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

ASA 77th NSC 2018

HISTORY OF MILITARY ANAESTHESIA

- Responding to disaster: the 2004 tsunami
- Anaesthesia care in the military environment
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THE MAGAZINE OF THE AUSTRALIAN SOCIETY OF ANAESTHETISTS

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

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

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A MEMBER SOCIETY OF THE WFSA

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INSIDE YOUR SOCIETY

WOULD YOU LIKE TO CONTRIBUTE TO THE NEXT ISSUE?

The March issue features of *Australian Anaesthetist* will focus on Safe Working Hours and Fatigue in the Workplace. 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 2019.
- Final article is due no later than 17 January 2019.

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

REGULAR

ASA EDITORIAL FROM THE PRESIDENT

DR PETER SEAL
ASA PRESIDENT

Welcome to the final edition of *Australian Anaesthetist* for 2018. This is my first Editorial as President, and it is a tremendous honour to be able to communicate with ASA Members in this way. There are several issues still awaiting resolution as we fast approach 2019.

On behalf of the ASA, I would like to wish Australian anaesthetists and their families all the very best for a safe and restful Festive Season.

ANAESTHESIA MBS REVIEW

At the time of writing, the Anaesthesia Medicare Benefits Schedule (MBS) Review appears to be drawing to a conclusion. The ASA remains hopeful that an outcome favourable for Australian patients and anaesthetists will have been reached.

In a process that has lasted for almost two years now, the ASA, alongside ANZCA and the academic institutions, has been working closely with the Federal Department of Health, and Minister for Health, to obtain a revised Anaesthesia MBS that is based on fairness, relativity, best evidence, and cost effectiveness. In addition, the Australian Medical Association (AMA) has rendered assistance and influence to an exemplary level that has been highly beneficial to achieve this end.

A most effective Working Group, with other key ASA personnel, has been extraordinarily dedicated in the struggle to preserve an Anaesthesia MBS that has served extremely well the Australian public and healthcare sector since it was introduced in 2001. More than 1,000 cumulative hours have been clocked up, especially during the past 18 months, including around 3,000 emails, not to mention phone calls, teleconferences, meetings, and visits to and from Canberra, Adelaide, Melbourne and Sydney.

The ASA has been informed that the revised Anaesthesia MBS will come into existence some time during 2019.

HUMANITARIAN CRISIS ON NAURU

For some considerable time now, the mental and physical health of refugee children, women and men on Nauru has been deteriorating steadily. A humanitarian crisis has arisen, especially since the recent expulsion of Medicins Sans Frontieres (MSF) from the tiny sovereign state by the Nauruan Government on October 6. MSF had been providing all psychiatric services on the island up until then.

In late September, over consecutive days, the AMA sent or released letters to the Prime Minister and every other parliamentarian in the House of Representatives and Senate, followed by a strongly worded media release, urging the immediate removal of asylum seeker families from Nauru:

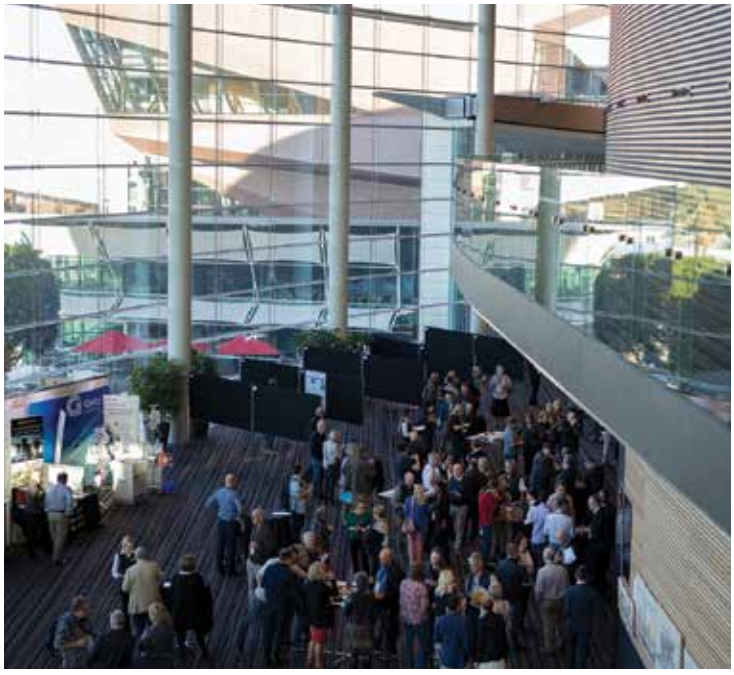
The Government must get 'fair dinkum' and give these long-suffering asylum seeker children, many of whom are extremely ill, and their families a fair go – bring them to Australia for proper care in the best possible environment for their severe mental and physical health conditions.

AMA President Dr Tony Bartone also has requested that the Prime Minister make it possible for an Australian medical delegation to access Nauru and make an evaluation of the health needs of those who remain indefinitely detained, including still a few dozen minors.

In early October, Sydney general practitioner Dr Sara Townend and Melbourne plastic surgeon Dr Neela Janakiramanan initiated a letter and petition to the Prime Minister. It gathered almost 7,000 medical practitioner and student signatories, and received the backing of a whole host of leading and influential organisations, including the ASA and ANZCA.

With the victory of former AMA President Dr Kerryn Phelps in the recent Wentworth by-election, and the creation of a minority Coalition Government, it has become more likely that the remaining refugees will be relocated permanently.

The ASA has taken a stance based on empathy, in which the human and ethical imperative far outweighs the political one. On this particular issue, the ASA view is identical to that of the AMA and the remainder of the medical profession.



Welcome drinks, NSC Adelaide 2018

Immediate Past President David M. Scott hands over to current President Peter Seal

WELLBEING

The ASA has been supporting the Welfare of Anaesthetists Special Interest Group (WASIG), in collaboration with the Everymind team in Newcastle, to develop a comprehensive toolbox enhancing mental wellness for anaesthetists and anaesthesia departments. The Long Lives, Healthy Workplaces program was launched by WASIG at the recent National Scientific Congress (NSC) in Adelaide. WASIG Member Dr Tracey Tay deserves much credit for getting this essential service up and going. The toolkit subsequently has been presented in New Zealand by Vice President Dr Suzi Nou at a recent conference. The ASA will work with WASIG to develop the continued roll-out and broader adoption.

The wellbeing of anaesthetists will remain as a major priority for the ASA, now and in the future. The ASA will seek to continue to improve our knowledge, understanding, management and care of such concerns as: suicide prevention and possible recognition; mental illness, including depression and anxiety; substance abuse of alcohol, licit and illicit drugs; sleep hygiene promotion and management; mentoring of younger and older practitioners, and any age in between; life balance, focusing on relationships, parenting, optimal health, fitness, exercise and nutrition.

NATIONAL SCIENTIFIC CONGRESS 2018 ADELAIDE

A most memorable, enjoyable and successful 77th ASA NSC was hosted in Adelaide near the start of October. As usual, there was a program of exceptionally high academic merit and social content. The international invited speakers, Professors Joyce Wahr from Minnesota and Lars Eriksson from Stockholm, delivered several wonderful presentations, and were warmly friendly and incredibly generous with their time. In keeping with the upcoming centenary of the Armistice signing from the Great War, Air Vice-Marshall Tracy Smart, a native of Adelaide, appropriately presented a military theme during the Kester Brown Lecture.

The weekend Gala Dinner at the magnificently rebuilt Adelaide Oval was immense fun and energetic, while the Family Night at the Adelaide Zoo was a relaxing way to wind down. During the final plenary session, we witnessed a sequence of stunning performances staged by the Hush Foundation examining major themes in Australian health delivery involving communication and bullying, in a search for improved patient experiences. It was a fitting finale.

We have an enormous debt of gratitude to the NSC 2018 Adelaide Organising Committee. Convenor Dr Simon Macklin, and Scientific Convenor Dr Kate Drummond, are to be commended for their extremely capable, sensible and calm leadership. They functioned brilliantly, especially under the exceptional circumstances of being cursed by the unfortunate unavailability, for a whole range of reasons, and non-appearance of more than a dozen presenters, including some keynote ones, often at very short notice. Scientifically there were high class Lectures, Masterclasses, Meetings,

2019 ASA MEMBERSHIP

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

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

You would have received your 2019 membership invoice by early December. If you have not received yours, please contact the **Membership Services Team** on **1800 806 654** or email **membership@asa.org.au.**

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Workshops and Small Group Discussions. As mentioned, the social activities will leave a lasting and ongoing impression of enduring friendship.

LEADERSHIP

The inevitable cycle of turnover within the ASA Board has occurred formally at the Annual General Meeting during the NSC in Adelaide.

Assoc Prof David M. Scott has become the Immediate Past President. David has reached the end of his presidency with the ASA in as influential and as solid a position as it ever has been in its history. David's term has been dominated by the Anaesthesia MBS Review. His hard work and dedication have helped to ensure that the ASA has emerged strongly throughout the countless meetings and negotiations. In addition, David was integral in the establishment of the governance structure of the current Board and Council.

Dr Guy Christie-Taylor has stepped down from the Board and is no longer the Immediate Past President. Guy has been a tireless contributor to the ASA over many years now. It is hoped that his input will continue to benefit the Society. His measured and perceptive reflections will be missed around the immediate table. The hotline to Guy's wisdom will continue on regardless.

Dr Nicole Fairweather has joined the Board as the new Executive Councillor. Nicole is the Immediate Past Chair of the ASA Queensland State Section Committee of Management. She was extremely accomplished in that role, and has been a fearless advocate for safe and efficacious healthcare in that state. She also has been a champion for fair working conditions for Queensland doctors. Nicole's sharp intellect will be an asset for the Board.

Dr Suzi Nou has been elected ASA Vice President. The ASA is indeed fortunate to have a leader of her excellent capacity and quality. She was the previous Executive Councillor. Suzi continues to be an inspiration to her peers. Unheralded she travels at regular intervals to Cambodia where she organises anaesthesia conferences, including its national annual meeting, as well as taking workshops and teaching. She has an abiding interest in the wellbeing of anaesthetists, and the ASA will benefit from her expertise and ideas in this area.

AN INTRODUCTORY NOTE

I graduated in Medicine from Monash University in 1988, and trained in Anaesthesia mainly at St Vincent's Hospital Melbourne and the Geelong Hospital. I received my Fellowship in Anaesthesia in 1998. This was followed by a Fellowship in Intensive Care Medicine in 2002.

I have continued in solo practice as an anaesthetist and an intensivist in both the public and private sectors. During this time, I have established a longstanding liaison with anaesthetic registrars, and was a Supervisor of Training from 1999 to 2013.

I became an ASA member 25 years ago, and joined the Victorian Section Committee of Management in 2005. I was the Victorian Education Officer between 2007 and 2013, and convened four Victorian Combined Continuing Education Meetings in 2008, 2010, 2012 and 2013, as well as the ASA Victorian Rural Meeting in 2011. I was a member of the Organising Committees of two separate ASA NSC's that Melbourne hosted in 2010 and 2016, in which I was a co-ordinator for the Small Group Discussions on both occasions.

In 2013 I was elected as the ASA Victorian State Chair, and served in this role until 2016, thus being on the Federal ASA Council. In 2014 I was asked to join the ASA Executive as the State and Territories Chairs Representative. Later in 2016 I was afforded the extraordinary and somewhat surprising privilege of being the national ASA Vice President.

Over the ensuing two years, I have been part of a leadership team of exceptional depth, breadth and capability, as exemplified by the ongoing Anaesthesia MBS Review process. This has culminated in my elevation to the office of ASA President last October. I am aware of the degree of duty, and the accompanying further sense of service to the ASA, and to Australian anaesthetists and patients. I embrace the commitment to the daunting office of the ASA Presidency with enthusiasm and excitement. I plan to pursue an emphasis on professional wellbeing and equity over the next two years.

I am the husband of Geraldine and the father of three teenage children, a son and two daughters. There is a solid foundation of social justice that has been the bedrock of my nurturing, formation and education within a large family. As a continuing avid long distance runner and a Melbourne Marathon Spartan, I maintain an abiding passion and love for fitness and sport, particularly Australian rules football through the Geelong Football Club, and Test cricket with the Melbourne Cricket Club.

The ASA is the oldest and arguably the best medical specialty society in Australia. Over the past 84 years it has continued to Support, Represent and Educate Australian anaesthetists. It exists to maintain Australian anaesthesia as first-class, and Australian anaesthetists as being the finest in the world.

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

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ASA UPDATE FROM THE CEO

MARK CARMICHAEL, ASA CEO

As we approach the end of another busy year, I believe it is valuable to reflect on the year that has been. In short 2017-2018 has been quite a successful year for the Society. The work of our various committees in particular, in relation to such matters as the MBS Review, have been demanding but hopefully rewarding. At the same time the Society was able to strengthen its financial position.

Looking back, there are two other areas I would like to examine a little more closely. They are membership and the services offered by the Society.

The ASA is a membership organisation and I am pleased to report that the overall membership of the Society has continued to grow. During the year the Society experienced nett growth of 1.9%, meaning that as of July 2018, just over 56% of the anaesthetic profession (FANZCAs plus trainees) were members of the Society.

Overall, membership stood at 3,598 up from 3,502 in 2017. During the year the Society welcomed 316 new members. Of those, 114 were new Ordinary Members, meaning our largest member category stood at 2,090.

Membership growth is the result of specific campaigns and personal contact. During the year we conducted three direct campaigns:

1. An approach to anaesthetist members of AMA who are not Society members.
2. An offer to those members, who in recent years have put their membership on hold for a variety of reasons, and are invited to rejoin.
3. Regain initiative aimed at those who in recent years, for whatever reason, let their membership lapse.

Combined these three campaigns resulted in 67 anaesthetists engaging with the ASA as an Ordinary member.

These organised approaches coupled with the tremendous work of our State Chairs and Committees and the active promotion of the Society by existing members have all assisted in building the membership.

A point of some satisfaction for all has been the continued increase in the number of trainee members. During the year 74 Introductory/Basic Trainees joined along with 108 Advanced/Provisional Fellow Trainees. There are now 543 trainee members accounting for <43 % of all trainees in Australia.

Like all membership organisations retention is key. It is pleasing to report that the ASA's overall retention rate remains very strong and sits at 92% (excluding deaths and retirements).

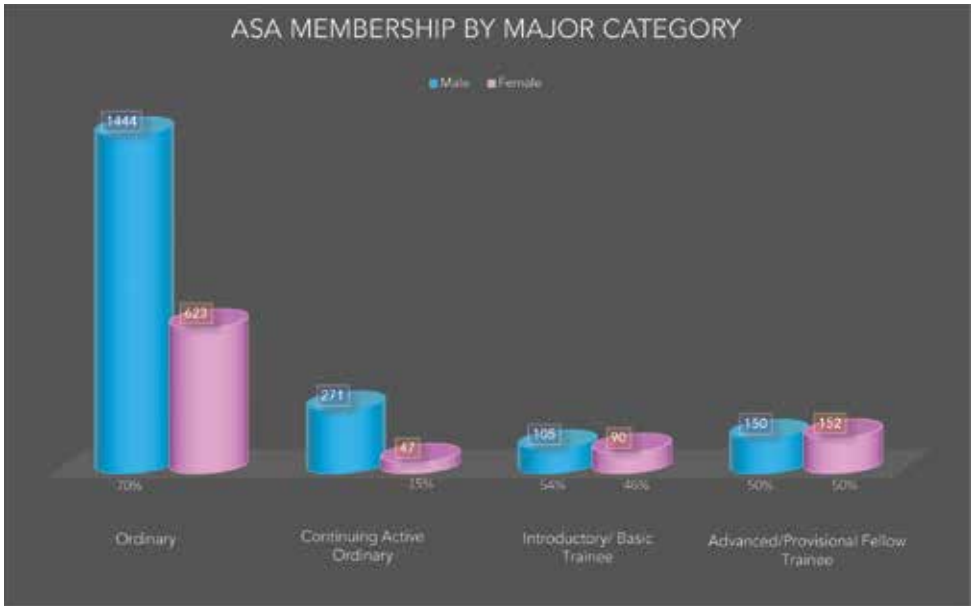
Member loyalty is acknowledged with thank you communications when members reach particular milestones. Our gold star for that is shown in the Continuing Active Ordinary category or 30-year members – during the year we welcomed 39 members into that category including the President Associate Professor Scott and Queensland State Chair Dr Jim Troup.

What does the membership look like? Currently it reflects the profession i.e. 68% of our members are male and 32% are female, which is the current breakdown of Fellows. From the trainee perspective the membership split is almost 50/50 which is slightly different to the composition of the overall training program which is 55% male to 45% female. Clearly this has implications as it is reasonable to believe that the composition of the anaesthesia profession will take on a different appearance in the not distant future.

From a member perspective the ASA is strong and getting stronger. The challenge remains to show to all the value of membership. That value is clearly identified through the services available.

The ASA vision to support, represent and educate its members is achieved in a variety of ways. It offers a broad range of services and opportunities some of which members are very familiar with and some not so obvious. It is worthwhile to reflect briefly on some of those services as they all contribute to the appeal and value of membership.

The wellbeing of doctors, not only anaesthetists, has attracted significant media attention in recent times. Mid last year the ASA allocated $55,000 in funding to the Everymind Centre, previously known as the Hunter Institute, in NSW to assist in the development of a program



ASA Major Member Categories by Gender June 2018

specifically for anaesthetists, designed to assist in their wellbeing in the workplace. This resource has now been developed and is available on the new ASA website. Members are encouraged to access this resource and look for ways to implement it in the hospitals in which you work.

The Everymind project, when added to the existing services offered through ANZTADC, ODEC, and the Anaesthetic Continuing Education (ACE) reflects the diversity of activities the Society is involved in.

The ASA is and should be proud of its various publications which include

- *Anaesthesia and Intensive Care* Journal (AIC);
- the annual History Supplement;
- the *Australian Anaesthetist*; and
- the *Relative Value Guide* all of which continue to be highly valued by the membership.

It is worth noting that Council has made the decision at the recommendation of the Editorial Board to outsource the publishing of the AIC, effective January 2019. This is seen as a prudent move and forms part of the Society's overall risk management.

The ASA continues to provide to final year trainees a copy of the *Anaesthetic Crises Manual*. A way of supporting new anaesthetists as they begin their careers.

The Annual Awards, Prizes and Research Grants, remains a clear expression of the ASA's ongoing commitment to education within the specialty.

A further commitment to the value of education are the three Common Issues Scholarships on offer to trainees designed to support their attendance at the national conferences of the Canadian, American and Great Britain Societies. This opportunity is greatly appreciated by trainee members as confirmed by the 17 applications received this year.

During the year the Society revamped its website. With a greater focus on functionality I would encourage all to log in and explore the new site.

The ASA's move to adopt and utilise the various forms of social media, most notably Twitter and Facebook, continues to be an area of growth. With regular tweets covering a multitude of topics, ranging from the MBS Review, drug shortages, right through to job vacancies, the number of ASA followers has grown to 3,515, up from 521 in April 2013, when Twitter was first introduced. This form of communication assists in positioning the Society to promote its message and reach audiences outside of our normal grouping.

The monthly President's eNews is central to providing members with concise, accurate and up to date information. With an average open rate well in excess of 60% per edition, members clearly welcome this form of communication.

Building on the success of the President's eNews, and as a way of providing a quick reference to upcoming educational meetings for members, the monthly Professional Development and Events eNews was introduced during the year and is proving popular with members.

Advocacy initiatives remain central to the ASA's operation. The work of Dr Grossi, Chair of the Professional Issues Committee, Dr Sinclair, Chair of the Economic Advisory Committee and Associate Professor Alicia Dennis, Chair of the Public Practice Advisory Committee and all who sit on those committees can never be underestimated.

I trust this snapshot of the Society is illuminating. In closing, I would like to acknowledge the work of recently retired President Associate Professor David M. Scott and all members of the Board, Council and all of the ASA Committees. All of whom have made a wonderful contribution to the work of the Society.

I look forward to 2019 and a continuation of the good work of the Society.

CONTACT

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

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LETTERS TO AUSTRALIAN ANAESTHETIST

WHAT'S IN A NAME?

In the UK during the 1960s and '70s, there was an oft repeated legend about the appointment of Dr Robert Macintosh to the first UK Chair in our speciality in 1937.

He was reputed to have been asked "What do you want your department to be called? Anaesthetics or Anaesthesiology?" He was always quoted as saying "Anaesthetics – like politics and economics."

That make sense, but it does not necessarily confine us to being called anaesthetists. As many of us have found during world travels, it is simpler to describe ourselves as anaesthesiologists, then there is no confusion in our international audiences. They then know our medical practitioner and speciality training. This also applies to talking to patients in Australia who come from non-Anglo Saxon cultures where nurse anaesthetists practice anaesthesia. There is much less confusion.

I am by nature a traditionalist, but reluctantly I have come to the conclusion that a name change is inevitable. We live in an international era. Get on with it.

Dr Andrew Bacon
Berwick, Victoria

The letter of Jackson Harding (*Australian Anaesthetist*, September 2018) mentions the use in Canada of the term 'anaesthesiologist' to describe our specialty status. In the early 1970s after obtaining the FFARACS and then having passed the LMCC exams in Canada and also completing the requirements for Fellowship in anaesthesia (FRCPC) and working for a further three years in Toronto, Canada in specialist anaesthesia practice I became aware of many of my colleagues in Canada referring to themselves as anaesthesiologists. At that time I did think that was rather quaint, especially when I moved back to Australia in 1975.

However with changing times it seemed to me that for all the reasons outlined by Jackson Harding, it would be a good idea to change my status to 'anaesthesiologist' and I did that on my business cards, which I gave to every patient, from about the year 2000 onwards until I retired from practice three years ago. The safest anaesthesia service in the world is taken for granted by Australians but the doctors providing this service are rarely recognised for it. Advertising and branding have become important in medical practice. The adoption of the ASA logo many years ago is a good example of a far-sighted move by a small number of our members who managed to convince the majority to change. Anyone who thinks that medical practices are not small businesses probably is unaware of the attack on the ASA by the ACCC in the late 1990s over alleged price fixing at Kareena Hospital in Sydney where ASA members were negotiating for an on-call fee for obstetric anaesthesia cover to be paid by the hospital. At that time no members of the NSW ASA State Committee (of which I was Chair) knew that our small businesses were subject to the Trade Practices Act and we were threatened by the ACCC with five million dollar fines for our practice companies, even though those 'Clayton's' medical practice companies were set up for the provision of superannuation entitlement and did not enjoy the income splitting and taxation advantages of every other company in Australia.

After surviving the ACCC attack I decided to change my business

CONGRATULATIONS

The ASA would like to congratulate Life Member and Past President Dr Andrew Mulcahy (Tasmania) on his recent appointment to the Tasmanian Board of the Medical Board of Australia.

approach: printing my own 'Anaesthesia & You' brochures with a description of 'anaesthesiologists', and including the term on my business cards. Some patients asked about the term but were usually satisfied with my explanation. So I wholeheartedly support the suggestion of Jackson Harding for all the reasons outlined by him and hope that ASA members adopt the name anaesthesiologist.

Alec Harris
Paddington, NSW

IN APPRECIATION

I would like to thank you and the ODEC for the privilege to attend the wonderful ASA Conference in Adelaide. Special thanks to Maxine for the wonderful organisation of the logistics for the whole trip.

It was a good learning experience for me not only in content but in conference organisation overall. It was all very informative and I have a lot to share with everyone now that I have returned.

All the conversations about the practice of anaesthetics in the advanced environment really helped me to reflect on our local practice and how I can contribute to change. On a personal practical note, I learnt about the Erector Spinae Block at one of the workshops and am very excited to use it and teach it back in my workplace.

Thank you once again and I will surely try to attend the next one.

Liz (Elizabeth) Inaido
Suva

REGULAR

WEBAIRS NEWS

The recent ASA NSC in October 2018 featured three presentations which were supported by data collected using the webAIRS server.

The first was a glimpse at the Triple A project (Airway Incidents in Anaesthesia Audit – Australia and NZ) by Dr Yasmin Endlich. The AAAP data (including denominator data) was collected from April to October 2018 with 12 participating hospitals in Australia and New Zealand. Closely following the methodology of the National Audit Projects of the Royal College of Anaesthetists (UK), the AAAP data is being analysed and a detailed presentation is planned for the 2019 Airway SIG meeting, which will be held immediately prior to the ANZCA ASM in Kuala Lumpur at the end of April 2019. An Audit Report will follow that summarises the information and some of the findings will be submitted for publication in a peer reviewed journal.

The session titled 'We cannot fix what we do not know' included 'What we have learnt from the webAIRS airway data' by Dr Yasmin Endlich and 'The Bowtie Diagram as a method for providing knowledge about critical Incidents' by Dr Martin Culwick.

The Australian and New Zealand Tripartite Anaesthetic Data Committee (ANZTADC) met on October 6, 2018 in Adelaide. The committee proposed a vote of thanks for Ms Sarah Walker who moved on from her role as ANZTADC Coordinator at the end of September 2018 after three and a half years of excellent service. The committee also proposed a vote of thanks to the outgoing ASA President Dr David M. Scott and to the immediate past ANZCA President Professor David A. Scott and welcomed new members Dr Rodney Mitchell (incoming ANZCA President) and Dr Peter Seal (incoming ASA President).

Strategic planning for ANZTADC is underway to review the current operations. More details will appear in the next issue of the *Australian Anaesthetist* after the review has been completed.

Discussions are underway for a masterclass and presentations for the 2019 ASA NSC in Sydney. It is hoped that one of the international invited speakers will take part in the presentation session.

ANZTADC looks forward to seeing you at these sessions in 2019.

FOR MORE INFORMATION

Find out more about ANZTADC/WebAIRS: http://www.anzca.edu.au/fellows/safety-and-quality/incident-reporting-webairs

Are you contributing to quality improvement in anaesthesia? Register yourself on webAIRS: www.webairs.net

ASA BENEVOLENT TRUST FUND

Established in 2001 the ASA Benevolent Trust Fund assists Australian anaesthetists, their families and dependents who are in dire necessitous circumstances.

The Trust Fund is maintained exclusively from members' donations and from interest on the balance of the Fund.

All donations are tax deductible.

To make your donation contact ASA by emailing maung@asa.org.au

NEWS

WORLD ANAESTHESIA DAY

Dr Richard Bailey helped HALMA celebrate World Anaesthesia Day recently on October 16, with a talk titled 'Ether Day'. Both the day and the subject celebrate the first public demonstration of the anaesthetic capabilities of ether at the Massachusetts General Hospital in 1846.

Richard spoke of his own experiences of providing open-ether anaesthesia as well as the history of analgesia down through the ages: the use of herbal extracts, mesmerism, nitrous oxide and ether (with their associated 'frolics'), chloroform and the introduction of ether into Australia.

The meeting was particularly honoured by the attendance of three members of Richard's own Graduating Class, including the former NSW Governor, Professor Dame Marie Bashir AD, CVO.

Dr Reg Cammack
Chair, HALMA

Professor Barry Baker, Dr Rajesh Haridas, Professor Dame Marie Bashir, Dr Richard Bailey, Dr John Alam and Dr Laurie Mather.

