seah

Intravenous lignocaine for the prevention of chronic postsurgical pain in women undergoing caesarean section – The I-Caesar Study

Jackson Rees Research Grant

Dr Jennifer Reilly

Development of a perioperative mortality risk prediction model for adults undergoing noncardiac surgery in Australia

Trainee Audit Prize

Dr Sneha Neppalli

An audit of labour epidural response times at a tertiary maternity hospital

Anaesthesia and Intensive Care

ANAESTHESIA AND INTENSIVE CARE EDITORIAL FELLOW

Dear Colleagues,

Applications are invited from ASA, NZSA, or ANZICS members within their final year of specialty training or within two years of obtaining their specialist qualification for the position of Anaesthesia and Intensive Care Editorial Fellow, 2020.

As with our current editorial positions, the position would be honorary and would be undertaken alongside the applicant's usual employment or training. The term would be for 12 months commencing February 2020.

The successful appointee would be exposed to both the production and editorial aspects of the journal, and would be involved in reviewing submissions, commissioning reviews, contributing to book and media reviews, and undertaking other journal activities, including social media development, all under the supervision of current editorial and/or production staff.

The appointee would be encouraged to attend Editorial Board meetings and the Editors' session at the annual ASA National Scientific Congress. It is anticipated that this activity would be eligible for CPD credits (to be negotiated with the Australian and New Zealand College of Anaesthetists).

Applications will be judged on the basis of applicant's demonstrated interest in research and medical publication. Previous publications experience is desirable but not essential.

Applications should take the form of a one page covering letter indicating the reasons for wishing to undertake this activity, a current CV, and the names of two referees.

Applications should be addressed to the Chief Editor, Anaesthesia and Intensive Care via email aic@asa.org.au by 31 December 2019.

Applicants will be notified of the outcome of their application by mid-January 2020.

Kind regards,

A/Prof John Loadsman
Chief Editor, Anaesthesia and Intensive Care

2019 AWARDS, PRIZES & RESEARCH GRANTS

Jeanette Thirlwell
Anaesthesia and Intensive Care Best Paper Award 2018

T.W. Painter, D.J. Daly, R. Kluger, A. Rutherford, A. Ditoro, C. Grant, S. Howell

Intravenous tranexamic acid and lower limb arthroplasty —a randomised controlled feasibility study

Anaesthesia and Intensive Care Junior Researcher Award 2018

P.C.F. Tan, A.T. Dennis

High flow humidified nasal oxygen in pregnant women

Anaesthesia and Intensive Care Biennial History Award 2019

M.G. Cooper, A.C. Gebels, R.J. Bailey, D.K.M. Whish

Unusual partnerships: The Corfe–McMurdie anaesthetic inhaler of 1918 and the 2nd Australian Casualty


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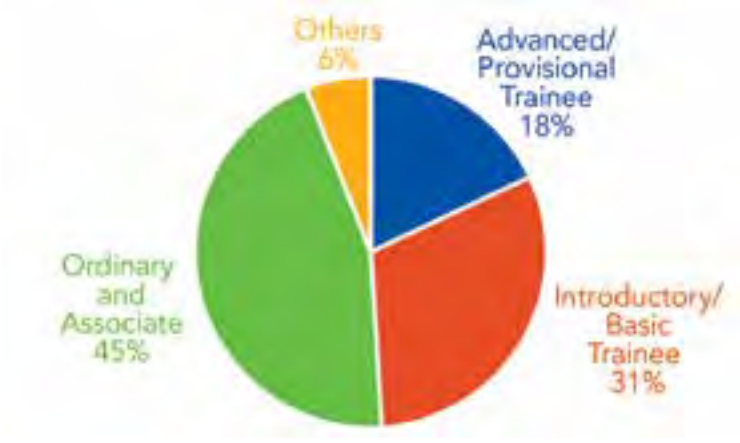
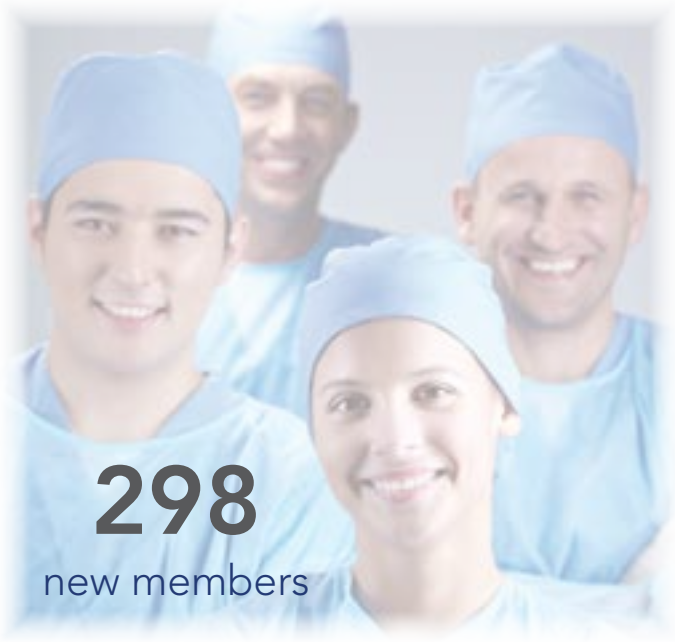
2019 IN REVIEW

MEMBERSHIP UPDATE

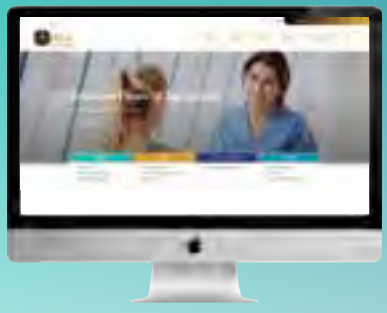
New member statistics





MARKETING & COMMUNICATIONS

ASA website



- **41%** increase in page views
- **71%** increase in new users
- **101%** increase in page views

President enews

> 68% open rate

> 15% click rate

Harry Daly Museum

2,355 visits to online collection

>4.5k followers

> 1.8k likes
> 1.7k follows

> 2.6k followers

ASA APPS

Total downloads

Relative Value Guide

377

Australian Anaesthetist

94

Note: All information and statistics for the period of 1 January to November 2019.

POLICY UPDATE

Submissions:

- **10** submissions to relevant fields of inquiry

Government consultation:

- **22** Stakeholder Engagement meetings

112 policy queries

82% resolution rate

EVENTS UPDATE

SYDNEY NATIONAL SCIENTIFIC CONGRESS
AN EYE TO THE FUTURE
AUSTRALIAN SOCIETY OF ANAESTHETISTS | 20-24 SEPTEMBER 2019

1,041
registrations at the NSC 2019

199
Exhibition registrations

999
people downloaded the NSC App

PMC 2019
PRACTICE MANAGERS CONFERENCE

72
attendees at the annual **Practice Managers Conference**

782+
members attended events
in addition to NSC

>40
events held including **trainee, state, social and combined ANZCA & CMEs**

NEW EVENT
Members' Forum

PART 3 eligible for **CPD POINTS**

FEATURE

PRACTICE MANAGER'S CONFERENCE

CANBERRA, 15-16 AUGUST 2019

The 2019 Practice Manager's Conference commenced with an outstanding networking event held on Thursday 15 August at the Burbury Hotel, Canberra. This event assisted to foster the growth of professional networks amongst the attendees, and provided the grounds to prepare queries and questions for the conference the following day.

The Practice Manager's Conference took place at the Rydges Canberra on Friday 16 August 2019. This year's conference had a landmark attendance of 79 delegates, marking the second consecutive year of the ASA hosting a record-breaking PMC.

This year's PMC focused on providing quality on-the-job information to assist delegates in their professional work environment. The event was segmented into three sessions, with speakers across the first two and a question and answer panel discussion.

Dr Mark Sinclair, Economic Advisory Committee Chair, opened the conference and presented an update of ASA activities over the last 12 months. The first area of focus in Dr Sinclair's presentation was in relation to the Medical Benefits Schedule (MBS) Review. Dr Sinclair informed the delegates in attendance of the incumbent changes and the work of the ASA in assisting to revise the draft report collated by the Anaesthesia Clinical Committee (ACC). It was made clear that of the 5,700 items reviewed, there would be less than 20 changes after the extensive talks the ASA, AMA, ANZCA, and other representative bodies held with the committee.

He reminded delegates that the Department of Health (DoH) has now released the final versions of the changes to the November 1 update of the MBS anaesthesia items. These updates will be published on the ASA website.

Dr Sinclair addressed the growing concerns around the actions and trajectory of private health insurers as his second area of interest. In his talk he outlined the issues that private health insurance had presented the ASA with at a recent stakeholder meeting. The PHI stakeholders indicated to the ASA that the current business model was

becoming unsustainable and they were modifying their payout schemes in an attempt to keep premiums low. Dr Sinclair communicated that issues with Garrison were still ongoing, but that BUPA representatives were apologetic about these problems and made a commitment to take the ASA's feedback to head office.

Finally, the 'bad vibes' were discussed. Dr Sinclair noted that medical practitioners had been broadly criticised in the media in the months leading up to the conference, with the targets of these exposés being high out-of-pocket fees and large gaps in medical bills. He stressed that medical practitioners and practice managers should continue performing their work courteously and professionally, and not let the negativity taint relationships with patients.

The next speaker was Ms Jacintha Victor John, Policy Manager, who gave an update to the delegates on the policy work undertaken. Focusing on illuminating the functions of the team and changes to its structure since the last PMC, Ms Victor John took time to introduce the new team member, Senior Policy Administrator, Mr Patrick Gifford, and give an update on the developments in Informed Financial Consent guides available. She highlighted areas of policy which the ASA engaged with throughout the year and emphasised the recent submission to the Northern Beaches Hospital inquiry. The ASA submission addressed the NSW Committee concerns in relation to work practices and the process of contract negotiation including the importance of due diligence within such engagements.

Since the last PMC, the ASA Board approved access to policy-related information on the ASA website to Practice Managers. Ms Victor John introduced the functionalities of the ASA website in full, giving the delegates in attendance an update on the features newly available to them. This included the President's E-News, policy update section and the newly developed My Health Record Education and Training sections.

These new features will assist delegates to keep abreast of policy developments of the ASA. A video tutorial was played for the delegates in which the Network & Systems Administrator of the ASA, Mr Paul Singh, guided the audience on how to access the features on the ASA website.

Dr Sinclair noted that medical practitioners had been broadly criticised in the media in the months leading up to the conference, with the targets of these exposés being high out-of-pocket fees and large gaps in medical bills.

The next section involved presentations from all our invited speakers for 2019. Speakers presented on a variety of topics ranging from the private healthcare industry, work place issues and MBS compliance.

Mr Harry McCay, Avant, spoke on the appropriate privacy procedures that should be undertaken in an anaesthetic practice to both comply with regulatory standards and to keep patients and staff satisfied. Focusing on the legal perspective on privacy, Mr McCay stressed that whilst only 2% of claims made to Avant are privacy claims, 35% of these claims are represented by breaches of confidentiality. He continued on to outline key areas which delegates should consider when drafting a privacy policy for their practice.

Mr Harry McCay, Avant spoke on privacy procedures

Mr Carey Doolan and Mr Abeer Rahman give a presentation on My Health Record (MHR)

FEATURE

The necessity of backups and regular destruction of unnecessary information was addressed, including the implementation of a privacy system which scrutinised the necessity of the need to collect or retain patient information. Mr McCay made it clear to the delegates that having both a cyber security policy and a cyber response plan is incredibly necessary when using any electronic forms of data storage or communication. According to Avant's statistics, the healthcare industry is over-represented in the total number of annual data breaches. Worryingly, these data breaches have mostly been the result of human error.

Dr April Armstrong, Business for Doctors, highlighted the largely unknown compliance requirements for medical practitioners hidden within the MBS and enforced by the Professional Services Review (PSR). She outlined how established business practices for anaesthetists and practice managers are not necessarily compliant with current legislation. Dr Armstrong encouraged those in attendance to familiarise themselves with the requirements hidden within the extensive literature on payment claims provided by Medicare and the other government bodies.

Dr Armstrong encouraged delegates to be familiar with recent changes to the Practitioner Review Program including the amendments to the *Health Insurance Act* 1973, which introduced the Shared Debt recovery Scheme. Some of the changes included Medicare being afforded the same debt collecting powers as the Australian Taxation Office (ATO), alongside the ability for it to audit back up to two years and a practice being liable for up to 35% for a practitioner billing incorrectly.

The Australian Digital Health Agency (ADHA), Education and Clinical Use Lead, Mr Carey Doolan and Product Manager & Operations Director, Mr Abeer Rahman gave an update on the state of the My Health Record (MHR) system rollout to the delegates. They provided an outline on the changes which have been made that will benefit anaesthetic practices, and a loose road map for future upgrades for MHR. Amongst the new features elaborated upon, Mr Doolan and Mr Rahman commented on the privacy and confidentiality systems in place with MHR, including the system's ability to flag unusual activity, and its password protection capabilities.

