ASAnews

July 2010 | AUSTRALIAN SOCIETY OF ANAESTHETISTS

Island Anaesthesia
Suva, Fiji

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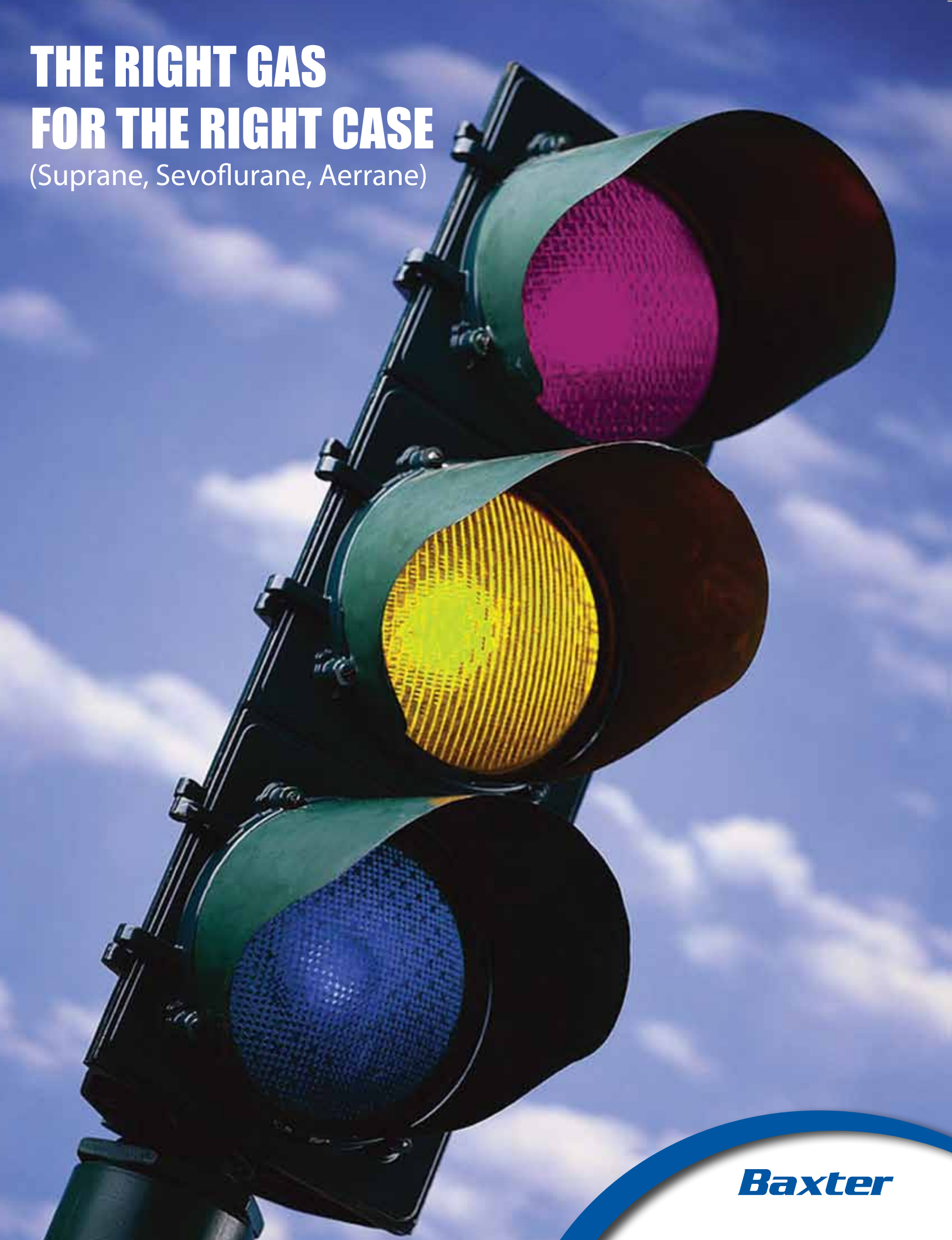
THE RIGHT GAS FOR THE RIGHT CASE

(Suprane, Sevoflurane, Aerrane)



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July 10

ASA news

Federal Newsletter of the Australian Society of Anaesthetists Limited
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The ASA Newsletter welcomes contributions. Articles and letters should be brief and apposite. The Society however cannot accept liability for statements and opinions of contributors.

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Island Anaesthesia
Suva, Fiji
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Editorial

Dr Elizabeth Feeney

The National Registration and Accreditation Scheme is established. We now have to wait to see if some of the positive aspects, such as increased ease of mobility of workforce that were generally supported by the profession, now come into play. For those requiring multi-jurisdictional registration, the process and cost should be less, despite the $650 registration fee that is disappointingly, but not unexpectedly, higher than previous fees in most states. Will increased mobility contribute to addressing the major flaws within our medical and health workforce provision? I think not.

There is a global shortage of all healthcare workers – workforce supply and demand is a major item on the agenda of most governments internationally. The prediction of the medical workforce is known to be challenging – the ASA and Australia and New Zealand College of Anaesthetists committed significant funds to surveying our workforce two years ago. I recently attended the 13th Asian Australasian Congress of Anaesthesiologists in Japan, where I was Chair of a session entitled "Manpower in Anaesthesia Setting". With speakers and attendees from the Asian Australasian region, as well as Europe and Africa, the session provided a global perspective on the issue. Dr Jannike Mellin-Olsen's (Norway) presentation "Anaesthesia manpower and female doctors in Europe" highlighted not only the effects of the increasing percentage of female anaesthetists in the workforce in Europe, but also the effects of the increased mobility that the single-labour market of the European Union has had. In Europe, females are less likely to work in rural areas and more likely to work fewer hours and to leave the specialty for shorter periods or permanently. Uncertainty is further exacerbated by the work-life balance choices of both males and females, the global mobility of the medical workforce in general, the European Safe Hours Directive and the broadening scope of anaesthesia practice.

Associate Professor Bauw Chi Ong from Singapore spoke in relation to broadening scopes of practice. In her presentation, she asked the question: "Patient safety; another subspecialty of anaesthesiology just like ICU and pain?" I believe the answer is no; safety and quality are core business. Anaesthetists are involved now in perioperative medicine, intensive care and pain medicine and, in some countries, emergency medicine. Certainly the engagement of anaesthetists in these other areas varies from country to country, but in general anaesthetists' skills are increasingly being utilised in areas outside the operating room.

Dr Mellin-Olsen also highlighted that the variation in type of anaesthesia assistants affected workforce needs. The scope of practice varies from country to country, from assisting the anaesthetist to administering anaesthesia under supervision of an anaesthetist. However, she was not supportive of the use of unsupervised non-medical practitioners, believing the administration of an anaesthetic to be a medical act.