'56 Club, St Vincent's junior residents: Left to right, Tony Cronin, Bernie Carew, John Alam, Richard Bailey, Jimmy Roche, Marie Bashir, Ray Holt and David Roebuck.

NEWS

INTRODUCING THE ASA VICE PRESIDENT

SUZI NOU
ASA VICE PRESIDENT

I sat in the opening ceremony of the recent National Scientific Congress held in Adelaide, knowing that I was soon to become Vice President. Instead of being a passive observer, I found myself paying keen attention to the formalities, noting nervously that perhaps one day, I would be on that stage.

Then President of the ASA, Associate Professor David Scott introduced Uncle Moogie, a Ngarrindjeri Elder to conduct a Welcome to Country ceremony. Uncle Moogie danced to the north, south, east and west. After his dance he explained how through it, he welcomed us all from all the directions that we had come. He also explained that the dance called upon our ancestors to guide us in our learning, to look after our safety and to wish us well for our journey home and onward.

During my time on the Board, I have been impressed with how supportive the ASA aims to be towards each of its members.

I considered the ancestry of the ASA and support of the current leadership and membership in nominating me as Vice President. During my time on the Board, I have been impressed with how supportive the ASA aims to be towards each of its members. There have been members who have come across challenging circumstances as well as members with great ideas. The mood of the Council and Board has always been "how the ASA can support them?" There may be differences of opinion and some may not get exactly what they want, so I particularly commend the members who continue to value that the ASA is much greater than the sum of its individual parts and much bigger than the influence of one person.

I thought about my own ancestors and how I have only known a life where both parents contributed equally to work inside and outside the home, sometimes with typical gender roles reversed. I consider myself incredibly lucky for having this experience early in life. I don't consider myself a feminist, as I'm not sure exactly what that means. I'm an anaesthetist, and now VP of the ASA, who happens to be a woman. I bring my perspective that one gender is no better than the other and that everyone deserves to be treated with respect and equality.

The ASA leadership, like many organisations has been composed mainly of men. Moving forward, it is important for both men and women to foster and support women into leadership roles. Leadership is something that is required at any stage of our careers, whether it be guiding our department through roster changes to developing a peer review group for solo private practitioners. I look forward to the 2019 NSC in Sydney which will feature an accessible leadership program relevant to all in our anaesthesia community.

Moving forward, it is important for both men and women to foster and support women into leadership roles.

I considered my personal history. After finishing my training with a paediatric fellowship in Melbourne, I went to work in Fiji. I predominantly anaesthetised small children undergoing surgery for pathologies to the extent I had not seen in Australia, using limited resources whilst teaching and overseeing the training program. After one child died in the post-operative period, I became more actively involved in developing their surgical PICU capability and was offered the position of Head of the Department of anaesthesia and ICU. Sending an obstetric team to a remote island to resuscitate and operate on a woman with a post-partum haemorrhage triggered my interest in retrieval medicine. Being part of the Ministry of Health surgical outreach program and anaesthetising in operating theatres we had set up in remote clinics after a cyclone, fostered my enjoyment in working in austere environments, something that I have been able to continue in Australia by joining the RAAF and Australian Medical Assistance Team (AusMAT).

After working in Fiji I worked in a children's hospital in Cambodia. At the time, it was one of the most surgically capable paediatric hospitals in the country, developing a cardiac surgical program and receiving over 200 international volunteers a year, many from esteemed global paediatric institutions. I was involved with developing their ER/PICU and impressed with the pace of development. I continue my involvement with that hospital, having introduced the Paediatric BASIC course. Our team, supported by the ASA Overseas Development and Education Committee (ODEC) is mentoring an instructor base so that within the next few years they will be able to deliver the course to local participants, in their own language, without the need for external instructors.

I see the ASA as a pivotal body in a health system that strives to achieve and maintain a high degree of patient safety, accessibility and affordability.

I then moved to Darwin where I appreciated the challenge of delivering care in a remote regional centre. A challenge that is ongoing. I was able to formalise my interests by completing a Masters of Public Health with a focus on global health and health systems strengthening. I see the ASA as a pivotal body in a health system that strives to achieve and maintain a high degree of patient safety, accessibility and affordability.

Uncle Moogie asked our ancestors to guide us in our learning. I have always valued the role of education in empowering people. Whilst a medical student at the University of Melbourne, I tutored and then directed the VCE Summer School, a two-week program aimed at helping 500 students from disadvantaged backgrounds. The program was supported by over 200 volunteer university students and I note that it still continues to this day. Whilst a registrar at St Vincent's Hospital, I became an EMST Instructor which then opened the door to instructing other courses such as ALS, Paediatric BASIC, adult BASIC, Primary Trauma Care, SAFE Obstetrics, to name a few. Through these courses, I have had the pleasure of working with health practitioners and educators across Australia, Asia and the Pacific.

Uncle Moogie conducting the Welcome to Country at the opening of the NSC 2018

Uncle Moogie asked our ancestors to look after our safety. As Chair of the Victorian ANZCA Trainee Committee, I was asked to consider a mentor program for registrars. That led me to dream that one day, every anaesthetic department would have a mentor program. I am pleased that anaesthetists across the country are making this change happen. Since then, I have learned that the greatest times of stress in our careers, once exams are completed, are the times of transition. Transitioning from training to specialist and from a specialist to retirement. I have also experienced mentoring as something that is relevant not just for trainees but for people throughout their careers, including Vice Presidents. I have been so proud to work with Dr Tracey Tay on the Long Lives, Healthy Workplaces toolkit and write more about it in this edition of *Australian Anaesthetist*.

Like Uncle Moogie, I wish to welcome Australian anaesthesia providers from all directions to the diverse community that is the ASA. I also ask us to look upon each other and the ASA to guide us in our education, our safety and the safety of our patients. Wherever this journey takes you, I hope that the ASA accompanies you.

NEWS

THE DAYCOR REGISTRY 'COMPLETING THE EXPERIENCE'

The Day Care Outcomes Recording (DayCOR) REGISTRY, developed by the Anaesthesia Continuing Education Day Care Anaesthesia Special Interest Group has now been in trial mode since March 2018.

We have now surveyed and recorded the outcomes of over 4,600 patients in a trial at two hospitals. The survey has proved to be robust, sound and popular. The overall response rate (adults and children) is 80% which is an excellent result for a trial of this nature.

ESTABLISHMENT

The registry was established completely in line with the Australian Commission on Safety and Quality in Health Care's 'Framework for clinical quality registries', 2014. (The ACSQHC was set up by the Australian Health Ministers Advisory Council (AHMAC) some eight years ago). It requires the establishment of a Steering Committee for management and the reporting of results at seven levels, including to the community on an annual basis.

THE SURVEY

A 15 question survey is sent by SMS and email to each patient 24 hours after discharge. The only identifiers are the patient's hospital Medical Record Number, mobile phone number and email address. There are two forms, a DayCOR Adult and a DayCOR Child.

The questions involve the need to make a contact for medical advice, persistent nausea or unresolved nausea, confusion, falls, and difficulty with instructions or resuming medications.

In the Child survey, confusion is replaced with behavioural problems.

The offer of making a positive comment, a negative comment or a suggestion provides an opportunity for canvassing other issues

THE RESPONSE

Of the 80% survey respondents, 61% provided a positive comment, whilst just under 8% offered a negative comment. When the response indicates no concerns, it is immediately de-identified and entered into the registry on a secure cloud server. Any concerning response, e.g. persisting vomiting or pain, confusion, falls, inability to resume medications or negative comment generates an 'Alert' report.

This alert is emailed to the treating anaesthetist and a senior hospital group of anaesthetist, nurse manager and administration. The patient is contacted and the concern resolved before being de-identified and registered.

CASE SELECTION

Every patient presenting for day surgery was selected.

Of interest, in one hospital 20% (234/1196) were of ASA3 status and 1.5% (19/1196) of ASA4 status. All had a satisfactory recovery which indicates the value in such a registry indicating successful management of the sicker patient and the ability to note this for the further assessment of sicker patients in the future.

Older and sicker patients are now treated with ideal optimisation of their medical state and offered increased confidence in their standard of care.

New operations and procedures can be managed as day procedures using recorded outcomes and many existing procedures, formerly of inpatient stature are frequently appearing as day cases.

HOSPITAL IT UNDERSTANDING

Each hospital IT department is closely involved with such a program. It is important for them to understand that DayCOR believes that it has attended to all the possible security and privacy issues. They are welcome to perform any penetration tests that they wish to use, but it is well known that there is no test which gives any warranty or guarantee of total protection. DayCOR provides the best standard which can be offered at the moment including total de-identification of patients and the registry storing information on an Australian Cloud Server.

ACTIONS SO FAR

Already, some very important issues requiring resolution have been recognised: complaints of prolonged fasting, lengthy waiting times or difficulty with instructions. The fasting times and waiting times should be easily resolved with good planning. These issues are being addressed by medical staff, nursing staff and administration.

Of interest, at one hospital 23% of patients surveyed were ASA3 status and 2% ASA4. The procedures undertaken on these patients covered the complete gamut of day care work. All recovered satisfactorily and as expected. Preoperative preparation of these patients involved the usual preadmission consultation and assessment of aftercare arrangements.

Presentations of the Registry creation and implementation have been made at all national ANZCA and ASA meeting over the last two years. There has been a lot of interest expressed and many private hospitals and private health care groups are investigating and implementing the program.

In the public sector, there is always the problem of funding the activities of a clinical quality registry

FUNDING

1. The cost of the survey itself

Currently at 50 cents per survey, this is paid by the hospital.

2. Costs of running the Australian Cloud Server

Currently combined with the survey cost, but there may need to be an extra provision in the future.

3. The Steering Committee functions and management

The committee, consisting of a Director as initial chairman, representatives of the involved bodies (ANZCA and ASA), senior administrative staff, a community representative and finance officer have the responsibilities of:

- Establishment of the program in hospitals through wide consultation with their anaesthetists, other medical, nursing and administrative representatives.
- Present results at National Specialty meetings (ANZCA and ASA), and provide them for meetings of hospital staff and groups of anaesthetists.
- Advising on problem-solving issues after establishment in a hospital.
- Co-ordinate educational activities arising out of results and QA activities.
- Produce a newsletter or contribute articles to the ANZCA *Bulletin* and the *Australian Anaesthetist*.
- Produce and supervise the various levels of reporting including finance and necessary fund raising.
- Create and discuss research opportunities with hospital outcome committees and interested individual anaesthetists.
- Ensure adequate staff and IT support are appointed for organisational efficiency.

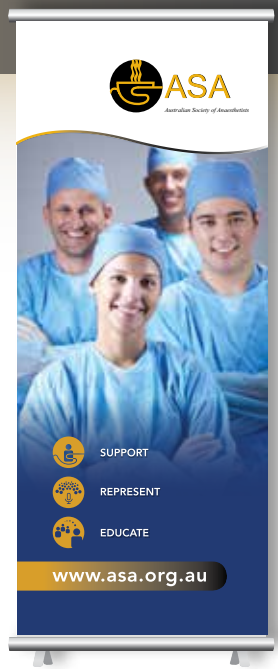
DayCOR is in advanced discussion with state jurisdictions on these funding requirements.

Dr Ken Sleeman, Chair
ACE Day Care Anaesthesia Special Interest Group

ASA BRANDING REFRESH

Recently the **ASA** branding has undergone a makeover – boasting a fresh new look and feel.

The new website and various other marketing materials have been updated to reflect the refreshed branding. **We hope you like it!**



ASA
Australian Society of Anaesthetists

FEATURE

A RAAF Critical Care Aeromedical Team, incorporating several anaesthetists, prepares for a long range, multiple casualty repatriation. Photo: ADF

ANAESTHESIA CARE IN THE MILITARY ENVIRONMENT – UNIQUE EXPERIENCES, OPPORTUNITIES AND CHALLENGES

Australian doctors have a long and distinguished history of caring for patients in wartime and disasters and anaesthetists have made great contributions to this.

Anaesthetists in the Australian Defence Force have been a major part of providing clinical care, and indeed in advancing patient care, in these challenging situations, whether this has been to Defence personnel or to civilians as part of a humanitarian aid role. Not surprisingly given the situation in which clinicians find themselves on Defence service, contemporary deployed military anaesthetic practice has some key differences from day-to-day practice, with elements of difference driven by the needs of the deployed environment.

Depending on the specific circumstances, practice environments can range from well-established and amazingly well supported field hospitals through to makeshift facilities. Anaesthetists are often involved in Aeromedical Evacuation, supporting intensive care services and may have administrative roles such as Director of Clinical Services.

The ability to provide surgical and anaesthetic services is often critical to a hospital's capacity to manage the injured and ill, and the perioperative team will find itself closely linked into the hospital's operations at many levels. Especially in small facilities – potentially with a single operating theatre and limited ward and ED capacity – there is often a high level of teamwork with other areas of the facility to ensure patients are cared for to the best possible standard and move quickly and effectively through the system.

…practice environments can range from well-established and amazingly well supported field hospitals through to makeshift facilities.

At a bigger picture level, these facilities will often be providing staged care, the

care delivered being part of a broader system. For example a small facility relatively close to a conflict area, which gives casualties very rapid access to a surgical facility (a Role 2E in the NATO parlance used by the ADF) may provide damage control resuscitation and surgery often with rapid onward movement to a larger (Role 3) centre for more definitive care. In such systems the use of protocols and standardised forms of communication are highly desirable.

High velocity weapon injuries and blast injury are thankfully relatively uncommon in Australia, as are mass casualty events.

Whatever the nature of the facility one is working in, teams may be rotated relatively frequently and may have members from various nations as members. Rapid team building and getting to know how other nations' medical systems operate become part of life. That a broader perspective on how things are done in other nations and a number of long-term friendships are offshoots of this process is a common 'plus-side' to this.

Clinical presentations in the military setting may also be very different to that typically seen in Australia. High velocity weapon injuries and blast injury are thankfully relatively uncommon in Australia, as are mass casualty events. These may represent a significant part of the workload in a disaster or war zone. In both disaster and warlike situations contaminated wounds are common which adds to the complexity of acute care. On the other hand even amongst war or disaster, non-violent accidents still happen and people still suffer other acute surgical issues e.g. appendicitis, so there is always an element of the familiar in the clinical caseload.

Clinical targets – the effective delivery of safe and effective resuscitation, surgical anaesthesia, perioperative medical care and acute pain management – are unsurprisingly the same as in Australia. Delivery of anaesthesia in such settings may range from using very familiar, comprehensive anaesthetic delivery systems in a hospital facility, to the use of total intravenous techniques with volatiles unavailable in others. Having approaches for managing complex patients with a variety of techniques is essential. The use of drawover volatile systems, once the linchpin of Australian military anaesthetic teams' equipment, is currently on the wane with either plenum systems available in larger facilities or TIVA with a variety of agents being the primary technique in smaller ones. Ultrasound and regional blocks have revolutionised practice in this area for surgery and for perioperative analgesia.

A pleasing part of deployed practice is a strong culture of reflective case audit and opportunities taken at all levels to improve clinical quality. Not only is this good practice it generally provides considerable peer support.

The requirement for limited size and weight, along with the need for robustness, may mean equipment is not that which practitioners are familiar with. That said the equipment used by the ADF is TGA approved in line with the principle of offering the standards of care available in Australia. Ensuring the ADF pool of anaesthetists is familiar with the relevant equipment is managed by each of the services and acknowledged as a key training point.

Some surprises are found when working in multi-national teams and the hospital itself belongs to another nation, with a different range of drugs available…

Limited space and capacity, plus the use of standardisation, also mean that deployed facilities will have a functionally comprehensive but still necessarily limited range of equipment and drugs available – not every brand of equipment can be represented when the hospital has to be flown in, trucked in or delivered on a ship. Some surprises are found when working in multi-national teams and the hospital itself belongs to another nation, with a different range of drugs available and familiar drugs

A deployed hospital structure under construction. Photo: ADF

FEATURE

A team at work in a Role 3 facility. Photo: ADF

being presented quite differently from formulations available here. If far from home or the logistic environment means that resupply may take time, the need to conserve resources is starkly underlined at times. In the deployed environment the principles of simple, safe, effective, resource conservative care are employed to their fullest.

The psychology of deployed health provision can be a challenge – remoteness from loved ones is difficult even in an era of effective rapid communication.

Demands on resources, both numerically and in terms of the clinical situations encountered, can vary widely both between deployments and at times within a deployment – situations that change with extremes of climate, regional infectious burdens and of course rates of injury and illness. Workloads can change rapidly both in terms of case nature and volume, and complex cases may be presented on short notice.

The psychology of deployed health provision can be a challenge – remoteness from loved ones is difficult even in an era of effective rapid communication. A somewhat less obvious issue is that in our workplaces at home, we are doing what the hospital does – provide healthcare. In a war, healthcare subserves a military imperative. It can be quite difficult getting one's head around the idea that what we do is not the primary aim of the organisation we are working for, and indeed the prerogatives of the military situation may to some degree dictate the nature of the care that can be provided. This is something that any military medical practitioner needs to accommodate, and anaesthetists are certainly not exempt from this.

Training for military anaesthetic practice is an area in which simulation is of great utility. Simulation of clinical scenarios and processes, using the equipment that will be available in the deployed location, is an excellent mechanism for bringing both individuals and teams to readiness. The ADF conducts regular exercises in Australia that involve setting up a surgical facility. Participating in these provides clinical support to the exercise and adds the elements of practicing life in the field, which is of great benefit as training.

Military anaesthetists often deal with a different and complex spectrum of injury in demanding environments, in tight-knit but intermittently changing teams, and need to do so in simple, effective, resource-conserving ways. Practice in this environment calls upon our best. To be able to work in this challenging environment has to me always been a privilege.

The opinions expressed by the author are his own and should not be construed as being made on behalf of the Australian Defence Force.

The author is a Reserve member of the Australian Defence Force. No other conflicts of interest were disclosed

Group Captain Michael Corkeron
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Directorate of Health Reserves, RAAF

DEFINITIVE ANAESTHESIA TRAUMA CARE COURSE: AN EVOLUTION

The Australian Defence Force (ADF) adopted the ULCO Field Anaesthesia Machine (FAM) in 1984, which was developed with the aid of LTCOL Dr John Taske. The FAM was an evolution of the Tri-service Anaesthesia machine used by the British Armed Forces.

It was based around two in-series Penlon Oxford Miniature Vaporizers (OMV) mounted in the lid of a box which carried the accessories to use them as either a draw-over system, or as a plenum circuit with a carbon dioxide absorber included.[1]

For a period of time after its initial acquisition, operational tempo for the ADF was relatively low, so the requirement for pre-deployment training on this unique machine was considered unnecessary, and was subsequently unfunded. ADF anaesthetists used the FAM in Operation TAMAR, the ADF's contribution to the UNAMIR peacekeeping mission to Rwanda, 1994-1995, and in Operation BEL ISI in Bougainville, 1997-2003. However, the predicted risk to ADF personnel was considered low, and as such specific speciality anaesthesia training was not deemed necessary. The only other ADF deployment of anaesthetists was to the Middle East for the first Gulf War, but this was to a US Navy Hospital Ship with sophisticated, conventional anaesthetic equipment requiring no supplementary training for anaesthetists familiar with modern plenum machines. Following the independence referendum in East Timor in 1998 and resulting civil unrest, the Australian-led peacekeeping force INTERFET was deployed to the new nation. This was the first time that the ADF had led a deployment for some time into a region with war-like conditions, whereby peacekeepers were likely to be targeted by a hostile organisation.

In 1999, Drs Hadyn Perndt and George Merridew were developing the Real-World Anaesthesia Course (RWAC), and were teaching draw-over anaesthesia in Hobart, Tasmania. Although not mandated by the ADF, many of those deployed to Bougainville on OP BEL ISI had found the RWAC invaluable. At the time of the INTERFET, Group Captain Merridew as

FEATURE

Chair of the ADF Anaesthesia Consultative Group (ADF AnCG), recognised that some further training for anaesthetists was required. Specifically the use of the ADF anaesthesia equipment, and a practical understanding of draw-over anaesthesia. He decided to modify the RWAC to have a military focus, and the resultant Military Anaesthesia (MILAN) course was introduced.

The MILAN course provided participants with the content of the RWAC. Significantly though it provided the course in a defence context. Participants discussed management of 'battlefield' trauma, ADF specific policies/protocols for blood management, medical evacuation, and triage. During the years of INTERFET and the following UNTAET (UN Transitional Administration East Timor) current ADF anaesthetists attended the MILAN course, and subsequently many deployed to East Timor. The MILAN course continued to be funded through various operational missions from 2000-2005, being conducted seven times during this period.

The nature of clinical wounding in combat was altered by the introduction of body armour and the use of Improvised Explosive Devices (IED).

The Army Logistics Training Centre (ALTC) was handed MILAN in 2006 for management and further development. Their assessment of the course was limited by a lack of knowledge of the course content, its context, and the practicalities of providing education for specialists with quaternary qualifications. As a result, investment was not made in the course and fell into abeyance for a number of years.

Following the attacks on the World Trade Centre in New York in 2001, world geopolitics altered. The nature of clinical wounding in combat was altered by the introduction of body armour and the use of Improvised Explosive Devices (IED). The US-led coalition into Iraq, and the NATO-led response into Afghanistan resulted in ADF anaesthetists being required to deploy to a very different war zone with new challenges for trauma management. At this time, it was also recognised that the ULCO FAM was now outdated, and lacked sophisticated modes to deal with the challenges of syndromes such as blast lung.

As a result, anaesthetic military training was still required, but needed to broaden its focus to include a range of clinical injury patterns (and their subsequent management) not seen in civilian hospital trauma settings.

In 2010, as the Chair of the ADF AnCG, I contacted the Director General of Health Capability Joint Health Command (DGHC), CDRE Robyn Walker with a request to re-establish the MILAN. After consideration, both DGHC and SGADF approved the concept and I began a collaboration with Kylie Douglas from Health Capability within Joint Health Command on developing the new course.

MILAN Mk 2 was to focus on many aspects of the first course, but added discussion of management of the injury patterns seen in the emerging conflict, DCR, and surgery, treatment protocols, surgical healthcare facilities for the three Services, and intensive care in the field (as many deployed anaesthetists had this as a duty as well). It was also appreciated that team training was important to good anaesthesia outcomes and familiarity with ADF anaesthesia equipment vital to the anaesthesia assistant, so for the first time, anaesthesia nurses and medics were included in the course. The first MILAN 2 was held at Amberley Air Force Base and Ipswich Hospital in November 2011. Subsequent courses were held at Ipswich and Gallipolli Barracks Enoggera, each time the course being further developed based on feedback and current medical intelligence from the field.

ULCO FAM Mk 2

In 2012 Colonel Michael Reade, then newly-appointed Defence Professor of Military Medicine and Surgery was invited to attend the International Association for Trauma and Intensive Care Definitive Surgery Trauma Care (DSTC) course in Sydney. He was struck by the value of the discussions on surgical management of severe trauma and the team training principle used with surgical nurses involved in the course. Concurrently, RADM Walker requested Kylie Douglas review the DSTC course, noting the work done within the UK Military's surgical teams training program. Discussions commenced with the DSTC Sydney convenor, Dr Scott D'Amours to run MILAN alongside the DSTC with the view to develop an embedded anaesthetics component in due course.

This first occurred in 2014 at Liverpool Hospital. The anaesthesia component of the new course carried much less emphasis on draw-over anaesthesia (appropriate as most military hospitals now had modern plenum machines), and instead the course focused on trauma management, DCR and ICU in the field. The course includes excellent practical application of skills learnt with the entire

Attendees at MILAN 2001, of note GPCAPT George Merridew front left, LTCOL (now BRIG) Michael Reade, second row left and Ms Kylie Douglas directly behind George.

surgical teams input to discussion and outcomes.

This course has continued to develop and now, in line with very similar courses run in Europe, has evolved into the Definitive Anaesthesia Trauma Care (DATC) course. It was first run as a DATC in Sydney in 2017 with a subsequent military focus due to the Sydney course convening a one-day Military Module at the end of the initial three-day DSTC/DATC course. It was first delivered as a civilian DATC course in Brisbane in February 2018 and has subsequently been delivered in Sydney (July 18) and will be delivered in Melbourne in November 18.

The course is multidisciplinary (surgeons, anaesthetists and perioperative nurses – anaesthetic and scrub/scout) and is targeted at those who work in trauma, either in a trauma centre, or in rural hospitals where severe trauma is infrequent but challenging. It includes group discussions, lectures, lab work and simulation sessions, along with break-out sessions for the various disciplines as required. It is the most comprehensive trauma team training that one can do if you wish to appreciate and improve your confidence in caring for trauma patients. The important focus on technical and non-technical skills ensures that the whole trauma team is engaged and involved in the learning process, and this logically leads to better trauma care and patient outcomes.

DATC specifically is pitched at the anaesthetist who has completed their fellowship exam or are full fellows – there is little discussion of the practical aspects of administration of anaesthesia, rather the principles of trauma anaesthesia and anaesthetic support staff. The course includes training on the management of massive haemorrhage (as expected) and on 'can't intubate can't ventilate' (CICO) situations. Completion of the course will meet these two ANZCA CPD requirements for emergency responses. It runs for three days and is most valuable for anybody who cares for trauma patients and who seeks to improve patient outcomes for trauma.

For further information please go to the ACE website, or https://dstc.com.au

Associate Professor David M. Scott
Group Captain, Royal Australian Air Force

Reference

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FEATURE

RESPONDING TO DISASTER: THE 2004 TSUNAMI

At 0758 on 26 December 2004 the Burmese tectonic plate slipped under the Indian plate. The ocean floor fell by 15 m over a 1,200 km stretch, causing an earthquake of magnitude 9.3 in the Indian Ocean, 160 km west of the city of Banda Aceh on the tip of the island of Sumatra. Trillions of cubic metres of water was displaced, generating a tsunami that spread out at speeds of 800 kph.

The earthquake collapsed buildings in Banda Aceh, and 20 minutes later a wall of water 13 m high hit the coastal city, channelling up rivers and canals leading into the heart of the city. The wave swept up fishing boats, coastal dwellings of corrugated iron and timber, raw sewage, animals, vegetation, vehicles and tens of thousands of people. The modern city centre of Banda Aceh was inundated by a two-storey high wall of debris, a toxic soup of mud, sewage, and bodies. This travelled 3.8 km inland, leaving a landscape of mud and debris.

Very little was known in Australia, but by that evening a group of ADF Reserve specialists had been stood up as a military team, at four hours notice to move. Move where? Do what? Nothing happened on the 27th, or the 28th – until 2200 hrs, when we were told we were flying out the next morning, but as a civilian team under the Department of Foreign Affairs and Trade (DFAT). The Indonesian government would not yet accept formal Australian military involvement.

We assembled at RAAF Richmond; two teams that soon joined to form CASTA – the Combined Australian Surgical Team Aceh. Team leaders Commodore Mike Flynn and Group Captain Paul Schumack, four anaesthesiologists (Brigadier Brian Pezzutti, Wing Commander David M. Scott, Lieutenant Commanders Paul Dunkin and Paul Luckin), four surgeons (three of them military), two logisticians – both also anaesthesiologists (Ken Harrison and Squadron Leader Alan Garner from CareFlight NSW), four OT nurses, two paramedics, two firemen, four ED nurses, plus two public health, one A&E and one infectious diseases physician.