Mr Doolan and Mr Rahman stressed the integral changes MHR has made to the landscape of Australian healthcare, with 90.1% of Australians registered for an account and 16,200 health care providers signed up. Their presentation to the delegates outlined how MHR would significantly improve the availability of information within healthcare and reduce instances of medications being prescribed incorrectly. Statistics indicated that of the 250,000 hospital admissions annually due to medication errors, 50% were avoidable with better patient data.

Professor Cathy Owen, ANU & Southern Local Health District, addressed the important issue of mental health in professional spaces. Professor Owen utilised her 34 years of psychiatric experience to give a participation-focused presentation, which focused on the experiences of the delegates in attendance. The presentation was delivered in three sections to cover the

Professor Cathy Owen gave a presentation on mental health

Dr Mark Sinclair takes questions

Chance to catch up

Panel discussion

two main areas of mental health stress within the anaesthetic practice: the mental health of patients, and that of practice staff, including practice managers and anaesthetists.

The main theme of Professor Owen's presentation surrounded the significance of clear and thorough communication. The presentation established the significance of employing empathy with those who are showing signs of stress, and communicating on their terms as well as possible. This was true of both communication with patients and colleagues. She then took the delegates through a mindfulness exercise, to demonstrate a useful, on the job, relaxation and refocusing tool which can be used to eliminate workplace stress.

Ms Cathy Baynie, National President, Australian Association of Practice Managers (AAPM) reminded the delegates of the importance of seeing themselves as business managers and their practices as businesses. In her presentation, Ms Baynie shared some of what the AAPM considers 'The Pillars of Practice Management', discussing business and succession planning, financial management, human resource management, and technology.

The final presentation for the day was from Mr Harry Rothenfluh, Assistant Secretary, Provider Benefits Integrity Division, Department of Health and Mr Phillip Cuttriss, Assistant Director, Medicare Benefits & Veterans Policy Section, Department of Human Services. Dr Rothenfluh and Mr Cuttriss discussed billing compliance and practices with the MBS, focusing on the compliance assurance process which practices undergo and the correct MBS item numbers to bill for patient procedures.

Dr Rothenfluh stressed that 95% of reviewed practices were compliant, and that only 1% of cases reviewed represented sustained non-compliance, inappropriate practice, or fraud. He outlined that the review process was designed first and foremost to serve the 95% of compliant practices. Mr Cuttriss highlighted the effectiveness of the RVG, and in which order MBS items within it should be billed to complete the billing process correctly.

The 2019 conference concluded with a panel discussion, featuring questions which were prepared by the delegates prior to the conference. Delegates engaged in a robust discussion of patient fees, payments, and debt recovery. It was the opinion of the panel that seeking third-party assistance in acquiring debt from a patient was an unwise financial decision for a practice, and it would be more cost effective to issue summons at a local court.

It was the opinion of the panel that seeking third-party assistance in acquiring debt from a patient was an unwise financial decision for a practice, and it would be more cost effective to issue summons at a local court.

Special thanks are extended to Ms Jade Melville, the ASA's Events Coordinator, for her hard work in making the 2019 PMC a successful event and her dedication to making the conference another excellent one to remember.

Feedback received from the PMC 2019 survey indicated that the practice managers in attendance enjoyed themselves thoroughly and found the event both engaging and informative.

We're looking forward to seeing you all in 2020!

Jacintha Victor John
Policy Manager

Patrick Gifford
Senior Policy Administrator

FEATURE

ASSOCIATION OF ANAESTHETISTS TRAINEE CONFERENCE, TELFORD, UK

3-5 JULY 2019

I received an unexpected telephone call to notify me that I was successful in my application for an overseas CIG scholarship. I had an exciting time planning my itinerary: it was my first trip to the UK so there were a lot of tours to book and places to visit.

After four days in London visiting palaces, castles, museums and enjoying the culture, I took the train to Telford, Shropshire. After the conference, my trip continued with a few days in Glasgow, Edinburgh and York.

The conference was held at the Telford International Centre. Prior to the opening of the conference on 3 July, I was invited to attend the Trainee Committee's formal meeting. It was really interesting to see the similarities and the differences between the trainee committees in Australia and the UK.

There is significant difference in the structure of the Trainee Committee. The committee members seem to be elected by trainees all over the country. So, they are not just representing their own area. Considering the geographical differences between the UK and Australia, it makes sense. The committee members were focussed on different tasks; e.g. a few were Wellbeing Leads, some were Environmental Sustainability Leads and so on. All activities were coordinated by the Chair of the Committee, Dr Sally El-Ghazali. Her role in maintaining a friendly relationship amongst the group, while ensuring the committee achieved their goals, was inspirational.

Panel discussion, left to right: Dr Kathleen Ferguson, President, Association of Anaesthetists, Prof. Colin Melville, Medical Director and Director of Education and Standards, GMC, Dr Janice Fazackerley, Vice President, RCoA and Dr Sally El-Ghazali, Trainee Committee Chair, Association of Anaesthetists

The committee were well supported by the President, Immediate Past President, Vice President and Chief Executive Officer of the Association of Anaesthesia, who attended the meeting. Other members included Immediate Past Trainee Committee Chair, Trainee Committee Local Organiser, BMA JDC Representative, Defence Anaesthesia Representative, RCoA Representative and SAS Representative.

In addition to the regular meetings that the Trainee Committee members attend (personally or via teleconference), they also try to organise the occasional informal gathering to keep in contact with each other.

Trainee members represent about 30% of the association's total membership which is about 11,000 members.

The motivation for joining the Association includes receiving industry-leading publications and discounts on books published by Wiley, and access to related publications from Cambridge University Press. Free patient transfer insurance cover, discounts on events, online learning, advocacy and campaigning for the anaesthesia profession, wellbeing and career support, networks and NUS cards for trainee members.

Occasionally, the Association of Anaesthetists run campaigns overseas to encourage more membership; recently a campaign was held in India.

Suggestions from attendees on small changes that could improve their working life

Left to right: Karin Pappenheim, CEO, Association of Anaesthetists, Dr Maryam Farzadi, ASA TMG and Dr Sally El-Ghazali, Trainee Committee Chair, Association of Anaesthetists

The trainee issues are the same and their strategic vision includes:

a. Trainees: aiming to provide excellent training including annual trainee meeting, promote eLearning and also being involved in BMA Junior Doctor Contract.
b. Wellbeing: Some of the activities are:
   - Establishment of the role of 'Wellbeing Leads' on the committee, launch of the trainee well-being initiative award, Initiative Fatigue infographic packs and direct negotiation with local MPs, collaborate with other stakeholders, including attending the meeting, publishing articles, using social media for awareness and wellbeing seminars.
   - Providing support for the Less Than Full Time (LTFT) group, preparing support, parents' guides, network and 'Supported Return to Training' seminar, handbook and network.
   - Fatigue management is taken very seriously. There are packages to inform trainees about how to report and manage fatigue.
c. Advocacy and campaigns:
   - Informing all anaesthetists including trainees, about major trainee issues and active networking via social media. A lot of ongoing initiatives continue to be promoted such as #youvebeenmugged, #coffeeandagas, WhatsApp Trainee Wellbeing Group and posters.
   - Advocating a mentoring program and anti-bullying campaign including awareness for active bystander/ civility in the workplace, work to form part of a relaunch of the #knockitout initiative, and being involved in charities such as SAFE Africa.
d. Environmental: Having trainee leads and also an Environmentally Sustainable Anaesthesia Fellow since 2013, shows how serious the Association is about the environment. There was a very useful talk during the conference about their activities and future planning. Overall, the enthusiasm and commitment of every single member of the association was really amazing.

The annual trainee conference is mainly planned and run by Trainee Committee members; thus, it follows the Committee's vision.

The first day of the conference consisted of three separate sessions, each with three topics, including perioperative medicine, core topics and trauma/retrieval. At the same time, a poster exhibition and judging was taking place. 'Papers of the year' were presented by Professor Andrew Klein, Editor-in-Chief, *Anaesthesia*. He also announced the new impact factor for the journal of 5.9.

A complimentary networking drink session was the best end to the day. It provided a great opportunity for trainees from different hospitals and trainee levels to meet out of their working environment. It seems that more than 350 trainees participated in this year's Trainee conference.

I found day two of the conference very interesting from start to finish. The first session was titled: 'What's new in the 'ologies', and included three talks on predicting bleeding risk in preoperative patients, ECMO and stroke thrombectomy.

Professor Colin Melville, with his vast experience as Medical Director, and

ASA TRAINEE MEMBERS APPLY FOR OUR 2020

INTERNATIONAL SCHOLARSHIPS

$4K*

Canadian Anesthesiologists' Society

HALIFAX, NOVA SCOTIA, CANADA

19-22 June 2020

Association of Anaesthetists

NEWCASTLE, UK

8-10 July 2020

American Society of Anesthesiologists

WASHINGTON DC

3-7 October 2020

APPLICATIONS CLOSE MONDAY 9 MARCH 2020

Download a copy of the application guidelines
https://asa.org.au/trainee-members-group-tmg/

If you are not already a member, please contact:
membership@asa.org.au or 1800 806 654

Each participating overseas Society provides one complimentary registration for the Scholarship winner to their meeting.

**Available exclusively to ASA Trainee Members. Each scholarship is valued at $4,000 to cover cost of airfares and accommodation.*

ASA
Australian Society of Anaesthetists

FEATURE

'60s themed party, Royal Air Force Museum, Telford

Association of Anaesthetists' Trainee Conference

Director of Education and Standards in GMC, started the second session with his talk about the global workforce crisis, which was well received by the audience, evidenced by their interactive questions.

Ongoing sessions were all about the different aspects of 'Dr Wellbeing'. First a panel covering the universal hot topics including anti-bullying campaigns, fatigue management, strategies for burn-outs and the question of 'Anaesthetist or Anaesthesiologist?'

An informal 'wellbeing lunch' was organised by the Association of Anaesthetists to advocate on all aspects of doctors' wellbeing and also provided a great opportunity for doctors in different hospitals to share their positive experiences. An interesting innovation was writing the wellbeing ideas on a sticky note and placing on a noticeboard. There were a lot of new and interesting ideas.

The afternoon session was mainly about advocating 'An attitude to gratitude', 'Mindfulness and resilience building' and 'mentoring' followed by an explanation of a successful 'Telford Initiative' and future technological innovation.

The final talk of the first day, via Skype, was the very interesting topic of sustainability. The Association of Anaesthetists, Newcastle upon Tyne Hospitals NHS Foundation Trust and the Centre for Sustainable Healthcare have appointed a fellow in environmentally sustainable anaesthesia. The fellow will create guidelines to be implemented in all hospitals by coordinating with an anaesthetic trainee in each hospital. I thought it was a good idea to have a comprehensive plan for the whole country instead of spontaneous, sporadic action at different levels in some hospitals.

The second day finished with a '60s-themed party at the Royal Air Force Museum in Telford. Held in an amazing setting and combined with a great band and their perfect music choice, it was a fun evening.

The last day of the conference was targeted at different groups. We had three parallel lectures for primary/final and post FRCA trainees. Post-final lectures covered similar topics to Part 3 courses in Australia. When they heard about the ASA's full day course and the topics that are covered, the Trainee Meeting Committee were interested and asked for a detailed programme.

The final session of the conference was an interesting debate regarding social media titled: "This house thinks social media is detrimental to the medical profession" which was quite interactive; the trainees were involved by being able to vote via the conference app.

I sincerely thank the Trainee Member Committee and the Association of Anaesthetists for their warm and friendly hospitality. I truly enjoyed attending this conference and it was an amazing and absolutely useful experience. I hope to have more interaction with the members of the Trainee Committee and to share experiences.

I would like to express my gratitude to the Australian Society of Anaesthetists and all Trainee Committee members, (especially Dr Richard Seglenieks the TMG Chair) and everyone who voted for me. It made this trip and wonderful experience possible.

Dr Maryam Farzadi
Royal Brisbane and Women's Hospital
Brisbane, Queensland

INSIDE YOUR SOCIETY

ECONOMICS ADVISORY COMMITTEE

DR MARK SINCLAIR
EAC CHAIR

MEDICARE BENEFITS SCHEDULE REVIEW

At the time of writing, the November 2019 edition of the Medicare Benefits Schedule (MBS) has only recently been released. The changes publicised by the ASA in this and other media during 2019 have now all been put into effect. Details of the changes are available to ASA members on the ASA website, via the banner on the home page, and at https://asa.org.au/mbs-review-package-for-november-1-change/

Two of the documents on this page are also available to the public:

- 'Why the Gap?', which explains the reasons for the existence of out-of-pocket (OOP) expenses for anaesthesia services in the private sector.
- 'MBS Changes for Patients', which is a brief summary of the November 2019 changes.

These two documents can be accessed by anyone visiting the ASA home page, by following the links *Patient Information/ Patient Resources*.