In the same presentation session, "Circumventing the shortfall of anaesthesiologists", Dr Y. K. Chan from Malaysia spoke of non-medical anaesthesia providers, pointing out many have no option. This was borne by the international audience during question time, with many countries having insufficient medical graduates to meet their needs and experiencing difficulty with attracting graduates to anaesthesia. This is further exacerbated by the fact that many of their graduates are attracted to the greener pastures of other countries, where they subsequently meet another country's shortfall. The failure of many developed countries to train adequate numbers of medical graduates is impacting on many nations, but most significantly on countries who may not be able to provide as many career and personal opportunities. For developing countries, the egress of medical graduates has enormous impact.

Dr Chan also raised the issue of efficient utilisation of the existing workforce through appropriate organisational structures enabling efficient management of caseload – an issue relevant to all jurisdictions. In many areas, this is a structural change involving hospital administrations and government, but it also should be driven at a local level through clinician-led initiatives. Opportunities must exist within all systems for clinicians to inform the decisions of health policy makers and administrations. We must engage both on a local level and through our professional societies and associations to best represent the interest of the medical workforce and, most importantly, we must be our patients' advocates.

Engagement was the theme of the recently held Australian Medical Association Conference. Entitled "Engaging in Health Reform", the conference was opened by the Prime Minister who took the opportunity to announce $58 million in funding for Lead Clinician Groups in Local Hospital Networks. This, coupled with the undertaking by Health Minister Ms Nicola Roxon during a debate with Mr Peter Dutton to ensure local clinician representation on local boards, should facilitate the return of our engagement, should these promises be delivered. There is underutilised medical manpower in Australia, in some jurisdictions more than others. Through the failure to engage, many clinicians choose to work less rather than suffer the frustrations and the lack of recognition for the skills that they bring to the table. The goodwill has been lost in many areas. If this is to change we all must avail ourselves of these opportunities for input. If and when they arise, we must not sit back and allow enthusiasts that are often ideologically rather than pragmatically driven to dominate. This will provide the best outcomes for patients.

In 2006, in response to workforce shortfalls, the Council of Australian Governments committed substantially to reforming the health workforce in Australia to provide a flexible and responsive workforce while maintaining quality and safety. The National Health Workforce Taskforce was established to develop reform innovations. Through collaboration with the Australian Health Workforce Institute and PricewaterhouseCoopers, it has formed the National Health Workforce Planning and Research Collaboration to undertake national health workforce research over a three-year period, including future supply and demand models for the health workforce. The research into anaesthesia supply and demand has been undertaken and is about to be reported. The ASA has had representation on this working party.

In the 2009 Federal budget, however, the National Health Workforce Taskforce will be subsumed by a new agency which has been announced, Health Workforce Australia. The Government has committed $125 million to the establishment and operation of the Health Workforce Australia, with a further $1.2 billion in combined Commonwealth and states and territory funding being administered through Health Workforce Australia over four years for initiatives under the Council of Australian Governments' health workforce package. As we are all aware, the setting up of costly agencies does not guarantee the delivery of solutions. It is essential that this one does deliver but not at the expense of quality and safety. The solutions must provide patient outcomes that are at least as good as the current system, but preferably better.

As autonomous individuals, we do much to influence the supply side of anaesthesia by making decisions about the type of work we do and where, how much and with whom we do it. We must ensure that this continues to be the case by providing a safe, quality and professional service.

We hope you like the free paediatric stickers in this issue of the *ASA news*. If you would like to obtain some more, they can be purchased in rolls of 250 for $18+GST from the ASA HQ. Just email Sarah at asa@fed.asa.org.au or call her on 1800 806 654.

Elizabeth Feeney
President

Stop Press!

The ASA congratulates Dr Haydn Perndt, AM on his award of a Member of the Order of Australia in the Queen's Birthday Honours for service to medicine, particularly in the field of anaesthesia, to medical education through the design and implementation of training programs for health care practitioners in developing countries, and to professional organisations.

The ASA also congratulates Professor Teik Oh AM on his award of Member of the Order of Australia for service to medicine, particularly through the development of protocols for the specialties of anaesthesia and intensive care, through leadership roles in clinical and academic practice, and with professional bodies.

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Executive Director's Report

Mr Peter Lawrence

Board of Directors

I recently had a conversation with a member concerning the structure and process to fill the positions on the ASA Board of Directors, which you may also find interesting. The Board is, through our Constitution, also the ASA Council. The Board is elected by members in two ways. The states and territories elect the Chair of their Management Committee at local Annual General Meetings. The Chair is then automatically a member of the ASA Board. Secondly, the remaining members of the Board, except one, are elected at the Annual General Meeting of the Society that is held in conjunction with the National Scientific Congress. The only Board member who is not elected is the Immediate Past President; this position is ex officio. In total there are 12 directors and the Chair of the Board (President) is, of course, directly elected by members at the Annual General Meeting. The ASA Financial Report (published immediately prior the Annual General Meeting and available on the ASA website) provides a summary of the Directors' attendance at Board meetings.

State and Territory Offices

I am pleased to advise members in Queensland and the Australian Capital Territory that we have now arranged for secretarial support for the respective committees and Continuing Medical Education functions from AMA Queenlsand and AMA ACT, respectively. The Queensland office was previously provided by ANZCA using ANZCA staff. With a review of the cost of operations it was considered our administrative needs could be met through the AMA. The AMA provides similar services to a number of medical organisations in Queensland so they were our natural alternative provider. The ASA has not previously had an office in the ACT so the new AMA ACT arrangement will be a well overdue first for the Territory!

Please note the telephone number for ASA enquiries for Queensland and the ACT will now be 1800 806 654.

Each state office has different support arrangements and I am in the process of aligning them to provide the best facilities for members and the State Committee.

However, as most enquiries to the ASA relate to national issues – economic, legal and policy, I suggest that members either go online and send an email to mail@fed.asa.org.au or call the ASA Headquarters on 1800 806 654. The enquiry will be directed to the appropriate office-bearer or committee for a quick response.

New Capabilities

Other staff changes in the ASA Headquarters are planned to occur this year. The objective of the changes is to align the staff teams into more functional groupings. The most significant change will be the introduction of a Policy Adviser. The new position will integrate the important activities of the Economics and Professional Issues and Advisory Committees with the development of ASA submissions and position statements. This work is very time-intensive so the new full-time professional officer will be very welcome to the staff.

The other major improvement is the development of full in-house typesetting capabilities. The ASA will be able to prepare the Journal, AIC, to the point immediately prior to printing. Previously this pre-production work had been carried out by the printer because of the special skill, software and time required. In 2008, we trialled in-house production of the *ASA news* and have been increasingly preparing ASA publications in house. This has demonstrated that with the appropriate software and training, we can undertake all pre-production work. The benefit is reduced operating costs and greater flexibility for the production team and editors.

These changes will bring the total staff number in the ASA Headquarters in Edgecliff to 19, or 16.5 full time equivalents (and one term appointment). The organisational chart shows the new restructure.