CareFlight NSW mobilised their Urban Search and Rescue cache; stores intended as short-term support for rescuers working in collapsed buildings. This had personal protective equipment, camp stretchers, sleeping bags and mosquito nets, four tonnes of bottled water, and a field amputation set consisting of a few Gigli saws, a handful of scalpels and artery clamps and sutures, and some gauze swabs. There was a small quantity of morphine, midazolam and ketamine, and some antibiotics – Ken Harrison scrounged a little more.

There was no anaesthetic or other surgical equipment. Deploying as a civilian team meant we had none of the extensive anaesthetic and surgical equipment we would have taken with us as a military team; we had to be completely self-sufficient.

We flew north, overnighting in Jakarta, then west, eventually hearing that we were needed in Banda Aceh, and would be permitted to land there. It was estimated that six thousand had died in the tsunami.

As we landed we were hit by the overpowering stench of decaying bodies. The smell and the taste was in our noses and our mouths every minute we were there, and for weeks after we came home. We unloaded 28,400 lb (13,000 kg) of stores by hand, and slept beside the airstrip; tired, sweaty, dirty, and hungry.

In the morning an Australian Army reconnaissance truck carried us into Banda Aceh. We drove past heavy earthmoving equipment digging huge pits, with a row of dump-trucks tipping bodies into them. Thousands of rotting bodies littered the rubble, the streets, the gutters, the buildings and the playgrounds. The river in the middle of the city was choked with a tangle of fishing nets and bodies. A local driver told us he could see how many people were not there anymore; he thought the death toll would be one hundred thousand in the city of Banda Aceh alone. This staggering figure turned out to be an under-estimate.

Fakina, a small private hospital four km inland, had been abandoned as the debris wave approached; it stopped 200 m from the hospital. We moved in, 28 of us living in two large hot, dirty, mosquito-infested rooms. Our two firemen stacked equipment trunks down the middle of the rooms, to catch the ceiling and roof if it fell in during the continuing earthquakes. They tied ropes to the veranda pillars, to climb down if the staircase collapsed. There were more than 20 quakes over magnitude 6.2 during the time we were there. Only one section of ceiling did collapse – but all that fell through was a startled cat. To wash we scooped stagnant water from a plastic basin, with bottled water for face and hands, and there was a squat toilet without water. We ate Army ration packs, and noodles.

After a few days we ignored the frequent quakes; the buildings would shake, floor tiles crack, door frames twist, waves form and slop out of any tiled wash tubs that still had any water in them. Wall tiles would shatter, dropping shards across the floor.

Fakina had a small operating room. We tried to find surgical equipment; the owner had locked it all away, and refused all requests to use it.

Word spread that the Australians had arrived, and the walking wounded started pouring in – few children, even fewer elderly; they could not outrun the wave. Brian Pezzutti and Paul Dunkin started work at Fakina that night, 30th December, with a modicum of basic equipment. Brian found and restored a disused halothane vaporiser, and had enough halothane for gas inductions on three children. He was able to do one femoral and one supraclavicular brachial plexus block, but otherwise relied on ketamine, morphine and midazolam. A local doctor refused to accept our female surgeon, until Brian said she was a professor. She repaired a hand using a Leatherman tool. The two NSW firemen blandly reported that at night a locked storeroom door somehow just swung open, and some oxygen cylinders rolled out, all by themselves.

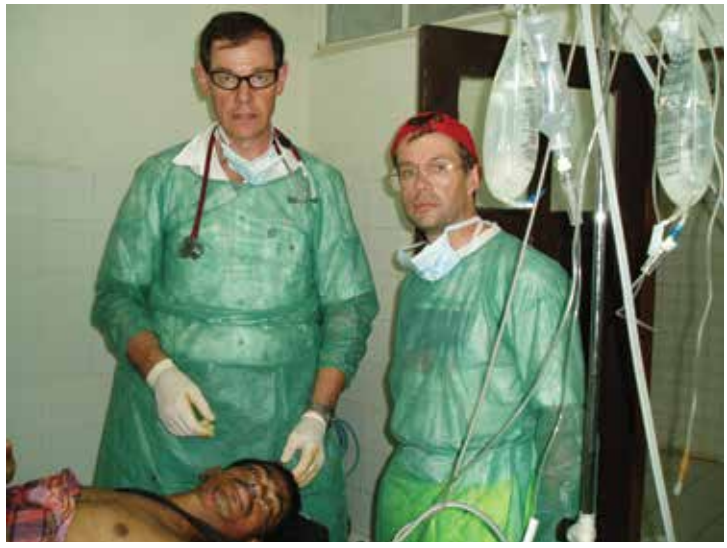
I was sent to reconnoitre the only other functioning hospital, called the 'military' hospital because the Indonesian Army had a small presence there, and had assumed command. There were two bare operating rooms, a small one with an operating table

Simultaneous amputations – note the saw on the table and the ration bag on the foot

David M. Scott re-triaging outside theatre

FEATURE

Re-triage in the theatre corridor



Paul Luckin and David M. Scott with a patient under dissociative anaesthesia

and an empty cylinder, and a larger one. No water, electricity occasionally and for short periods, no doors, no windows.

David M. Scott and I returned early next morning with two surgical teams, nine of us in total, and a small amputation kit. We passed hundreds of bodies, on the roads, in the debris, in crumpled cars, bundled in black plastic, in the river.

At the hospital we were initially not welcomed by the Indonesian colonel in charge, until it was revealed that our senior people were all military – we were then allowed in.

The hospital was overflowing with the worst of the casualties. Those with abdominal and thoracic wounds had already died, leaving those with limb wounds, predominantly lower limbs.

Patient selection in the wards was triage at it's most brutal, left to David and me once the surgeons had chosen those they thought operable. All had grossly infected penetrating wounds, all were septicaemic, and most had pneumonia from aspiration of the grossly contaminated water. Many had pre-existing anaemia from malaria, and were poorly nourished. Many were clearly beyond salvation.

We selected only those we felt might survive extensive debridement or amputation. All our patients were ASA 4.E. 'Informed consent' was difficult, across cultural, religious and language barriers, especially in desperately ill patients with no surviving relatives and sometimes little will to live. Some patients refused amputation, as they believed they could not enter Paradise unless they were whole, despite knowing they were deteriorating and it would soon be too late to reconsider. Those we chose were carried to theatre on stained and soiled canvas stretchers. We re-triaged them on the floor outside theatre, sending some back to the wards because they had deteriorated, or because we had been too optimistic.

David and I put two tables in the larger theatre, so we could give each other practical and moral support. The theatre was dirty, hot and humid, full of flies, with no fresh air. Occasionally the lights would come on for a while. The adjacent squat toilets didn't drain because there was no water, adding to the smell.

Typically limbs were swollen with gaping wounds, leaking black pus, with dead muscle. The surgical challenge was to debride more and more proximally, until they reached living tissue.

The anaesthetic challenge was to keep the patients alive while they did so. We found a broken oxygen concentrator and a non-functional rotameter. With ingenuity we were able to get a trickle of oxygen for David to use, with his one Hudson mask. I had a half-full large black cylinder, which I was told contained oxygen, and one set of nasal prongs.

We had no airway equipment and no suction. We were very fortunate in that we did have morphine, midazolam and ketamine, two antibiotics, and some local anaesthetic. I had used ketamine extensively for severe trauma in Africa.

We had a limited supply of syringes, but plenty of needles, small IV cannulae and IV saline. We shared a small NIBP, ECG and oximetry monitor, but had no electrodes.

David did one femoral nerve block, successfully, but felt even the short time taken precluded further regional blocks. I did one spinal, on a patient lying on a stretcher on the ground singing his death prayers. The assistant holding the patient turned away, the patient moved to bow to his deity, and I was left with a bent needle and half the dose in the CSF. I straightened the needle – the only spinal needle we had – and completed the block. The only sterile things were the needle, my gloves, and the paper the gloves came in. Thereafter the lack of equipment, sterility

and time made us abandon regional anaesthesia.

Thereafter we used dissociative anaesthesia, titrating drugs to effect. Our patients required very low doses of drugs; David or I would typically give 1 or possibly 2 mg of morphine, perhaps 1 mg of midazolam, and 10 mg of ketamine. Patients breathed spontaneously, with a little supplemental oxygen. Most received generous intravenous saline, both to rehydrate them and to replace blood loss, in the absence of any other resuscitative fluid. Increments of 5-10 mg of ketamine were given if needed. Patients undergoing large scale debridement or amputation rarely required as much as 40 or 50 mg of ketamine in total.

After the first cases we covered the bare operating tables with body bags, and later sheets of building plastic, so each patient had a clean surface to lie on, and to be put back on the soiled stretchers. I found some plastic tubing to use as tourniquets. The plastic bags from our Army ration packs served to contain limbs about to be amputated. We had non-sterile paper gowns, plastic aprons, and some sterile gloves. The paper from the gloves provided the 'sterile' surface under the site of surgery.

The surgeons had what we carried or could find lying around; a handful of scalpels, forceps, artery clamps, and a few Gigli saws. The nurses had Betadine, some disposable plastic trays, and a small quantity of green swabs. The patients' condition and the number waiting required swift and skilful surgery. Often extensive debridement alone was adequate, often below or above knee amputation was unavoidable. Amputation and closure generally took about 40 minutes. While David or I took our patient out to the corridor and got the next patient on the table the surgeon would mop the floor and a local assistant would carry out the waste, while our nurses soaked the Gigli saw and instruments in Betadine. Their wash-up area was a tiled trough and a few bottles of drinking water. The Gigli saws soon grew blunt and snapped. I had seen an old tenon saw lying on the floor; we scraped off the rust, soaked it in Betadine, and shared it between the two tables. At one stage we did amputations on the two tables simultaneously for four days in succession.

A few patients who had refused below knee amputation changed their minds as they deteriorated. On two occasions we agreed to take them to theatre, now for above knee amputations; one exsanguinated on David's table, I managed to get my patient off before she died. They joined the rows of plastic-covered bodies lying in the carpark.

I took one patient to what was called 'ICU', where patients were basically just left to die.

Patients 'recovered' on the floor outside theatre, and were carried back to the wards as more were carried to theatre.

Brian Pezzutti and Paul Dunkin continued work at Fakina, while the physicians moved between that hospital and the community. The Australian Army water purification unit came to Fakina hospital, but found the water there so contaminated they could not use it. They moved to a river in the city, and started producing and distributing potable water, probably making the single most important contribution to the health of the community.

We were pulled out after two weeks, by which time the worst cases had either been treated by our teams at the two hospitals or had died. The death toll in Banda was now estimated at 160,000. Aid had started pouring in from across the globe; our team leader was considered the grandfather, holding twice daily multi-

Debris nearly 4 km inland

Ablution facilities, Banda Aceh airport

FEATURE

Left to right: Bernie Hanrahan (arriving), David M. Scott, Paul Luckin, Ken Harrison, Paul Dunkin, James Bramley and Brian Pezzutti, all leaving Banda Aceh

national briefings and effectively directing the entire response. An Australian Army Field Hospital arrived, and started clearing the mud, debris and bodies from the third and main hospital in Banda Aceh, which became known as the ANZAC Hospital.

We were flown to Jakarta, where everyone spent a long time in the shower, then the bath, then the shower. We were taken to buy clean clothes, leaving the old ones to be burnt by the hotel.

We were very fortunate in that the senior clinicians were all very experienced at working in austere environments. Brian, David and I had all been deployed overseas multiple times before. We were only there for two weeks, but by then we were physically and emotionally spent, and needed to leave. From the beginning David and I recognised that this would be a difficult and damaging deployment. No-one goes to a place where 160,000 people have died and comes away intact. We consciously looked after each other – and still do, and also our team members. We kept in touch with them for some months, and many months later we were all brought together for a debrief, which was badly handled and valueless. Many of our team suffered badly when they came home, and some still do.

In the December 2017 edition of *Australian Anaesthetist*, David wrote a courageous and honest, but perhaps understated, account of his post traumatic stress disorder (PTSD) on returning home. Coming home was for me a major adjustment. I was stunned at how clean the streets were. I could not believe that there were no bodies in the gutters or on the pavements; I could still smell them and taste them. I showered as often as I could. Walking back into our normal theatres, with clean water, with electricity, with equipment, and healthy patients, was surreal. I felt completely out of place.

An Air Force psychiatrist called me. He asked if I was sleeping; No. Having bad dreams; Yes. Unwanted and intrusive flashbacks; Yes. Detached; Yes. How did I feel I was doing? About as well as I expected. "Yes", he said. "I think what you are experiencing is pretty normal considering where you have been". And that was exactly what I needed; understanding, reassurance, compassion. I knew that I could call him at any time, day or night, and he would help. I had an out if the going got tough. A few words, but still of great comfort now.

Some time later a close friend asked how I coped; I said it was a month before I felt normal. My wife laughed and said, "Try three months!"

The final estimated death toll for all areas affected was 227,000.

A physician colleague commented that sending a surgical team to Banda Aceh was a drop in the ocean. That is true, but every drop was a life saved.

I thank David M. Scott, Brian Pezzutti and Ken Harrison for correcting some of my errors; the remainder are all mine.

Dr Paul Luckin, AM CStJ

ABOUT THE AUTHOR

Paul Luckin is in private practice in Brisbane. He is a Captain in the Royal Australian Navy Reserve, with service in Bougainville, East Timor and later Timor Leste, the rescue and resuscitation team for the first Bali Bombing, Solomon Islands, and Afghanistan. He was in the first medical team into Banda Aceh after the 2004 tsunami, with David M. Scott.

Paul teaches Police Search and Rescue at state and national level, and advises SAR teams on survivability. He is Medical Advisor to the Australian Maritime Safety Authority; was President of Royal Life Saving Society Tasmania, Director of Advanced Airway Management Training, Ambulance Service Tasmania, and Medical Director, Medical Services, St John Ambulance Qld.

In 2006 he received the National Search and Rescue Award, has been invested as a Member of the Order of Australia, and as a Commander of the Order of St John.

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Associate Professor Thomas Bendtsen

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

Associate Professor Chad Brummett

Chad Brummett is an Associate Professor at the University of Michigan where he is the Director of Pain Research. He is the Co-Director of the Opioid Prescribing Engagement Network (OPEN), which aims to apply a preventative approach to the opioid epidemic in the US. In addition, his research interests include predictors of acute and chronic post-surgical pain and failure to derive benefit for interventions for interventions and surgeries primarily performed to treat pain.

Associate Professor Ki Jin Chin

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

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REGISTRATION NOW OPEN

FEATURE

Operating theatre, Role 2E hospital, 2nd General Health Battalion, Australian Regular Army

CLINICAL LEADERSHIP IN A DEPLOYED MILITARY HOSPITAL – A NATURAL FIT FOR AN ANAESTHETIST?

Clinicians focussed on individual patient management occasionally dismiss the importance of hospital culture, governance and leadership and their effect on patient outcomes and staff welfare.

Australian Defence Force (ADF) surgical teams were deployed to the US-led NATO Role 3 military hospital in Kandahar, Afghanistan, between 2012 and 2014. News reports (highlighted boxes), describing this hospital in 2014 and 2016, highlight the fallacy of this belief.

Every hospital, military and civilian, must strive to emulate the first of these examples and avoid the second. Bad leadership can destroy team cohesion, make the workplace intolerable and lead to adverse patient outcomes even when individual clinicians are dedicated and skilled. This brief paper outlines the role that clinician-leaders take in this process in the Australian Defence Force (ADF), highlighting the particular talents that anaesthetists can bring to this role.

LEADERSHIP, MANAGEMENT AND TECHNICAL EXPERTISE

Clinicians sometimes mistake the authority that derives from their technical skill and seniority for 'leadership' (as defined by this article). It is usually true that the senior doctor in a resuscitation team (for example) is its 'leader', providing direction on the administration of drugs and performing the more complex procedures. Similarly, for much of the time in an operating theatre, the surgeon considers him or herself the leader of an essentially self-organising team. However, organisational 'leadership' of the type required to influence the hospital cultures described in the introduction requires entirely different skills. The essence of this definition of leadership is the ability to influence people to act in an appropriate way in the absence of

2014: NATO Role 3 hospital team saves Romanian soldier

In any game plan, success requires focus and consistent mental and physical effort from every one of the players. A team with heart and the same end in mind can counter just about any offensive that comes their way. The Role 3 Multinational Medical Unit at Kandahar Airfield, Afghanistan, is such a team. Dan Grabo, chief of trauma, recalled "a great team effort. With everyone doing their job at each station, my job was very easy. Amongst the chaos, the other trauma teams were giving me information on every other critically-injured patient", Grabo said. "We were sending them to the scanners, and to the intensive care unit, while we went to the OR with this really sick guy. I knew I could trust each of those teams. We all come from very different backgrounds, whether civilian or active duty military, but we're here for a purpose, to take care of our troops at a moment's notice". The NATO hospital was awarded a certificate from the Romanian army that reads: "For your professionalism, commitment and effective work with a decisive impact in saving our servicemen's lives. Your great devotion, compassion, and friendship shown to Romanian allies, were the last barricade in front of death, darkness and desolation. Our endless gratitude for your firm hands, brilliant minds and beautiful souls."

(Abridged from https://www.army.mil/article/129254/nato_role_3_hospital_team_saves_romanian_soldier)

specific directions. This role is sometimes, but not necessarily, combined with a management function that involves the efficient allocation or organisation of resources – such as controlling a budget, writing a roster, or allocating operating theatre time. However, managerial functions are usually impersonal; leadership is an essentially interpersonal activity that requires constant presence in the clinical environment and knowledge of team members. Organisations are managed; people are led. Leaders build effective teams willing to work towards the strategic vision of the organisation as well as their own immediate goals, if necessary reconciling competing priorities of different teams. The ADF recognises that the most important person in a particular situation may be the one with the technical expertise to solve a problem, while the leader is the person who sets the conditions for that person and their team to work most effectively. While clinicians tend to view the terms as synonymous, that the leader is often not the most important person in a particular situation is ingrained in Defence culture. Translating this into a civilian operating theatre, it might well be that a surgeon's skill is the most important factor determining many patients' outcomes, but the efficiency of the list, the tone of the working environment, and the effectiveness of communication and teamwork in case of a life-threatening emergency are all at least as much within the power of the anaesthetist to lead.

In addition to leadership, the ADF also actively promotes (and rewards) the notion of followership. That is, the actions taken by team members that support an appointed leader in attaining team goals. Followership can be practically-focussed (e.g. making suggestions on what needs to be done, or simply anticipating this and acting independently), but often more importantly is culturally-focussed, assisting the leader implement his or her values and the desired organisational culture.

With this understanding of the influence of leadership on institutional culture, the ADF places a very high value on aligning personal and organisational integrity. In some areas of Australian culture, such as politics and business, moral transgressions by leaders are sometimes excused if a person is technically skilled or a good manager. Such behaviour is incompatible with the ADF concept of leadership. The infrequent occasions when this code is breached are routinely reported in the media and the individuals dismissed, highlighting the seriousness with which such matters are treated.

CLINICAL LEADERSHIP IN THE ADF

Until the mid-2000s, ADF field hospitals were commanded by doctors. Driven partly by a lack of suitably senior clinicians, and partly by the increasing number of capable General Service Officers attaining command rank, this is no longer

2016: Hostile, 'creepy' commanders: Inside a field hospital run amok

A major trauma center in a war zone is no place for distrust and dysfunction. But that's exactly what happened over nine months, during which a hospital commanding officer trash-talked her colleagues behind their backs, a command master chief verbally abused his sailors and an executive officer known for his ineptitude as a physician made sexual comments to nurses. Staffers said the environment at the center went beyond toxic to repulsive. "Physicians were at odd with nurses, junior officers were openly hostile to their department heads …" Much stemmed from personal conduct by senior officers, tacitly ignored by the commanding officer. Allegations included bigoted remarks, threatening and condescending language, and a reluctance by junior personnel to report any of these issues. The commanding officer's staff stated that she used foul language, made derogatory remarks about her subordinates, and referred to her junior officers as "toddlers". The entire command team was replaced as a result of an internal investigation.

(Abridged from https://www.navytimes.com/news/your-navy/2016/08/14/hostile-creepy-commanders-inside-a-field-hospital-run-amok/)

FEATURE

the case. Recognising that non-clinical commanders could not provide effective direction to many aspects of the clinical work of the hospital, the Army's only field hospital, the 2nd General Health Battalion, appointed a Director of Clinical Services (DCS) in 2009. The Commanding Officer is the equivalent of a civilian hospital's Chief Executive Officer, responsible to government for delivering a targeted scope and quantity of healthcare, staffing, and the logistic and business functions of the hospital, while the DCS is analogous to a civilian hospital's Chief Medical Officer, responsible for quality and safety, maintenance of professional standards, coordination of medical specialties with the nursing and allied health professions, and compliance with legal and ethical community expectations. The deployable hospitals of the Royal Australian Air Force and Royal Australian Navy have more recently mirrored this arrangement, which has also been implemented in the ADF hospital deployed to Iraq since 2015.

Recognising that non-clinical commanders could not provide effective direction to many aspects of the clinical work of the hospital, the Army's only field hospital, the 2nd General Health Battalion appointed a Director of Clinical Services (DCS) in 2009.

The practical manifestations of the responsibilities of the DCS include:

- Defining the scope of practice of hospital specialists, taking into account the risk of not performing certain procedures in the deployed environment as well as the risk of working outside a core skillset;
- Triage of patients into, out of, and within the hospital, taking account of the defined medical rules of eligibility but appreciating that policy definitions of 'life threatening conditions', for example, rarely take into account the full consequences of not admitting a patient to the military hospital;
- Fair allocation of key hospital resources e.g. operating theatre time and consumables, blood;
- Review of all significant patient management decisions on ward rounds each day;

A Role 2E (light) hospital of the 2nd General Health Battalion, Australian Regular Army

- Reporting of individual and summary patient information to the higher headquarters medical co-ordinator;
- Arranging transfer of patients out of the hospital to a suitable destination;
- Team formation, rostering, and fatigue management (along with the senior nursing officer and commanding officer);
- Clinical audit, including formal quantitative audits of clinical documentation and key performance indicators;
- Career development and mentorship of junior medical staff;
- Preparation and assessment of collective training activities;
- Correct operation of all clinical major systems (sterilisers, electrical safety, anaesthetic gases, etc.), along with compliance with mandated regulations and standards;
- Forecasting requirements for clinical supplies; and
- Ultimately, deciding which risks are clinically acceptable and which are not.

In contrast, the commanding officer is responsible for:

- Siting and construction of the hospital as dictated by the tactical and geographical environment;
- Provision of ordered clinical supplies;
- Forecasting and provision of non-clinical resources (fuel, communications, etc.);
- Liaison with higher headquarters and non-clinical supporting units (e.g. engineers, signals, supply, transport, force protection); and
- Command and administration of hospital personnel.

In short, the commanding officer builds, staffs and supplies the hospital, while the DCS runs its clinical functions.

The incumbent must have the respect of their clinical colleagues in making decisions on patient care and therefore be a clinician in active hospital practice.

WHICH SPECIALTY BEST SUITS A CLINICAL HOSPITAL LEADER?

The DCS position in the ADF is not tied to any particular specialty. Currently, the Army hospital DCS is an anaesthetist/intensivist, while the Navy and RAAF have an orthopaedic surgeon and general surgeon, respectively. The incumbent must have the respect of their clinical colleagues in making decisions on patient care and therefore be a clinician in active hospital practice. They must have sufficient knowledge of all hospital specialities to be able to distinguish good from bad advice, but clearly cannot be a master of every discipline. They must have experience of reconciling competing clinical demands, and be willing to understand the perspective of the hospital commanding officer making decisions on resource

limitations and strategic priorities. They must be able to see the perspective of colleagues who they ultimately need to disappoint or disagree with. From a nebulous series of facts, opinions and probabilities, they must be able to formulate and articulate concrete plans once their decisions are made. While many surgeons, physicians and other hospital specialists would make a highly capable DCS, the consultative, collaborative nature of anaesthetics and critical care medicine, along with the routine requirement in these specialties to prioritise and ration resources, make training and practice as an anaesthetist or intensivist particularly suitable preparation for such a role.

CLINICAL LEADERSHIP AT EVERY LEVEL

Avoiding the toxic environment described in the second example above needs more than sound leadership from the top. All clinicians have a direct influence on hospital culture. Even the most junior intern, by holding themselves to a high standard of followership and implicitly expecting their registrars and consultants to lead with integrity, has a profound cultural influence. In leading their small, self-organising clinical teams, consultants can model behaviour that builds towards institutional goals – by taking responsibility for influencing strategy and appreciating the implications of competing strategic priorities rather than sniping at administrators, displaying respect, humility, empathy, and working to build consensus rather than highlighting divisions between clinical teams. Even the small, seemingly inconsequential negative comments about administration or other specialties that are commonplace in many civilian hospitals all combine to destroy, rather than build, team cohesion. If there is a central characteristic that defines ADF leadership, both clinical and non-clinical, it is that an ADF officer takes responsibility – if there is a problem, every officer has a personal responsibility to help fix it, rather than criticise those nominally charged with this responsibility.

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FEATURE

ASA 77TH NATIONAL SCIENTIFIC CONGRESS ADELAIDE 2018

It has been a huge privilege and a great honour to have been the Convener of the 77th National Scientific Congress that was held in Adelaide at the Adelaide Convention Centre.

There were many highlights over the four days of the meeting and I will come to that shortly. For me, the professionalism and the enthusiasm of the local organising committee, drawn from my colleagues in the Department of Anaesthesia at the Royal Adelaide Hospital, is what is firmly embedded in my cerebral cortex. Furthermore, without the support from the Department, the task for the LOC would have been much harder and so I extend my thanks to them.

Early on we chose to follow the lead of previous ANZCA and ASA meetings and provide facilities for parents with a room for parents and toddlers into which we streamed the presentations from the major lecture theatre and also a crèche. We also decided that we would redirect the budget allocation for satchels and speaker gifts to continue the Society's support for Lifebox. The 'Wine Wall', managed by our own oenophile and Social Co-coordinator, Kris Usher, contributed a massive $6.3K to the cause clearing 150 bottles of fine wine donated by local South Australian wineries. A big thank you to Kris for the hard work this entailed and to all who supported the wine wall.

At times it felt as if we were jinxed and we were setting records with the number of speakers that we lost in the lead up to the program. Sadly, A/Prof Duminda Wijeysundera – one of our Invited International Speakers had to withdraw with four weeks to go, due a serious family illness. We were hoping to welcome Prof Donat Spahn as an Industry Supported speaker but he had to return to Zurich mid-journey in response to another family crisis. There were other losses along the way – a total of 17 lectures, workshop facilitators, small group discussion hosts and session chairs needed to be filled. All was not lost, however, and the indomitable spirit of the local organising committee (especially Kate Drummond, our Scientific Convener) together with the response of the anaesthetic community both local and from overseas meant that with a few minor adjustments, we were able to offer

a full program. At short notice, Dr Will 'Style over Substance' Harrop-Griffiths was able to step forward to fill the gap vacated by Duminda and we all enjoyed his provocative Plenary lecture 'Regional Anaesthesia is good for you… or not?' which gave us plenty to reflect upon in the conduct of our own practices. Behind the entertainment were some powerful messages.