As members will be aware from previous correspondence, the overall result of the November 1 changes will be a decrease in Medicare expenditure on anaesthesia services of approximately 3%. Coming on top of a 7-year Medicare indexation freeze, and decades of consistently inadequate annual indexation of rebates, this is most disappointing. *The ASA was opposed to all funding cuts recommended by the MBS Review Anaesthesia Clinical Committee (ACC).* After two years of difficult negotiations with the Department and Minister, the ASA was able to minimise the impact of the ACC recommendations on anaesthesia funding. However, the Department was insistent on implementing some recommendations. Nevertheless, the final result is still far better than what was expected if the full set of recommendations of the ACC had been adopted.

Another positive outcome of the ASA's work on the MBS Review has been the formation of the Anaesthesia Implementation Liaison Group (AILG) through the Department of Health. The role of the AILG, to date, has been to oversee and provide advice on the November 1 changes to anaesthesia items in the MBS, in particular the numerous changes to the wording of descriptors and explanatory notes which were required.

The plan is now for the AILG to continue to meet on a regular basis. The stated aim is to continue stewardship of the MBS Relative Value Guide (RVG) for anaesthesia, to reflect changes to surgical and anaesthesia practices as we move forward. The first post-November 1 teleconference meeting of the AILG will be held in mid-December.

As always, members are encouraged to approach the ASA via policy@asa.org.au if they have suggestions for changes or additions to the RVG.

The ASA has engaged in regular meetings with the AMA, to plan how we will respond with the AMA and ASA versions of the RVG. These two versions are virtually identical, but do contain a small number of differences to the MBS. These differences will be highlighted in the RVG booklet.

The ASA and AMA work together closely on the issue of introducing new ASA/AMA items or making changes to existing items. The approach of the two organisations to MBS changes introduced as a result of the Review are very similar, but with subtle differences.

The ASA will add or alter items in its schedule whenever this is seen as appropriate and reflective of safe and contemporary anaesthesia practice. Typically, the process will start with feedback or suggestions from ASA members or groups of members (eg an ASA/ANZCA Special Interest Group). The Economics Advisory Committee (EAC) will formally consider such suggestions, and if agreed, will recommend the change to the ASA Board and Council. If all ASA bodies are in agreement, the change will be made. The ASA will then also recommend the resulting alteration(s) to the AMA.

Both the AMA and ASA reserve the right to reject changes to their Schedules as a result of the MBS Review, if these changes are seen as inappropriate. For example, both organisations may well reject alterations/deletions if they appear to be aimed purely at cost savings.

As a result of the enormous number of changes expected to the MBS across all specialities, the AMA has formed a Fees List Committee, specifically to address these issues. The agreed policies of this new Committee are:

- *the MBS item descriptors will be reflected in the AMA List of Medical Services and Fees, which have been identified by a formal assessment process, such as the MBS Review Taskforce or the Medical Services Advisory Committee;*
- *where the MBS fees have been reviewed (through a formal process such as the MBS Review Taskforce or the Medical Services Advisory Committee) the AMA will use the new MBS fees as the starting basis to revise the AMA fees but at the AMA fee level to maintain relativity with existing AMA fees, using the AMA Fee Setting Methodology;*
- *if the peak specialty college, association or society provides the AMA with a copy of its submission to the relevant assessment process that demonstrates that it sought, and provided evidence to support, a different outcome to the recommendations of the Government process, the AMA Fees List Committee will review the item descriptor and/or fee for inclusion in the AMA List of Medical Services and Fees; and*
- *where an unnecessary restriction, identified using the AMA Guidelines on AMA and MBS Alignment, is placed on the MBS item descriptor's use, the AMA Fees List Committee will consider whether it should be highlighted to members that the AMA does not support the MBS restriction, because it has no value and appears to be designed to reduce expenditure rather than being decided on a clinical basis.*

This is an entirely reasonable approach, but it does mean that an extra level of formal dialogue between the Fees List Committee and organisations such as the ASA is necessary, whenever a particular specialty group disagrees with the results of the MBS Review.

Table 1

MBS Item	Anaesthesia Service	AMA/ASA Item	MBS Change	AMA/ASA Schedule
20902	Anorectal procedures	CH902	Exclude 'banding of haemorrhoids'	No such exclusion
21922	Radiological procedures	CS922	Decrease to 6 units	Remains at 7 units
21936	Trans-oesophageal echo	CS936	Decrease to 5 units	Remains at 6 units
22070	Cardioplegia during CPB	CV070	22070 deleted	CV070 remains
25015	Age modifier	M1	Changed to <4 yo, ≥75 yo	Accept <4 yo, remains ≥70 yo

Dr Andrew Mulcahy and myself met via teleconference with the AMA Fees List Committee in October. As a result, there are a number of items which will not be changed in the ASA and AMA versions of RVG, despite being altered or deleted in the MBS. These are listed in Table 1.

These differences between the ASA/AMA and MBS versions of the RVG are obviously important where anaesthetists are remunerated according to the AMA or ASA Schedules, for example, workers' compensation or 3rd party motor vehicle accident cases in some states, or after-hours emergency cases in some public hospitals.

I again express my thanks to the members of the EAC, the Professional Issues Advisory Committee, the Public Practice Advisory Committee, the ASA MBS Review Working Group, the AMA, and the ASA secretariat at North Sydney, for the enormous effort involved in attaining a far better-than-expected outcome from the MBS Review.

POST-MBS REVIEW

The ASA, ANZCA and AMA will continue to have input into the AILG in 2020 and hopefully beyond. The MBS deletions or cuts with which we disagree will be highlighted. Examples include the deletion of items relevant to medical perfusionists (22070 for cardioplegia administration), and blood transfusion (22001). The case of 22001 (collection of blood for autologous transfusion) is particularly interesting, given the Patient Blood Management Steering Committee of the National Blood Authority has supported services such as isovolumic haemodilution. We are fortunate that Dr Greg Deacon will join the committee reviewing MBS items for blood transfusion services. All members will know Greg well, as a past EAC Chair, ASA President and Life Member. Greg also has a special interest in cardiothoracic anaesthesia, and therefore is an ideal person to provide input on the use of blood products during anaesthesia care. Also, we have already had some success, in that there is agreement from the Department that rebates for cardiopulmonary exercise testing (CPET) should not be restricted to the services of respiratory physicians, but applicable to any suitably qualified specialist.

Each individual anaesthetist must now decide how he/she will respond to the cuts to the MBS. It is perfectly reasonable to continue to base fees on the AMA/ASA version of the RVG, despite cuts to,

INSIDE YOUR SOCIETY

Table 2

Source of health consumer OOP	Expenditure	Percentage of total
Non-prescribed 'over the counter' substances	$9.4b	30.8%
Dental expenses	$6.0b	19.6%
Referred/non-referred medical services	$4.0b	13.1%
Hospital services	$3.9b	12.7%
Other (devices, prescribed medications, allied health etc)	$7.3b	23.8%
TOTAL	$30.6 billion	

or deletions of, the relevant MBS items. Obviously, best possible informed financial consent (IFC) practices are essential, here. Members are welcome to utilise the ASA's online IFC resources, or to contact the ASA for assistance if required.

The importance of IFC cannot be overstated. Out-of-pocket (OOP) expenses for doctors' fees have been receiving an enormous amount of negative attention in recent times. Obviously the ASA does not support the rare cases of extremely large OOP expenses which are regularly highlighted in the media. The ASA position is that the AMA Schedule of Fees represents a reasonable maximum, unless there are extenuating circumstances (eg a need to travel to a distant location and/or fund accommodation, in order to provide services).

The vast majority of doctors charge fees which are fair and reasonable, but clearly this does not suit the rhetoric of some stakeholders with ulterior agendas. Furthermore, in the current climate, fee charging practices which involve any OOP expense, but which are not accompanied by best possible IFC practices, are enthusiastically seized upon. It should be noted that for in-hospital services in the private sector, the incidence of 'no-gap' billing remains high at 87% for all medical services, and 75% for anaesthesia services.

Figure 1: year-by-year increases (inflation-adjusted) in OOP expenses

It is worthwhile noting certain statistics in the report 'Health Expenditure Australia 2017-18' released by the Australian Institute of Health and Welfare (AIHW) earlier this year. This report is available to the public at aihw.gov.au. Private practice doctors' fees are regularly being negatively reported in the media, and are being subject to government initiatives such as the online fee comparison website being planned.

Yet 87% of OOP expenses to Australian health consumers were for goods and services other than medical fees (Table 2). The largest expense was for medications not subsidised by the Pharmaceutical Benefits Scheme (PBS), including over-the-counter (OTC) medications, vitamins and health-related products. These accounted for $9.6 billion (31%) of out-of-pocket healthcare expenses. Despite unproven efficacy and unnecessary costs for OTC substances, with billions of consumer dollars being wasted, there appears to be no political or media appetite to address this situation.

Furthermore, the year-by-year increases (inflation-adjusted) in OOP expenses for doctors' services show an interesting pattern, when compared to other costs of living, and Medicare rebates (Figure 1). Clearly, the widespread, negative, and at times overtly hostile attitude towards doctors' fees is nothing but a distraction from a number of real issues.

PROFESSIONAL ISSUES ADVISORY COMMITTEE

DR ANTONIO GROSSI
PIAC CHAIR

Technological advancements and regulations are intended to improve life, promote safety and save us time. If one considers technological improvements in motor vehicles, seat belts, stricter enforcement of traffic laws and better roads, there is no doubt that lives have been saved. For anaesthetists in the front line of healthcare service delivery, teaching and research, implementation of perhaps well-intentioned regulations such as 'Safe Script', the 'Electronic Medical Record', and even changes to the MBS are causing an increased compliance burden for members.

CHANGES TO THE MBS 1 NOVEMBER, 2019

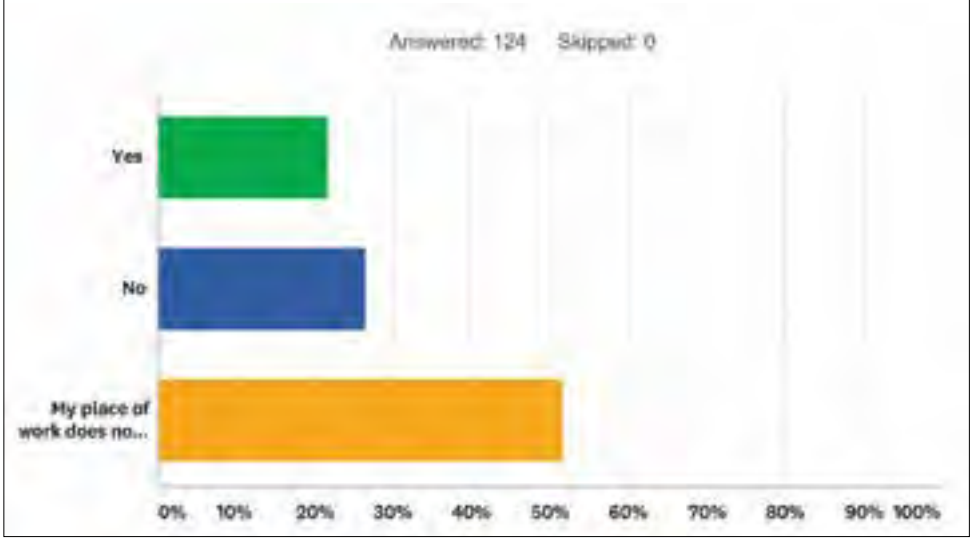
By now most ASA members have been updated on these changes. Dr Mark Sinclair has covered this area extensively, including presenting at well-attended forums throughout the country. The ASA is still receiving enquiries as anaesthetists consider how these changes may affect their practice and impact their patients' rebates. When anaesthesia services are provided, clinical decisions are made about the most appropriate consultations, referrals, use of drugs and equipment, monitoring, regional techniques for intraoperative and postoperative analgesia and broader perioperative care. Patient factors (including sociocultural beliefs and financial circumstances), medical issues, anaesthetic considerations, and surgical factors are taken into account when developing and discussing the anaesthesia plan. A professional anaesthesia service will generate an anaesthesia fee. What the government is prepared to rebate the patient for that service should not influence the clinical decision to provide the best and safest care for the patients. Monitoring arterial blood pressure for example, came under scrutiny in the MBS review process. The importance of managing blood pressure carefully in the perioperative period has been well documented in reducing morbidity and mortality. Members are advised to document their clinical reasoning in the medical record to comply with any increased descriptor regulatory requirements to avoid unnecessary scrutiny with regard to use of any RVG MBS item numbers. Utilising best possible informed financial consent tools and clinical patient information documents are also recommended.

SAFE SCRIPT TO BECOME MANDATORY APRIL 2020

The opioid epidemic is a major concern and has cost lives overseas and in Australia. PIAC, and the anaesthesia community more broadly, have been discussing the importance of opioid minimising strategies for some time.