Upgrade for the Anesthesia and Intensive Care Website

Over the next three months, the *Anaesthesia and Intensive Care* website will be redesigned and re-launched. The original website is nearly a decade old and, while it has been continually fine tuned, it is now ready for a major revamp! I expect we'll have a trial website available for review before the next National Scientific Congress. And while discussing technology, the database of the ASA is also to be upgraded with a new server and significantly enhanced

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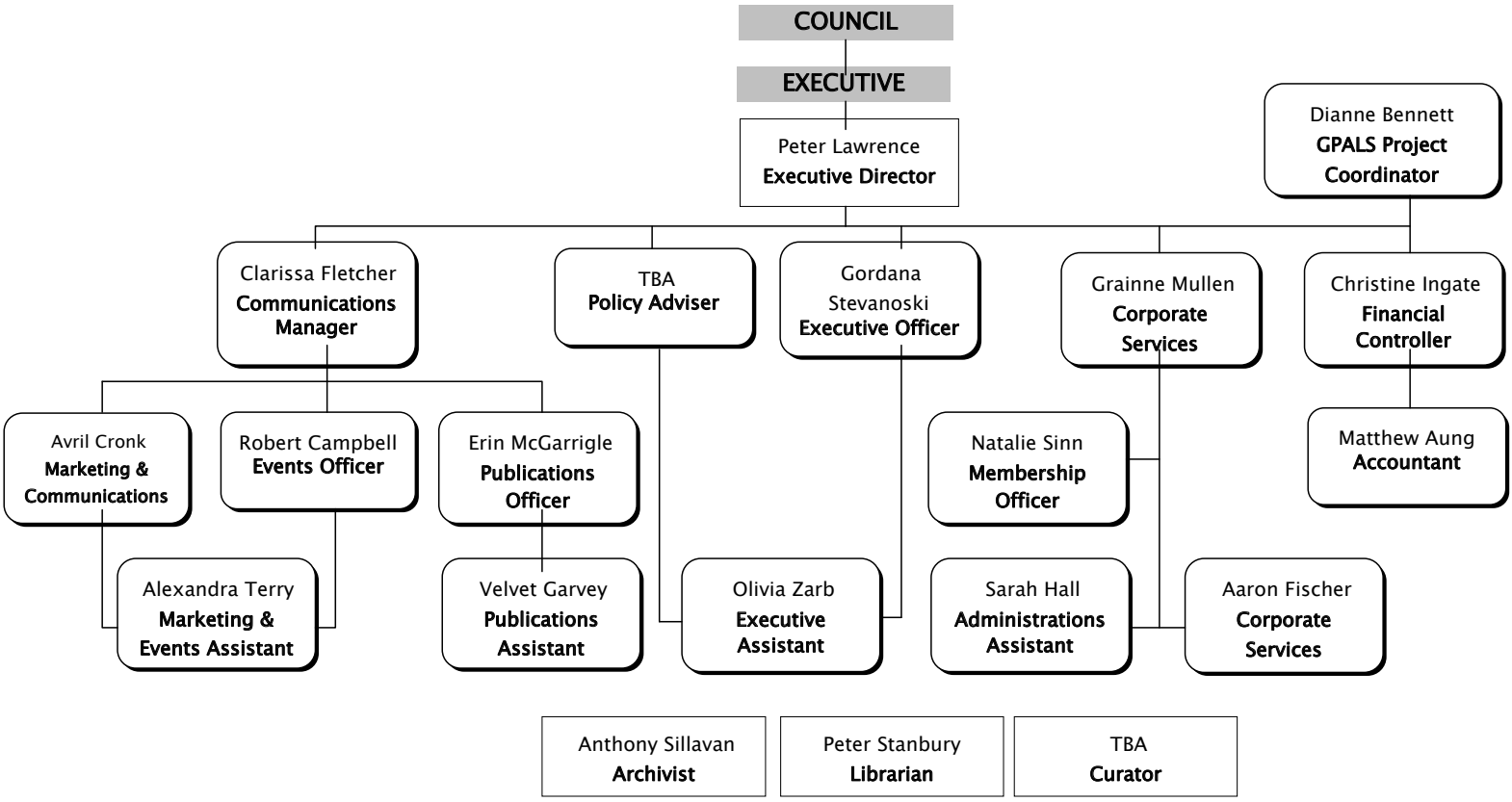
ASA Headquarters - Organisational Chart



capacity. The database is also capable of assisting in the management of meetings and educational events.

All these changes are needed as the Society continues to expand to meet your needs. Fortunately, the recent recovery of our investments (and further to go, we all trust) has enabled us to undertake these capital investments without creating a deficit or increasing fees freater than the CPI.

Locums Sought for the General Practitioner Anaesthetist Locum Service

We are halfway through the roll-out of the federally funded General Practitioner Anaesthetist Locum Service (GPALS). During the GPALS feasibility study, we surveyed members to ascertain whether specialist anaesthetists would contribute to the supply side of GPALS. We had quite positive responses, but since the launch of GPALS only a scant number of specialist anaesthetists have expressed interest in it.

Another assumption made about specialist anaesthetists contributing to the supply side was that rural hospitals/practices would be agreeable to employ a specialist anaesthetist in lieu of a GP anaesthetist. This assumption is only viable if a placement request is from a hospital rather than a practice, and the feasibility study did not examine the degree to which placement requests would be from rural hospitals rather than GP practices.

However, as GPALS is unfolding, it is apparent that the provenance of the most placement requests is from rural and remote hospitals (70%), where the locum will be required for their anaesthesia skills only. This means the placement requests being successful would be more likely if there was greater participation by specialist anaesthetists in the supply side.

Rural/remote hospitals pay specialist anaesthetist rates in the absence of being able to fill the position with a GP anaesthetist. Some remote hospitals are paying specialist rates to GP anaesthetists to entice them to work in undesirable locations.

If you would like more information please call Ms Dianne Bennett at the ASA on 1800 806 654.

Service and Colleagues

From time to time, the ASA seeks volunteers for short-period overseas assistance, training and supervision. If you would like to register your interest please let me or Dr Rob McDougall know.

Finally, if you would like to put forward members who you feel should be recognised for their services to the Society or the Australian Community at large, please let me know. All enquires are obviously treated in confidence.

Peter Lawrence
Executive Director

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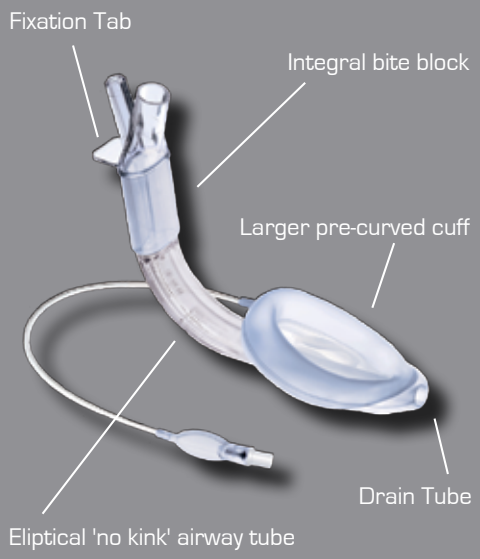

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ASA Council Report

Council met for two days at the end of May. The first day was a routine Council meeting, much of which will be dealt with in the various reports that follow in this *ASA news*. However, a few items of interest appear below. The second day involved the Councillors and the Chairs of the Economics Advisory Committee and the Professional Issues Advisory Committee in a strategic planning day. The Council reviews its strategic plan on a regular basis to ensure that the Society is not only meeting its existing mission statement but is able to identify any new areas, roles and challenges that may be on the horizon and deal with them pre-emptively where possible.