The meeting opened with a very traditional 'Welcome to Country'. Major 'Moogy' Sumner AM (Uncle Moogy) welcomed us to the land of the Kaurna people and it was difficult not to feel humbled by his depth of feeling for and connection to the land.

It is 100 years since the Armistice that heralded the end of the First World War and a military theme ran through the meeting. Air Vice-Marshall Dr Tracy Smart is the Surgeon General of the Australian Defence Force, its highest ranking medical officer. Her Kester Brown Oration showed how a very traditional institution is capable of adapting to the changing ethos demanded by a modern world with a contemporary workforce. A/Prof David Scott – in one of his final duties as President of the ASA – gave the Geoffrey Kaye lecture and recognised the contribution of Major-General Sir John Monash. It is considered that Monash changed the course of the war by changing the approach to trench warfare with a revolutionary attitude that placed the value of the common soldier on a completely different footing. Interesting that this came from an Australian civil engineer of German/Jewish ancestry which probably contributed to the lack of recognition afforded him by the 'establishment'. Later on in the program, A/Prof Susan Neuhaus (Colonel [Rtd]) gave an emotional account of the troubles faced by frontline forces.

Our other two International Invited Speakers were Prof Joyce Wahr from Minneapolis and Prof Lars Eriksson from Stockholm. Both were travelling the world with only carry-on baggage! (Note to wife.) Both were stellar performers and fully engaged in the spirit of the ASA NSC. Lars brought fascinating insights into brain function after anaesthesia and if you were able to catch his presentation in the session 'Big Changes for Little People' titled 'Academic performance after early childhood anaesthesia', you will be reassured by the data from a large longitudinal study from Scandinavia that would suggest that family circumstances have a 20-fold greater impact on academic performance than early anaesthesia.

Joyce inspired us to think about safety in terms of the strong leadership, driving a culture of safety by changing behaviours and responses to adverse events, encouraging a system of non-punitive incident reporting and removing the hierarchy of reporting such that all members of the healthcare team feel empowered to report. The final session of the meeting on Tuesday – two short plays by the Hush Foundation provided a nice 'bookend'. 'Hear me' explored the management of a critical event in a scenario that would have resonated with many.

Our Australasian Speaker was Prof Lorimer Moseley from the University of South Australia and he opened our eyes to developments in pain management and the biopsychosocial approach to patient management. No-one in the audience will forget the 'physio walk'!

We were able to make use of some of the pre-Congress meetings' speakers in our program, so thank you to the SIGs for your co-operation. A/Prof Justiaan Swanevelder, Dr Enrique Goytizolo and Prof Judy McKimm all contributed in various ways, both with planned and unplanned presentations! It was a pleasure to be in their company.

Our Industry supported speakers were another highlight of the meeting. A/Prof Simon Mitchell, Dr James Winearls, Prof Ellen O'Sullivan, A/Prof Sheila Myatra, Dr Jan Akervall and Prof Freidrich Puhringer all added to the wonderful flavour of the meeting. It was a pleasure working with the industry representatives from Draeger, KarlStorz, Haemoview Diagnostics and MSD that allowed this to happen.

Our workshop program, under the careful auspices of Johanna Somfleth, kicked off with two days of emergency response workshops many of which were held at the new Medical School Simulation laboratory with high fidelity simulations for obstetrics, airway, paediatrics and ALS Emergency Response sessions. It is interesting to note how well the younger generation have adopted simulation learning as an integral component of their learning experience and I expect this area of our NSC to grow rapidly in the years to come. Special thanks must also go the Cameron Main for overseeing the Emergency Response Workshops and to Yasmin Endlich for being facilitating airway workshops and presentations on all four days of the meeting.

The Small Group Discussion and Masterclass program was conducted in the West complex of the entertainment centre and unravelled to mysteries of TIVA, opioid free anaesthesia and 3-D printing to name a few. Good job Min-Qi Lee and your team for arranging a successful component to the overall program.

Another change this year was to move the Gala Dinner to Saturday night. "The best laid schemes o' mice an' men/Gang aft a-gley" according to Robbie Burns. Never has a truer word been said, when we discovered that we would be sharing the Adelaide Oval Venue with 'Monster Trucks' screaming across the hallowed turf. It brought 'pre-dinner' entertainment to a new level and I throw down the gauntlet to future convenors to match it! The Magarey Room provided an excellent venue for the dinner with a Black and White themed masquerade ball. Music was provided by the Adelaide Big Band who turned their show into a karaoke. No one present will forget the performance of one of

FEATURE

our VIPs! There were two presentations made: the ASA Medal to Dr Will Harrop-Griffiths for his out-standing contribution to anaesthesia and the President's Medal to Piers Robertson for his contribution to the Society. Will and Piers are two highly worthy recipients of these awards. Laura Willington and Kris Usher did a wonderful job as social co-convenors putting this together. It started with the hugely successful Gin Bar in the Welcome Reception, through the Gala Dinner and Exhibitor Drinks to the social evening at the Adelaide Zoo (in spite of the fact that the hippo died, the giraffe had a crook neck, the flamingo passed away and the pandas were… well nobody really knows what the pandas are up to. Procreating does not seem to be on their agenda!)

The Adelaide Convention Centre is an ideal conference facility situated on the banks of the River Torrens and in close proximity of a large range of accommodation. We were able to centrally locate the Exhibition Hall with the lectures in the recently opened East Complex and Workshops and Small Group Discussions/ Masterclasses held smaller rooms in the West Complex. Transit times between the various educational sessions and the Exhibition Hall was minimal and delegates were treated to views over the river and the new Adelaide Oval on their journey.

We were victims of our own success and had not anticipated a last minute rush from exhibitors. It meant that we located three displays in the foyer, co-located with the poster displays and the Art Exhibition. Had we known, we would have arranged for a larger exhibition space so that posters, art and exhibitors could all have been together. Such are the benefits of hindsight! Anaesthesia is a mix of science and art, so we decided to resurrect the ASA Art Exhibition in 2018 and we had the great pleasure of admiring the many and varied talents of our members. In the science, congratulations to Gilbert Troup winner Prof Kwok Ming Ho; 1st Best Poster A/Prof Alwin Chuan, 2nd Best Poster Dr Christine Pirrone and 3rd Best Poster Dr Zoe Keon-Cohen; Trainee Best Poster Dr Leigh White; PhD Support Grant Drs Jennifer Reilly and Patrick Tan; and Kevin McCaul Prize Dr Marissa Ferguson.

Adelaide 2018 witnessed the changing of the guard with Peter Seal being elected President of the Society. The Society is in highly capable hands and I look forward to Pete's safe steerage over the next two years, assisted by Suzi Nou as Vice-President and Nicole Fairweather as Suzi's Executive Councillor replacement. Further changes have taken place with Piers Robertson stepping down as National Scientific Officer after many years of involvement with the NSC. Anthony Coorey, NSC Convenor on two previous occasions, is Piers' successor. Anthony is well versed in the challenges of bringing an NSC to successful fruition and it has been a great pleasure to work with Anthony in a period of transition during the lead-up to this year's meeting. I am sure he will be a great support to the 2019 team and beyond.

I look forward to Sydney 2019 and wish Anne Jaumess and Alwin Chuan every success.

Finally, a big thank you to my 'team', whose patience knows no bounds and without whom this would not have been possible. Kate Drummond, Johanna Somfleth, Min-Qi Lee, Laura Willington, Kris Usher, Chien Wei Seong, Munib Kiani, Cheryl Chooi and Nicole Diakomichalis can all take a bow! It would be remiss not to acknowledge the support of Ms Denyse Robertson, Senior Events Co-ordinator at ASA and the team from ICE, our PCO.

Simon Macklin
NSC 2018 Convenor

Piers Robertson receives the President's Medal from ASA President David M. Scott

Will Harrop-Griffiths receives the ASA Medal from Past President Guy Christie-Taylor


ASA President David M. Scott officially opens NSC 2018


Welcome to Country, Major 'Moogy' Sumner AM (Uncle Moogy), Kaurna people


Simon Macklin, convenor, NSC 2018


Air Vice-Marshall Dr Tracy Smart, Surgeon General of the ADF gives the Kester Brown Oration


Invited International Speaker Joyce Wahr


Invited International Speaker Lars Eriksson


Invited Australasian Speaker Lorimer Moseley


Ellen O'Sullivan


Sheila Myatra


Simon Mitchell


James Winearls


Greg Luck

FEATURE

ASA WELCOME DRINKS


Nicholas Grant, Pam Thompson and Alex Ritchard


Paul O'Sullivan and colleague


Kathryn Hagen, Daniel Aras and Usha Padmanabhan


Steven Greenhalgh with colleagues


Catching up with friends


Guests at the welcome drinks


Laura Willington and David Costi


Alan Smith with colleagues


Exhibitors mingling with delegates


Cheers


Industry reps at Welcome Drinks


Having a laugh

PRESIDENT'S COCKTAIL RECEPTION


Dr David Elliott and Mr Michael Ellis


Nicole Diakomichalis, Phuong Markman and Daryl Jones


Lars Eriksson chats with colleagues


Libby and Piers Robertson and Millie Coorey


Joyce Wahr chats to Greg Luck


Yasmin Endlich and Johanna Somfleth


Time for a catch up


David M. Scott presents Rex Pearlman with his 50 Year Membership certificate


Simon Macklin, Bronwyn Aberline, Gilberto Arenas and Piers Robertson


Greg Deacon and Peter Lillie


Steve Kinnear, Judy Willoughby and Tenzin Yoezer


Delegates listening to President's speech

FEATURE

ASA GALA DINNER

ASA President David M. Scott with the NSC 2018 Organising Committee

Pre-dinner drinks

David Costi and Laura Willington

Where's your mask sir?

Kwok Ming Ho, Mrs Kermani, Wai Ling and Dr Kermani

Catching up with friends

Dressed to the nines

Delegates mingling at the pre-dinner drinks

Having a laugh

All smiles

Cheers

Mark Colson, David Vote and colleague enjoying the evening

Dressed to impress

Petra and Mark Williams

Peter Waterhouse and colleague

Will the real Simon Macklin please step forward

FEATURE


Adelaide Big Band entertain the crowd


Nicole Diakomichalis and Daryl Jones

Laetitia Deknudt, Sam Whitehouse and Anisha Kulkarni


Delegates enjoy the karaoke


Tripping the light fantastic


Delegates hit the dancefloor


Catching up with friends

All masked up


Who is that masked man? Matthew Grant, Jan and Mrs Akervall on the right


Guests enjoy the atmosphere

FAMILY NIGHT AT ADELAIDE ZOO


Alwin Chuan with colleague


David and Rachel Scott, Ellen O'Sullivan, Sheila Myatra and fellow delegates


Relaxing with friends


Libby Robertson, Roger Capps, Piers Robertson and Anthony Coorey


Baby possum


What's in here?


David Costi and Laura Willington with their family


Families enjoying the day


Children enjoying the baby animals


David and Neralie Bednarczuk and daughters


Min-Qi Lee, Su-May Koh and friends


Zookeeper and owl, with Mark Colson

FEATURE

SESSIONS & WORKSHOPS


David Canty conducts a session on perioperative ultrasound


Zoe Keon-Cohen


Interested delegates at workshop


Jonathan Taylor


Airway ultrasound


Harry Laughlin, Vida Viliunas and Richard Seglenieks


Natalie Smith speaks on new developments in anaesthesia for laparoscopic surgery


Jocelyn Christopher


Liz Inaido, President PSA/Fiji


Interested audience at a session


Brigid Brown


James Winearls, Tom Painter and Michelle Roets


Sara Allen


SGD 9: Tim Porter speaks about bullying


Regional Anaesthesia SIG, Kelly Byrne


Lunchtime educational with Ashleigh Gehlig


Yasmin Endlich


Ellen O'Sullivan conducts refresher sessions


Martin Culwick


The art of responsible team management with Sarah Flint and Michelle Harris


Michael Penniment


Rowan Ousley and Rebecca Munk


Ching Li Chai-Coetzer speaks on sleep apnoea


Participants at SGD 17

FEATURE

EXHIBITION & EXHIBITORS' DRINKS


David M. Scott presents Roberta Dean, winner of the travel voucher, with her prize


Getting hands-on


Nicki Caruso, Peter Seal and Invited International Speaker Joyce Wahr


Checking out some new products


Simon Gower, Ross Mackenzie, Mark Colson (on the right) with colleague


Alison Brereton and Carolyn Wood with fellow delegate


Libby Robertson, David Vote and Fiona Stanley


Jeydoss Jellasinghe, Min-Qi Lee and Chien Wei Seong


Demonstrating equipment, Fujifilm Sonosite


Checking out the latest technology


Catching up with friends


Chatting with industry rep

On behalf of the ASA NSC 2018 Organising Committee, we would like to thank all the sponsors who supported this year's NSC. We look forward to welcoming you all to Sydney in 2019

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2018 AWARDS, PRIZES & RESEARCH GRANTS

WINNERS ANNOUNCED

PhD Support

Dr Jennifer Reilly

Dr Patrick Tan

ASA Best Poster Prize 1

Associate Professor Alwin Chuan

Impact of Visuospatial and Psychomotor Ability on Fibreoptic Bronchoscopy Performance.

ASA Best Poster Prize 2

Dr Christine Pirrone

Intraoperative systolic blood pressure in traumatic brain injured patients.

ASA Best Poster Prize 3

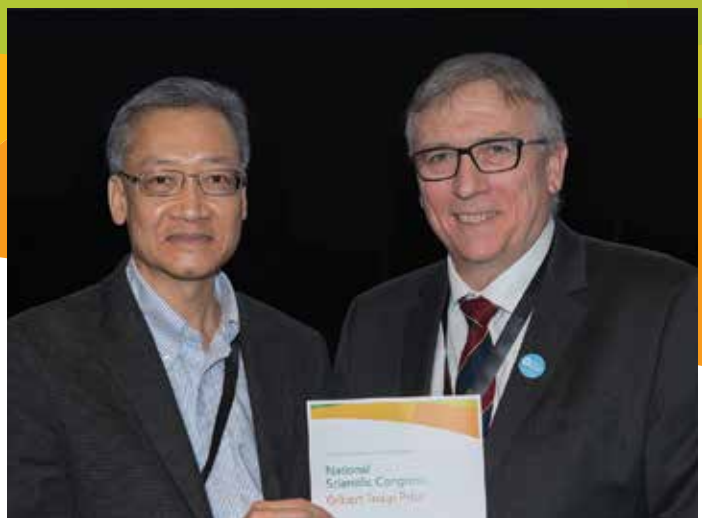
Dr Zoe Keon-Cohen

Perioperative End-of-Life Care and Risk Assessment. A Multi Centre Surgical Mortality Audit.

ASA Trainee Best Poster Prize

Dr Leigh White

The safety of buprenorphine compared to morphine in acute pain: A systematic review and meta-analysis.



Gilbert Troup Prize

Associate Professor Kwok Ming Ho

Detailed assessment of benefits and risks of retrievable inferior vena cava filters on patients with complicated injuries: the da Vinci multicentre randomised controlled trial.

Kevin McCaul Prize

Dr Marissa Ferguson

Jeanette Thirlwell *Anaesthesia and Intensive Care* Best Paper Award

P.J. Cowlishaw, P.J. Kotze, L. Gleeson, N. Chetty, L.E. Stanbury, P.J. Harms

Randomised comparison of three types of continuous anterior abdominal wall block after midline laparotomy for gynaecological oncology surgery.

Anaesthesia and Intensive Care Junior Researcher Award

L. White, T.M. Melhuish, L.K. White, L.A. Wallace

Apnhoeic oxygenation during intubation: a systematic review and meta-analysis.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FEATURE

GEOFFREY KAYE ORATION
ADELAIDE 2018

Associate Professor David M. Scott presented the Geoffrey Kaye Oration at the National Scientific Congress, Adelaide 2018.

HAMEL, MONASH, AND ONE HUNDRED YEARS – WHAT CAN WE LEARN?

I would like to take you back a hundred years to 1918 drawing on the contributions to the end of the Great War by one of Australia's greatest leaders, General Sir John Monash. I will commence however, in the middle of last century for Geoffrey Kaye, who he was, and why this oration is named for him. After Monash I will move onto today and what we as a speciality and a Society might learn from Monash. I will finish up with a brief summary of Sir John's contributions after Hamel.

Geoffrey Kaye

So, let's start by introducing Geoffrey Kaye: Geoffrey Alfred Kaye, anaesthetist, was born on 9 April 1903 in Melbourne, of Prussian and Victorian-born family. He was educated in England, and studied medicine at the University of Melbourne.

As RMO at the Alfred Hospital, he had decided to specialise in the field of anaesthetics in 1927 and three years later, he was appointed an honorary anaesthetist at the Alfred Hospital in 1930. After his appointment he travelled to the UK, Germany and North America, developing knowledge and networks.

After traveling Kaye set out to improve the science of anaesthesia in Australia. He wrote text books, lectured, travelled, and as a result of his lobbying helped establish the ASA in 1934 (one of seven founders).

He started as secretary and newsletter editor of the ASA, and in 1939 he completed a Diploma of Anaesthesia, jointly awarded by the English Royal colleges of Surgeons and of Physicians, in London.

Geoffrey Kaye.

From 1937 Kaye worked on the design and manufacture of anaesthetic equipment for the Australian Military Forces, he was appointed a captain in the Australian Army Medical Corps. He

served 2 years in the Middle East with the 2/2nd Australian General Hospital he was appointed adviser in anaesthetics to the AIF.

Kaye was described as formal in style, tall, lean and idealistic, he was a man of incisive mind and complex personality: reserved, demanding, sometimes intemperate and unforgiving – but capable on closer acquaintance, of generosity and warmth.

He is considered a visionary of the speciality in of anaesthesia in Australia, seeking to establish an anaesthesia research institute (to be based at his home) to develop the science of anaesthesia, with Australia as a leader in the field.

Dr Kaye was elected an honorary life member of the ASA in 1944.

He collaborated with Robert Orton and Douglas Renton in writing the book *Anaesthetic Methods* (1946). In 1949 he was elected a fellow of the faculty of anaesthetics, Royal College of Surgeons.

He sought full national, professional representation of anaesthetists, and he vigorously opposed moves to amalgamate the ASA within the Royal Australasian College of Surgeons, however acquiesced in election as a foundation fellow of the faculty of anaesthetics RACS in 1952.

Kaye had a particular interest in the history of anaesthesia equipment and was curator of a museum for the ASA. In 1958 the museum was named in his honour, becoming a lasting monument to his work which is now at the College headquarters in Melbourne.

In 1974 he received the Orton medal from the faculty of anaesthetics.

On the 50th anniversary of the founding of the ASA in 1984, he addressed an international meeting of anaesthetists at the Sydney Opera House. He never married and died on 28 October 1986.

A great Australian anaesthetist, inventor, educator, researcher, author, historian and visionary – this is why this oration is named for Geoffrey Kaye.

John Monash

To introduce General Sir John Monash, I will start with a brief account of the Battle of Hamel which was fought just over 100 years ago near the hamlet of Hamel, in the Somme Valley France.

Before midnight on the 3rd of July 1918 Australian Diggers, American infantry and allied tanks were silently moving into position around the French village of Hamel. The opposing forces were hunkering down in preparation for the now routine barrage of heavy shelling that they expected at dawn.

The Infantry, artillery, armour, and the Air corps had been preparing for weeks for this day. Their General – Sir John Monash (the man on the $100 bill), an engineer by profession, a citizen soldier and veteran of Gallipoli had been planning this battle meticulously.

The war in France had been dragging on in a relative stalemate since the allies stopped the initial German assault in 1914.

The allied and German generals had repeatedly attempted frontal assaults against the trenches with limited results apart from the terrible slaughter of men.

The Germans had recently completed a major offensive in March 1918 with the troops they recently acquired from the now cancelled Russian front and had hoped to reach an armistice before the Americans got into the war in large numbers.

The Allies were on the defensive as they had a poor record of winning battles. Thousands of lives had been wasted in failed offensives like the Somme, Ypres and Passchendaele. Both sides were doing the same thing, throwing men at machineguns wire and artillery and hoping for a breakthrough. Einstein described insanity as doing exactly the same thing and expecting a different result. WWI was mostly insanity, it took a reservist engineer,

Sir John Monash c.1920s.

not a professional soldier to show how to end the insanity.

It is said that the first casualty of a set battle is the plan – because it never goes as planned. Monash however had a different plan: use the latest technology, aircraft, artillery, mechanised armour (tanks), telephone communication, harmonised in a coordinated way to produce a combined effect, and protect the infantry men.

This provided real-time communication from the battlefield which allowed him to respond in an agile fashion to the events of the battle and make strategic changes to achieve his objectives. His plan was not a casualty because he planned to change it as the battle developed. To us today this seems sensible, logical and obvious, then is was revolutionary.

His plan was to take 90 minutes to complete and to minimise causalities, with all objectives achieved. He made sure of this, his troops trained together with the tanks (which from previous experience they didn't trust), he made sure that everybody, right down to the corporals in the infantry knew the terrain, the objectives and the plan through to completion of their part.

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Everybody was primed and prepared for the battle. Planning was detailed, troop resupply by tank and aircraft was in place, aerial mapping of the battle's progress and informing command was in place, care of the wounded was prepared, nothing was left to chance. Afterwards troops commented that his plan was so thorough that hot meals were delivered soon after the battle to them.

Monash had planned to augment his forces with United States troops who were freshly arrived to the front. This plan was agreed to by General HQ and GEN Haig. Immediately before the battle GEN Pershing was made aware that his men would be fighting under the command of a foreign General and sought to have his troops withdrawn – even though they had been training together. Fortunately, Monash out-manoeuvred the Americans and general Rawlinson and got to keep the 1,000 US troops. In fact, this was the beginning of a long association between the US and Australian military working and training together in conflicts around the world including: WWII, Korea, Vietnam, and the Middle East today.

The battle commenced with a rolling barrage by the artillery and coloured smoke shells imitating gas, forcing the enemy to take cover, and the Diggers and tanks to advance forward behind the bombardment.

Once they reached the trenches they silenced the machine guns and overwhelmed the defenders.

It was the hard-hand-to-hand fighting seen in Gallipoli, but rarely on the front as the machine guns stopped them before they got there. What made this battle different was that Monash knew what was happening.

Unlike previous battles where the generals sat back and waited, or wandered behind the trenches out of contact, while the troops fought and died Monash was immediately updated on the progress of the battle. He was hands-on, making changes and directing movement of troops and supplies to support his men and the unfolding battle.

At 3:14 am on the July 4th, 1918, the most well-prepared battle to date of the First World War began with artillery barrage. The preparation and training for the Battle of Hamel was so great that all objectives were taken within ninety-three minutes of the battle starting with less than 1,400 casualties.

The mostly Australian troops, led by Lieutenant-General John Monash, who believed that a battle could only be won after a great deal of preparation fought with distinction. So, with this battle and its preparation came some 'firsts' for the Great War:

1. For the first time, tanks were used to supply the front troops with food, water, ammunition and medical supplies. The tanks were also used as a moving wall to protect the troops. The usage of the tanks in these ways gave the Allies a definite advantage over the enemy.
2. Another first was the way in which Monash used the Air Force:
    a. Leading up to the battle he frequently sent planes over the German lines, photographing their positions so that accurate maps could be prepared and the enemy troop disposition was known.
    b. He used their noise to mask the sounds of tanks being bought forward.
    c. During the battle, the planes dropped ammunition to the forward troops and after the battle was won, the Australians in the front-line lit flares, so as new maps could be drawn to show the new Allied front. The maps were then dropped to Monash back at Headquarters.

In the nights leading up to the battle, raids were carried out along the German frontline. When the battle began, the German troops were expecting just another small raid and were not prepared for a battle.

Compared to other battles, the Battle of Hamel was not large. But what makes it so special is that for the first time in many months, the Allies began to think and move offensively.

It is for this reason that some people believe that the Battle of Hamel was the beginning of the end of the war.

This was the first time that Australians were primarily commanded by an Australian in WWI and the first time Americans fought with Australians.

One thousand six hundred German troops were captured along with much of their equipment and around 2,000 were killed.

While small in scale, the Battle of Hamel was to have far-reaching consequences for trench warfare, because it provided a practical demonstration of tactics for attacking an entrenched enemy using combined arms tactics.

The strategy employed at Hamel was then successful on a much larger scale in the Battle of Amiens and was a major factor in Allied successes later in the war.

Despite the concerns of the Australian infantry, all but three of the British tanks, although initially delayed, eventually reached their objectives. At least five of the Allied tanks were damaged during the attack, but these were later repaired; casualties among the British tank crews were minimal.

The Allied casualties were 'light' in the context of the war and the attack was considered 'extremely successful' for the Australians. A large quantity of British equipment that had been captured by the Germans when they had taken Hamel in April was also recovered.

The four American companies that had joined the Australians during the assault were withdrawn from the line after the

battle and returned to their regiments, having gained valuable experience.

Monash sent US General Bell his personal thanks, praising the Americans' gallantry, while Pershing set out explicit instructions to ensure that US troops would not be employed in a similar manner again, this was ignored.

They would subsequently play a significant role in the fighting that followed right up until the end of the war, as US reinforcements came to tip the manpower balance in favour of the Allies.

Two Australians were awarded the Victoria Cross for their conduct during the battle and 14 Americans were awarded British medals.

One Corporal was awarded the medal personally by King George V on 12 August 1918. He would also later receive the Medal of Honour. He and seven others were also awarded the US Army's Distinguished Service Cross for actions during the Battle of Hamel.

Hamel became the template for all future allied offensives on the front in WWI. General Monash was knighted in the field by the George VI (the first time in 300 years) and history would go on to regard him as possibly the greatest and best military generals of WWI. Field Marshal Bernard Montgomery, the World War II British army commander described Monash as the best World War I general on the Western Front in Europe on either side.

A remarkable feat of leadership, coordination and communication, which changed forever the paradigm of trench warfare. Now a little more about Sir John Monash, and who he was:

General Sir John Monash, Knight Grand Cross of the order of St Michael and St George, Knight Commander of the order of the Bath; was a civil engineer and the leading Australian military commander of the First World War.

He was born in Melbourne in June 1865 of East Prussian Jewish parents (the same as Geoffrey Kaye), raised mostly in Richmond (he did spend a year in Jerilderie in the Riverina where he actually met the bushranger Ned Kelly) and educated at Scotch Grammar school, where the progressive headmaster accepted bright boys from all backgrounds. He excelled in mathematics and science and distinguished himself at school coming equal Dux. He went onto Melbourne University to study science, humanities and engineering. After completing his engineering degree Monash was involved in the construction of the Princess Bridge in 1884, Melbourne, he was the engineer in charge of construction for the suburban outer circle rail line in 1887, and in 1892 he was appointed assistant engineer and chief draftsman for the Melbourne Harbour Trust.