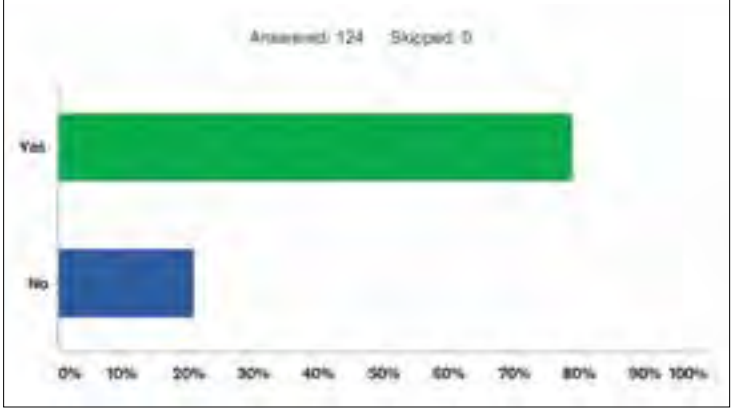
From April 2020, it will be mandatory for health practitioners prescribing discharge

Q7: Will the EMM your place of work uses be compatible with SafeScript?

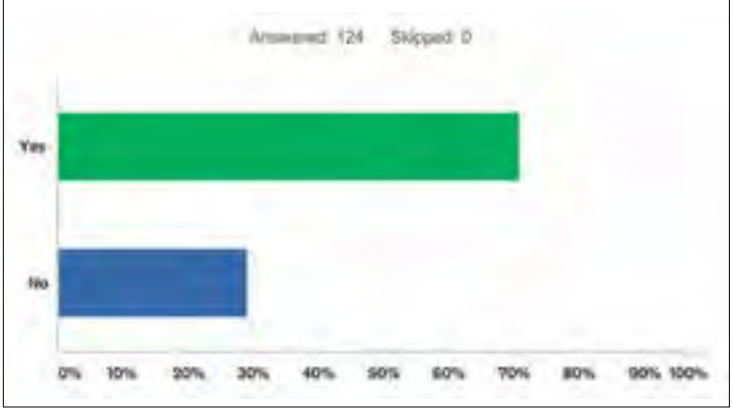


INSIDE YOUR SOCIETY

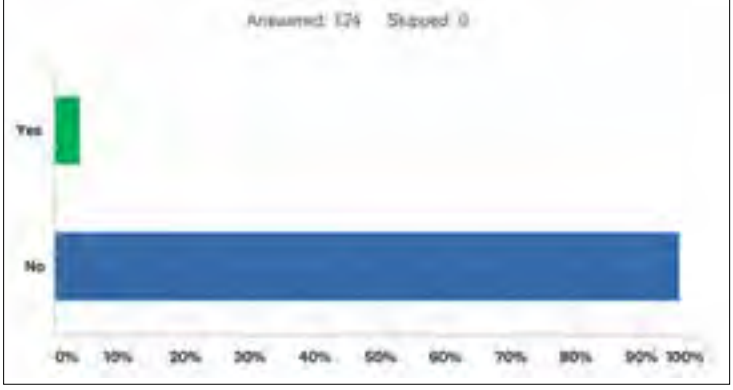
Q8: Are you currently responsible or delegated to prescribing discharge analgesia?



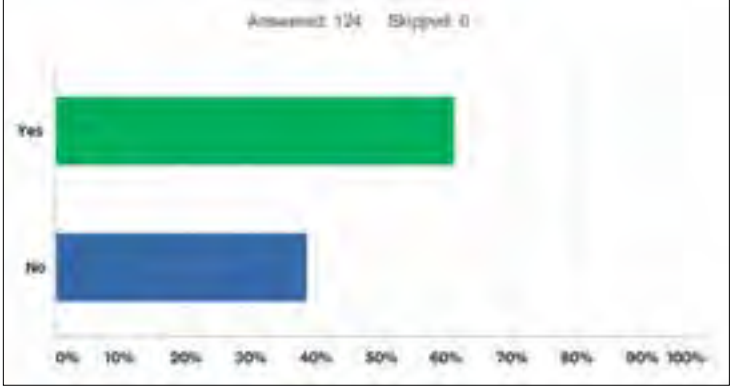
Q9: Would you anticipate performing the SafeScript check will significantly delay the theatre changeover of cases?



Q10: Have the hospital(s) you provide anaesthesia services made arrangements to facilitate the implementation of SafeScript without detracting from the quality and safety of care?



Q11: Do you believe there is a potential for patients to be under-prescribed adequate analgesia with the implementation of SafeScript?



Schedule 8 drugs, selected Schedule 4 medications codeine, benzodiazepines, the Z drugs and quetiapine to be registered with Safe Script and obtain an access code to identify if their patient is at risk of opioid misadventure. PIAC has received a number of enquiries from members concerned that implementation of this policy will not be possible with current technology, software and work practices without detracting from the attention required for acute patient care.

Results of a survey conducted for Victorian ASA members demonstrated that most members work in both the private and public sectors in capital cities and only 40% have registered with Safe Script. Approximately 75% of hospitals still use paper drug charts and only 25% of hospitals have Safe Script compatible EMM software. Up to 80% of anaesthetists are delegated to prescribe the discharge medications. Approximately 70% of those surveyed felt performing the Safe Script check would delay the theatre changeover of cases and 95% felt the quality and safety of care may be compromised with the current proposed implementation. 60% felt that patient analgesia 'under-prescribing' may occur.

With the nature of workflow in the acute perioperative setting, it is not practical for anaesthetists to log on to the Safe Script website using additional passwords and codes on numerous screens whilst caring for the patient intraoperatively. Despite assurances from the *SafeScript: what you need to know (and do)* many hospitals are still using paper drug charts or their electronic medical management system does not integrate with Safe Script software. The multifactor authentication and 6-digit mobile phone code is a significant regulatory burden in practice.

The private and public healthcare systems are under increasing fiscal pressure to deliver more services with fewer resources. It is not feasible, practical or equitable to expect healthcare providers, practitioners and patients to absorb the Safe Script implementation

costs without potentially incurring other deleterious consequences. This proposal may place the anaesthetist in the unenviable position of having to spend time complying with Safe Script rather than caring acutely for their patient. In the setting of post-acute care, the ASA strongly supports a team approach including the use of multimodal, regional and other opioid sparing techniques. Where opioids are prescribed, these should be in the minimum dose and quantity that is appropriate for the patient with relevant follow up where required. The introduction of the existing Safe Script policy may expose patients to unconscious abandonment as time poor clinicians 'under-prescribe' analgesia. Transferring this responsibility to other perioperative physicians or general practitioners is wasteful of limited healthcare resources and inconvenient for patients. The extra costs associated with these additional consultations may be a deterrent for some patients to access care and increase healthcare costs more broadly.

The *SafeScript: what you need to know (and do)* document seems to maximise the 'carrot' and minimise the 'stick' approach of this policy. The reality is that penalties apply if a practitioner fails to comply with this policy even if the factors such as inadequate software, time, workflow expectations, are beyond the control of the anaesthetist. This will generate enormous stress for anaesthetists.

Unintended consequences include:

1. Clinical focus on the patient compromised whilst attending to even more 'screen time'. The quality and safety of acute care delivered will be compromised.
2. Delay in theatre changeover time frustrating surgical referrers and nursing staff leading to decreased productivity and increasing the costs of delivering healthcare.
3. Changes in prescribing patterns avoiding these medications when clinically required which may lead to inadequate discharge analgesia and unconscious patient abandonment.
4. Non-compliance exposing practitioners to regulatory penalties.
5. Reputational risk for institutions and individuals.
6. Frustration amongst prescribers and clinicians leading to avoidance behaviours.
7. Financial implications for patients, institutions, and the healthcare system.

The inappropriate use and prescribing of opioids needs to be addressed. The ASA supports initiatives that are evidence based, cost-effective, appropriately resourced, practical and do not compromise the quality and safety of patient care.

ELECTRONIC MEDICAL RECORD

This topic has been covered extensively in recent editions of *Australian Anaesthetist* including the potential benefits and risks. Workshops around the country continue to describe the process of implementation. The ASA continues to discuss anaesthesia interface concerns.

AHPRA DRAFT GUIDELINES FOR MANDATORY NOTIFICATIONS ABOUT REGISTERED HEALTH PRACTITIONERS

PIAC has considered the proposed updated guidelines and supports AHPRA's recommendations. Overall the changes make it clearer when a practitioner may need to be reported for impairment by a treating practitioner, non-treating practitioner and employer. Also students have a separate document. The key areas that require may require an obligation for reporting are (WA exception):

1. Practising with an impairment.
2. Practising while intoxicated by alcohol or drugs.
3. Practising in a way that significantly departs from accepted professional standards.
4. Engaging in sexual misconduct in connection with their practice.

Hopefully the net result will be that anaesthetists that require referral and management for a health issue, will not be deterred from accessing the treatment they require and deserve for fear of mandatory reporting. Please refer to the AHPRA website for more information about what constitutes impairment and mandatory reporting, with exclusions for West Australia.

As we approach the festive season, I would like to thank all the PIAC members and federal secretariat that continue to work tirelessly to support, represent and educate members about key issues that affect the delivery of care for patients and wellbeing of anaesthetists.

INSIDE YOUR SOCIETY

POLICY UPDATE

NO COLLUSION!! NO OBSTRUCTION!!

Encouraged by Medicare rules and reductions, medical providers today use a perverse form of a sliding scale that charges the most for patients who can least afford it. Primary care physicians typically charge uninsured patients one half more than they receive from insurers for basic office or hospital visits, and mark-ups are substantially higher for high-tech tests and specialists' invasive procedures.

In a managed care type of market system (USA), competition is used with the aim to reduce prices. The most financially successful businesses are those which find some means of avoiding competition or influencing it by securing leverage so that they can negotiate higher prices

In Australia, Ramsay Health Care and Healthscope prospered by buying specialist or country hospitals where they faced no nearby competitors.[1] Ramsay is wholly owned by Ramsay Health Care Limited which is an ASX-listed global healthcare provider with reported revenue of $8.7 billion for the last financial year. It is Australia's largest private hospital operator with about 70 hospitals and day surgeries nationwide. Each year, Ramsay facilities in Australia admit almost one million patients and account for more than half a million procedures.[1]

COMPETITION AND CONSUMER ACT 2010

Medical practitioners, especially anaesthetists, may be at a considerable disadvantage when negotiating with wealthy and powerful insurers who operate across the country and are in a position to dictate payments. The laws defining when a particular arrangement is considered collusive and anti-competitive can be complex and confusing.

…Ramsay Health Care Limited…is an ASX-listed global healthcare provider with reported revenue of $8.7 billion for the last financial year.

Cartel conduct is prohibited in a variety of ways in Australia. Most directly, it is prohibited by Part IV, Division 1 of the *Competition and Consumer Act*,[2] which defines and prohibits, both civilly and criminally, cartel conduct. The definition of cartel conduct is lengthy (it runs to 36 paragraphs), but encompasses agreements between competitors to:

- Fix prices
- Divide markets
- Rig bids or
- Restrict outputs

Conduct falling within this definition of 'cartel conduct' is prohibited per se. Anti-competitive conduct which falls outside the definition of cartel conduct, or which benefits from an exemption from the per se prohibition, may still contravene other provisions in the *Competition and Consumer Act*; most notably section 45 which prohibits anti-competitive agreements and, following changes commencing 6 November 2017, also prohibits anti-competitive concerted practices.

As highly trained professionals, medical practitioners are free to place their own value on their professional skills and expertise, and determine what they consider to be a fair and reasonable fee for the services they provide. But what does this mean when more than one practitioner is making such a determination? At what point does it become collusion?[3]

WHEN IS COLLUSION A CRIME?

In a twitter post the American President posted "Collusion is not a crime, but that doesn't matter because *there was no collusion*".[4] Since this post the word 'collusion' has been among the most frequent lookups in dictionaries.

We know that collusion has a few different definitions and that 'collusion' is not an actual criminal charge (keeping this discussion out of United States politics), but when are acts that can be characterised as collusion crimes? Even though collusion is not a legal term of art, quite a few offences are characterised by collusion acts and may require special counsel. For example, the simple act of lying is not in itself a crime, but it becomes a crime in specific situations such as when lies are told under oath (perjury)[5] or to gain something of value (fraud).

In a twitter post the American President posted "Collusion is not a crime, but that doesn't matter because *there was no collusion*". Since this post the word 'collusion' has been among the most frequent lookups in dictionaries.

The *Competition and Consumer Act* 2010[6] requires medical practitioners to set their fees independent of other medical practitioners, unless otherwise authorised by the Australian Competition and Consumer Commission.

It is illegal for competing businesses to get together and agree to fix their prices (or to agree to charge certain fees).[6] Price fixing agreements do not need to be in writing – a verbal agreement or an informal understanding is sufficient to be considered anti-competitive behaviour.[3]

ACTIONS UNLIKELY TO BREACH THE ACT

Generally, the following would not be considered by the ACCC to be likely to breach the Act:

- Merely being aware of the fees that other doctors charge – it is normal commercial behaviour to know what your competitors charge.
- Doctors practising through separate entities informing other doctors of the fees those entities have independently decided to charge, for the purpose of obtaining informed financial consent from patients.
- Doctors practising through separate entities discussing economic factor, information or formulae that have been or will be used independently determining their fees (based on their own individual costs and expected levels of profit). This type of discussion may sometimes occur at professional association meetings or conferences, in the context of discussions about the factors affecting an industry or profession.
- The fact that two or more doctors practising through separate entities happen to charge the same fee.[6]

ACTIONS LIKELY TO BE A BREACH OF THE ACT

The ACCC considers that the following would risk breaching the Act:

- If a decision is made between doctors practising through separate entities to charge the same fee.
- If a decision is made between doctors practising through separate entities to charge different fees or increase or decrease fees.[6]

This is also regardless of whether the agreement is actually put into effect by some or all of the doctors.