Changes in Office Bearers

Drs David Brown and Philip Morrissey, the respective State Chairs of Tasmania and the Australian Capital Territory, attended their first Council meeting and we look forward to their future input into the Council. Dr Reg Cammack attended his last meeting as the New South Wales State Chair – his contribution to Council has been invaluable and will be greatly missed – his replacement is yet to be elected.

Honours

Council accepted two nominations for the President's Award: Drs Linda Weber and Mark Sinclair. Linda has made an enormous contribution to the Society, having been on Council for two periods as the Chair of the Australian Capital Territory Committee of Management. During her second term, she also represented the State Chairs on the Executive, where her considered approach was invaluable. Linda continues to serve on the Editorial Board of *Anaesthesia and Intensive Care*.

Dr Mark Sinclair is currently Chair of the Economics Advisory Committee and in the past has contributed to the Society greatly in a number of areas. Mark was Chair of the South Australian Committee of Management from 2006 to 2008, as well as overseeing the updating of the Relative Value Guide on a regular basis. The highly successful Darwin National Scientific Congress was also convened by Mark. His tireless contributions to the Society continue in his current role.

Position Statements

Council approved the promulgation of a new position statement, 'Anaesthesia for Office-based Surgery'. This statement is now available to assist those engaged in this area and also for those setting up such a facility. Feedback on this new statement would be most welcome.

GASACT

To facilitate communication between the Committee and trainees at a local level, email addresses for each state representative have been set up.

Elizabeth Feeney
President

ASA Membership Survey

The ASA will be undertaking a survey of members in September 2010, the first in four years. The ASA is a member-based organisation and our role is to promote the interests of Australian anaesthetists, in particular the professional and economic aspects of anaesthesia practice both in the private and public sectors. Through the Professional Issues Advisory Committee and the Economics Advisory Committee, the ASA represents the professional interests of Australian anaesthetists whether they are members of the ASA or not. Some of the ASA's activities are mentioned in this *ASA news*, including a submission to the National Health Workforce Taskforce of Health Workforce Australia, submissions to the Productivity Commission, consultation and collaboration with the Australian Medical Association, and ongoing consultation with the Medicare Benefits Schedule Quality Framework. It is to be expected that during the life of this government, reviews such as these will continue and the ASA will continue to represent the interests of Australian anaesthetists.

There are many changes impacting on anaesthesia practice including ageing of the population, increasing rates of diabetes and obesity and a greater propensity of the population to consume diagnostic and therapeutic medical services. At the same time, there is an increase in the number of medical graduates, an increase in the proportion of female graduates and generational change, all of which may impact on our ability to provide a quality anaesthesia service to the Australian population. It is clearly important to the anaesthesia profession that the numbers of graduates in anaesthesia is in keeping with the anticipated demand for anaesthesia services. In order for the ASA to best represent our members, we need up-to-date data about the demographic make-up of the anaesthesia workforce and your views on workforce participation and professional and economic issues related to your practice of anaesthesia. Accordingly, we need as many people as possible to complete the major forthcoming survey, which will be conducted in September. I would like to thank you in advance for your participation in this very important survey.

Richard Grutzner
Executive Councillor, Member PIAC

Economics Advisory Committee

Dr Mark Sinclair

The MBS Quality Framework

As mentioned in the last edition of the *ASA news*, the Federal Government has announced that it will provide $9.3 million over two years to implement an "evidence-based framework" for managing the Medicare Benefits Schedule (MBS) into the future. This "MBS Quality Framework" (MBSQF) aims to establish new listing, pricing and review mechanisms to ensure that prospective and already listed items are effective and safe, likely to lead to improved health outcomes for patients and represent value for money.

The four key components of the program are:

- A time-limited listing (three years) for new MBS items which do not undergo an assessment by the Medical Services Advisory Committee (MSAC). The MSAC will assess all proposed items involving "new technology". The Medical Benefits Reviews Taskforce, which is responsible for implementation of the MBSQF, reserves the right to involve MSAC if they believe it is necessary to do so.
- An evaluation process for all time-limited items at the end of the time-limited period, before items can be approved for long-term listing in the MBS. Items will have to meet pre-determined criteria (including financial) to gain permanent listing.
- Strengthening arrangements for appropriately pricing and listing new MBS services.
- Establishing monitoring and review processes in order to appropriately amend or remove existing items.

The entire process still remains at an early stage, but the Department of Health and Ageing (DHA) has released a more up-to-date discussion paper. This paper addresses the above four points in more detail, and also introduces the three committees it intends to set up to provide advice to the DHA. The largest of these is the MBSQF Reference Committee. This committee's role is, in broad terms, to provide advice to the DHA on the direction of the MBSQF and any initiatives which need to be considered, and to consider changes to policies or processes as necessary.

The other two committees are the MBSQF Expert Advisory Committee and the MBS Fee Advisory Committee. Both of these committees will consist of nominees who are considered experts in the relevant fields. The former will require experts in, for example, evidence-based medicine, health economics or consumer issues. The latter will consist of people from various fields of healthcare, who will have expertise in similar areas but will work on fee-setting methodologies for MBS items. The DHA states that members of these committees will be appointed based on their areas of expertise, and not as representatives of medical organisations or Colleges. Advisory committee members could be limited in their ability to discuss matters outside of committee deliberations. Representatives of the Society met with the DHA in late May and made strong arguments that medical societies and Colleges should have the opportunity to assist in the setup of all three committees, not just the Reference Committee. We also took the opportunity to learn more regarding the progress of the MBSQF in general.

Fortunately, the necessity for ongoing consultation with, and input from, all relevant stakeholders has been repeatedly acknowledged in the discussion paper. The discussion paper and terms of reference for the three MBSQF committees can be downloaded from www.health.gov.au/mbrtg

Proposals Before the DHA

The DHA is currently considering several proposed changes to the MBS, as mentioned previously. These include:

- The introduction of items for insertion of peripherally inserted central catheters.
- The introduction of a modifier item for anaesthesia for procedures performed in the prone position.
- The introduction of a modifier item for anaesthesia for patients in the third trimester of pregnancy.
- The introduction of a modifier item for anaesthesia for morbidly obese patients.
- The use of ultrasound for nerve blockade or vascular access.

In the current environment (with the introduction of the MBSQF and significant staff changes within the

DHA), progress has been relatively slow but we have had some assurances from the DHA.

The peripherally inserted central catheter line proposal appeared to be well received by the DHA and we have been informed it will need neither application via the MBSQF process, nor assessment by MSAC. We hope to hear back from the DHA in the near future.