While at university he joined the university regiment and commenced his military training. He commanded the 13th Infantry Brigade before the war and then, shortly after its outbreak, became commander of the 4th Brigade in Egypt, with whom he took part in the Gallipoli campaign from day one. In July 1916 he took charge of the newly raised 3rd Division in north-western France and in May 1918 became commander of the Australian Corps, at the time the largest corps on the Western Front. The successful Allied attack at the Battle of Amiens on 8 August 1918, which expedited the end of the war, was planned by Monash and spearheaded by British forces including the Australian and Canadian Corps under Monash and Arthur Currie. Monash is considered one of the best Allied generals of the First World War and the most famous commander in Australian history.

Part of today's presentation was to pay tribute to the men and women of the ADF who served in WWI, on the (almost) centenary of the armistice which ended the Great War. A four-year war which took more than 60,000 Australian lives overseas and left countless with life altering and life diminishing physical and mental injuries.

I would now ask you to consider what we can learn today from General Monash and his leadership. None of this was easy for him.

John Monash had to face many personal and professional challenges to achieve what he did:

He had to overcome five levels of discrimination:

1. He was of German heritage (however, he loved Australia and had no sentiment at all for the country of his parents);
2. He was not Regular Army (as such not considered to be a proper soldier – a problem which at times exists even today);
3. He was Jewish (anti-semitism was apparently common at that time);
4. He was from a Dominion and so not 'British' enough to command; and
5. Some of his adversaries were spreading rumours that he was a German spy.

Monash was a unique man, and a disruptive thinker. He thought differently about fighting wars – and said: "I had formed the theory that the true role of the infantry was not to expend itself upon heroic physical effort, nor to wither away under merciless machine-gun fire, nor to impale itself on hostile bayonets, nor tear itself to pieces in hostile entanglements".

Instead, he wanted his troops "to advance under the maximum possible protection of the maximum possible array of mechanical resources, in the form of guns, mortars, aeroplanes (also tanks); to advance with as little impediment as possible; to be relieved as far as possible of the obligation to fight their way forward".

No general on either side in WW1 thought like this.

Why did his battle plan work? I suggest that it was due to the following five points

FEATURE

- Communication
- Collaboration
- Preparation and Innovation
- Disruptive thinking
- Professional citizenship

Communication

Of all the lessons to learn this is the most important. If we examine almost anything that has gone wrong in our world one of the main contributing factors has been poor communication.

If the Titanic had good communications between ships most of the doomed passengers would have been rescued during the three hours she took to sink. The terrible aircraft crash at Tenerife in 1977 which took 583 lives would have been avoided if the aircrew had followed crew resource management policies now in place (as a result of that crash) and warned the senior captain not to taxi onto the runway. Maybe if Barnaby had have communicated that he had not had a vasectomy…

During the process which was the MBS Review for anaesthesia the outcome may have been completely different if the Anaesthesia Clinical Committee had communicated with colleagues (as instructed). The ASA working group strove very hard with limited information from the ACC to determine the trajectory of their deliberations, and through effective communications with the Health Minister Greg Hunt, his advisors, AMA President Michael Gannon, and the Department of Health has managed to redirect the process, and prevent some destructive and inappropriate changes from being made. Changes which would have significantly diminished rebates of more than 1.2 million patients.

The ASA, along with the NZSA and College has opened the debate on our speciality's name. Our name communicates to our patients and the world who we are and what we do.

Today almost the whole world uses the term anaesthesiologist to describe a medical practitioner who specialises in anaesthesia and perioperative care. In fact, only Australia, NZ and the UK use the term anaesthetist. The Irish voted in May to change their College name to Anaesthesiologist. The WFSA – an organisation of which the ASA is a founding member, defines the term anaesthesiologist, and notes in some countries anaesthetist is used. Surely, it's time for us to join the rest of the world? It's not Americanisation, it's joining the global community.

In truth many patients already differentiate between anaesthesiologists and anaesthetists because they watch television medical dramas, where, when everything turns to custard its always the anaesthesiologist who comes to the rescue (till then we are invisible). I guess most superheros behave in a similar fashion! Mind you I am not taking up wearing a cape or my underpants on the outside!

This debate needs to be held. The outcome is about having our speciality, other specialists, the wider healthcare system and the public understand our important role in caring for our patients. It's not so much about differentiating us from alternate anaesthesia providers, rather it's promoting the understanding of the key role of anaesthesia in the holistic care of patients through their operative experience, from preoperative preparation through to return to normal life.

Collaboration

Just as Monash saw that the solution to overcoming the enemy was through collaboration with combined forces of both the Australian Military and the Allied Forces, so has the ASA been working to collaborate.

The MBS review, the Minister's Out of Pocket review, the Private Health Insurance Review, the Medical Board of Australia Revalidation Review, to name but a few that have threatened the speciality in significant ways during my time as President, have all required us to collaborate with other specialities, and government organisations to ensure the right outcome for our patients, and the speciality (and keep me very busy!).

The ASA has collaborated closely with the Australian Medical Association, the Department of Health, the Minister of Health – Hon Greg Hunt, the Senior leadership of ANZCA, key leaders in the ASA, and with academics to fight the MBS review recommendations in what has been described, by some, as the greatest existential threat the Society has faced for a long time.

This group has worked tirelessly for the last two years to ensure that the interests of our patients and the fee for service model of anaesthesia provision has remained intact and viable.

We have worked closely with the Federal Department of Health to help them understand how the ill-informed and misguided recommendations of the MBS review Anaesthesia Clinical Committee (ACC) would have been both harmful and inappropriate to our patients.

How the ACC impugned the speciality and denigrated the importance of appropriate application of individualised, evidence-based care, accusing us of doing it just for the money. Analysis of data by the ASA, supplied by the Department – data available to the ACC but not requested or considered, clearly refuted this assertion. The ACC on multiple occasions suggested that many of the treatments instituted by anaesthetists as part of individualised care were in fact only done for the money. They called it a perverse incentive and used the term in their first report seven times for different therapies.

With objections from the ASA, and the College the term perverse incentive was altered, but the intent to suggest that

these items were claimed only because there was money for performing them, remained. When the data was looked at the contrary was revealed.

Take arterial lines for example: there is good evidence that even brief periods of hypotension in the elderly is associated with higher rates of perioperative myocardial infarction; thus arterial line insertion growth of nearly 30% was completely explained by a 27% increase in patients over 70, and a 47% in patients over 80 undergoing surgery of more than two hours duration, and suggestions of systematic rorting by claiming for arterial lines in procedures like knee arthroscopy revealed it happened seven times (out of millions of anaesthetics). No evidence (other than hearsay) was provided to support the claim of rorting, but the ACC recommended removal of funding to keep us honest and prevent gaming the system.

Thanks to the dedicated and prolonged hard work of the ASA, and its collaborators we have averted this disaster, which would have cut rebates to over 1.2 million patients annually and inappropriately bundled payments for others. The ASA has also worked hard with the Department and the Minister to ensure that responsible stewardship of the RVG will continue into the future, but with the ASA and key stakeholders, not the ACC. Hopefully we can now look forward to an ongoing, well-reasoned and considered rebalance of the MBS anaesthesia section, which will continue to support Australian anaesthetists in public and private practice and ensure that our patients get the best value for money from the Australian tax payer.

Responsible stewardship of the schedule must continue to be the role of the ASA, with collaboration with the College, appropriate academics and the Department of Health.

Preparation and innovation

One of Monash's strengths was his logical mind and his training in engineering. He understood the complexities of a system with many interdependent components. He appreciated how to orchestrate all the different tools available to him into a symphony which could be used to build a bridge, or win a battle against a stubborn and entrenched opponent. He also understood that careful planning is required to complete such a task, and that if just one step is omitted, or one component neglected it could mean the difference between success and failure. This was something not appreciated by other WWI generals.

As part of writing the symphony and preparing the battle Monash also held conferences with his subordinate commanders, where every aspect of the plan was discussed and critiqued. Every leader had input to the final plan, and so they all had ownership.

So too with leading an organisation like the ASA, any problem presented to us must be considered as a complex situation. We are fortunate that we have a leadership structure which has evolved to assist us. The principal committees of Professional Issues, Economic Advisory and Public Practice, along with Communications allows us to address challenges with many dedicated people considering options. This process of consultation has led to robust decision making, and comprehensive consideration of issues.

I have to acknowledge and thank the leaders of these committees who have been so productive and helpful in dealing with the challenges of the last two years.

Disruptive thinking

When Monash conducted the Battle of Hamel he did it in a completely new way. Using all the techniques described, when the Australian troops reached the enemy lines they were still hiding waiting for the artillery to end so they could set up their machine guns. There was almost complete surprise.

This was what we would today call disruptive thinking. Disruptive thinking has been credited as one of the reasons new conservatives like Trump have been elected – probably not a good thing – depending on your politics, but effective.

What are the aspects of disruptive thinking we may consider?

a. A mindset to discard old clichés and remake the landscape and never accept the status quo

The speciality of anaesthesia must be looking to do this. The future of the speciality is in our hands at the moment. It is the responsibility of the Society and the College to ensure that we as specialist doctors continue to provide a comprehensive service for perioperative care that represents good value to our patients and to the fund payers. To achieve this, we must be prepared to consider all options for work styles and payment to ensure that we are able to work independently and maintain the current world best high standards of anaesthesia care.

Perioperative medicine must be a role we advocate for and guide. New models of care around the surgical experience are arising, and it is crucial that anaesthetists are leaders, and clinicians who lead. Opportunities for extended postoperative care led by anaesthetists are currently being researched and will lead to better outcomes for our patients while saving costs and resources.

We as a speciality, have to look to working outside of the operating room and lead these innovative approaches, or we run the risk of being relegated to being technicians in the operating room.

b. Another key to Disruptive thinking – requires realistic thinking, discarding old trends, but keeping within the scope of what we do.

This represents one of the challenges for our society and speciality. Anaesthesia, like emergency medicine, radiology and

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pathology plays a crucial role in patient care, and yet often not understood by the general public. Many believe we have an image issue with patients and in some cases other specialities. We all, at times struggle for the recognition we feel we deserve, and yet at times our level of 'invisibility' works to our advantage. Our patients rarely tell us what anaesthetic they need, and Dr Google is not terribly helpful. The complex nature of what we do is somewhat of a black box to most people.

It has been said that we need to elevate the profile of the speciality in order to get the respect we feel we deserve. I don't disagree, but a word of caution, this needs to be done in a way that truly enhances people's understanding of who we are and what we do.

Clearly, we run the risk that if not done well, the public and journalists will deduce that our motivation is about money or turf protection.

How then do we achieve such an outcome? The recent events of the cave rescues in Thailand and the exploits of the rescue teams and Dr Harris have probably done more positive work for out profile than any advertising campaign costing millions. This work, in so many ways, was of anaesthesia and perioperative medicine, the surgery was the extrication from the caves.

The Society and the College must be able to articulate our value, and demonstrate leadership in tackling important issues - like inappropriate opiate usage, or the difference we can make to patient outcome by extending PACU care, to help the public and our colleagues understand our commitment to the community. This sort of action will raise our profile without raising accusations of greed.

c. We need to have a leadership mindset, to move away from the pack, and make the pack follow.

Our society must be able and prepared to go onto the front foot with policy for our advocacy. So much energy of the last two years has been expended in response to external threats. The MBS review, Minister's Out of Pocket review, The Private Health Insurance review, to name a few – much of this driven by politically funded "think tanks" who have peddled their own views on the Australian Health Care System representing them as scientific and balanced.

Right now, the Australian healthcare system produces some of the best outcomes in the world, while being below average cost compared to other OECD countries. Surely this represents good value? I believe collaboration with like-minded societies and associations and the AMA is vital in this space. We need to change the pack dialogue and have the political pack follow the lead of the profession, until we do we will continue to be attacked by outside organisations seeking to control us.

d. Radical thinking, technology is more often only the enabler.

As part of our brand renewal and website reconstruction we have sought to show leadership in the professional delivery of anaesthesia services, particularly in the areas of informed financial agreement and patient satisfaction. The ASA is collaborating with Avant to develop resources on the ideal ways of obtaining informed financial agreement, and how this should be recorded. We are developing new technologies to provide member tools for IFA and also for patient feedback, which will facilitate member's CME activities for quality assurance, and at the same time provide the ASA with deidentified pooled data attesting to the levels of satisfaction and quality of anaesthesia services. Unsubstantiated derisive comments have been used against the speciality over the last two years seeking to cut our funding by making Trump-like assertions about our professionalism.

In the future we want to be able to silence such deliberate mis-information (or fake news) with hard data.

e. At the end, the key to Disruptive thinking lies in the mind. Let's not just think outside the box- let's think like there's no box at all.

The key then to successful disruptive thinking is the disruptive-constructive model – first disrupt leaders or their businesses from their comfort zones, and then jointly sit and reconstruct the 'new box'.

This is what Monash did – he used the new ideas and technology to disrupt the conventional thinking of the day and then he collaborated with his leaders and his subordinates to make a new paradigm of warfighting.

This is also what we must learn as a speciality and Society. We must learn to work constructively and collaboratively with each other and outside agencies to develop new ways of approaching the apparently never-ending attacks we face from lobby groups, profit-taking insurers and so-called think tanks whose real agenda is so often politically based and motivated.

What's our new box? I'm not sure, but I believe that anaesthesiology could well be it. Anaesthesiology as the all-encompassing term for the perioperative physician, who provides the comprehensive preoperative preparation and assessment, the skilled intraoperative care for an increasingly elderly and sick population, and the careful and ongoing care extended into the post-anaesthesia care unit for the unstable patient.

Our challenge is to make this happen, and to ensure that it's funded appropriately in the public and private sector, to ensure that the savings we generate come back to us as appropriate compensation for the work done.

Professional citizenship

Professional citizenship is the willingness

to accept responsibility and ownership for the present and the future state. To achieve this, you have to be a team player, demonstrating both leadership and followership. You have to always do your fair share of the work, leading by example, and always stand up for, and doing the right thing. It's about giving back as well as taking and supporting your mission with your time and energy.

Monash saw that his present state was parlous and it needed to be changed. He had the vision to see what that change should look like and then set about making it happen. Anaesthesia as a speciality in many ways needs to do the same thing. Our future state is one where we are in control of our destiny and speciality. Where we are leading the way to better outcomes for our patients and better value to our funders, and government.

This requires us all to think about how we deliver our high-quality care and how we may innovate and cooperate to be even better. Over the last two years as president this has been one of my goals, how can the ASA lead the speciality to greater engagement with the policy makers, fund holders, and statutory bodies. We have engaged at every opportunity to represent the speciality and members. We have made sure we are at the table, not on the menu!

I have been asked do we need a society in this day and age, and my answer is clearly absolutely.

When you travel on an aeroplane you generally don't for a second consider "what if the plane crashes and I don't get home?", normally we think about the in-flight entertainment or the service, or why is that annoying kid kicking the back of my seat!

Why is this? It is because of the outstanding safety record – due to two things:

1. The Air Services Australia regulations which ensure airworthiness of aircraft, and regulates air traffic control to ensure collisions are avoided. The bureau of meteorology provides accurate weather information to the aircrew to ensure safe navigation.
2. The pilot's and cabin attendants' associations which ensure good working conditions so that aircrew are not fatigued, or working two jobs to pay bills, and are able to effectively focus on their crucial role in the human component of flying.

So, the two pillars of safety are the regulations (Air Services Australia) and the people (Professional associations).

When we take our patients on their journey of surgery, from the lifelong care of their GP, through the detour of surgery and back, they feel the same level of confidence. Sometimes however the patient is injured, or crashing, or is not functioning well. A pilot would rightly refuse to take off – for us we carefully take off and the surgeon then attempts in-flight repairs. The other big difference is if the aeroplane crashes the pilot goes with it.

Australian anaesthesia also has an excellent safety record, for very similar reasons:

1. Regulations and training governed by the College produces highest quality specialists and sets standards on equipment staffing and facilities to ensure the safest environments for anaesthesia delivery; and
2. the ASA has long advocated for appropriate remuneration and conditions to ensure anaesthetists are suitably supported, so they don't have to work excessive hours to pay their costs. These conditions in the private sector then influence the industry and so raise the benchmark for public specialists.

Our two pillars and standards of care and monitoring (ANZCA) and the wellness of our people (ASA).

The ASA is all about making sure that when things don't go to plan, we are all like Sully!

Here is a list of some of the activities that have occupied much of our time representing our members and the speciality during my time as President:

1 Governance Restructure – implementation of a new Board/ Council model including the establishment of terms for all elected positions.

2 Engagement of Credit Suisse – which has led to better and safer management of the ASA's investments.

3 MBS Review – active involvement working directly with the Health Minister and the Federal Department of Health. This is ongoing and has represented one of the greatest external threats to the speciality ion the last decade.

4 Branding Refresh – professional appearance of the ASA productions has been updated and made more consistent.

5 AIC Journal – production is to be outsourced as part of improved risk management and improved value to members and the Society.

6 Website Refresh – currently under way this will lead to greater functionality, and interaction with members and the public through enhanced services.

7 Adoption of an Equity and Diversity Policy – applicable to all aspects of ASA.

8 Engagement with RANZCOG working on how to improve value for private obstetric services.

9 Working with the Health Minister and Chief Medical Officer on how to deal with medical out of pocket expenses.

10 Worked with the College and other agencies to address rural anaesthesia workforce issues, including meeting the Rural Health Minister and The Rural Health Commissioner.

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11 Collaborated with ANZCA, RACS and NZSA to set up the pilot for the Australian and New Zealand Emergency Laparotomy Audit, and further engaged with the Health Minister to maintain funding for this crucial quality audit.

12. Worked with Wellbeing of Anaesthetists Special Interest Group and Everymind on a comprehensive package for the mental wellbeing of anaesthetists.

13. Represented the ASA at the CIG meetings in Canada and London ensuring the ASA is up to date with our colleagues in the English-speaking world.

14. Engaged with the European Society of Anaesthesiologists and signed a MOU to enable closer cooperation between our societies.

15. Appointment of our CEO – including development and institution of CEO assessment and appointment process.

16. Collaborated with Interplast Australia, ASA, NZSA and ANZCA in a new memorandum of Understanding for the ongoing support of LifeBox, through ODEC.

This is not an exhaustive list but does cover most of the major issues. Going into the future the importance of active advocacy with Government and fund payers, as well as active collaboration to ensure the ongoing improvement in quality and safety for anaesthesia are some of the key roles the ASA will be continuing to undertake.

In closing, and in keeping with the military theme I want to thank a number of people who have helped with this exhausting list of activities:

- I start with Office in Charge of Home – my wife Rachel, who generously agreed to me taking on this challenging role. She has been there through the whole thing and I'm sure if she never hears of the MBS review again it will be too soon! Thank you!
- Next is my number two – Mark Carmichael who has skilfully redirected me when I needed it and supported me when I was on the right track!
- The troops in the Headquarters Division: Ms Sue Donovan and all the troops – who make it all happen so seamlessly that I am continually amazed.
- Then the ASA Board – a finer group of officers you will not find:
  - the retiring past president Guy Christie Taylor who has been one of my sounding boards;
  - incoming president Peter Seal who has kept me focused and on track, and who brings a different view;
  - Treasurer Andrew Miller with his razor-sharp mind and wit who lets nothing past him;
  - Executive Councillor Suzi Nou – an impressive worker, sharp mind and future leader.
- The leaders of our principal committees, like platoon leaders they work hard with their teams to produce strong advice and reports to represent the Society:
  - Mark Sinclair of Economics Advisory Committee and Board;
  - Antonio Grossi of Professional Issues Committee and Board;
  - Alicia Dennis of Public Practice Committee, who continue to be instrumental in helping the society fight our battles.
- I want to particularly thank this group for their incredible hard work in responding to the MBS review. I'm not sure anybody but myself and Mark Carmichael understand to amount of work put in by these people, along with
  - past President and RVG genius Andrew Mulcahy, and collaboration with
  - Prof David A. Scott,
  - Phillipa Hore, and
  - independent academic Prof David Story.

Through the work of this excellent team, it's safe to say disaster averted, and I believe we are ushering in a new era of deliberate consultation and collaboration with the Department, to ensure responsible guardianship of the schedule.

Thanks also to Chief Editor John Loadsman, and to all the other captains and corporals in the ASA leadership corps.

Battle of Hamel

I will now finish up with a final stanza on what happened to Australia's greatest son after the battle of Hamel.

From the start of the Battle of Hamel, through to the planned withdrawal of the Australian Corps from the front line some three months later Monash led the Allies through a remarkable series of battles which were all successful, with objectives achieved beyond the wildest dreams of the allied command.

From the 4th July to 5th October 1918 the Australian corps had been in almost constant battle. During that time, they had taken almost 30,000 prisoners, liberated 116 towns and villages, and recaptured 660 square kilometres, and the Germans suffered in the order of 60,000 fatalities.

In the same time the Australians lost 5,500 killed, 24,000 wounded. This was the least 'costly' period for the Australians for the whole war, despite the fact that they were the spearhead for the battles.

They had taken on 39 enemy divisions and beaten them all (including the crack Prussian Guards).

Well before their attack in March the Germans knew to stay away from Dominion troops. After 8th August the German commanders admitted that the combination of tanks and Australians was overwhelming.

The key reason for this success was the brilliance of Monash in placing the emphasis on machinery and weapons to protect the infantry, without diminishing their role. His ideas and strategies caused

the Australians to stand out from the rest of the combatants on either side. This marked a change in warfare and ended the concept that men were cannon fodder. His detailed command of technology, machinery, and equipment put his thinking 50 years ahead of every other commander. That he was in a position to put his ideas into practice, with devastating effect on the enemy is a tribute to his drive, vision and tenacity.

On October the 5th the Australians were withdrawn from the front line for a well-deserved rest. On the same day Prince Max von Baden, on behalf of the German government asked for an immediate armistice. The fighting continued for another month, but the enemy had no line of defence in France, and were continually on the retreat from then on.

After the war Monash wrote of the decisive role the Australian Corps played in the 1918 allied campaign, giving it five stages: He said:

1. Stopping the German offensive in march
2. Turning the German offence into defence
3. Commencing the offensive thrust from Hamel onto Amiens and the 'great, initial and irredeemable defeat.
4. Preventing the Germans from resting after defeat at Amiens and pushing them from the Somme, thus preventing the war continuing till 1919, and
5. Overthrowing the great defensive system of the Hindenburg line, thus preventing the Germans from bargaining on their terms.

After the armistice of November 11th 1918 there were thousands of Australians in Europe who had to get home. The PM Billy Hughes was keen to get them home, but he was afraid of Monash, who he feared would make a formidable opponent. He arranged for Monash to be in charge of the repatriation and of keeping the troops 'occupied' in England till they could get a ship home, and till after the 1919 Federal elections!

Monash made sure the 4th ANZAC day would be celebrated in London when 5000 diggers marched 5 km through London, taking the salute from the Prince of Wales, Haig and Chauvel-Hughes was there as well (not enjoying being second fiddle to Monash).

Monash returned to Melbourne December 26th 1919, where the PM (Hughes) failed to meet him. The Governor-General (Munro Ferguson) failed to meet him, and General Birdwood (his old commander who he now outranked) failed to meet him. They were all terrified of him, and could not accept that a native-born Australian could be smarter, more educated and articulate, be a better leader and have finer military skills than an Englishman.

After returning to Australia he was invited to hundreds of events to praise him and his achievements. His wife Vic fell ill and passed away the next February which left him devastated. After this he found his real role as senior advocate for the ANZACs. He laid the corner stone for ANZAC House in Melbourne, lectured at the Australian War memorial, and was in constant demand from the press for comment.

Hughes, the Army and the Governor-General continued to ignore him, and deliberately snubbed him for high office, military promotion, or recognition. The British generals got large sums of money and titles, even Birdwood his inferior, was given a title. The Canadian General Currie got some recognition after complaining. Monash got to keep his sword!

In 1920 he took over and set up the Victorian State Electricity Commission. He almost single-handedly, through the SEC, set-up electricity generation and distribution for the state. He was also instrumental in the building and design of the Melbourne Shrine of Remembrance, and remained an advocate for digger's welfare till he died at 10:55 am on the 8th of October exactly 87 years ago.

A portrait of Lieutenant General Sir John Monash, GCMG, KCB, Commanding, Aust. Corps, wearing red/white/red Corps Headquarters armband on right arm above five years' service stripes; Western Front. Photo: Australian War Museum

Thank you for your indulgence and attention, I trust you have found this engaging, entertaining and educational. Thank you also to all servicemen and women past and present for your sacrifice for your country, to those who paid the ultimate price, and the families and loved ones who were left behind to pick up the pieces.

Finally, I wish to express my appreciation to the Australian Society of Anaesthetists for trusting me with the duties of President. I have appreciated the trust and responsibility placed in me by you, the members.

I have always attempted to do the right thing in representing you, what is best for you the members and the speciality of anaesthesia as my guide. It has been an honour and a privilege – thank you.

FEATURE

LONG LIVES HEALTHY WORKPLACES PROJECT

Associate Professor David Scott launched the Long Lives Healthy Workplaces Toolkit at the opening ceremony of the recent ASA NSC in Adelaide. This was the culmination of many years of hard work and marks the start of a call to action.

The ANZCA/ASA/NZSA Welfare of Anaesthetists SIG was formed in 1995 to predominantly raise awareness of the issues that affect anaesthetists and can impact on their mental health and wellbeing. This has been achieved with the preparation of Resource Documents on topics such as retirement, medico-legal issues and substance abuse.

There has also been a vision to develop "workplace practices that support anaesthetists and keep them well".[1] Early iterations can be found amongst the Resource Documents. RD 16, 'Welfare issues in anaesthetic departments and private groups'[2] was written in 1996. Over two-and-a-half pages long, it describes offering orientation to new staff, mentoring, fatigue and crisis management and appointing a welfare advocate.

Nearly 20 years later, at the 2015 Combined Scientific Congress in Darwin, the Welfare SIG conducted a workshop, led by Drs Tracey Tay and Prani Shrivastava on 'Caring for colleagues and ourselves – what really works'. They asked the question "what would a model of care for anaesthetists in their workplace look like?" They were joined by Ms Jaelea Skehan, Director of Everymind (known formerly as the Hunter Institute of Mental Health). Jaelea, in 2014, was included in the AFR and Westpac list of Australia's 100 women of influence and spoke powerfully on the benefits of investing in mental health in the workplace. She provided the analogy of anaesthetists being like basketballs and resilience as the ability to bounce back from difficulties or adversities. Everyone has this intrinsic ability to recover, we all have resilience and we can all build better resilience. Throughout our careers we experience difficult moments from which we bounce back. Some of us return to previous form. Some, after too many bounces, start to fall flat. What if our workplaces, instead of being like a hard basketball court, were like a trampoline? How much easier would it be to bounce back?