A DIFFICULT SITUATION

Doctors must set their fees in a manner consistent with their practice structure, which will determine how to set fees so they don't breach the Act.

Financial aspects of the doctor-patient relationship are a risk for anaesthetists in particular because of the large difference between the Medicare Benefits Schedule rebates and the Australian Medical Association (AMA) fees, including the long-term freeze on any healthcare costs indexation.[7] There is also the expectation of insured patients that they should not have out-of-pocket expense. This has been reinforced by health insurer product structure that drops rebates to MBS level if gaps are 'too large' but still less than the AMA rate.

Financial aspects of the doctor-patient relationship are a risk for anaesthetists in particular because of the large difference between the Medicare Benefits Schedule rebates and the Australian Medical Association (AMA) fees.

Anaesthetists face additional issues when their services are required in last-minute bookings and urgent procedures with limited opportunity to advise patients of costs ahead of time.

Doctors who exchange fee information to assist in obtaining informed financial consent from patients will not breach the Act, so long as they do not agree on what fees will be charged to patients.[8]

Just remember to refrain from making a decision together to set fees. Individuals found guilty of such conduct could face criminal or civil penalties.

Jacintha Victor John
Policy Manager

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CONTACT US

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

Email: policy@asa.org.au

Phone: 1800 806 654.

INSIDE YOUR SOCIETY

OVERSEAS DEVELOPMENT AND EDUCATION COMMITTEE

DIFFICULT AIRWAY WORKSHOP
BHUTAN, 10-11 AUGUST 2019

PLANNING

About a year ago, the indefatigable Dave Pescod approached me with the idea of running a difficult airway workshop in Bhutan, along the lines of others that he had been involved with in other countries in Asia. I put the idea to some of my friends in the Anaesthetic Department at the Jigme Dorji Wangchuck National Memorial Hospital (JDWNRH) in Thimphu, Bhutan. They were keen to do it, having never done anything like this before, and so planning began. The workshop was run over the weekend of 10th and 11th August 2019. The 9th August was spent meeting with the key local stakeholders, and preparing the venue for the workshop.

FACULTY

The Faculty for the teaching programme were:

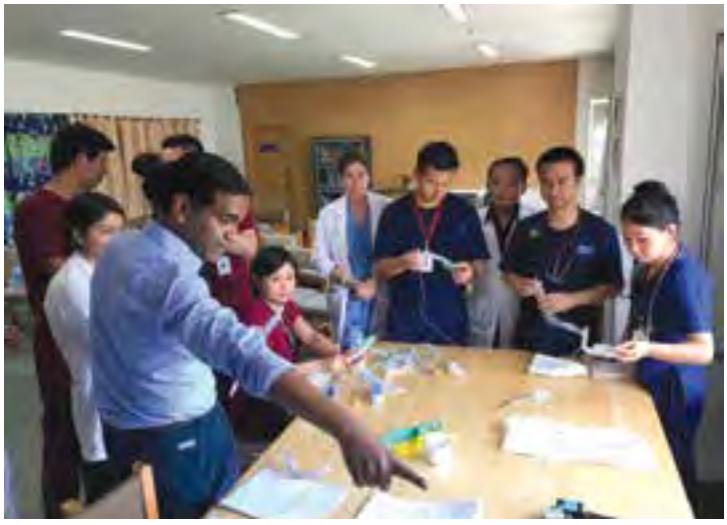
- Dr Stephen Kinnear, Adelaide, South Australia – organiser;
- Dr David Pescod, Melbourne, Victoria;
- Dr Sathi Seevanayagam, Melbourne, Victoria;
- Dr Noelle Lim, Singapore;
- Dr Avin Gobindram, Singapore.

The first three are all specialist anaesthetists. Dr Lim is Director of Anaesthesia and Director of Intensive Care at the Changi Hospital, Singapore. Dr Gobindram is a staff specialist anaesthetist at the same hospital. He has also taught on several previous difficult airway management courses. Dr Pescod and Dr Seevanayagam have both taught on this workshop in recent years in Nepal, Myanmar, and Cambodia.

Dr Seevanayagam also arranged for three technical staff from Karl Storz Pty Ltd (Delhi, India) to attend, and to bring with them a range of airway access teaching equipment. Karl Storz paid for all their flights, accommodation, and in-country costs.

WORKSHOP

The day before the workshop commenced, we had meetings with several key people in the health management hierarchy of



Tutors with participants at end of Day 2. Dr Dathi Seevanayagam teaching about various items of anaesthetic equipment

Tutors: left to right. Dr David Pescod, Dr Sathi Seevanayagam, Dr Avin Gobindram, Dr Noelle Lim and Dr Steve Kinnear

Bhutan. The workshop was held in two large rooms above the Intensive Care Ward of the JDWNRH Hospital and run over two days.

Each participant attended for one day. Each day's group was split into two concurrent groups, with each group running for three hours. So, each participant had six hours of tutorials, discussions, and hands-on training on airway equipment.

During the tutorial/discussions stream, participants had a hands-on refresher on the principles of difficult airway management, including teaching on the 'Vortex' approach to difficult airway management. This was followed by discussions on cases presented by the Faculty and the participants.

The second stream rotated through six work-stations, in which small groups of two or three participants had hands-on exposure to video-laryngoscopes, fibreoptic equipment, front-of-neck access manikins, and emergency simulation manikins. The Elaine Bromiley re-enactment video was also shown at one station.

There were 59 participants – 22 on the first day, and 37 on the second day. They included specialist medical anaesthetists, nurse anaesthetists, OT technicians, emergency department resident medical officers, surgical RMOs, and medical RMOs.

All attendees completed a pre-test MCQ prior to starting the workshop. At the end of the day, they all completed a post-test MCQ and an evaluation form.

At the conclusion of each day, each attendee received a Certificate of Attendance from the Faculty.

As the workshop progressed, it was our impression that the course was very useful to all attendees, and this was borne out by the responses in the evaluation forms.

TEST RESULTS AND EVALUATION

Pre-Test: Combining the data from both days, 28 of the 59 participants passed the 18-question MCQ pre-test.

Post-Test: 49 of the participants passed the post-test. Mean scores for the both fail and pass groups improved considerably in the post-test compared to the pre-test.

Three participants had little or no change in their scores from pre- to post-test. Difficulties with reading the English language for those participants were the likely cause for this.

Dr Kuenza Wangmo receiving her Certificate of Attendance from Dr David Pescod

The evaluation form also asked participants to rate the workshop on a range of parameters, with 1 being a poor score, and 5 being an excellent (highest) score.

The scores given were 4 or 5 (mostly 5) from the vast majority of attendees for both days.

Participants were also asked to make any comments regarding the workshop, both positive and negative. There were very few negative comments.

INSIDE YOUR SOCIETY

Dr Noelle Lim teaching participant FONA technique

SUMMARY

This workshop was the first of its kind to be held in Bhutan and, as such, we were unsure as to how it would be received.

Our Faculty of five were taken out for a meal in the evening at the end of the workshop, attended by the Dean, and the Head of the Anaesthetic Department.

They made it very clear to us that they thought that the workshop was very useful to them, and that it would be good to repeat it sometime in the future.

The President of the Khesar Gyalpo University of Medical Sciences, Dr K.P. Kinsang, indicated that we should work towards setting up a Memorandum of Understanding between the University and the Australian Society of Anaesthetists, which would facilitate repeating this workshop, and introducing other educational workshops to the hospital and university.

We would like to thank the Australian Society of Anaesthetists for its support for this workshop.

Dr Steve Kinnear
Organiser, Difficult Airway Workshop

EAST TIMORESE ANAESTHESIA – A GREAT LEAP FORWARD

Dr Helena da Silva, Dr Mingota Herculano, Dr Mario Soares, Dr Amir Shrestha (DFAT ATLASS II Anaesthetist [RACS]), Dr Colom Da Silva, Dr Brian Spain, Dr Filomina Monica, Dr Maria Jose A. da Piedade

I was delighted to go to Dili, East Timor as a representative of the Australian Society of Anaesthetist's Overseas Development and Education Committee (ODEC) for the first East Timorese Anaesthesia Conference, planned to coincide with World Anaesthesia Day on October 16.

What I hadn't realised was that the dinner the evening prior was to be preceded by a 'business meeting' that was in fact the meeting to finalise the formation of the East Timorese Anaesthetists Society. It was a most historic meeting, and having been involved in supporting anaesthesia for East Timor in various ways over 20 years, it was an extraordinary privilege to be in attendance.

Sadly my Tetum (the lingua Franca) of East Timor is very poor, and most of the meeting was conducted in it. I could follow the gist of proceedings and had occasional snippets of translation provided.

What was clear was that the group, composed entirely of East Timorese medical and nurse anaesthetists, were committed to a democratic and equitable process including equality of membership for different professional streams. They had much discussion, several rounds of voting and used the World Federation of Society of Anaesthesiologists (WFSA) template to adapt their own constitution.

In the end the President: Dr Colombianus Da Silva, Secretary: Mr Cesaltina Maya and Treasurer: Dr Helena da Silva were elected.

Oaths and a blessing on the newly-formed organisation were followed by a celebration feast.

The First East Timorese Anaesthesia Conference followed the next day with a variety of presentations from nursing and medical anaesthetists from across the country on their work and the challenges. The meeting was attended by various officials from the Ministry of Health, WHO and the hospital, as well as the Prime Minister's wife. I even managed the technology to present a pre-recorded video greeting and congratulations from our own ASA President, Dr Suzi Nou.

It is now 20 years since the vote for independence in East Timor in 1999, and the violence that followed. The health system has slowly been rebuilding and from a time of one Indonesian-trained nurse anaesthetist and no medical anaesthetists there is an increasingly robust service provided both in Dili and in the district hospitals that is less and less reliant on international medical staff.

There were 21 nurse anaesthetists trained between 2005 and 2009, most of them are

INSIDE YOUR SOCIETY

Formation meeting of the Anaesthesia Society of East Timor (SAnesTiL)

Treasurer Dr Helena da Silva, Secretary Mr Cesaltino Maya, President Dr Colombianus Da Silva taking their oath of office

Dr Brian Spain, Dr Flavio Brandao, Dr Colom Da Silva, Mr Tino Maya and Dr Ming Herculano

still working and spread across six hospitals in East Timor: Dili, Bacau, Maliana, Maubisse, Suai and Oecussi. More recently three anaesthetists have completed their Masters of Medicine in Anaesthesia through the Fiji National University – Dr Flavio Brandao, now also Clinical Director of the Hospital Nacional, Guido Valaderes (HNGV), as well as Dr Mingota (Ming) Herculano and Dr Colombianus (Colom) Da Silva. They had each commenced with a medical Diploma of Anaesthesia program in East Timor over 18 months prior to commencing training in Fiji.

There are now an additional eight graduates of the East Timor Diploma who are working across the country. The success of all these medical and nurse anaesthetists is mostly due to their hard work, sacrifice and commitment but also built upon the training framework set up by Dr Eric Vreede, who worked in East Timor for 14 years and was awarded the ASA medal to recognise his efforts.

East Timorese anaesthesia will still benefit with support from nearby colleagues, including the ASA, with training, but they are well on the way to having a comprehensive workforce with East Timorese medical and nurse anaesthetists and a new society to bring them all together.

Dr Brian Spain
Director of Anaesthesia
Royal Darwin Hospital
ASA ODEC Committee member

INSIDE YOUR SOCIETY

ASA MEMBER'S GROUPS UPDATE

NATIONAL SCIENTIFIC CONGRESS (NSC)

Another brilliant and highly successful NSC was held in Sydney on 21-24 September. Attendees were treated to an array of excellent local and international speakers, workshops, small group discussions, an exhibition hall, research and audit presentations and prizes, and a fun social program (one highlight was a crowd-free Luna Park experience with food, drinks and free rides!). Trainees were particularly well-catered to, with dinner and drinks on Friday night, a Part 2 Boot Camp on Saturday, and a trainee lunch on Sunday followed by a full afternoon stream of trainee sessions. These covered practical career topics (including private practice), exams, audits and important wellbeing issues.

Next year will be a Combined Scientific Congress (CSC) together with the New Zealand Society of Anaesthetists (NZSA) held in windy Wellington on 16-19 October. It's sure to be another great meeting and I look forward to seeing many of you there. Remember that the CSC is also eligible for reimbursement in the same manner as the NSC (i.e. you can claim one complimentary NSC or CSC registration during AT/PFT or in your first year after training provided you have been a financial AT/PFT member of the ASA for two years).