The success of the modifier item proposals appears less likely in the current climate but the DHA has committed to progressing the proposals without the need for a MBSQF application.

Likewise, the ultrasound items (for ultrasound in conjunction with already existing items for nerve blockade and vascular access in association with anaesthesia) will also progress via the DHA without the need for a MBSQF application.

Ultrasound for vascular access or nerve blockade procedures currently attracts benefits under diagnostic imaging item 55054. However, items in the Relative Value Guide would be more satisfactory in the view of the Society, for various reasons. In particular, the need to comply with the diagnostic imaging accreditation requirements set down by the DHA would no longer apply. The Economics Advisory Committee (EAC) will continue to work towards having all anaesthesia-related ultrasound procedures recognised in the Relative Value Guide, not just those related to the current vascular access and nerve block items.

The proposals for a broader availability for items for nerve blocks used for postoperative analgesia and for five-minute time items after four hours of anaesthesia time (currently 10-minute items) will both require application via the MBSQF.

Other MBS Matters

Members have been advised (via the website) of the replacement of after-hours consultation items 97, 696 and 697 by items 598 and 600 from May 1 2010. The May 2010 version of the MBS can be downloaded by following the link "MBS Online" in the section "Related Websites" on the DHA home page at www.health.gov.au

Medicare Australia has indicated that it has concerns with the appropriate use of some item numbers and that it intends to significantly increase its number of audits. Anaesthetists have been specifically identified as a target. Specific concerns are "...not meeting the requirements of item descriptors, and up-coding anaesthesia time units and pre-anaesthesia consultations". There has been no evidence presented to suggest that inappropriate practices may be occurring. Nevertheless, members are advised that, as always, accurate documentation both in consulting rooms and operating theatres is the best defence. Members are welcome to contact the Society should they receive a request for information from Medicare Australia, or notification of an audit.

A recent newspaper article has again drawn attention to the possibility of salaried doctors "double dipping" by charging Medicare items while working in the public sector. According to *The Age*, there are at least three cases being investigated by Medicare Australia. There are many forms this practice may take, for both public and private patients in public hospitals. Some are no doubt legitimate but members are reminded that the ultimate responsibility for appropriate billing rests with doctors, and not necessarily hospital administrators. Should inappropriate billing practices be proven to occur, it is likely the treating doctor will be the one to face sanctions or punishment (e.g. removal of provider numbers, financial penalties). Members who are uncertain about any such practices in their own hospitals are welcome to contact the Society and may need to be referred to their professional indemnity organisation for advice.

Members are reminded that the EAC is prepared to assist with any enquiries related to the MBS. We regularly receive queries from members who have already approached Medicare Australia or the DHA directly, and have found the task difficult or have received replies which still leave them uncertain. The EAC meets regularly with senior staff from the DHA and other relevant departments and, if necessary, can quickly direct queries to the correct people. This will usually result in more efficient handling of any issues raised

National Bowel Cancer Screening Program Quality Framework

The Department of Health in Victoria has been given the responsibility of developing of a quality framework for the National Bowel Cancer Screening Program. As members will be aware, the Program aims to improve the early detection of colonic malignancy, using faecal occult blood testing as a screening tool in Australians over the age of 50.

The National Bowel Cancer Screening Program Quality Framework aims to ensure the Program is achieving its aim of reducing morbidity and mortality from bowel cancer but, importantly, in a cost-effective manner. Much of the work of the Program will be essentially irrelevant to anaesthetists (e.g. comparing different methods of faecal occult blood testing, analysing polyp detection rates, caecal intubation rates or scope withdrawal times). Nevertheless the Society feels that as the anaesthesia profession has an important role to play in the safe, efficient delivery of colonoscopy services, we must be represented on the working group. The first meetings of the working group have been held in Melbourne and Sydney – I attended the latter. The agenda was very broadly based at this early stage with no specific

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discussion of issues such as those listed above, or anaesthesia services. However the working group is aware of our interest in the Program and we will continue to be involved.

Health Fund Schedules

All funds have now indexed their Relative Value Guide unit values since the last MBS indexation in November 2009. Table 1 summarises the situation.

Table 1

Fund	RVG Unit Value	Last Indexation	Month of Indexation
MBS	$18.70	2.2%	Nov 09
DVA	$30.85	2.3%	Nov 09
AMA	$69.00	3.0%	Nov 09
CPI		1.3%	12 months to Sep 09
Known Gap			
Medibank Private	$30.55	1.8%	Nov 09
AHSA	$31.39	2.3%	Nov 09
HBF	$27.40	3.2%	Nov 09
No Gap			
MBF	$29.65	2.7%	Feb 10
HCF	$32.05	1.9%	Nov 09
BUPA	$33.31	2.8%	Apr 10
NIB	$29.05	3.4%	Nov 09
HBF	$35.00	2.9%	Nov 09

The values for Bupa and the Australian Health Services Alliance are average values, which vary from state to state. MBF has now been acquired by Bupa but continues to set its own unit value (and its own terms and conditions).

The indexation by virtually all funds was below the 3.0% indexation in the AMA Schedule; in some cases well below. One exception was NIB, however this fund did not index its own contribution to the unit value for several consecutive years, instead only passing on the MBS indexation. Its unit value is still the lowest of the major insurers. HBF does not offer its 'no gap' product to anaesthetists outside of WA, but those wishing to access it must commit to 'no gap' for all HBF patients. If the 'known gap' product is used, the gap must be 10% or less of their 'known gap' unit value; if exceeded the patient receives only the MBS rebate.

Other Current Projects

Thanks to Dr Andrew Mulcahy and the staff at the ASA in Edgecliff (particularly Mrs Gráinne Mullen, Mr Robert Campbell and Mr Peter Lawrence), the Practice Managers' Workshop held in Sydney on Thursday, 25 March was very successful, with over 60 people attending and excellent feedback received from the delegate surveys. These workshops have proved very popular in the past, but given the tyranny of distance, eastern state workshops have attracted little interest from Western Australia. Dr Rob Storer (Western Australia EAC Representative) is in the process of organising a Practice Managers' Workshop in Perth in late August.

Mark Sinclair
Chair, Economics Advisory Committee

Scenes from the Practice Managers' Workshop in Sydney. Left to right: Hands raised for Dr Andrew Mulcahy; Dr Andrew Mulcahy; speaker Dr Mark Sinclair.