Tracey developed an example of a workplace good mental health model as a pyramid (Figure 1). The base is to support good mental health for all staff. The next level is to consider strategies for staff at increased risk. Increased risk could

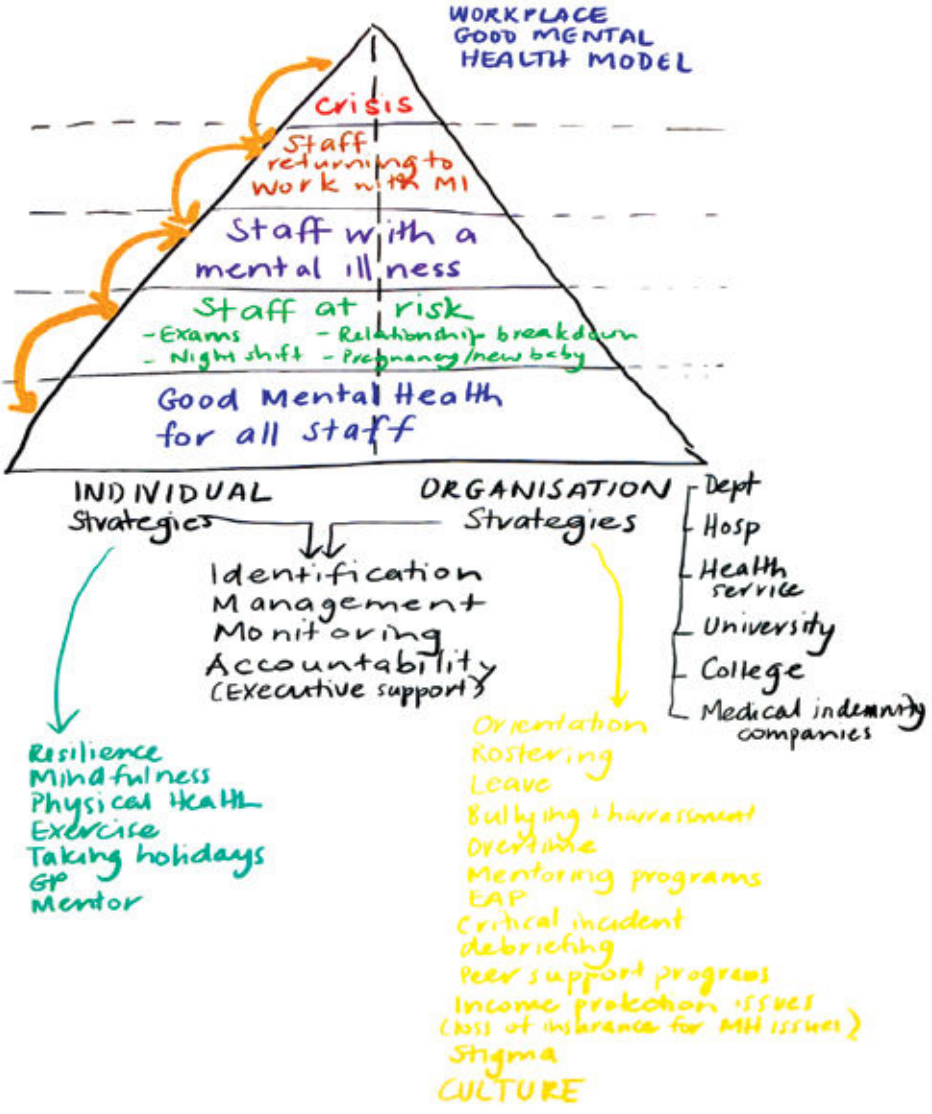

Figure 1: Example of a workplace good mental health model.

be brought about through planned or known events, such as exams, pregnancy or a new addition to the family but also unplanned events such as a relationship breakdown, a patient complaint or adverse clinical event such as a drug error. The nature of our work means that any one of us could become a staff member at risk at any time. The next levels seek to identify and develop strategies for staff with a mental illness, staff returning to work with a mental illness and those at crisis. Interestingly, burnout, known to increase stress, affect inter-personal relationships and reduce patient safety is not regarded as a mental illness, in that there is no DSM-V criteria. It does, however, contribute to poor mental health and thus working on good mental health in workplaces does help to prevent burnout as well as reduce the impact of mental ill-health.

The 2015 workshop accelerated efforts to support workplace mental health in anaesthesia departments and also began the ongoing collaboration between the Welfare SIG and Everymind. Everymind is a leading national mental health research institute dedicated to improving wellbeing and reducing suicide and mental ill-health. They have worked successfully with other industries, such mining and education and through the *Tackling the Mental Ill-Health of Medical Students and Doctors* initiative, they are defining national policy. With their support, the Welfare SIG has developed the Long Lives Healthy Workplaces Toolkit, an evidence based operational toolkit, linked to national policy, which aims to promote and support good mental health in the workplace.

Development of the toolkit was guided by a national steering committee, chaired by Dr Tracey Tay and included anaesthetists from around Australia: Dr Prani Shrivastava, Dr Jane McDonald, Dr Greg Downey, Dr Marion Andrew, and myself, as well as Ms Jaelea Skehan and a psychiatrist, Dr Shirley Prager. Financial support was provided by the ASA and in-kind support from Everymind, by way of providing a research and communication team.

Everymind is a leading national mental health research institute dedicated to improving wellbeing and reducing suicide and mental ill-health.

Development of the toolkit was based on a literature review, policy review and qualitative data gained from interviewing anaesthetists and trainees. Once the toolkit was prepared, it was tested in two pilot sites for its feasibility before being prepared for wide dissemination.

The result is a toolkit that is 46 pages long, an enormous development from its humble two-and-a-half page Resource Document origins. It is freely and publicly available on the ASA website as an interactive pdf which can be downloaded and printed for offline use. It highlights the importance of a strategic and coordinated approach. My

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Long Lives Healthy Workplaces Toolkit

analogy is to compare workplace mental health to cardiac disease. It would be a poor distribution of resources if health planners were to invest only in building cardiac catheter labs in every facility across Australia. Reduction of cardiovascular disease requires health promotion activities such as education on lifestyle modification such as avoidance of smoking or smoking cessation. It also requires primary prevention in identifying at risk populations and screening and treating for conditions such as hypertension and diabetes. Those with cardiac chest pain need rapid early intervention and transfer to a cardiac catheter lab or access to pre-hospital thrombolysis. After undergoing cardiac surgery or having an AMI, cardiac rehabilitation has been shown to improve survival.

Likewise, supporting mental health in the workplace needs to consider all of the areas of mental health promotion, primary prevention, early intervention (referred to also as secondary prevention) and tertiary prevention, or recovery and reducing the impact of mental ill-health. There has been a burgeoning increase in the number of resources available to support wellbeing. We may have heard of program x being very effective in hospital y. Adopting programs on an ad hoc basis may mean that key at risk groups have not been included. A structured and coordinated approach aims to reduce this and avoids a patchwork, siloed process.

Whilst it may seem onerous to work through a 46-page document, the toolkit contains an assessment tool to guide practitioners through the process. Again, this can be used as an interactive pdf or printed to use as a hard copy. The first step is to identify a leadership team. Consider those that have an interest in supporting wellbeing, such as a welfare advocate, specialists and trainees. In a training department, the SOT should also be included as they may be the first point of contact for trainees. Ideally, the Director of a department should be included as again, they will often be the first point of contact for specialists or nursing staff. Identify champions both from within and outside of the team who will be important to your mental health strategy. For example, through this process, I have learnt that my hospital has appointed a hospital-wide Wellness Officer in the Human Resources Department. The ICU has also expressed an interest in using the toolkit in their department, as well as the junior medical workforce unit. This has created the potential to identify common areas and a sharing of resources and ideas across the hospital.

The next step is to describe what activities are currently being undertaken to support mental health. Identify existing policies, programs, supports and practices, and consult with staff and other stakeholders to identify issues and seek feedback on the current approach. As a team, consider your department's current actions across the following strategy areas described in the toolkit:

1. Improve the training and work environment to reduce risk.
2. Improve the culture of medicine to increase wellbeing and reduce stigma.
3. Improve capacity to recognise and respond to those needing support.
4. Better support trainees and doctors impacted by mental ill-health and/or suicidal behaviour.
5. Improve leadership, coordinated action and monitoring.

Once these activities have been defined, the next step is to analyse the situation. Consider which of these activities are working well, or are a strength, and which strategic areas require further development.

The third major step is to establish an action plan. Prioritise, based on the analysis performed in the previous step, which strategic area requires focus. Then develop a goal. This goal should be SMART: specific, measurable, achievable, relevant and time specific. An example of a SMART goal is included in the assessment tool. Some other examples might be to ensure that 80% consultant staff receive a 15 minute break per session per day by the end of 2018 or that an overnight rest facility is provided for consultant and registrar staff by the end of the year. In defining a goal, it is important to identify who will be responsible, and the tasks they are required to do, what resources are available and what further resources are required, when it is hoped to achieve this goal by and when to review this goal.

The final step is to monitor, review and improve the action plan. Is the action plan being implemented by the right people, in the right way? Is the action plan as sustainable as possible? What is our working group seeing and experiencing with implementing the action plan? What is working well and where do we need to improve? This is not a process of 'set and forget' but a journey of growth and change. The toolkit includes some validated instruments for gathering baseline data and measuring wellness.

This toolkit is a call for action. It has been developed by anaesthetists, for anaesthetists, although it could be applied more widely. Section three of the toolkit has been developed for use by individual anaesthetists who work in solo practice, or across many hospitals and departments. It contains suggestions, tips and resources to improve your own mental health and wellbeing.

This toolkit is a living, breathing document. The toolkit, like most things by the time they go to print in this fast paced digital world, is already out of date. Some of the links have already been updated. We welcome feedback on the toolkit and a feedback form can be found on the ASA website. A discussion group is also being formed so that those involved with implementing the toolkit can liaise with and support each other. All ASA members will be automatically added (with an opt-out option) to the discussion forum, as we value the mental health and wellbeing of all members. Non-ASA members can join the forum by providing their details via the feedback button.

I have been incredibly impressed by the hard work of Dr Tracey Tay, the Steering Committee and the Everymind team in creating this toolkit. I hope to see it widely implemented in anaesthetic departments, private practices and hospitals and amongst individual anaesthetists and look forward to seeing you in the discussion forum.

Dr Suzi Nou
Executive Committtee Member
Welfare SIG

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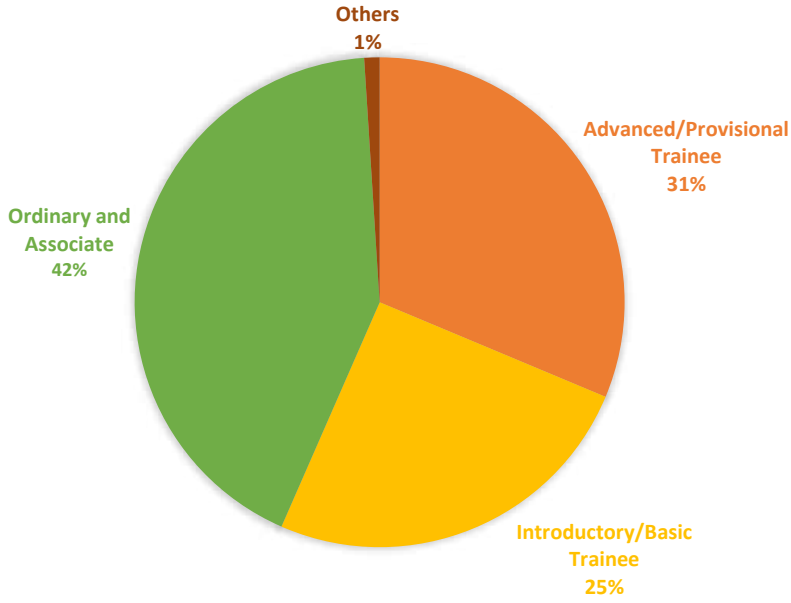
2018 IN REVIEW

MEMBERSHIP UPDATE

New member statistics

255
new members



POLICY UPDATE

Submissions:

- **4** Medical Benefit Scheme Review
- **5** Government submissions

Government consultation:

- **21** meetings

144
policy queries
with
86%
resolution rate

ASA APPS

Downloads increase*

Anaesthesia and Intensive Care
13%

Relative Value Guide
23%

Australian Anaesthetist
47%

**Percentages indicate increase in App downloads, in comparison to the previous year.*

2018 IN REVIEW

NEW ASA WEBSITE LAUNCHED SEPT. 2018!

MARKETING & COMMUNICATIONS

ASA website

- **25%** increase in page views
- **33%** increase in new users

President enews

> 62% open rate

> 22% click rate

Harry Daly Museum

5,400+ visits to online collection

(including onsite visits to 30 Sept. 2018)

> 1.6k likes
> 1.7k follows

> 3.7k followers

> 1.9k followers

EVENTS UPDATE

ADELAIDE NATIONAL SCIENTIFIC CONGRESS
AUSTRALIAN SOCIETY OF ANAESTHETISTS | 6-9 OCTOBER 2018

PMC 2018
PRACTICE MANAGERS CONFERENCE

600+
members attended events
in addition to NSC

1,000*
registrations at the NSC 2018

511
people downloaded the NSC App

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

31
events held including **trainee, state, social & combined ANZCA & CME's**

Note: All information and statistics for the period of 1 January to October 2018.

FEATURE

REAL WORLD ANAESTHESIA COURSE DARWIN 17-21 SEPTEMBER 2018

"If not now, when? If not you, who?"

Hillel the Elder

The Real World Anaesthesia course is supported by the ASA and was held in Darwin this year. It was something I wish I had done decades earlier.

WHERE IS THE REAL WORLD?

Where is the 'Real World'? It is where five billion people do not have access to safe, affordable surgical and anaesthesia care for easily treatable conditions. It is where many millions of disability-adjusted life years can be averted by the provision of timely surgical and anaesthetic care.

The 2015 Lancet Commission report on Global Surgery 2030 (evidence and solutions for achieving health, welfare and economic development https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(15)60160-X/fulltext) frames the current conversation around health needs and aid in low and middle-income countries.

This exhaustive document was given life, explanation, detail and examples from the lived experiences of the facilitators during the course in Darwin.

WHAT IS THE RWAC?

The RWAC is a starting point for anyone who is thoughtful about health care delivery in the real world.

The facilitators shared reflections on a long-term stay in Fiji and how to manage a job in Nepal one year and in Newcastle the next. How to incorporate such choices in the trajectory of a career, other interests, family and friends was also part of the conversation.

Facilitators from all corners of the world were very generous in sharing their experiences of the psychology of adaption, the trauma of tragedy and disaster response and the politics of aid.

A strong message during the course was the importance of good aid governance. This demands a needs assessment and analysis of delivery of services and education. Successful visits devote time and energy to develop an understanding of the local circumstances and the impact that a visit or program will have on a community.

The question of whether all aid is good aid was addressed, as was the value of short-term vs long-term missions. Working through outcome measures of successful missions was an interesting exercise. More often, it's not the number of cases performed, but the teaching that is left

Dr Phil Blum, RWAC course coordinator

Dr Megan Walmsley and Dr Brian Spain

Dr Kaeni Agiomea, a long-time friend of the RWAC was presented with the ASA medal by ODEC Chair Dr Chris Bowden in Darwin

behind and the relationships that are formed that are valuable to a community.

There are few courses where every session is acutely relevant. Presentations were technical and practical (circuit trouble shooting, drawover techniques, gas and power supplies), clinical scenarios, pharmacological (revisiting halothane and ketamine).

After our exposure to lectures and scenarios, we had the privilege of being able to implement techniques in the operating theatres. Phil Blum, Brian Spain, operating theatre personnel and patients at the Darwin Hospital were incredibly accommodating and generous to us. The Anaesthetic department orchestrated seamless visits to operating rooms all week with a welcome that was genuine and did not fade.

The big bonus of the course in Darwin was the visit to the AUSMAT (Australian Medical Assistance Teams) storage facility. This is where medical care equipment and other kit is stored and inventoried for ready deployment to disasters in our region. It is a logistician's dream-world where everything down to toothbrushes are in a packed bag with a "ready" tag - a literal and metaphorical labelling of the response readiness.

The National Critical Care and Trauma Response Centre is also in Darwin and is the seat of clinical and academic leadership and training in trauma and critical care. The NCCTRC infrastructure was established on the Pacific doorstep after the 2002 Bali bombings to equip and manage Australia's disaster response nationally and internationally.

Spectacular sunsets marked the welcome dinner, harbour cruise and beachside cocktails. Most delegates stayed in in the Darwin CBD precinct and caught a bus in the morning to the hospital - the organisers thought of everything to facilitate an easy stay for us.

There were sessions devoted to Fellowship courses and work opportunities: no-one leaves RWAC without plans…

WHO

Nineteen anaesthetists from nine jurisdictions flew in to Darwin to experience and enjoy another (the 27th) Real World Anaesthesia Course.

Seventeen facilitators with international experience conducted the course: anaesthetists, engineers, intensivists and theatre personnel. These people were willing to share their insights learned over years, their development of judgement, triumphs and short-comings during the course. They were modest, reflective and good-humoured. I take this opportunity on behalf of the delegates to say thank you to each one of them.

WHEN

The RWAC course began in Hobart in 1999 and now rotates annually between three centres: Darwin, Frankston and Christchurch.

The next one is in Frankston on 28 October-1 November 2019.

For more information and resources go to www.realworldanaesthesia.org

WHY?

Because you can and because you should.

Dr Vida Viliunas

INSIDE YOUR SOCIETY

PROFESSIONAL ISSUES ADVISORY COMMITTEE

DR ANTONIO GROSSI
PIAC CHAIR

ARE ANAESTHETISTS INADVERTENTLY CONTRIBUTING TO THE OPIOID EPIDEMIC?

Introduction

Anaesthetists regularly administer and prescribe opioids for the management of acute perioperative and chronic pain. The opioid epidemic has received substantial media coverage both here and abroad. There has been significant controversy surrounding the release of the joint ANZCA and FPM (2018), 'Position statement on the use of slow-release opioid preparations in the treatment of acute pain'.[1] This may reflect the problem of 'implementation science' which aims to reduce the 'evidence to clinical practice' gap.[2] It is possible that inappropriate opioid use may lead to tolerance and opioid-induced hyperalgesia reducing their effectiveness and perhaps promoting to the transition or exacerbation of chronic pain.[3] Excess or inappropriate opioid discharge prescriptions may be contributing to the opioid crisis.[4]

The opioid epidemic

The use and abuse of opioids has escalated to dramatic proportions in the past 20 years. In 2016, there were 63,632 fatal opioid drug overdoses in the United States, which is higher than those who died in the peak of the HIV/AIDS epidemic in 1995 (43,000) and in the entire Vietnam War (58,000).[5] Australia is not immune to this problem with a steady increase in opioid deaths over the past decade. In 2016 there were 2,177 opioid related deaths.[6] Opioid prescribing has increased in Australia with morphine equivalents (DDD-defined daily doses), increasing from 15-20/1,000 population to 30-35 DDD/1,000 population through the period 2009 to 2014. Accidental death from oxycodone, morphine or codeine is responsible for most opioid-related deaths.[5] In response the Australian government is considering a number of regulatory options.[5] This has prompted the anaesthesia and pain medicine community to consider these issues in detail with the key recommendation from the ANZCA/FPM joint position statement that "slow-release opioids are not recommended for use in the management of patients with acute pain."[1] There are also increased costs associated with the use of slow release opioids in the perioperative period[7] and increased complications (thromboembolic, infectious, gastrointestinal, and length of stay).[8]

What is known about opioid pharmacology and clinical acute pain management?

1. There is an eightfold to tenfold inter-patient variation in opioid requirements due to pharmacokinetic and pharmacodynamics factors.[9]
2. Significant variations in blood concentrations of opioids may exist within patients following repeated doses.[10]
3. Once the opioid minimum effective blood concentration is reached, the drug needs to cross into the central nervous system to have an effect on the central opioid receptors. This will depend on the drug's lipid solubility, degree of ionisation, drug binding, concentration gradient, and integrity of blood brain barrier.[10]
4. Effective analgesia requires the careful individualised titration of opioid dose.[3]
5. The most important factor when selecting the initial opioid dose for an opioid naïve patient is age.[11]
6. Titration of opioids requires selecting an appropriate initial dose, dose interval and subsequent dose.[10]
7. Bathing opioid receptors with excessive opioid may lead to tolerance and opioid-induced hyperalgesia.[3]
8. Not all pain is opioid responsive.[3]
9. Nocioceptive pain may be initially best managed with local anaesthetic blocks and non-steroidal anti-inflammatory drugs.[10]
10. The aim is to remain in the therapeutic corridor without developing side effects such as opioid-induced ventilatory depression.[12]
11. Patients need to be reassessed to determine their response to opioid treatment, evolving analgesia requirements, degree of sedation, respiratory rate and functional assessment particularly degree of

analgesia with breathing, movement and mobilisation.[10]

What is the problem with routinely using slow release opioids indiscriminately for acute pain?

1. Slow release opioids are not licensed for use in acute pain and contraindicated for use in acute pain according to product information.[13]
2. Based on the pharmacokinetics of slow release preparations, it is very difficult to titrate the opioid dose. Expected time of onset with slow release oxycodone is four hours compared with immediate release at 45 to 60 minutes.[10]
3. Given that a steady state of opioid concentration will not be reached until several doses have been administered over several days, the acute analgesic requirements will have changed considerably. It is likely that the cumulative dose for many patients will be above the therapeutic corridor exposing the patient to opioid-induced hyperalgesia and other opioid side effects such as opioid-induced ventilator depression,[12] sedation, reduced mobility and gastrointestinal motility.
4. Use of slow release opioids for acute pain in the perioperative setting has been associated with increased costs,[7] complications,[8] length of stay and rates of readmission.[3]

Why do some clinicians advocate the use of slow release opioids for acute pain?

Clinical experience has demonstrated that effective analgesia can be provided with slow release opioids. Some patients will testify that following procedures such as LSUSC, the addition of these drugs provided less need for breakthrough analgesia. Following procedures such as major hip and knee joint replacement utilising a regional anaesthetic, the addition of a slow release opioid that takes effect at four hours when the regional block is regressing, provides sustained analgesia for the initial 12 to 36 hours.

Titration of the opioid dose using appropriate initial and follow up doses of immediate release opioids, requires frequent assessment by skilled nursing staff with the back up of an acute pain service or similarly experienced perioperative medical team. This is not always available given the contextual differences of practice across private, public, metropolitan, regional and rural sectors. Financial, human resource, governance and infrastructure limitations

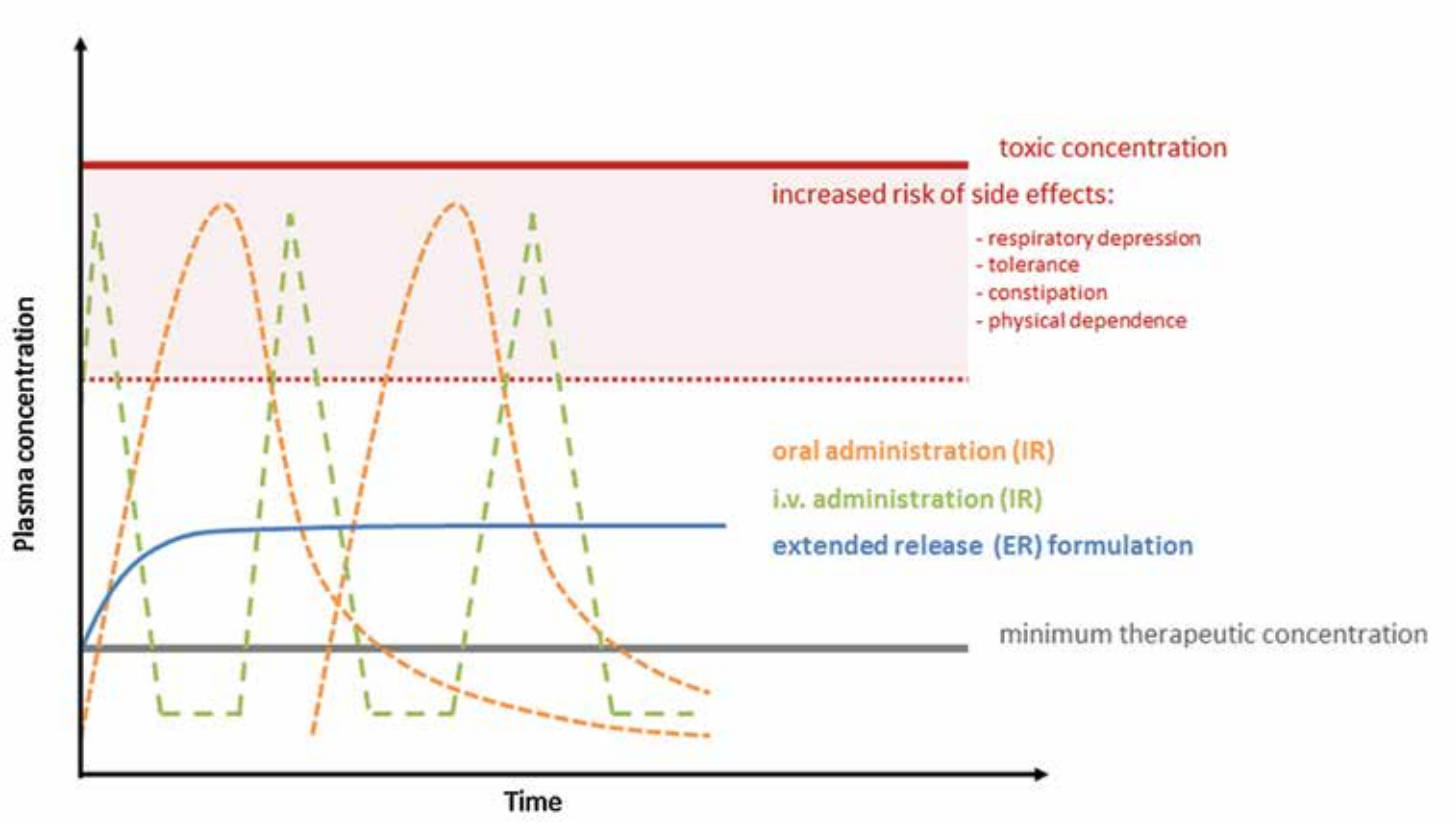


Figure 1: Schematic representation of opiod plasma concentrations in function of the administration route (IR: immediate-release and ER: extended release). Figure reproduced from: Martin C, De Baerdemaeker A, Poelaert J, Madder A, Hoogenboom R, Ballet S. Controlled-release of opioids for improved pain management. ScienceDirect, Volume 19, Issue 9, November 2016, pp. 491-502. https://doi.org/10.1016/j.mattod.2016.01.016. https://creativecommons.org/licenses/by-nc-nd/4.0/

INSIDE YOUR SOCIETY

may be barriers to the ideal form of practice based on the known scientific evidence of opioid pharmacology.

The consequence will be that some patients may be receiving more opioid than they initially require. This may lead to side effects and perversely the demand for ongoing opioids. Many of these patients may be managed more effectively with opioid sparing pharmacological and non-pharmacological treatments and appropriately used immediate release opioids.

As a harm minimisation strategy, perhaps the use of slow release opioids should only be used for a limited number of doses and not on the discharge prescription unless appropriate provisions and reviews have been activated.

Implementation science

There is often a long lag time between the publication of scientific evidence and the routine implementation into clinical practice. This has given rise to implementation science whose goals are to promote the uptake of scientifically proven evidence-based practices.[2] Perioperative studies may identify implementation barriers and then test implementation strategies. Outcomes may be thought of as implementation outcomes affecting process outcomes, which ultimately affect patient outcomes.[14] Implementation outcomes include 'acceptability, adoption, appropriateness, costs, feasibility, fidelity, penetration and sustainability.'[14] Implementation science assumes the evidence-based science is contextually applicable and is based on quantitative and qualitative research. Hybrid effectiveness-implementation research may assist in providing evidence for effectiveness to breakdown implementation barriers.