WORKFORCE CHALLENGES

At the NSC, I had the opportunity to join a panel at the Anatomy of the Specialty session to discuss the ASA Members Survey results. While there's a lot of interesting data there, I thought it particularly relevant for trainees to know how the responses of members within five years of attaining their fellowship differed from the overall membership cohort. This early career group were more likely to have experienced a period of underemployment, more likely to be unhappy with their current volume of work, and more likely to want more work (both in public and private). They were also more likely to undertake work outside of their comfort zone for financial reasons, with one quarter finding it more difficult to generate an income than they expected and, concerningly, one in four feeling that their current practice is inadequate to maintain their skills. Given these challenges, it's unsurprising that the majority think that too many anaesthetists are being trained.

INSIDE YOUR SOCIETY

TMG lunch

TMG face-to-face meeting

While our survey results can't shed much light on workforce distribution, it seems that the competitive pressures are particularly prevalent in large metropolitan centres (e.g. Sydney and Melbourne). Opportunities, supply and demand vary greatly across time and between locations – I'm told there is still plenty of work in rural areas! There are myriad reasons why an individual will or won't move for work, however, the reality is that it's likely some of us won't have a choice.

NEW YEAR

I will be stepping down as Chair of the ASA Trainee Members Committee at the start of next year. It has been a great honour and privilege to serve in this position for the last two years and I thank you for the opportunity. I am proud of what we have achieved during this time. Much of this activity flies under the radar but I think it's important to share with you to highlight the importance of ASA membership beyond the more obvious and tangible benefits. Our recent activities have included:

- Trainee Handbook – we have almost completed this extensive resource to be released early next year.
- Pregnancy and parental leave – we solicited feedback from the anaesthetic community regarding these important issues; and formed a working group which produced an article in Australian Anaesthetist, a presentation at the Combined SIG meeting, and two outstanding documents (hopefully soon to become welfare resource documents) to help trainees and fellows with working while pregnant and returning to work after leave.
- Critical incidents – we advocated to ANZCA and the societies for additional attention to be given to debriefing after critical incidents, which is now being addressed through the college's Trainee Wellbeing Project Group.
- RVG – we have secured access to the RVG for advanced trainees and provisional fellows, and we're currently working on expanding educational programs to help trainees better understand how to use it correctly.
- CIG scholarships – we have continued to award these highly valuable annual scholarships, have developed new processes to improve the transparency and ease of submission and assessment, and have further revised the process for next year to make it easier for applicants to make leave and logistical arrangement prior to the meetings.
- Fatigue and rest facilities – we assisted with advocacy efforts on this important and topical issue for trainees.
- Electronic examinations – we communicated with the college following high-profile failures with electronic examination systems used by other medical colleges to help prevent this from affecting anaesthetic trainees.
- Website – we were actively involved with the ASA website overhaul, including improving design and ease of access to resources.
- Other – we've also engaged with multiple local issues across a range of states/territories and health services, provided input to the ASA Council and committees on trainee issues (including workforce planning), helped organise a range of events (e.g. Part 3 Courses), maintained ongoing year-on-year growth in ASA trainee member numbers, modified key by-laws to improve fairness and transparency in selection of new committee representatives, promoted other trainee-led organisations (such as TRIPOM and Trainee-Research Networks), and enhanced our communication with trainee members (including through these updates and the trainee eNewsletters).

Nominations for the 2020 Chair will have closed by the time this is published and we will announce the successful applicant in due course. Thank you all for your ongoing membership of this important organisation. The ASA does a lot of important work that will impact on your future career, life and income. Your membership is vital to ensure that this work can continue to benefit you, your colleagues, and our patients.

Dr Richard Seglenieks
Chair, ASA Trainee Members Committee

RETIRED ANAESTHETISTS GROUP

The Retired Anaesthetists Group (RAG) remains very active particularly in the larger states where numbers are greater. RAG's greatest value is for those retired anaesthetists who wish to stay in touch with their fellows and continue relationships forged over many years in practice. Most have regular lunch meetings and often have a guest speaker with a great variety of subjects varying from trout fishing to shipwrecks, terrorism to jewellery. The addition of a guest speaker at most lunches has been a popular attraction for RAG members with many really looking forward to the next 'event'.

Membership of RAG remains fairly stable at over 400 and is currently 412. RAG continues to be a valuable resource group for the ASA in general, both for its knowledge of past clinical practices and also of relations with government and other authorities.

RAG is very grateful to both the ASA and the College of Anaesthetists for their continuing support. The College each year hosts a RAG lunch at its Annual Scientific Meeting as does the ASA at its NSC.

Dr Donald C Maxwell
MBBS FANZCA FRCA
National and NSW Chairman RAG

RAG lunch, National Scientific Congress 2019

INSIDE YOUR SOCIETY

MEMBERSHIP UPDATE

With more than 3,400 members, the Society continues to 'support, represent and educate' our members to provide the safest anaesthesia across the country. Let's reflect on another productive and busy year!

MEMBERSHIP GROWTH

As we approach the end of 2019, we have maintained a rising trajectory for our Ordinary members as we welcomed 27 new members. However, this was balanced with the loss of 13 Associate members and 40 Advanced/Provisional Fellow trainees, the latter of which will be a key focus for 2020. Chart 1 represents the membership growth for our active Trainees, Ordinary and other membership (this includes complimentary and other paying members) over the last three years.

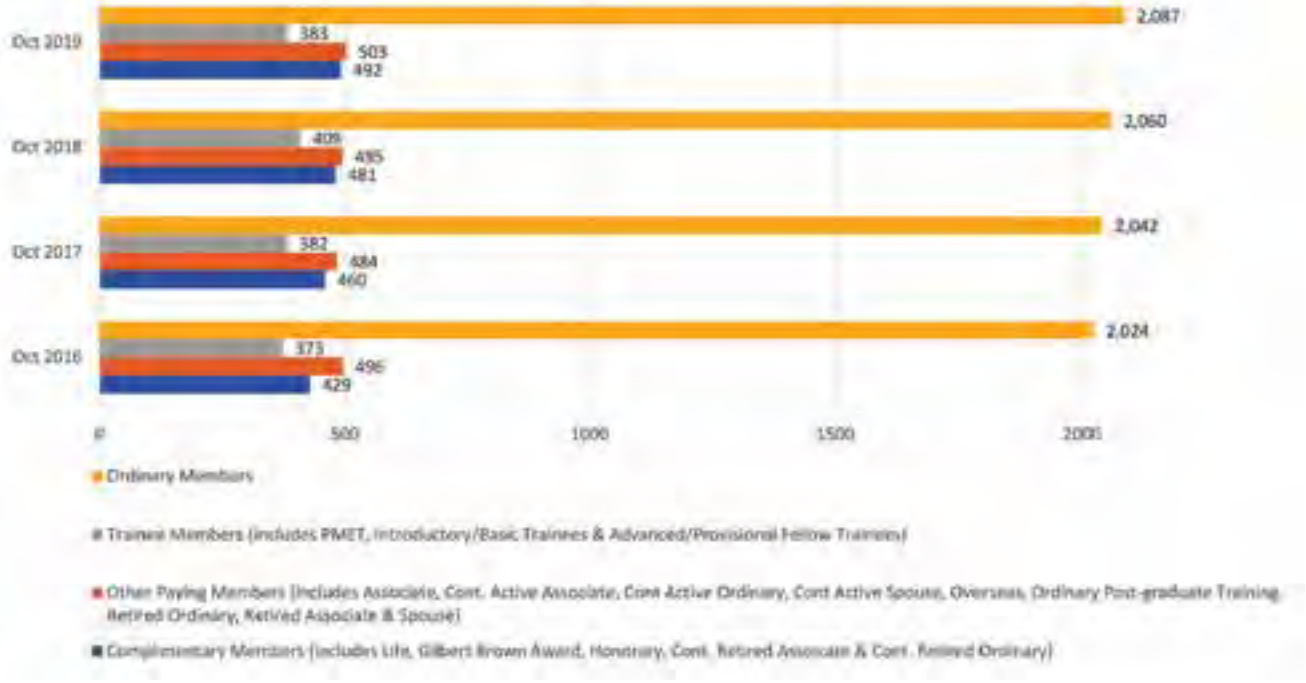
KEY ACHIEVEMENTS IN 2019

As with all membership organisations we need to remain relevant to our members and the following are just some of the highlights of membership services provided throughout the year:

Represent

- Representing our members and the needs of the specialty to a variety of bodies including:
  - Department of Health regarding the ongoing MBS Review.
  - Ramsay Healthcare in NSW regarding the pay cuts for on-call anaesthetists.
  - NSW Senate inquiries regarding the public-private partnership at Northern-Beaches Hospital.
  - State and Federal Health Departments regarding proposals for pill-testing at music festivals.
  - Australian Healthcare and Private Health Insurers regarding rebates and out-of-pocket expenses
  - Ten submissions relating to a wide range of medical related topics including anaesthesia workforce issues, the National Medical Code of Conduct and changes to the Medical Benefit Scheme (MBS)
- Representing members at 22 various stakeholder meetings with the Department of Health, Australian Digital Health Agency, Federal Department of Health, BUPA, NIB, Medibank and MIGA.

Chart 1: ASA Membership Growth 2016 - 2019



Support

- 700 members have used the Informed Financial Consent website since it was launched.
- Providing support to our Practice Managers Network, with 72 Practice Managers attending our annual Practice Managers Conference held in Canberra.
- Access to complimentary patient information pamphlets and Anaesthesia & You brochures which can be downloaded and distributed to patients.
- Our Policy Team have resolved 92 enquiries from ASA members, Practice Managers and from the general public between September 2018 and September 2019.
- After introducing more convenient methods for renewing membership, 20% of members renewed via BPAY with 5% of members signing up for monthly payments

Educate

- More than 520 ASA members attended this year's National Scientific Congress meeting in Sydney.
- 71 Trainees attended our Boot Camps for exam preparations.
- Over 150 complimentary Anaesthetic Crisis Manuals were issued to our Advanced/Provisional Fellow Trainees, which has proven to be a great resource for Part 2 preparation.
- 25 Advanced/Provisional Fellow Trainees claimed their NSC registration reimbursement entitlement.

We have also implemented a number of new events this year including:

- NSW Trainee Boot Camp to assist in preparing for exams convened by Dr Lan-Hoa Le.
- NSW Members Forum.
- Neuroanaesthesia SIG Journal Club 2019.
- WA Inaugural PCH/SCGH Anaesthesia Grand Round.
- WA SIG in Perioperative Cardiac Conundrums.
- State networking and membership events across all states.

The quality material available in the Harry Daly Museum, Gwen Wilson Archives and Richard Bailey Library is progressing with leaps and bounds thanks to donations and support from our members. In the last year over 30 items have been added to the museum's collection, all kindly donated by ASA members. These items can be viewed in the museum or online https://ehive.com/collections/4493/harry-daly-museum. A new archive project has also begun which will see the ASA's archives become more user friendly and accessible for members!

Both the Harry Daly Museum and the Richard Bailey Library have recently been granted deductible gift recipient status by the Australian Taxation Office (ATO). By receiving this endorsement from the ATO it means that any financial donations to the HDM and RBL are now tax deductible. This also means that if you are donating an object to the Museum or a book to the Library it may also qualify as a tax-deductible donation. For more information regarding donating please contact the ASA's Curator, Librarian and Archivist 02 8556 9708 or BMcMartin@asa.org.au

PLANS FOR 2020

Next year will continue to be another dynamic year for the ASA as we focus on new areas of development for our members including:

- An increase in public practice content through the newly reinstated Public Practice Advisory Committee.
- Building stronger relationship with governments and industry bodies.
- Segmented email updates for different sectors within our membership.
- ASA member video testimonials to promote membership.
- Improved website content and access to that content.
- Better social media engagement.
- Wider usage of the BPAY system for membership fees.
- Improved Presidents eNews.
- Staging of Members' Forums or the like in each state as a way of enhancing member engagement.
- A review of the ASA Advantage Program offerings.
- Investigation into new technologies to improve our service delivery.

As we end 2019 on a positive note, we look forward to your ongoing involvement and loyalty for 2020. On behalf of the ASA thank you for your continued support.

Natalie Sinn
Membership Officer

2020 MEMBERSHIP RENEWALS

We kindly ask members to pay your 2020 membership fees on or before the 28th February 2020.