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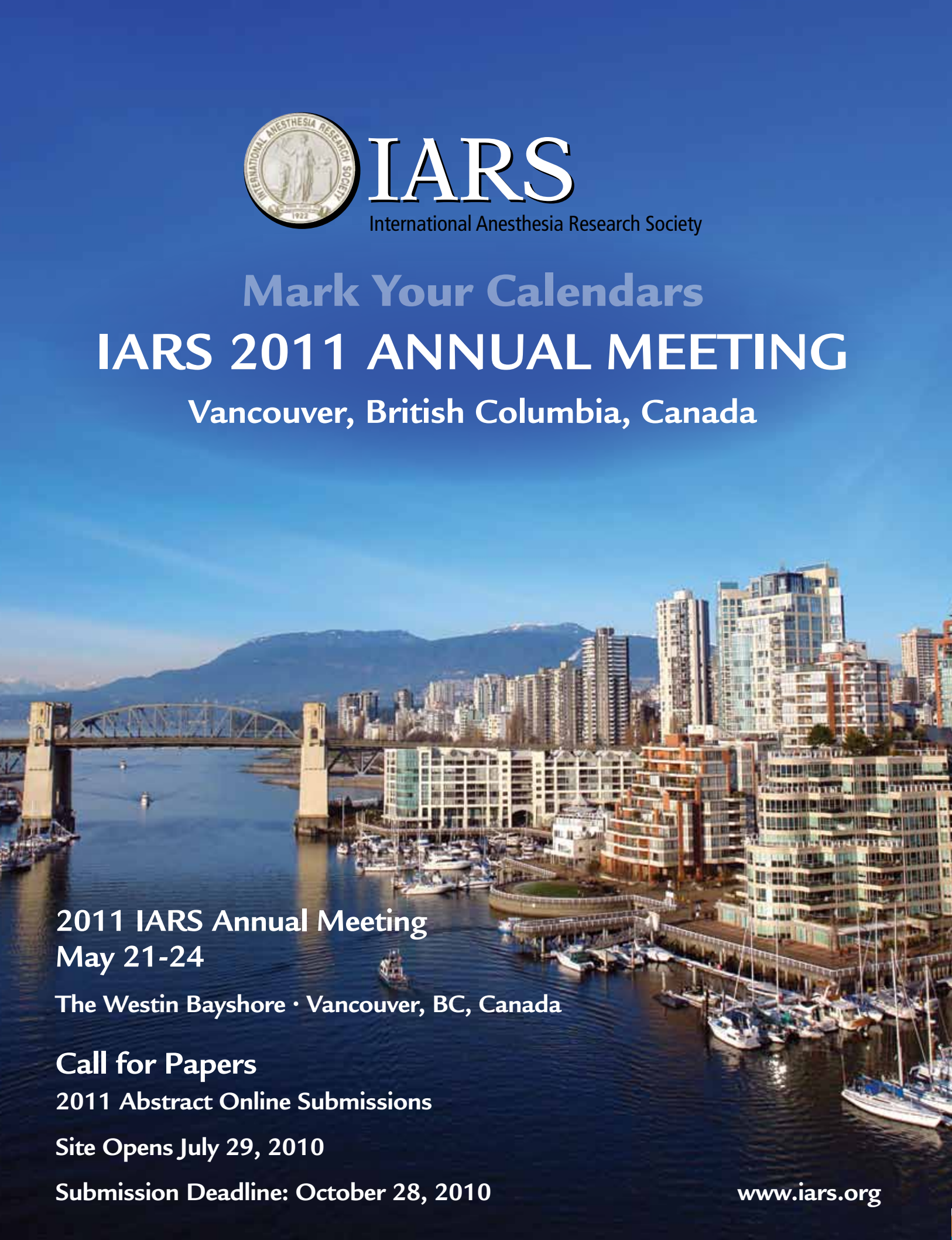

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Professional Issues Advisory Committee

The last few months have seen the bringing together of the recommendations and findings from the various commissions and committees that were established following the election of the Rudd Government in 2007. These have been combined with the May 2010 Budget and the latest Council of Australian Governments Health Agreement to set the agenda for the next few years. We have now seen the release of further detail in relation to proposed changes to Federal and State health care funding arrangements and we have some idea of what changes we may see in state/public/teaching hospitals. The lack of attention given to the 'private' sector has been noteworthy.

The Australian Medical Association was a key professional advocate, with its submission "studied and acknowledged" by the Government. The ASA was involved in the consultation and commission process through independent submissions and submissions made jointly with the Australian Medical Association.

Although health care was anticipated to be agenda-setting, in political terms, for the conclusion of this political cycle, at the time of writing it has been overshadowed by other developments.

The Professional Issues Advisory Committee (PIAC) has conducted its affairs online over the Council meeting cycle of March and May 2010, with a face-to-face meeting held in late June.

National Registration and Accreditation Scheme

As mentioned in the President's report, the rollout of the National Registration and Accreditation Scheme continues and will likely be in place on 1 July 2010.

National Health Workforce Taskforce

Dr Richard Grutzner is addressing this matter through PIAC now that the Workforce and Survey Committee has been incorporated into PIAC. Plans in relation to anaesthesia workforce issues and surveys are outlined below.

Surveys

A Society workforce survey will be conducted this year. A follow-up survey focusing on obstetric practice in the private sector is also planned. The content of these surveys was addressed at the PIAC June meeting.

Private Hospitals

Beyond the immediate question of the anaesthesia workforce, its distribution and its current workload, there are a number of emerging issues arising in the private sector. These include the initial credentialling and privileging of 'new anaesthetists' in facilities that are seemingly well served by those already having privileges, and the possibility that some established practitioners could have their privileges revoked at some private facilities if there is a failure to meet a certain workload or other commitment. Further, there are signs that the administrations of some private facilities are prepared to robustly engage their Visiting Medical Officers over 'out of hours' issues, paid and non-paid, obstetric or general.

An emerging and increasing workload in relation to medical student placement is noted, with some intern and advanced trainee positions pending. The supportive position of Colleges in relation to private sector training is also a matter of record. The views of members in relation to all the above are subjects for capture within the next survey.

Medical Indemnity Issues

There is renewed interest in the 'consent process', with a separate article in this *ASA news*. PIAC will address this issue throughout this year. The medical indemnity industry seems stable, with little to be heard in the wider context, i.e. capitalisation seems adequate.

Continuing Professional Development

The Medical Board of Australia has recently published in relation to Continuing Professional Development. The lead role of Colleges in relation to this for Australian/Australasian Fellowship holders is confirmed. Those practitioners with 'overseas' qualifications have other options. The ASA is able to advise on request.

ASA Position Statements

The document on office-based surgery and anaesthesia was approved with minor change by Council and is available for perusal and comment on the website and in this issue.

'State Bulletin Boards'

Discussions earlier in the year in relation to changes in the Coroner's Acts in Queensland and New South Wales lead to the suggestion that 'State Bulletin Boards' should be established to focus on matters peculiar or particular to State and Territory jurisdictions. This work is ongoing in co-operation with the Communications Committee.

Other matters

Beyond the above, discussion has ensued regarding issues shared with the Economics Advisory Committee, such as billing of private patients who appear on a public list and the appropriate (or inappropriate) use of some Medicare numbers.

Jim Bradley
Chair

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ASA Member Honoured for Service

Anaesthetist and ASA member Dr David Scott has been honoured in a special ceremony in which the Netherlands Government acknowledged 13 Royal Australian Air Force Health Services personnel for their work in Afghanistan. The 13 Australians received Netherlands Peace-keeping Operations Commemorative Medals during the ceremony, which was held in Canberra.