Conclusion

Anaesthetists are well placed to take a leadership role to limit the opioid epidemic in Australia. Investing in training staff, developing and implementing safe, effective and sustainable pain services and using opioid minimising strategies is a start. By considering the clinical situation carefully, reserving opioids for rescue analgesia, applying known opioid pharmacokinetic and pharmoacodynamic factors to determine the appropriate choice of drug, dose and dose interval, the analgesia regimen may be titrated to suit the individual patient's dynamic needs. This requires frequent reassessment and review.

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Membership benefits

SUPPORT

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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.

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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

INSIDE YOUR SOCIETY

ECONOMICS ADVISORY COMMITTEE

DR MARK SINCLAIR
EAC CHAIR

MEDICARE BENEFITS SCHEDULE (MBS) REVIEW

At the time of writing, the ASA believes that the Anaesthesia MBS Review will be drawing to a conclusion in the very near future, and the ASA remains hopeful that an outcome favourable for Australian patients and anaesthetists will be reached, in line with the ASA position. The report of the Anaesthesia Clinical Committee (ACC), responsible for the review of anaesthesia MBS items, has been released to certain organisations as part of a 'targeted consultation', prior to the final decisions being made. The ASA does not have access to the full list of organisations consulted, but is aware that the AMA and the Society for Paediatric Anaesthesia in New Zealand and Australia (SPANZA) have been involved. Both organisations have indicated to the ASA that they share our concerns regarding the ACC report.

In a cover letter provided to these 'targeted' stakeholders, the MBS Review Taskforce stated: "Extensive discussion has already occurred with stakeholders including the Australian Society of Anaesthetists (ASA), the Australian and New Zealand College of Anaesthetists and the Australian Medical Association through their ASA representative."

The ASA has highlighted the misleading nature of this statement to the Department of Health and the AMA. One of the ASA's key criticisms of the process has been the distinct lack of consultation by the ACC with stakeholders. The ASA and ANZCA have certainly had 'extensive discussions' with ACC and Taskforce representatives, but our input was almost entirely dismissed, with the ACC report being vigorously defended despite its obvious problems.

Naturally the ASA will keep members up-to-date with developments, via the website asa.org.au, and ASA President Dr Peter Seal's regular 'e-news' distribution.

ASA members will also be aware that the Review has recommended abolishing MBS items for the services of assistant surgeons. The proposal is that the rebates be 'bundled' into the surgical MBS item, and that the surgeon would then be responsible for paying the assistant's fee. The ASA has echoed the concerns of the Medical Surgical Assistants Society of Australia (MSASA) and the AMA, and has lodged a submission criticising this proposal (available on the ASA website). The submission states in part: "All doctors are independent practitioners, and should be recognised as such. The collection of payments by one for another might have implications for taxation, and also for industrial complexities, such as whether the fiscal relationship is that of a contractor/subcontractor, or an employer/employee. In any case, there almost certainly would need to be contractual arrangements

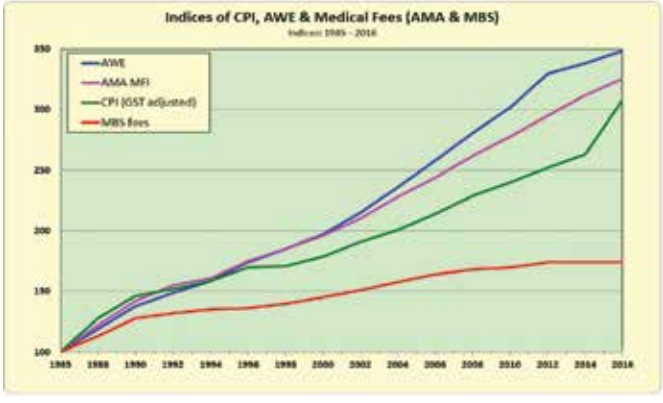

Figure 1: Indices of CPI, AWE and medical fees (AMA and MBS)

Figure 2: Anaesthesia no gap known gap and combined

in place. These would add unnecessary complications, and into the equation also would introduce new costs, which well could be passed on the patients."

The ASA has also highlighted the fact that assistant surgeons are often registrars-in-training, and that the assistant role forms an essential part of their education.

It is of concern that people with a very strong 'bundling' agenda occupy senior positions in the MBS Review process. The concern that anaesthetists' fees may be next in line for 'bundling' proposals is very valid.

You can find the relevant documents here: https://asa.org.au/mbs-review-documents/

MEDICAL FEES AND OUT-OF-POCKET (OOP) EXPENSES

The issue of OOP expenses for health care in the private sector continues to receive much attention in various forms of media, including online and hard copy newspapers. Almost invariably, the focus very quickly shifts from a brief mention of the various sources of OOP expenses (e.g. pharmaceuticals, dental care for uninsured patients) and concentrates on doctors' fees. In many cases there has been no consideration whatsoever of other sources of costs. Despite that fact that existing data clearly show a large majority of doctors' fees involve 'no gap' to patients, OOP expenses for doctors' services have been publicly described as a 'wicked problem' which undermines the health system and which may endanger the viability of the private healthcare sector.

There have also been 'roundtable' meetings convened by bodies such as private health insurers, media companies, and consumer groups, at which medical organisations, including the ASA, have been represented. The pattern here has been the same, with almost all of the focus being on doctors' fees and what measures should be adopted to solve this 'wicked problem'.

Interestingly, but perhaps not surprisingly, there was virtually no mention of:

- The failure to reasonably index Medicare and private health insurance rebates, year after year for the past three decades (see Figure 1, courtesy of the AMA).
- The fact that there has been no indexation of Medicare rebates since 2012 (except for a 1.5% increase in rebates for attendance items in July 2018, as detailed in the last edition of *Australian Anaesthetist*).
- The fact that health insurers have either followed the Medicare freeze, or provided only tiny indexations, since 2012.
- The fact that over $1.5 billion in profits is being enjoyed each year by the for-profit health insurers (with well over 80% of insured Australians now being covered by these companies).
- Additionally, the actual data on medical OOP expenses have, at one of these meetings, been dismissed as 'meaningless'. This is despite that fact that the data comprehensively show the very high compliance with 'no gap' and 'known gap' health insurance products. 'No gap' services involve no OOP expense to the patient whatsoever, and 'known gap' accounts must comply with insurance company rules, which almost always involve a specific limit on the OOP charged. Figure 2 (with thanks to Dr Andrew Mulcahy) shows this data for anaesthesia billing over the last decade. Over 95% of anaesthetists' services are currently billed either as 'no' or 'known' gap. Clearly, these figures are in no way 'meaningless', despite the best efforts of some parties to portray them as such.

Clearly, various stakeholders and commentators are taking the easy way out, by blaming the medical profession for the issues at hand. This may suit the agendas of some stakeholders, by removing any consideration of their responsibilities, creating an interesting newspaper read, and generating public criticism of doctors rather than other parties, but it does not help the broader issues of consumers' OOP expenses for their necessary health care, and the ongoing viability of the private healthcare sector, which is of course vital.

This is not to say that the issue of OOP medical expenses is unimportant. Clearly, it is of the utmost importance to our individual patients. It is however only one factor in the challenges currently faced by the private healthcare sector. The position of the ASA remains clear – that the AMA fee schedule represents a fair and reasonable reflection of the value of our services, and that charges in excess of the AMA fee cannot be supported unless specifically justified. The truly egregious fees being charged by a tiny minority of doctors cannot be supported, and will continue to attract criticism by bodies such as the ASA. Each individual patient's circumstances must be taken into account when deciding on fees. Best possible informed financial agreement (IFA) practices are essential, where there is any OOP expense to the patient.

The Economics Advisory Committee remains most willing to assist members with these issues, and can be contacted via the federal ASA office on 1800 806 654 or policy@asa.org.au

INSIDE YOUR SOCIETY

POLICY UPDATE

ASA PRACTICE MANAGERS' CONFERENCE – ADELAIDE

Q&A panel: Dr Mark Sinclair, Jacintha Victor John, Lexie Harris and Cheryl Wood

Gina Nardone and Tori Phoenix, Workplace Consultants (People Vision)

The Practice Manager's Conference took place at the Adelaide Hotel Grand Chancellor on Friday 17 August 2018. The exceptional attendance of 70 delegates makes the Adelaide event the largest PMC the ASA has hosted.

The 2018 conference focused on topics beneficial to delegates within their role as practice managers and to highlight the purpose of the ASA and resources available to all members. The event was structured into two parts, all invited speakers presented during the morning session followed by the afternoon session, where a panel of speakers engaged in open discussion with the audience.

Invited Speakers for 2018 included Dr Mark Sinclair Economic Advisory Committee Chair, Jacintha Victor John Policy Manager (ASA), Dr Charlotte Hespe, Clinical Reference Lead (Australian Digital Health Agency), Gina Nardone and Tori Phoenix Workplace Consultants (People Vision), Lincoln Smith and Ganesh Krishan (Norman Waterhouse Lawyers), Tony Cafasso, Tim Servin Health & Benefits Manager (BUPA) and Paul Wilson Customer Service (BUPA Health).

The conference commenced with opening remarks from the ASA Policy Manager with the introduction of keynote speaker Dr Sinclair who presented his opening address. He discussed health economic issues such as the Medicare Benefits Schedule (MBS) Review, Private Practice and Medicare and Private Health Insurance (PHI) rebates. He announced changes to the Medicare Benefit Schedule (MBS) and outlined the principles and approaches undertaken by the ASA MBS working group, in addressing each MBS item for review. The strong and persistent advocacy efforts of the ASA led to the opportunity to provide valuable recommendations regarding specific items in the MBS Relative Value Guide (RVG) to the MBS Review Taskforce.

An update of the private health insurance involving the Private Health Legislation and its changes were discussed which initiated questions from the delegates and extensive discussion surrounding out-of-pocket cost and the affordability of private health insurance. Dr Sinclair also mentioned newer developments, such as the Minister's Committee on Out-of-Pocket medical expenses, and the recent changes initiated by BUPA.

Dr Hespe (ADHA) gave an overview of how the My Health Record (MHR)

system operates. She explained in detail the MHR repository of documents which is a summary of an individual's key health information shared secured online, between the individual and their healthcare providers. She further discussed the following six key benefits of the MHR, it avoids adverse drug events, creates an improved system through secondary use of data, enhanced patient self-management, improves in patient outcomes, reduce time gathering information and to avoid duplication of services.

In particular, the different level of patient control to permit access to a practitioner was explained. The aim of such a system is to allow individuals to view their health summary, upload clinical documents, manage access to their record, by setting a Record Access Code (RAC) and access to clinical documents by setting a Limited Document Access Code (LDAC). She concluded by discussing the different levels of security involved to safe guard the online platform. These include audit logs, secure login/authentication mechanisms, firewalls and strong encryption.

The first attempt to introduce a Sponsor PitchFest during the conference session was a success. This segment provided delegates the opportunity to hear from a range of sponsors as they expand on their services and software to delegates. Sponsors included Avant Mutual Group, MDA National, MediTrust, Direct Control Medical, MillerBiller, and Anaesthetic Private Practice. The intensity of the session was dynamic as each sponsor elaborated on their services and encouraged delegates to discover ways to amplify innovation in their business. ASA thanks all sponsors for their outstanding involvement and continued support of the PMC.

Gina Nardone and Tori Phoenix (PeopleVision) presented on a workplace issue preventing mental illness through promoting mental wellbeing. They both discussed the different types and degrees of severity in relation to mental illness and steps required to be considered by individuals in such circumstances. In Australia, mental illness is governed by five different legislation. There is a legal obligation for People Conducting a Business or Undertaking (PCBU) to ensure workplace environment is safe, healthy and does not cause ill health or aggravate existing conditions to employees. Delegates were reminded to familiarise themselves with resources available for assisting other employees.

The arrival of the new millennium has increased the use of social media in the workplace. Social media is no longer a novelty, however, the use of social media in the workplace is a fine line. Lincoln Smith (Norman Waterhouse Lawyers) presented on social media 24/7 connectivity in the workplace. While social media certainly benefits company marketing when used appropriately, it can also be a drain on employees' productivity. Lincoln addressed the legal risks associated with social media for organisations such as liability for employees acts of defamation, misleading and deceptive conduct, breaching continuous obligation, worker's compensation claims, bullying and harassment, unfair dismissal application and unreasonable hours.

The audience gained the following tips on how to manage 24/7 connectivity, communication with employees, employee expectations, implement a social media policy, clarification on after-hours emergencies, consistent and fair work hours, demonstrate appreciation and share responsibilities. He also encouraged

Ganesh Krishan, Norman Waterhouse Lawyers

Paul Wilson, BUPA Health

Networking event, Apothecary 1878 bar and restaurant

the importance to implement policies, procedures and training for employees within the work environment.

Ganesh Krishnan (Norman Waterhouse Lawyers) discussed the legal aspect of patient privacy and health. He explained the framework of the Australian Privacy Principle (APP) which facilitates an open relationship between health service providers and their patients. This framework allows the provider and patient to reach a shared understanding of how the patients' information, including contact details, will be used and disclosed. He reminded delegates the importance for patient consent, prior to obtaining health information. This will ensure that health information will only be used and disclosed in accordance with a patient's expectations.

The BUPA Team outlined, the claims processing system and the automation submission channels they offer providers. Tony Cafasso discussed the current claims channels and the technology to process manual claims. Due to recent changes to the way Medicare receives inpatient claims from Private Health insurers, BUPA implemented change to its manual claims processes. The aim of the new processing technology, is to provide simpler and faster claim outcome to providers.

Jacintha Victor John (ASA) delivered an overview of the ASA wide-ranging policy activities and the requirements of Informed Financial Agreement (IFA). Delegates were introduced to the three Policy Team Committees and the area of speciality they each focus on. A brief overview of ASA representation with different stakeholders including government, to support, represent and educate the profession was discussed. The focus of the organisation is to advocate on behalf of its members on important matters surrounding anaesthetists.

Discussion included the concept of IFA and its importance. In order to assist members, delegates were reminded to undertake written or verbal dialogue between the medical practitioner or representative and the patient. This will ensure the patient understands the associated procedure fee and rebates, fewer disputes over accounts, lower debt recovery costs and increase patient satisfaction. The new ASA website launch was also introduced which will contain detailed information to guide members.

The Panel Speakers for the afternoon session included Lexie Harris (Wesley Anaesthesia) and Pain Management, Cheryl Wood (Associated Anaesthesia Group Ltd), EAC Chair and Policy Manager (ASA). The speakers engaged with the audience on a number of topics such as training opportunities and views on workplace matters.

In addition, it was suggested, and widely supported by the audience, that practice managers of ASA members could have greater access to ASA communications. It was pointed out that it is often the practice managers who first act on new developments such as changes to the MBS, rather than anaesthetists. Since the meeting, ASA Council has agreed that ASA-registered practice managers will be included in the monthly President's e-news releases, and will have access to the online version of this magazine.

The 2018 PMC received positive feedback from the survey conducted. We received a large number of delegate responses, expressing how the networking evening held on Thursday 16 August was effective in developing new connections. A special thanks is extended to Jade Melville (Events Coordinator) for her work in making the 2018 PMC a successful and memorable event.

Looking forward to PMC 2019!

Jacintha Victor John
Policy Manager

ASA TRAINEE MEMBERS
APPLY FOR OUR 2019

INTERNATIONAL SCHOLARSHIPS

$4K*

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CALGARY, CANADA
21-24 June 2019

Group of Anaesthetists in Training
TELFORD, UK
3-5 July 2019

American Society of Anesthesiologists
ORLANDO, FLORIDA
19-23 October 2019

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JANUARY 2019

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ASA
Australian Society of Anaesthetists

INSIDE YOUR SOCIETY

ASA MEMBERS GROUPS UPDATE

NATIONAL SCIENTIFIC CONGRESS 2018

Thank you once again to Dr Simon Macklin and the whole organising committee for staging an outstanding congress in Adelaide during October. In particular, I'd like to commend Dr Nicole Diakomichalis and Dr Cheryl Chooi who did a fantastic job putting together an interesting and informative trainee program. Highlights included international guest speaker Professor Lars Eriksson discussing important considerations when planning to undertake clinical research (during a trainee lunch with a spectacular view); Part 2 Exam preparation advice from Dr Vida Viliunas and Dr Anthony Coorey; and a series of highly relevant forward-looking sessions from Dr Ammar Ali Beck, Dr Scott Ma and Professor Guy Ludbrook.

I also want to make particular mention of a workshop on hypnosis by Dr Allan Cyna, Chair of the Communication in Anaesthesia SIG and President-elect of the Australian Society of Hypnosis. Dr Cyna underscored the importance of thoughtful communication and the power of the words we choose to use when talking to patients. Whether we realise it or not, we all influence our patients' experience through positive and negative suggestion. Through simple strategies, such as emphasising 'safety' and 'comfort', we can alleviate unpleasant symptoms without the adverse effects commonly associated with our usual pharmacotherapies. There are numerous books and articles[1] available for those interested in learning more.

Anyone who missed out on attending the NSC this year, seize the opportunity to visit Sydney in 2019 (September 21-24). I'm sure there will be something to interest everyone; I'll keep you all updated as plans progress. National conferences provide valuable opportunities for personal and professional development, networking and enjoyment – I strongly encourage you all to consider registering.

TRAINEES WITH AN INTEREST IN PERIOPERATIVE MEDICINE (TRIPOM)

I would like to also take the opportunity to inform everyone about TRIPOM, a multidisciplinary collaborative network of trainees interested in perioperative medicine. The local arm, TRIPOM ANZ (Australia and New Zealand) is up and running with our own committee and projects. TRIPOM aims to help trainees interested in perioperative medicine to network, facilitate the production and sharing of educational materials, and provide information about relevant opportunities (e.g. courses and fellowships). For more information see September's *ANZCA Bulletin*[2] and check out TRIPOM's website (https://tripom.org/).

Trainee Members' Group lunch, NSC, Adelaide 2018

Art show at the National Scientific Congress

FATIGUE & REST FACILITIES

The TMG is aware of significant issues in some hospitals regarding fatigue management and rest facilities. Fatigue in anaesthetists and trainees is a serious safety concern and has the potential to put the lives of patients and practitioners at risk. We are working towards solutions both in individual hospitals and at a systemic level. Please contact us at trainees@asa.org.au if you have any concerns about this where you work – or if you've seen it managed well and can suggest how other centres might be able to improve.

PARENTAL LEAVE

We are continuing to seek feedback from any trainees who have taken parental leave during training in order to identify common issues and areas for improvement. Comments will remain anonymous and can be sent to trainees@asa.org.au or to one of your local state/territory representatives. Thank you to all who have contacted us already. Further updates will follow in future communications.

Dr Richard Seglenieks
Chair, ASA Trainee Members Committee

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CIG SCHOLARSHIP REPORT: AMERICAN SOCIETY OF ANESTHESIOLOGISTS ANNUAL MEETING, SAN FRANCISCO, 2018

I was privileged to have received the Australian Society of Anaesthetists Common Interest Group (CIG) Scholarship to attend the American Anesthesiology Conference in San Francisco in October 2018.

This was an excellent opportunity to engage with and learn from peers and leaders from other countries, and was very well suited to my interest in improving the quality of patient care at both an individual and institutional level.

The theme of the conference was focused on 'harnessing innovation' and turning raw ideas into meaningful results. The opening session of the conference was delivered by a successful tech entrepreneur and investor, Josh Linker, who provided a relevant and inspirational presentation on embracing new ideas, the importance of resilience, an approach on how to change rules, and how to bring creativity to an institution.

A highlight of the conference was the vast number of session streams covering all anaesthesia sub-specialties with around ten session streams or workshops to choose from in any given time slot.

I attended a large variety of sessions ranging from mental health problems and burn-out in physicians, to cerebrospinal fluid drains in thoracic aneurysm repairs, to international multi-centre outcomes research in paediatric anaesthesia. I was impressed by the number of the large multi-centre trials conducted across the United States. Networks of hospitals initially collect data for observational studies, and in doing this develop stronger relationships between institutions, which enables them to later conduct prospective randomised trials within these networks.

I was also invited to attend the American Society of Anesthesiologists House of Delegates Resident Meeting, which had over 100 attendees. This meeting began with governing council election speeches and voting. The candidates were impressive and it was highly competitive to attain a position on this resident committee. This was followed by a delegate discussion on key issues, including policies on parental leave, social media, firearm violence, and their plans to establish a sub-committee on Physician Health and Well-Being.

Some of these issues were common to those being currently addressed by the Australian Society of Anaesthetists Trainee Committee, and it was interesting to learn and share experiences surrounding this with international peers.

I would like to thank the Australian Society of Anaesthetists for the opportunity to attend this conference. It was a worthwhile and rewarding experience, and I would strongly encourage all trainees to apply for future ASA CIG scholarships.

Dr Cheryl Chooi
Anaesthesia Provisional Fellow
Flinders Medical Centre
Adelaide, South Australia

INSIDE YOUR SOCIETY

REPORT OF ATTENDANCE AT THE ASSOCIATION OF ANAESTHETISTS GREAT BRITAIN AND IRELAND (AAGBI) GROUP OF ANAESTHETIC TRAINEES (GAT) ASM 2018

It was surprising to arrive in the UK in the midst of a major heatwave with temperatures well above 20°C even in Scotland. Which given how often it was mentioned, must not occur particularly regularly.

The AAGBI GAT is the equivalent of our ASA TMG and runs an annual scientific meeting – ran by registrars, for registrars.

GAT COMMITTEE

The meeting began with the GAT Committee meeting. It was reassuring to see that much of our attention is dedicated to very similar issues. The key activities included:

- Presentation on the AAGBI strategy for the coming 12 months. This includes a real drive towards digitising all of the AAGBI platforms for interactions with members, sustaining their advocacy activity and specific campaigns such as fighting fatigue. This was a great way to engage the trainee committee with the overall organisational strategy.
- Break up groups to discuss each of the AAGBI core values and a strengths/weaknesses type of appraisal of the trainee committee's performance.

A couple of interesting points of discussion included:

- Retaining the immediate past chair on the committee to improve retention of corporate memory.
- The AAGBI is undergoing/considering similar rebranding exercises as the ASA and are formally changing their name including the name of the GAT committee (although there was not mention of anaesthetists vs anaesthesiologists…).
- Welfare/well-being is the major focus of the both the whole organisation and GAT – an internal department/cost-centre dedicated to the topic has been established in the AAGBI for the first year ever.

Overall, it was refreshing and energising to spend time with such dedicated and capable individuals that contribute so greatly to improving the UK/Irish trainee experience.

PRESENTATIONS AT THE CONFERENCE

I won't give a detailed blow-by-blow account of every session but here are some notes on the more influential.

Leadership

A thought-provoking presentation on the development of leadership theory and it's evolution in the National Health Service (NHS), including a movement in last decade or so to re-establishing clinical leadership. The NHS has developed a leadership academy and has some very useful resources at https://www.leadershipacademy.nhs.uk. I thought this was particularly relevant given ASA President Dr Scott's comments about incorporating a leadership training/development aspect to our ASA TMG Face to Face meeting in Adelaide.

Difficult Airway Update

A member of the Difficult Airway Society described the evolution of the guidelines for the unanticipated difficult airway. Interestingly, the society is finalising similar guidelines for the anticipated difficult airway. And furthermore, will release a guideline/discussion paper of the ethics of using actual patients for the development of airway skills and techniques – right from the medical student attempting laryngoscopy through to teaching a registrar fibreoptic intubation through and LMA on a otherwise healthy patient.

RAFT

The UK has developed a very impressive trainee research network. It's a networks of networks – which co-ordinates both regional research projects as well as game changing national studies. Some of the studies you will heard of such as iHype and COMs were produced through this excellent network. After the success of the EpiCCs project hopefully we can continue to build upon our trainee network to produce some top class publications.

Welfare

Welfare of anaesthetic trainees and doctors in general in the UK was the number one theme to the conference. The Bawa Garba case has sent shockwaves throughout the medical community and the relationship between doctors and the GMC appears somewhat fraught. It was a real pleasure to hear Dr Sangeeta Mahajan speak about doctors being human which finished with her own experience of tragedy in the loss of her son to suicide. It was the most emotional and heart wrenching talk I have ever seen at a conference. The AAGBI is very interested in discussing with the ASA TMG about the amazing work (led by Scott Popham) on trainee welfare.

Social program

There was a fantastic atmosphere to the whole conference which was exemplified by the formal conference dinner. It was a full Scottish ceilidh (Scottish folk music and dancing) and I found myself doing dances that I haven't heard of since primary school. It was an incredible night whereby I got to share a meal with many of the authors of the textbooks/journals that got me through my exams.

Martin Dempsey

RETIRED ANAESTHETISTS' LUNCH – ADELAIDE NSC 2018

There are now 420 members of RAG and 44 of them from states across Australia met with their wives and partners for lunch on 7th October at the Adelaide Convention Centre on the occasion of the ASA NSC for 2018.

The NSC itself was a great success and particularly successful was the luncheon for the Retired Anaesthetists Group (RAG). Friendships were renewed and a few stories told over good food and wine.

The incoming President of the ASA, Dr Peter Seal, addressed the group with some entertaining insights as to current ASA activities, adding to the occasion.

Several ASA Past Presidents attended as did a number of other prominent ASA identities as seen in the accompanying photograph taken at the lunch.

Dr John A. Crowhurst
Chair, SA RAG

GET IN TOUCH

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

Or you can call the ASA office on 1800 806 654.

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HISTORY OF ANAESTHESIA LIBRARY, MUSEUM AND ARCHIVES NEWS

ANAESTHESIA AND INFLUENZA

"The greatest medical holocaust in history" – this is how some historians have described the 1918-19 influenza pandemic, which ravaged the world 100 years ago.[1] Estimates of the number of people killed vary from 50-100 million people.[2] Between 20-50% of the world's population was infected. Even though there are no official statistics, we can confidently say that the post-war influenza pandemic killed more people than the First World War (which had a death toll of 18 million worldwide).[3] There are many memorials to the brave soldiers who fought in the 'Great War', but where are the memorials to the brave doctors, nurses and volunteers who helped patients in emergency hospitals, worked at quarantine camps and staffed relief depots? While anaesthesia is not used to treat patients with influenza, some anaesthetic equipment and drugs are used to support those who are critically ill. This article will provide a brief history of the influenza pandemic and conclude with items from the Harry Daly Museum relevant to this illness.

The influenza pandemic reached Australia in January 1919 due to factors which combined to create a perfect storm. Firstly, the troops returning from the front en masse provided a pathway for the virus to move from Europe to Australia. Densely populated towns, ships and trains provided many hosts for the germs.

Secondly, in civilian life, natural selection favours a mild strain of flu. This is because when civilians get very sick, they stay home and don't spread that strain of bacteria. If they are only slightly sick, they might continue going to work and spread the milder strain of flu. However, in a war zone, the mildly sick stayed in the trenches and the very sick were sent to crowded field hospitals and troop ships to be sent to base hospitals, thus spreading the more severe strain of the virus. These were the very sick men who came back to Australia in early 1919 and subsequently spread a dangerous form of the influenza virus.