Please contact the Membership Services Team for further assistance via email: membership@asa.org.au

Over the phone: 1800 806 654

Or by post: PO Box 6278, North Sydney NSW 2059

INSIDE YOUR SOCIETY

HISTORY OF ANAESTHESIA RESEARCH UNIT NEWS

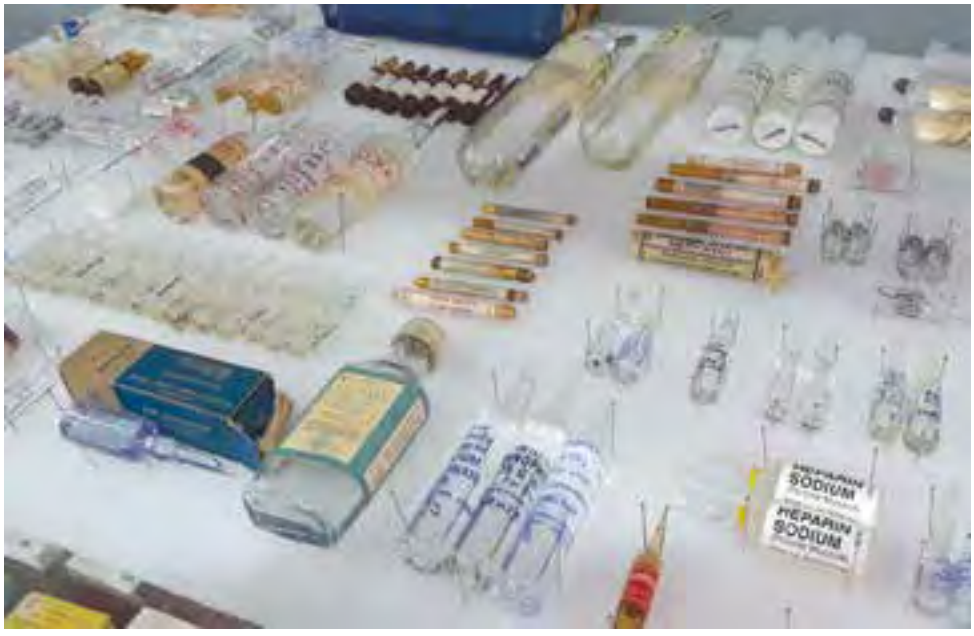
THE DIFFICULT TOPIC

Here at the ASA's Harry Daly Museum (HDM) we receive many donations and sadly we cannot accept them all. Space is at a premium in the museum so the HDM collection policy is designed with this in mind. If you have offered an item to the collection and found it recently being returned, you'll find this is because of one of two reasons. Firstly, it may be a duplicate (if it is in better condition than the existing item, we may choose to accept it and deaccession the existing item); or secondly it may be in very poor condition. While I am happy to treat all kinds of mould and age damage (where necessary) some items are just too damaged to be of any benefit to the museum's collection. If the item is particularly special, we may make an exception however, if the item poses a hazard to other items in the collection then it is likely we'll kindly say "thank you, but no thank you".

With those guidelines in mind then, in theory, the HDM should be able to accept all kinds of donations but is this the case?

What about schedule 8 anaesthetic drugs?*

This is the current hot topic for the HDM and has seen me undertake meetings industry-wide to try and determine the correct path going forward. As a museum we are duty bound to preserve history but what do we do when that duty crosses legal lines? In the past the NSW Department of Health have been called to review the museum's collection and have assisted in the disposal of some S8s. This has left a number of empty packages in the museum, which begs the question – does the item still mean the same without the substance? For security and safety this is a much more agreeable situation but are we doing history an injustice by disposing of the difficult parts?



Harry Daly Museum Display

Here at the ASA we have a strictly no S8 policy. You'll find no S8s in the HDM, if you do see a box or vial, you'll find it is just packaging. In ensuring this policy is effectively enforced, an audit was recently undertaken of the museum's S4 collection, which saw the items moved into a new display cabinet that met legal requirements.** Strictly speaking a museum is allowed to maintain an S4 collection, however this is probably more of an oversight of the law than an actual endorsement of museums having S4s in their collection, especially as technically museums cannot dispose of an S4 without assistance from the Department of Health, which puts some limitation on what a museum can acquire as, if there is a possibility it may need to be disposed, a museum is unlikely to accept it.

So if you've got a nice little historic drug collection you were thinking of donating to the HDM, please email me first before

* Substances which are addiction- producing or potentially addiction- producing, such as morphine and pethidine. Possession, supply, prescribing and use are strictly limited – NSW Department of Health S8 definition.

** Substances which in the public interest should be supplied only on prescription – NSW Department of Health S4 definition.

Dr Peter Mathers

you bring it into the museum so I can review the items on offer, and please don't be offended if I go running from any S8 drugs you may have to offer!

Note: all substances are reviewed before they are accepted into the HDM collection. Therefore, if they are found on the Schedule, there is a chance, even if they are not an S4 or S8, that they may be rejected if they are an S6 or S7.

RECENT DONATIONS

The HDM recently received a very nice donation of anaesthetic equipment from Paul Mathers. These items included an early Midget CIG (this was displayed at the recent NSC), haemocytometer, haemoglobinometer and oscillotonometer. The items belonged to his father, Dr Peter Mathers, who used them in the 1940s when he was a GP in Cessnock. Of Greek origin, Dr Mathers' name was originally Matis, however he changed it to the anglicised Mathers after receiving his certificate of 'proficiency in the administration of anaesthetic' from the University of Sydney Medical School in 1937. He undertook his instruction in anaesthesia at St Vincent's Hospital, where Harry Daly provided instruction to

Midget CIG

trainees. At the time, the ASA was working with the University of Sydney to have a post-graduate course established for the administration of anaesthesia, however this wouldn't come to fruition for a number of years.

As anaesthesia developed as a profession, so too did the technology and tools associated with its practice. As such, many anaesthetists showed true innovation by creating homemade devices based on information and images seen in journals and books. Some anaesthetists also invented their own devices to meet a need they saw as necessary. This CIG Midget machine, made by Commonwealth Industrial Gases, made anaesthetic machines accessible for those operating outside a hospital, e.g. a country doctor. Comprising two flowmeters, a CO_2 absorber and a vaporiser, these devices were often secured to a solid foundation that was easily transportable for anaesthetists.

The Midget machine that belonged to Peter Mathers is reflective of the ingenuity required by country GPs during this era when they were called upon to undertake all manner of medical duties.

ST GEORGE ANAESTHESIA EQUIPMENT MUSEUM

HALMA have been pleased to learn of an anaesthetic collection that has been developing at St George Hospital, Kogarah. Under the guidance of former department head Dr Richard Morris, and, with the assistance of Dr Michael Cooper, the collection has been slowly growing over the years. Dr Morris has now catalogued the collection and a display has been established in the foyer of the department, which will hopefully become publicly accessible. At the moment the collection is able to be viewed by appointment at the hospital, however it is also available online https://ehive.com/collections/9263/st-george-anaesthesia-equipment-museum

It is very encouraging to see

INSIDE YOUR SOCIETY

Dr Michael Cooper and Dr Richard Morris with the display of historic anaesthetic equipment at St George Hospital

anaesthetists taking it upon themselves, within their own hospitals, to ensure the history of anaesthesia is preserved. I was privileged to recently visit the collection and I was very impressed and pleased with the work of Dr Morris and Dr Cooper. The work they are undertaking is important to the preservation of the history of anaesthesia, particularly within the hospital and will hopefully inspire anaesthesia departments in other hospitals to follow their lead.

If you have a similar collection or have some historic pieces of anaesthetic equipment being stored in your department and would like to start your own departmental display please let us know (it is much easier than you think)!

NSC HALMA

At the recent NSC in Sydney, HALMA was pleased to have a 'pop-up' museum, including items from the library and archives on display. The HALMA booth had prime position outside the main plenary theatre, which meant that many people stopped by to have a look. We were especially pleased with the number of interstate and overseas visitors who came to say hello and reminisce on the items on show.

HALMA ON SOCIAL MEDIA

HALMA have arrived into the 21st century with a special Facebook page dedicated to the history arm of the ASA! Please show your support by 'liking' this page https://www.facebook.com/ASA-Museum-100557004665520/ and joining in the conversation!

Belinda McMartin
Curator, Librarian and Archivist
Harry Daly Museum, Richard Bailey Library and Gwen Wilson Archives

CONTACT US

Contact us to arrange a visit to browse or for research. We are open by appointment Thursday to Friday, 10am to 3pm. Please phone ASA head office on 1800 806 654.

CONGRATULATIONS

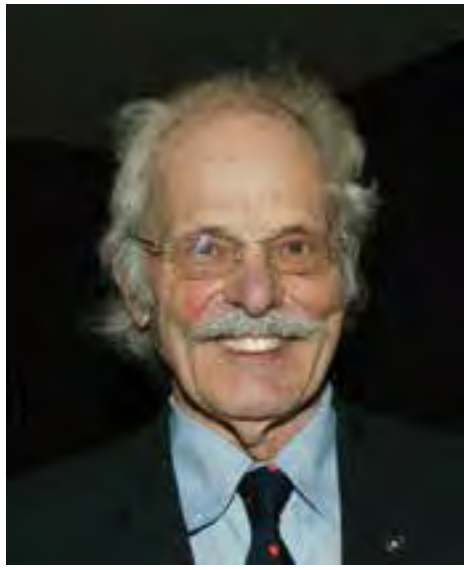
The ASA extends its heartiest congratulations to the Honorary Curator of ANZCA's Geoffrey Kaye Museum and member of the ASA's HALMA committee, Dr Christine Ball, for being named the 2020 Wood Library-Museum of Anesthesiology Laureate. This is the most prestigious award for the history of anaesthesia internationally and is awarded every four years to an outstanding scholar and contributor in the field.

The significance of Dr Ball's achievement cannot be understated especially as she is only the second Australian and second female to receive the honour. Dr Ball is in esteemed company with the only other Australian to receive the Laureate being Dr Gwen Wilson (whom the ASA archives are named after), who was not only the first female to receive the award but also the inaugural Laureate recipient in 1996.

THE RECOLLECTIONS OF A RETIRED LIBRARIAN

Having now fully retired from the ASA, most recently serving as the Richard Bailey Librarian, I have been asked for some impression of my 14 years with the ASA. My overwhelming thought is one of gratitude to the Society for entrusting me with the task of bringing the old anaesthetic objects collected by so many out of the triple garage at the old Edgecliff headquarters into a purpose-designed museum space; in addition, I had the honour of adding to the work of Alison Bartlett, in cataloguing the books accumulated by the ASA, and especially those from the library of Dr Richard Bailey, onto shelves in a fine new Library.

I must acknowledge the skill and zeal of Drs Greg Deacon and Ross Holland and the then CEO, Mr Peter Lawrence, in encouraging the Council to fund both ventures. Without their persuasive powers the ASA would be without our present resources to carry out research into the history of anaesthesia of national and world significance. Such research has been well exemplified by the work of Drs Michael Cooper, Reg Cammack, Rajesh Haridas and particularly Richard Bailey who continues to give treasures to the Library, provide support for researchers and advocate the importance of the Society's Archives and oral history.



Another strong supporter of the Museum and Library has been Dr Jeanette Thirlwell, who for many years also was deeply involved with the editorial work of the Society's journal, Anaesthesia and Intensive Care.

Thank you all for your collegiality and support which made working for the Society such an enjoyable and rewarding task. I wish future success to HALMA's History of Anaesthesia Research Unit, being a vital and intrinsic part of the ASA.

Peter Stanbury OAM, PhD
Honorary ASA Member
Retired ASA Librarian (September 2019)

WHAT'S IN A NAME?

You may notice that HALMA have been using a new name in recent times – History of Anaesthesia Research Unit (HARU). While HALMA (History of anaesthesia, Library, Museum and Archives) is still the committee who manage HARU, this new name has been adopted to better reflect the work that HALMA undertakes and to promote the ASA's historic resources to those engaging in research.

DONATIONS WELCOME

The ASA is pleased to announce that both the Harry Daly Museum (HDM) and the Richard Bailey Library (RBL) have been granted deductible gift recipient status by the Australian Taxation Office (ATO). By receiving this endorsement from the ATO it means that any cash donations to the HDM and RBL are now tax deductible.

This also means that if you are donating an object to the HDM or a book to the RBL it may also qualify as a tax-deductible donation. For more information regarding donating an item to the HDM or RBL; or for information regarding making a cash donation please contact the **ASA's Curator, Librarian and Archivist on 02 8556 9708 or email BMcMartin@asa.org.au**

INSIDE YOUR SOCIETY

AROUND AUSTRALIA

NEW SOUTH WALES

Ammar Ali Beck, Chair

The committee have made a submission to the NSW Parliamentary inquiry into the operation and management of the Northern Beaches Hospital. The inquiry was set up to examine the arrangements related to the model of care i.e. Public Private Partnership, contracts, the way the hospital was set up and its impact on the community.

Ramsay Health Group and a few other service providers have indicated remuneration to the obstetric on-call service will be decreased. The media barrage continues in earnest throughout 2019, blaming doctors for the perceived diminishing value proposition for patients retaining their private health insurance. It is needless to say that anaesthetists play an important role in service provision, and they need to be listened to and included in any discussions. It is equally important to mention that OOP expenses and anaesthetic fees are for anaesthetists to decide.

I was invited to the Retired Anaesthetist Group lunch on 27 August to talk about 'Anaesthesia Practice in NSW Today'. It was a great opportunity to spend an afternoon with a wonderful group of retired anaesthetists, full of enthusiasm and passion for the profession.