Dr Scott and his colleagues were deployed to Tarin Kowt in southern Afghanistan in 2008, where they and their Dutch counterparts provided health support for the NATO-led International Security Assistance Force. They provided health and medical support to the coalition as well as local Afghans. The deployment has been described as demanding, particularly because nearly one-third of their patients were Afghan children.

Dr Scott is a member of the Australian Medical Task Force 2, which treated the largest mass casualty of Australian Defence Force members since the Vietnam War. Their surgical and intensive care services included eye, limb and life-saving treatment.

Air Force, official newspaper of the Royal Australian Air Force, May 27 2010

Dr David Scott (centre right) and the Australian recipients of the medal in Canberra

Australian Medical Association Update

Dr Ian Woodforth

The highlight of the Australian Medical Association's (AMA) year is the Parliamentary Dinner, held in the Great Hall of Parliament House in conjunction with the meeting of Federal Council on 10 and 11 March. The Prime Minister and Leader of the Opposition attended, along with the Health Minister and Opposition Health Spokesman and leaders of medical groups, colleges and medical industry bodies from across the full spectrum of the profession. The Prime Minister and Leader of the Opposition each spoke about the proposed Federal takeover of much of health spending. With details of the plans very vague, there were no new insights given, but the Prime Minister stayed for two hours and discussed concerns about healthcare delivery with a forum of elected representatives of the medical profession which only the AMA can provide.

Professor Ian Frazer was presented with the AMA's Gold Medal. He provided some perspective by pointing out that Australia has the world's second highest life expectancy with reasonable medical costs comparatively, and this was not achieved by reforms to health funding. He added that with the proposed move to case-mix funding, it will be important that spending on teaching and research, which is not closely identifiable with expenditure on a given medical service, is not neglected.

Federal Health Funding Takeover and Public Hospital Management Boards

The AMA has been supporting the Commonwealth takeover of health funding, with decision-making to have greater clinician input and to occur closer to the point-of-care delivery. The plans announced in "A National Health and Hospitals Network for Australia's Future" are broadly in line with the recommendations of the AMA in its "Priority Investment Plan" from last year. However, the details of implementation will be important and there is no point just adding another layer of bureaucracy. The number of proposed local hospital networks will create a great demand for skilled administrators. The Commonwealth has stated that it will fund 60% of the "efficient cost" of hospital services and that this will not be capped. Determination of the "efficient cost" will be contentious, and the states have a limited capacity to fund the other 40%.

Collaborative Care

The AMA President appeared before the Senate Community Affairs Legislation Committee Inquiry in relation to two bills requiring nurse practitioners to have collaborative arrangements with a medical practitioner in place. Collaboration between the AMA and Government has progressed to a point where the AMA is supporting the legislation, while the midwives and nurse practitioners are protesting against it. The Government is working on providing increased funding for practice nurses working with doctors as an alternative to independent nurse practitioners. The ASA has been involved in supporting this campaign and there are major benefits from the outcome for the future of anaesthetic practice.

National Registration and Accreditation

The enabling legislation has been passed and received Royal assent in Queensland, New South Wales and Victoria. The Ministerial Council has issued its first policy direction to the Australian Health Practitioner Regulation agency and the 10 national boards. This policy direction reflects the decision to retain the complaints scheme in NSW and provides that the registration fee in NSW is not to include the cost of the national complaints scheme. Registration fees will be announced soon and there is to be no cross-subsidisation between the professional boards.

The Board is proposing to adopt the Australian Medical Council's "Good Medical Practice: A Code of Conduct for Doctors in Australia" which the AMA was heavily involved in re-writing. The AMA supports adoption of the Code and has asked that it be regularly reviewed.

Medical Training Review Panel

The Government has finalised its long-awaited response to a review by the Department of Health and Ageing of the Medical Training Review Panel. It has accepted the key recommendations of the review. Consistent with the submission by the AMA, it has decided that the Panel should have an expanded role in monitoring and providing

advice on medical workforce training across the whole spectrum of medical education. The Panel will play a key role in providing data and information on training numbers and help identify shortfalls in training places, which will be essential for the AMA's campaign for increased training places.

Health Workforce Australia

The Board and Chief Executive Officer of Health Workforce Australia have been announced recently. The Hon. Jim McGinty has been appointed Chair of the Board. Health Workforce Australia is currently stepping up its activities and the AMA is arranging a meeting with the Chief Executive Officer to present its submission on proposals to expand capacity in pre-vocational and vocational training.

The Role of the AMA in Industrial Relations

With the new *Fair Work Act* 2009 the Commonwealth has progressively expanded the coverage of the Federal industrial relations system so that it now covers the vast majority of employees nationally. All states except Western Australia have handed over their industrial power with respect to private sector employees to the Commonwealth. Except for Victoria and the Territories, states retain control of public sector industrial relations. This will necessitate a reshaping of the responsibilities of the Federal and State AMAs and potentially of their relationship with the Australian Salaried Medical Officers' Federation, which is currently under negotiation.

Healthcare Identifiers Bill 2010

This Bill was tabled in Parliament on 10 February. A display at Medicare Australia demonstrates how the healthcare identifiers would work in practice. The information attached to the healthcare identifier and stored by the healthcare identifier service operator (currently Medicare Australia) will be only demographic information and it will not contain health information.

National Conference

The Conference will be held over two days in Sydney with the theme "Engaging in Health Reform".

International Medical Graduates and the 10-year Moratorium

The AMA has called for the dismantling of the moratorium along with the introduction of new programs and incentives to attract doctors of all backgrounds to practise in country areas. The Government has already lifted restrictions on graduates of medical schools in New Zealand and New Zealand nationals who undertake training in Australia.

AMA Craft Group Representative Elections

AMA Craft Group Representatives are elected by AMA members who belong to the relevant craft group. Terms are for two years and commence after the National Conference. At the close of nominations I was the only candidate for election for the term commencing at the 2010 National Conference.

Ian Woodforth
AMA Craft Group Representative

ASA
Australian Society of Anaesthetists

ASA PS-14

POSITION STATEMENT
Anaesthesia for Office-based Surgery

Preamble

Introduction

Anaesthesia for surgery performed in a doctor's premises ("Office-based Surgery", OBS) constitutes only a small proportion of the total anaesthesia performed in Australia. In other countries such as the United States, anaesthesia for OBS has increased substantially in recent years and the same increase may occur in Australia.

OBS is practised commonly in Australia with and without local anaesthesia, less commonly with sedation, and relatively uncommonly with general anaesthesia.

The type of anaesthetic administered would usually be determined by the medical practitioner undertaking the procedure, taking into account patient preference and the nature of the planned procedure.

For the purposes of this document, 'anaesthesia' for OBS would incorporate techniques variously referred to as analgesia, sedation and general anaesthesia.

This document focuses in particular on OBS practised with *general anaesthesia*, offering guidelines which could underpin acceptable standards of practice.

Rationale for OBS

It is claimed that OBS is less expensive than the traditional models of hospital or 'Day Surgery' care, and that appropriately selected patients are able to undergo selected OBS with little risk of morbidity or mortality.