Thirdly, these were men whose immunity has been depleted by harsh winters, a monotonous military diet low in vitamins, and fatigue, stress and injuries which are part of fighting a war. Their lowered immunity made it easier for the virus to take hold and harder for them to fight it off.

Finally, penicillin was not yet available for treating bacterial infections. It only became available during World War II. Catching the flu virus made people more susceptible to catching a bacterial infection.

The 1918-19 influenza pandemic is more commonly known as the 'Spanish flu'. This is because Spain, being a neutral country during the First World War, did not censor its press, so when it reported that the King of Spain and many of his subjects had contracted influenza, it became known as the Spanish flu. It had already spread through much of western Europe, but countries such as Germany and France were controlling what their media reported, otherwise it could have been known as the French flu. The word influenza comes to us from 15th century Italy, where an upper respiratory tract infection was thought to be influenced by the stars, thus giving the disease its name.[4]

At the beginning of 1919, New South Wales had no more than 2,000 hospital beds. Between January and September 1919, more than 21,000 people were hospitalised.[5] The Randwick racecourse became a 430-bed hospital and the

Bird Mark 7 respirator – the first reliable, low cost, mass produced medical respirator, c. 1980. Harry Daly Museum 2011.144

A laryngoscope, used to assist with inserting an endotracheal tube for ventilation. Harry Daly Museum, 2011.142.

Royal Agricultural Society Buildings at Moore Park became a hospital as well as quarters for doctors and nurses. When some schools and kindergartens were closed, wards were set up in classrooms. In country areas, temporary hospitals were established in whatever public buildings were available, such as the school of arts or showgrounds. The field hospitals of the war front were now on the home front.

The various levels of government struggled to contain the panic and confusion while addressing the most serious and widespread public health issue it had ever encountered. When authorities took precautionary measures to stem the spread of infection – such as closing schools, theatres, racecourses, pubs and libraries – this had the negative consequence of increasing public hysteria and sometimes false information. The New South Wales government introduced three preventative measures which the Medical Consultative Committee ultimately determined were pointless.

Firstly, it decreed that people wear masks "completely covering mouth and nose and made of gauze or suitable material, to exclude germs" if they were catching public transport or out in public, or face a fine of £10.[6] ASA and HALMA member Dr Richard Bailey recounts a family story that when his parents married in Marrickville, Sydney in 1919, everyone present had to wear a mask, including the priest.

Secondly, the NSW government set up inhalation chambers across Sydney, and even within some trams. Citizens were encouraged to breathe in a fine mist of sulphate of zinc as a preventive measure. Thomas Herbert, a young boy growing up in Paddington, Sydney, records in his diary: "Mon. Disinfected by sprayer at school. More than half our class away. Influenza getting very bad. A very great shortage of doctors and nurses".[7] Grace Brothers invited customers to visit the inhalation chambers in their stores to receive 24 hours of protection from catching the flu – a spurious boast. Instead of preventing infection, it is likely that this initiative spread germs as the crowds of people queuing to get into the inhalatria coughed and sneezed on each other.[8]

Riley Street Public School Inoculation Depot Influenza Epidemic, 1919.[10]

Thirdly, a vaccine was developed in Australian in 1918 from the sputum of passengers at the North Head Quarantine Station but as scientists hadn't yet isolated the influenza virus, there was no guarantee of success. The government offered free inoculations of two doses per person, but the 1,265 depots they set up in Sydney were virtually stampeded forcing them to halve the dose to meet the demand. Peter Curson estimates that about 450,000 people or 25% of the state's population was inoculated. However, given that 91% of the 752 doctors, nurses and wardsmen working in Sydney hospitals who had been inoculated went on to catch flu, it's efficacy was minimal at best.[9]

Historians think that 13,000-15,000 Australians died of the flu during the pandemic.[11] In NSW, 6,244 people died with nearly 4,000 deaths being in Sydney. The mortality rate amongst Indigenous people was as high as 50% in some areas. About 30-40% of Australia's population were infected, which was then about five million people. As a comparison, during the 2017 flu season in Australia, which was the worst in a decade, about 1% of the population were confirmed to be infected and an estimated 1,127 people died.[12]

Unlike most influenza epidemics when infants and seniors are the most vulnerable, the 1918-19 pandemic had the

Propofol marketed as Diprivan, used as a sedative and muscle-relaxant, Harry Daly Museum, 2013.476

INSIDE YOUR SOCIETY

worst impact on adult men aged 25-39 years who were in their immunological prime. One possible explanation for this is that the virus created a cytokine storm, causing their immune systems to go into over-drive. Their bodies produced too much fluid in response to the H1N1 infection, and their inflamed lungs filled up with the excess liquid.[13] Today, these extremely sick people would be admitted to hospital and treated using the same equipment which is used in anaesthesia. They would be intubated with an endotracheal tube, connected to ventilators to support their respiration and given sedative and muscle-relaxant drugs such as propofol. Advances in medical science, more sophisticated equipment and improvements in hygiene mean that you are much less likely to die from a severe influenza infection today, than you were 100 years ago.

Alison Wishart
Curator, Harry Daly Museum

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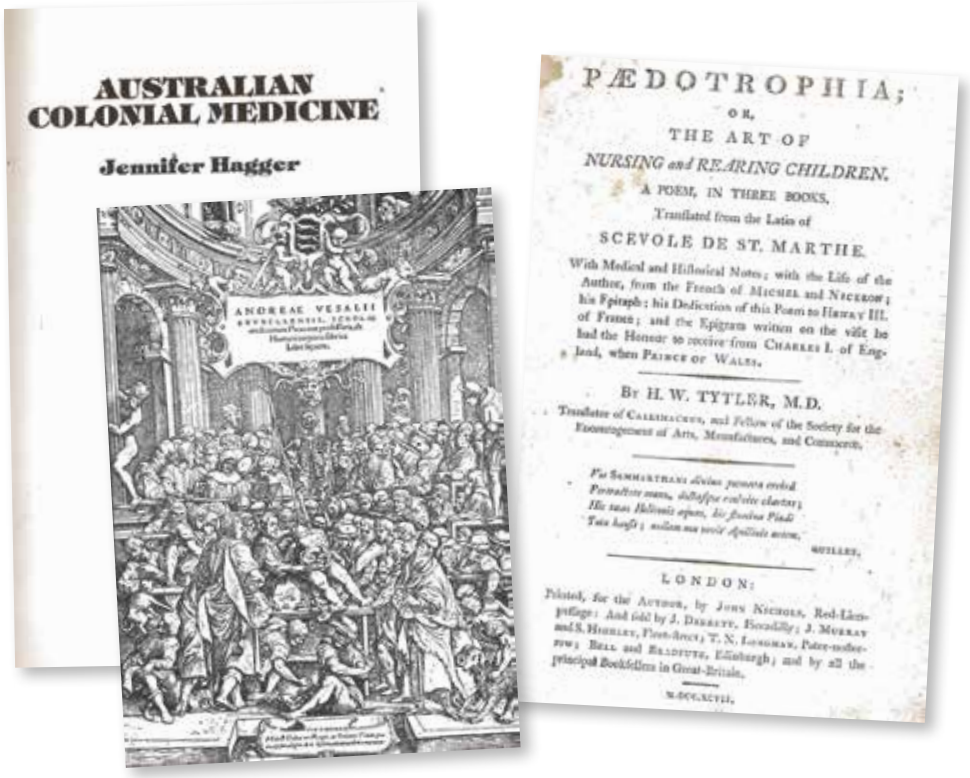
TITLE TALES OR A BRIEF HISTORY OF THE WORDS DESIGNED TO ATTRACT READERS



WRITING AND BOOKS

The first writing was on clay, stone, bone, leather and metal. The first 'books' were metres long scrolls of papyrus or Venetian blind affairs made of bamboo or palm leaves, or shaped like a fan (fastened at one fixed point). The Romans made books that are more recognisable by us today. They consisted of folded parchment (animal skin) sections between wooden covers. The Chinese invented paper around 100 CE and started pasting pages together into a concertina-like form, readily recognised as a book with pages.

Another major step forward was the invention of block printing on paper. However, paper took another 750 years or so to reach the Western world and the idea of printing equally as long. So for

hundreds of years in Europe each book had to be written or copied by hand and each usually was painstakingly illuminated by coloured and gilded paintings. Every book was different, created patiently to the glory of God, or because of the wealth of a patron. Owners instantly recognised their prized book, or just a few books, by their shape or the place where it, or they, were stored, so titles were largely unnecessary.

EARLY TITLES

Gutenberg's revolutionary invention of moveable and re-useable type in 1448 meant not only could many identical copies of a book be produced, but the type itself could be reused many times. Printing presses industriously appeared everywhere. The range of texts available at first were fewer than the number of printers; the name of the printer became of paramount importance so people knew where to buy books. Printers were publishers and booksellers. The title was less important (could be indicated by a word or two), whereas the name of the printer and where the book could be purchased was vitally important if the printer was to continue in business.

There was certainly demand for books; before the invention of the printing press, books numbered in the thousands, by the 1500 and 1600s there were millions of books in existence. The difficulty for printers was that because of the labour involved in typesetting, many copies of a book had to be sold. Printers at first tried to imitate hand-illuminated manuscripts by introducing woodcuts on the title page and sometimes elsewhere in their books. Authors were fond of giving their book a 'mirror' title such as 'A looking glass for the soul…' or 'A looking glass whereby the reader may behold…' Printers obliged by framing the title words with an ornate graphic design like the frame of a mirror. The idea of this form of title was to give the reader some idea of the contents of the book, and for the printer, an advertisement and a marketing device to attract purchasers. In due course there were instances where the words used in the title bore no resemblance to what could be found in the text. The titles were mere advertising puff.

PRINTERS, AUTHORS AND TITLES

Many printers copied books because the concept of copyright did not exist. Religious works and government information were soon widely distributed, but in due course printers became thought of as a menace because of widespread pirated editions. Book titles and even the names of authors were changed by unscrupulous printers. Authors and authorities became restless. Authors wanted to protect their work, see their name in print and have a strong input into the title of the book. The chance came when the English and Scottish parliaments united in 1707; a copyright law came into force in 1710 that protected contents of books for 14 years. Some other countries followed but much dispute eventuated. The main aim was to strike a balance between authors' rights and widely dispersed knowledge. Authors exercised their right, if they so wished, to ensure that a long title properly summarised the contents, or to choose a snappy short title designed both to inform and attract. In general, the English preferred long titles whereas European titles were often shorter. It is important to bear in mind that printer sold most books unbound, the title and perhaps the name of the author were the principal attractants to the purchaser. Disputes continued well into the 18th century with the readers sometimes complaining about deceptive titles or pirated copies

COVERS AND TITLES

In the late 1700 and early 1800s publishers began to sell books bound, i.e. not just as a pile of folded sheets. Most initially were covered or bound in paper, either with the title printed directly onto both the spine and front cover, or just on a separate paper label glued to the spine (often in the case of books covered in coloured, ornately design paper). Some publishers provided a spare spine label inside the back cover of the book. If the spine title label became dirty or peeled off, the spare label could be brought into service. Later in the century when cloth became the usual covering, the spine paper label sometimes persisted, but usually the title on the spine was printed in colour or gold directly onto the cloth.

In the mid to late 19th century publishers introduced illustrated pictorial cloth covers, sometimes highly artistic and for children's books, illustrative of the contents. The title became part of the design, part and parcel of the advertising to the reader. When cost became a concern in the 20th century, the illustrated paper dustjacket was substituted instead of decorated and/or embossed cloth – or for still further economy – the paperback with its often eye-catching image. Once again the impact of the title often became subservient to advertising.

SCIENTIFIC AND MEDICAL TITLES

The titles of scientific papers and medical books and the renown of the author still determine whether the paper or book is widely read. To attract a wider audience, will your next title be alluring, descriptive, precise or jejune?

Peter Stanbury
Librarian, Richard Bailey Library

CONTACT US

Contact us to arrange a visit to browse or for research. We are open by appointment Thursday and Friday, 9am to 5pm. Please phone the ASA head office 1800 806 654.

INSIDE YOUR SOCIETY

AROUND AUSTRALIA

NEW SOUTH WALES

Dr Ammar Ali Beck, Chair

Industrial and contractual issues continue to dominate NSW. Our members across the state continuously have to renegotiate their contracts as NSW Health push to change pay conditions and cut down on long-standing privileges and outsourcing public work to private hospitals. Anaesthetists are being caught between private insurance attempts to control payment and NSW Health encouragement of patients to use their private health cover. It's permissible under Ministry policy to retrospectively reclassify patients as private, the patient liaison officer is expected to obtain financial consent. However, it is becoming more common to get a phone call from the admission office informing us that the patient has been reclassified as a private patient after the surgery is done, making the discussion about fees and gaps near impossible.

In conjunction with the Federal Office we have been raising the issue of fatigue management with the Ministry of Health. Lack of on-call rooms in some public hospitals is putting our young doctor's lives at risk by having to drive home on Sydney's congested roads after a night shift.

Finally, the Private Health Facilities Act 2007 (Act) has been amended. From 17th of September 2018 it will be an offence, attracting a maximum penalty of up to $55,000, to perform cosmetic surgery in an unlicensed private health facility. It is the doctor's responsibility to check that the facility they are operating in is licensed as required under the Act. Regulation also requires licensed private health facilities to display a copy of their licence in the entrance foyer. It is important that anaesthetists check the facility license prior to providing their services.

If you would like to discuss this matter or require any further information please do not hesitate to contact Leonora Tyers, AMA Legal Officer on 9424 5863 or at leonora.tyers@health.nsw.gov.au.

TASMANIA

Dr Michael Challis, Chair

The major issues in the Tasmanian health landscape of recent times don't just affect anaesthetists. An independent health policy analyst claims that the Tasmanian government has underfunded the public health system to the tune of $1.6 billion over the last four years, by diverting Federal GST money that should have been invested in the health system to other areas. Given our comparatively small population that amount of money could obviously make a huge difference in the delivery of public health services across the state.

There have also been issues in the private sector, with Calvary's largest Tasmanian hospital (in Hobart) identified as having a significant number of issues requiring urgent action during their recent accreditation visit. These issues are being addressed, but this comes hot on the heels of some bad publicity for Calvary in relation to the practice of a senior gastroenterologist. Calvary contacted approximately 400 patients and offered them a repeat colonoscopy, based on concerns that their initial colonoscopies may not have examined the entire colon.

I recently had the opportunity to clarify the ASA's position on the independence of anaesthetists in private practice (particularly regarding fee setting) when some correspondence was received in relation to outsourced public patients having surgery in the private sector. The major point of contention from our viewpoint was that negotiation with the surgeons does not constitute appropriate engagement with anaesthetists. One public hospital business manager was of the opinion that they could agree with the surgeons on what was appropriate anaesthesia billing! Since my strongly worded letter the issue of some private anaesthetists having their bills questioned – despite being at their usual, fair and reasonable rates (well below AMA rates) – seems to have been resolved satisfactorily.

SOUTH AUSTRALIA

Dr Brigid Brown, Chair

We welcome ANZCA Fellow, Dr Richard 'Harry' Harris as our guest speaker at the next CME meeting; he will share his experience from the extraordinary international rescue of 12 young soccer players and their coach, from a remote cave in Thailand.

Dr Harris, who has been described as the linchpin of the rescue with his unique combination of medicine and cave diving,

showed incredible leadership and courage in teaching other rescuers to administer life-saving sedation to the team. Dr Harris, the last person to exit the cave after the successful rescue of the team and coach, earned himself the Star of Courage Award (awarded for acts of conspicuous courage in circumstances of great peril) and a Medal of the Order of Australia in the process.

Celebrating a successful NSC in Adelaide

A huge congratulations to the team in South Australia who put together an overwhelmingly successful NSC in Adelaide this October. Thank you to the amazing local organising committee of Simon Macklin, Kate Drummond, Piers Robertson, Laura Willington, Kris Usher, Cheryl Chooi, Minivans Kiani, Min-Qi Lee, and Nicole Diakomichalis, you did South Australia proud!

WESTERN AUSTRALIA

Dr Philip Soet, Chair

The Part 3 Course is on 8 December at The University Club at UWA.

The anaesthesiawa.org website will be closing in the near future. In response to this closure, the ASA Website now has links to information regarding anaesthesia allergy reporting, malignant hyperthermia testing and anaesthesia mortality reporting in WA. To find the links you will need to log in to the members page and use the Represent/WA State news tabs. If you have any other important state information affected by this closure that you would like added to these resources please contact Melanie Roberts.

Lastly, Dr Richard Riley was named to the Society for Simulation in Healthcare Academy Class of 2019 Fellows. He will join 49 existing fellows with 10 other new fellows in 2019. The international fellowship recognises outstanding and sustained contributions to the development of SSH and to the field of healthcare simulation. The WA ASA committee thanks Richard for has work and congratulates him on this prestigious fellowship.

It was reported in The West Australian newspaper recently that a number of our colleagues have been injured in bicycle related accidents. On behalf of the ASA I would like to express our concern and support for them and to say that the ASA stands ready to assist them if needed at the appropriate time. We wish them well.

VICTORIA

Dr Jenny King, Chair

The Victorian AGM will be held on Saturday February 16 at the Kooyong Tennis Club.

SOUTH AUSTRALIA COMMITTEE

Dr Brigid Brown

After spending the last two years working and travelling overseas, I have really enjoyed returning to Australia and getting involved again with the ASA. I have previously been the chair of the ASA trainee committee and the senior registrar ASA representative for South Australia and I am very excited to be taking on the role of state chair; working with some incredibly experienced team members as well as introducing some new members with new ideas to the group.

Professionally, I work in both public practice at Flinders Medical Centre and in private practice as an associate with Pulse Anaesthetics. I enjoy a varied casemix although have a special interest in both regional anaesthesia and airway management.

I also have a strong passion for anaesthesia in low and middle income countries. I have been involved in some teaching and clinical work overseas and have recently completed the Real World Anaesthesia Course (RWAC) through the ASA and am very excited about the opportunities this presents.

Personally, I am enjoying settling back into Adelaide with old and new friends, going for runs, and learning the art of making kombucha.

I am looking forward to the next year as state chair and hope to continue to build on the growth of the ASA's profile and membership in South Australia. Please contact me with any ideas and issues you would like addressed with the ASA.

Welcome to the new **ASA** website

The Australian Society of Anaesthetists (ASA) is proud to launch our newly redesigned website **www.asa.org.au**

The site was redesigned with our members in mind – streamlining menus to the three ASA pillars: **Support, Represent, Educate** – simplifying navigation, building a responsive layout for all platforms and providing more resources and information.

We encourage everyone to visit and explore our new and improved website.

TOP 10 FEATURES

1 MORE FEATURES FOR MEMBERS

Sign into the members area of the website using your **member ID** to explore all the new features.

Easily connect with members using the 'ASA Forum', a secure online chat group for members and external key stakeholders. Join an open chat group, Committee chat group, post new topics for discussion and share files. **www.asa.org.au/asa-forum**

The public website displays different information to our members website. Please login if you are a member.

2 DEDICATED PATIENTS' AREA

Refer your patients to the dedicated patients' area. Here they can access useful information on anaesthesia. **www.asa.org.au/patients**

3 INFORMED FINANCIAL AGREEMENT

A new tool available for ASA members! Login using your **member ID** and test the three online forms available.

Ask for your patients' agreement for anaesthesia fees, consent for anaesthesia procedure and get their feedback using the patient survey. **www.informedfinancialagreement.org.au**

4 IAMONLINE

Sign in to iamonline interactive anaesthetic modules. With its improved functionality, CPD points are only a click away. **www.iamonline.org.au**

www.asa.org.au

5

COMMITTEE MEMBERS

Committee members can easily view all upcoming meeting details, related documents and other important information. Simply login to the members area of the website. **www.asa.org.au/committees**

6

BOARD & COUNCIL MEMBERS

Easily view current Board and Council members on our 'Structure and Governance' page. **www.asa.org.au/structure-and-governance**

7

STATE NEWS PAGES

Find out more about your State Committee Chair, view upcoming State events and news. Login to the **members area >** select **'Represent'** from the drop down menu **> select your State.**

8

INTERNATIONAL ENGAGEMENT

Learn more about how the ASA engages with other anaesthetic related organisations worldwide. **www.asa.org.au/internationalengagement**

Above: New ASA members homepage headings.

9

EVENTS CALENDAR

You can now simply view and export the new and improved events calendar in just one click. **www.asa.org.au/asa-events**

10

ASURA 2019 – NOOSA QLD

Are you getting ready for ASURA 2019? Find out more on the ASURA webpage. Registrations open soon! **www.asura2019.com.au**

OTHER NEWS...

Long lives HEALTHY WORKPLACES

Long Lives, Healthy Workplaces toolkit prepared to support better mental health and wellbeing for anaesthetists and anaesthetic trainees – now available for download! **www.asa.org.au/welfare-of-anaesthetists**

Looking for something? Try out the new search function!

Please contact us if you have any questions or feedback you would like to share

INSIDE YOUR SOCIETY

NEW AND PASSING MEMBERS

The ASA would like to welcome all new members from August to November 2018.

TRAINEE MEMBERS

Dr Sean John Davies	SA
Dr Tomasz Dzioba	NSW
Dr Elyse Farrow	NSW
Dr Biljana Germanoska	NSW
Dr Mohammad Behruz Jamshidi	QLD
Dr Chak Man Jane Li	NSW
Dr Kasia Nowak	QLD
Dr Lauren Pilz	NSW
Dr Charlotte Louise Taylor	SA
Dr Marthinus Vermeulen	SA
Dr Kristie Jade Whyte	VIC
Dr Tony Ka Kei Wong	NSW
Dr Alexander Robinson	QLD

ORDINARY MEMBERS

Dr Jonathan Kok Kwan Chua	NSW
Dr Hussein Abdel Hag Sabir Ahmed	VIC
Dr Gareth Ansell	QLD
Dr Simon Andrew Campbell	NSW
Dr Rachel Di Lernia	SA
Dr Jonathan Andrew Galtieri	VIC
Dr Robert Hackett	NSW
Dr Claire Hinton	WA
Dr Vivian Wei-Ying Ho	NSW
Dr Eugene Andre Mansour	NSW
Dr Adam Isaac Mossenson	WA
Dr Gilberto Walter Nogueira Arenas	SA
Dr Cameron David Osborne	VIC
Dr Katelyn Priester	NSW
Dr Evelina Shepherd	VIC
Dr Christopher James Stokes	VIC
Dr Felicity Kate Stone	NSW
Dr Debbie van Niekerk	QLD
Dr Phak Hor (Alvin) Yeap	SA
Dr (Hoi Tin) Rex Yuan	NSW

IN MEMORIAM

The ASA regrets to announce the passing of ASA members Dr Kenneth Tweedale, NSW; Dr Kevin Leahy King OBE, QLD; Dr William Eric Mann, SA; Dr David Carne, TAS; Dr Vilim Stanisich, VIC; Dr Michael James Tisdall, VIC; Dr Kester (TCK) Brown AM, VIC; Dr Graham Dale, WA.

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

UPCOMING EVENTS

JANUARY 2019

Mindful Practice Workshop 2019

Date: 26-27 January, 2019

Venue: The Playford Hotel, Adelaide

Contact: events@asa.org.au

FEBRUARY 2019

ASURA 2019

Date: 21-23 February 2019

Venue: Peppers Noosa, Queensland

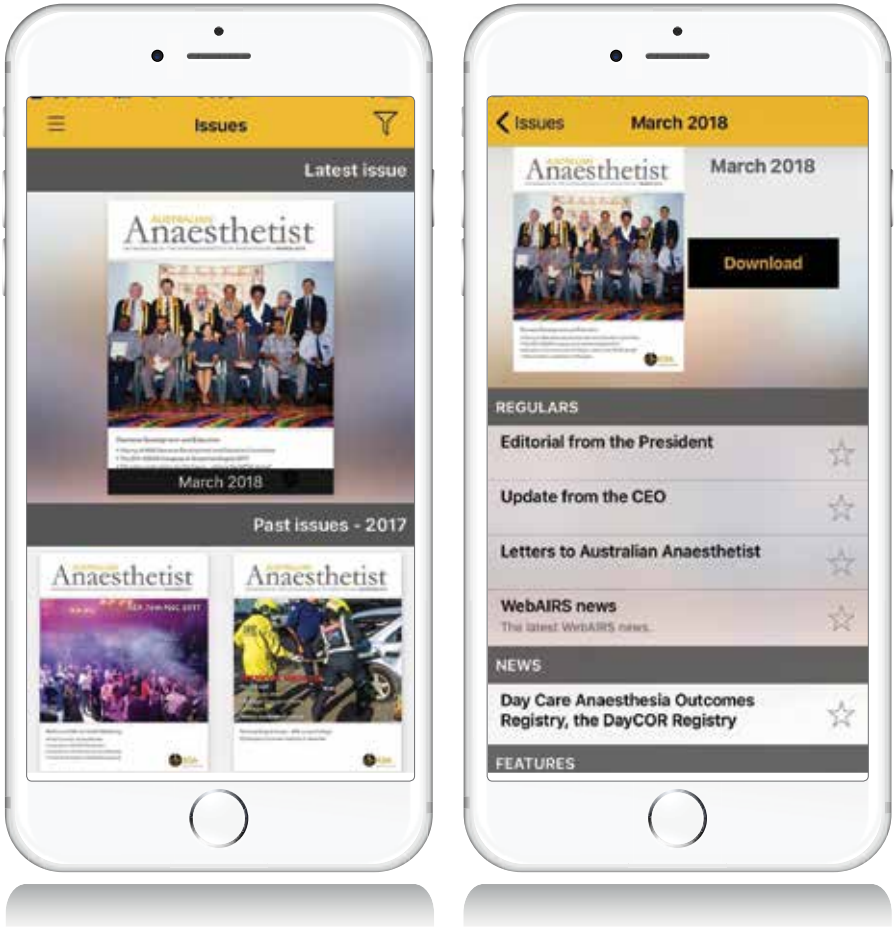
Contact: jmelville@asa.org.au

AUSTRALIAN Anaesthetist

THE MAGAZINE OF THE AUSTRALIAN SOCIETY OF ANAESTHETISTS

Available as an App

The App can be accessed using your standard ASA member login details.



FOR ASA MEMBERS!

To download the App search for 'Australian Anaesthetist' in your App store and look for the following icon:

Download on the App Store

ANDROID APP ON Google play

Please contact: membership@asa.org.au if you have misplaced your login details.

ASA

Australian Society of Anaesthetists

SYDNEY NATIONAL SCIENTIFIC CONGRESS

AUSTRALIAN SOCIETY OF ANAESTHETISTS | 20-24 SEPTEMBER 2019

SAVE THE DATE 20-24 SEPTEMBER 2019

Professor
Iain Moppett

ENGLAND

A/Prof. Glenn
Woodworth

USA

Professor
Colin Royse

AUSTRALIA

A/Professor
Lisbeth Evered

AUSTRALIA

Professor
Pam Macintyre

AUSTRALIA

For all enquiries please contact: Denyse Robertson

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THE ASA NSC
FUTURE DATES

www.asa2019.com.au