NSC 2019 – Sydney was a great success, with an excellent line-up of speakers, and a healthy number of delegates and industry participants. Everyone seemed to have enjoyed the social events and returned home with lots of good memories.

We are in the process of finalising a meeting in early March 2020 on the Central Coast, aiming to educate anaesthetists on how to make a successful transition into retirement, something a lot of us struggle to do.

QUEENSLAND

James Hosking, Chair

The 42nd Queensland Annual ANZCA/ASA Combined CME meeting was held on the Gold Coast on the 31st August and 1st September. The meeting had a new format this year, being held over two days at the QT Hotel.

There was an evening lecture on October 29. There were two presentations on 'Perioperative perils of the liver patient' and 'Hard to swallow: food bolus obstruction and foreign body ingestion'.

QUEENSLAND COMMITTEE

Dr James Hosking

I graduated (MBBS) from the University of Queensland in 2001, having previously completed B. Biomedical Sc. at James Cook University and gained my Fellowship from ANZCA in 2009.

I work part-time as a Staff Specialist at the Logan and QEII Hospitals and also in private practice predominantly at the St Andrew's War Memorial Hospital in Brisbane.

Previously, I have been the Chair of the Queensland Regional Committee for ANZCA and am currently a member of the Day Care SIG Committee. After a number of years on the Queensland Committee of Management this is my first term as Chair.

SOUTH AUSTRALIA

Brigid Brown, Chair

Congratulations to the South Australia CME Committee for a successfully run ACE conference in October. The event was well attended and the program was very well received.

Further congratulations to Dr Nik Fraser on hosting an excellent Part 3 course a few weeks ago for senior anaesthetic trainees and to all of the consultants who donated their time and expertise to present to the group.

With the recent changes to the MBS commencing at the start of November, South Australia was better informed thanks to Dr Mark Sinclair, who visited private groups around the state to provide background and information about this process.

Wishing everyone a very happy upcoming holiday season and all the best for 2020!

WESTERN AUSTRALIA

Dr Philip Soet, Chair

As many of you will have already heard, Dr Fiona Sharp sadly passed away on 17 October 2019 in a diving accident whilst in the Caribbean. She was a passionate and popular anaesthetist with extensive experience in diving and dive medicine. Her tragic passing has been noted by a very wide network of friends and colleagues, all of whom will miss her deeply. To quote her sister,

"It is with great sadness we have lost the best daughter, sister, sister in law and aunty to the ocean today," her sister, Donna Bird, wrote on Facebook.

"She passed doing what she loved. We will miss her fun loving, energetic and bubbly nature."

INSIDE YOUR SOCIETY

PIERS WILLIAM ROBERTSON 1961-2019

MBBS, B.MED.SC (HONS), DA (UK), FANZCA

Piers Robertson was a highly respected Senior Anaesthetist at the Royal Adelaide Hospital, who sadly lost his struggle with cancer on 30th March aged 58 at home. He died peacefully surrounded by his family. He achieved more than most in a career brought to a premature end.

The Robertson family were pastoralists at 'Chowilla', a station on the Murray near the New South Wales border, and although Piers' life was in Adelaide, he retained close ties with the country, enjoying 'Chowilla' and the Murray with friends and family. He graduated from St Peter's College in 1978 to embark upon a career in medicine at the University of Adelaide, graduating in 1986 obtaining a Bachelor of Medical Science (Honours) in Department of Clinical and Experimental Pharmacology in the process.

Piers started his anaesthetic career as a Senior House Officer in 1989 at the Royal Hallamshire Hospital in Sheffield, where he gained the Diploma in Anaesthesia from the College of Anaesthetists (UK) (the College gained its royal accolade by charter in 1992). He returned to Adelaide and gained a place in the South Australian Vocational Anaesthetic Training Scheme, being awarded his FANZCA in 1996. He joined the Hyperbaric Medicine Unit at RAH for six months as a Provisional Fellow. Rather than make the smooth transition from junior to senior ranks in Adelaide, he showed his adventurous colours. Along with his wife Libby, a radiographer whom he married in 1988, and their three young children, he set off for Duke University Medical Center, Durham, North Carolina for a year to further his interest in hyperbaric medicine. He developed a keen interest in regional anaesthesia which remained with him until his retirement in 2018. Prior to returning to Adelaide the Family Robertson spent six months exploring America in a recreational vehicle.

In 1998 they returned to Adelaide and Piers immersed himself in the activities of the Department of Anaesthesia at the RAH. He was Deputy Director of the Department for two years from 2006-08.

Outside the operating theatre, he was:

- The Department's Liaison Officer for Eye Surgery and Post Anaesthesia Care Unit (PACU);
- A member of the RAH Disaster Planning Committee; the Anaesthesia Management Group, the Clinical Pathways Taskforce for PACU and ICU and the Equipment Committee.

He was coordinator of the departmental Quality Assurance Program and Resident Medical Officer Supervisor for Anaesthesia, inspiring a succession of trainees. The current chair of the Trainee Members' Group of the ASA, Dr Richard Seglenieks, attributes his career in anaesthesia to Piers' inspiration, when he was a medical student attached to the department.

With the experience gained in America, Piers initially divided his full-time public practice between anaesthesia and the hyperbaric unit at RAH, providing telephone assistance for diving related medical emergencies throughout the South Pacific via DAN, the Divers Advisory Network. He worked tirelessly to develop regional anaesthesia as a consequence of the North American experience and was an early adopter and proponent of ultrasound-guided regional anaesthesia. It is difficult to find a better example of the value of an overseas Fellowship to enhance hometown practice.

He developed the Adelaide Regional Anaesthesia Workshop, which held its

inaugural meeting in 2003 and became an annual fixture in the conference calendar until 2014. In conjunction with the Anatomy Department of Adelaide University, he developed a series of prosections to offer one of the earliest cadaver based Regional Anaesthesia workshops in Australia. The university laboratory staff fondly remember him strolling down to the lab on a Friday afternoon (Friday was his non-clinical day) in his maroon cardigan, to check on the progress of 'his' cadavers. This workshop continues today and is a testament to the infrastructure he established.

In 2001, he wrote and was chief (and sole) editor of *What a Gas*, the department's weekly newsletter. A regular feature of the newsletter was the introduction and welcome to department of new members of staff – both junior and senior. (In that first edition, he welcomed a certain Dr Rod Mitchell, former GP and staunch advocate, even then, for Aboriginal healthcare, who had just passed the Primary FANZCA exam.) The newsletter appeared, without fail, on a Friday afternoon and it continues to this day.

Piers stood down from these positions when his health began to fail in 2017.

Piers had the gift of being a natural organiser and a great networker. This was nowhere more evident than in his involvement with the Australian Society of Anaesthetists (ASA). He was the Scientific Program Convenor for the ASA National Scientific Congress (NSC) in 2002 and 2006. Not many people are willing to act as Scientific Convenor on more than one occasion! He volunteered to be overall NSC Convenor for Darwin in 2015. Being overall convenor is a challenging task at the best of times and is even more so when convening from afar and in the months after major surgery!

He was also:

- ASA Federal Scientific Programme Officer 2003-10 acting as chair of the NSC Federal Scientific Programme Sub-committee from 2003-08.
- He 'morphed' into the ASA NSC Scientific Congress Officer from 2010-18 and chaired the ASA NSC Federal Committee from 2010-18.

Piers Robertson was presented with the President's Medal by then ASA President David M. Scott at the NSC 2018

He received the President's Medal in 2018 for service to the ASA.

Libby and his children John, Alexa and Caroline deserve recognition for their support during these extra-curricular activities.

It would be inappropriate to describe Piers as simply a 'medical' man. He loved swimming, cycling, the Australian outback and 4WD expeditions, the family station and the Murray River.

Machines with motors gave him enormous pleasure and he owned a succession of Alfa Romeos. Pride of place went to his collector's item, a 1974 *Montreal*, extensively refurbished in 2008. He took it to an Alfa car club track day where the club president described him as having driven the car in the way it was meant to be driven: "He drove it like he stole it!"

As a brother, husband, father, friend, colleague, mentor, quiet voice of reason, authority and sound advice, Alfa enthusiast and committed ASA member, for whom life was meant to be lived and opportunities taken, he is sorely missed.

We should be grateful and consider it an honour and privilege to have spent a short time walking with him on his journey.

Piers William Robertson – Rest in Peace.

Dr Simon Macklin

INSIDE YOUR SOCIETY

NEW AND PASSING MEMBERS

The ASA would like to welcome all new members from September to November 2019.

TRAINEE MEMBERS

Dr Samuel John Boyers	NSW
Dr Brian Koon Kiu Chan	NSW
Dr Gregory David Evans-McKendry	VIC
Dr Kathleen Fixter	NSW
Dr Daniel Foong	ACT
Dr Kanathiban Kathirgamanathan	NSW
Dr Alyce Jane McKenzie	QLD
Dr Sian Louise Myers	NSW
Dr Craig Melville Rainbird	WA
Dr Callum James Robinson	VIC
Dr Matthew Hugh Routley	QLD
Dr Ashley Gordon St John	VIC
Dr James Paul Turnbull	SA
Dr Boris Waldman	NSW
Dr Hannah Watson	NSW

ORDINARY MEMBERS

Dr Andrew John Winston Arrowsmith	NSW
Dr Bhavesh Dineshbhai Bhandarker	QLD
Dr Andrew James Cluer	NSW
Dr Joachim Dieterle	VIC
Dr Julia Catherine Groves	QLD
Dr Sanaa Mohammed Ismail	VIC
Dr Atlas Ching-Hong Ko	VIC
Dr Jean-Philippe Lalonde	QLD
Dr Melinda Lattimore	NSW
Dr Fung Nien Lim	VIC
Dr Kian Loong Lim	QLD
Dr Georgina Stewart Mahony	NSW
Dr Fousia Manthodi Kulangara	QLD
Dr Ryan Maslen	WA
Dr Alyson Patricia McGrath	NSW
Dr James McKevith	NSW
Dr Alisteir James Norton	SA
Dr Shaun James Roberts	QLD
Dr David Schapiro	QLD
Dr Andrew Leslie Simons	VIC
Dr Wan Yee Tey	NSW
Dr Danielle Ashleigh Volling-Geoghegan	QLD
Dr Leigh Karen Winston	QLD
Dr Sze Ming Wong	VIC

IN MEMORIAM

The ASA regrets to announce the passing of ASA members Dr Brian Hill, NSW; Dr Terence Mark Hoolahan, NSW; Dr Brian Luden McLaughlin, NSW; Dr Barbara Leonie Slater, NSW; Dr Malcolm Evans, VIC; Dr Paul Howard Francis, VIC; Dr Robert Mager Gray, VIC; Dr Robert John Knight, VIC; Dr Leonard Vincent Russo, VIC; Dr Fiona Catherine Sharp, WA.

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

Membership benefits

SUPPORT

REPRESENT

EDUCATE

Advocacy and representation

At a wide range of levels including federal and state governments, private health insurers and regulatory bodies.

Education and events

- Online anaesthetic modules
- Awards, prizes and research grants
- National Scientific Congress
- Trainee members workshops
- Practice managers conference
- CMEs

Publications

- Anaesthesia and Intensive Care
- Australian Anaesthetist
- Relative Value Guide

Historical collection

- Harry Daly Museum
- Richard Bailey Library

ASA Advantage Program

A range of benefits available exclusively for our members.

To join the ASA please complete the form at www.asa.org.au/join

For further information visit www.asa.org.au
or contact our Membership Services Team

Email: membership@asa.org.au • Phone 1800 806 654

ASA
Australian Society of Anaesthetists

SAVE THE DATE

16-19 October 2020

WELLINGTON, NEW ZEALAND

CSC2020
COMBINED SCIENTIFIC CONGRESS
NZSA & ASA • WELLINGTON NZ
16-19 OCTOBER 2020

INTERNATIONAL INVITED SPEAKERS

Professor Denny Levett

Dr Levett joined UHS in July 2015 as a consultant in critical care and perioperative medicine. She's also clinical lead for cardiopulmonary exercise testing and surgical high dependency, and co-lead for perioperative medicine. Dr Levett is experienced in diagnostic and perioperative cardiopulmonary exercise testing, perioperative fluid management, enhanced recovery after major surgery and looking after high risk surgical patients.

Professor Steven Shafer

Professor Shafer is professor of Anesthesiology, Perioperative and Pain Medicine (Adult MSD) at the Stanford University Medical Centre. His professional interests are the clinical pharmacology of intravenous anesthetic drugs. This has led him to clinical studies of many of the intravenous opioids and hypnotics used in anesthetic practice. However, his passion is not the drugs themselves, but rather the mathematical models that characterise drug behaviour.

Professor P.J. Devereaux

Dr Devereaux is the Director of the Division of Cardiology at McMaster University. He is also the Scientific Leader of the Anesthesiology, Perioperative Medicine, and Surgical Research Group at the Population Health Research Institute. Dr Devereaux is a full Professor and University Scholar in the Departments of Health Research Methods, Evidence, and Impact (HEI) and Medicine at McMaster University.

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