Critique of anaesthesia for OBS

The projected cost savings may be less if general anaesthesia is provided due to the significant increase in equipment and personnel required, with the need to balance against the possibility that anaesthesia in the office-based environment may be less safe than the traditional hospital or 'Day Surgery' environment.

Based on experience in the USA, reasons for concern include:

- anaesthesia equipment may not meet the minimum standards required for hospital or 'Day Surgery' care.
- personnel may be less well trained and qualified than in hospital or 'Day Surgery' facilities.
- physical facilities may not meet the standard of hospital or 'Day Surgery' facilities.

Current status of anaesthesia for OBS in Australia

OBS is most commonly performed by dentists, plastic surgeons, general practitioners and other practitioners performing cosmetic and associated procedures.

These types of surgery have most commonly been performed under local anaesthesia with minimal risk.

More recently, there has recently been a move by some surgeons working in an office-based environment to offer more complex anaesthesia including general anaesthesia.

This change may significantly increase the risk to patient safety if the standards for sedation/general anaesthesia do not meet the standards required for traditional hospital or 'Day Surgery' care.

Recent high-profile deaths associated with 'dental sedation' in dental surgeries in Australia have served to illustrate the risks associated with OBS.

Claims associated with OBS may have a greater severity of injury and a higher proportion and amount of payment than claims from other ambulatory anaesthesia settings. In addition, a

greater proportion of injuries in office-based claims are believed to be preventable, especially in relation to the postoperative period.

Conclusion

The ASA believes that anaesthesia for OBS is more likely to be associated with a higher risk for patients than anaesthesia in hospital or 'Day Surgery' facilities.

Accordingly, it believes that guidelines for the safe conduct of office-based anaesthesia are warranted.

ASA Guidelines for Office-based Surgery and Anaesthesia

Governance and Administration

- Facilities performing anaesthesia for OBS should have a medical director or governing body that establishes policy and is responsible for the activities of the facility and its staff.
- The medical director or governing body is responsible for ensuring that facilities and personnel are adequate and appropriate for the type of procedures performed.
- Policies and procedures should be written for the orderly conduct of the facility and reviewed on an annual basis.
- The medical director or governing body should ensure that all applicable local, state and federal laws and regulations are observed.
- All health care practitioners should be registered and credentialled as they would be for hospital or ambulatory surgery care facilities.
- All personnel should be qualified to perform services commensurate with their levels of education, training and experience.
- All personnel should participate in ongoing continuous quality improvement and risk management activities.
- The medical director or governing body should recognise the rights of its patients, and a document that describes this policy should be available for patients to view.

Safety

- Facilities performing anaesthesia for OBS should comply with all applicable national, state and local laws, codes and regulations pertaining to fire prevention, building construction and occupancy, accommodation of the disabled, occupational safety and health, and the disposal of medical waste and hazardous waste.
- Policies and procedures should comply with laws and regulations pertaining to controlled drug supply, storage and administration.

Patient and Procedure Selection

- All procedures undertaken should be within the scope of practice of the health care practitioners and the capabilities of the facility.
- If patients are to receive sedation such that there is a risk that they will not remain in verbal contact at all times, or general anaesthesia, a medical practitioner appropriately trained in anaesthesia should attend exclusively to that patient's anaesthesia.
- Procedures should be of a duration and degree of complexity such that the patient can recover and be discharged from the facility within an appropriate timeframe.
- Patients who by reason of pre-existing medical or other conditions may be at undue risk for complications should not have their procedure in an office, but rather be referred to a more appropriate facility.

Perioperative Care

- The facility, medical director and/or governing body, and accredited anaesthetists should refer to the current standards and guidelines promulgated by the Australian and New Zealand Society of Anaesthetists (ANZCA) (1) and the Australian Society of Anaesthetists (2) with respect to standards of anaesthesia and perioperative care. A list of these documents (current at 20 Apr 2010) is referenced below.
- Anaesthetists when involved should be physically present during the intraoperative period and immediately available until the patient has been discharged from the initial

post-anaesthesia care area ('First stage' or equivalent).

- Discharge of the patient after general anaesthesia is a medical practitioner responsibility. This decision should be documented in the patient record.
- Personnel with training in advanced resuscitative techniques should be immediately available until all patients are discharged home.

Monitoring and Equipment

- At a minimum, all facilities should have a reliable source of oxygen, suction, resuscitation equipment and emergency drugs.
- There should be sufficient space to accommodate all necessary equipment and personnel and to allow for expeditious access to the patient, anaesthesia machine (when present) and all monitoring equipment.
- All equipment should be maintained, tested and inspected according to the manufacturer's specifications.
- Back-up power sufficient to ensure patient protection in the event of an emergency should be available.
- In any location in which anaesthesia is administered, there should be appropriate anaesthesia apparatus and equipment to allow monitoring consistent with current ANZCA standards and guidelines, and documentation of regular preventive maintenance as recommended by the manufacturer.
- In an office where anaesthesia services are to be provided to infants and children, the required equipment, medication and resuscitative capabilities should be appropriately sized for a paediatric caseload.

Emergencies and Transfers

- There should be written protocols for cardiopulmonary emergencies and other internal and external emergencies such as fire.
- All facility personnel should be appropriately trained in the facility's emergency protocols.
- The facility should have medications, equipment and written protocols available to enable the treatment of malignant hyperthermia if triggering agents are used.
- The facility should have written protocols in place for the safe and timely transfer of patients to an alternate care facility when extended or emergency services are needed to protect the health or well-being of the patient.
- The design of the facility should permit ready access and egress should ambulance transfer of patients be required.

Acknowledgement

The content of the resource documents of the American Society of Anesthesiologists is specifically acknowledged.

References

1. ANZCA Position Statements (accessible online at http://www.anzca.edu.au/resources/professional-documents).

These include:

a. PS2: Statement on Credentialling and Defining the Scope of Clinical Practice in Anaesthesia
b. PS4: Recommendations for the Post-Anaesthesia Recovery Room
c. PS6: The Anaesthesia Record. Recommendations on the Recording of an Episode of Anaesthesia Care
d. PS7: Recommendations on The Pre-Anaesthesia Consultation
e. PS15: Recommendations for the Perioperative Care of Patients Selected for Day Care Surgery
f. PS18: Recommendations on Monitoring During Anaesthesia
g. PS20: Recommendations on Responsibilities of the Anaesthetist in the Post-Anaesthesia Period
h. PS21: Guidelines on Conscious Sedation for Dental Procedures in Australia
i. PS26: Guidelines on Consent for Anaesthesia or Sedation

j. PS28: Guidelines on Infection Control in Anaesthesia

k. PS29: Statement on Anaesthesia Care of Children in Healthcare Facilities Without Dedicated Paediatric Facilities

l. PS31: Recommendations on Checking Anaesthesia Delivery Systems

m. PS37: Statement on Local Anaesthesia and Allied Health Practitioners

n. PS51: Guidelines for the Safe Administration of Injectable Drugs in Anaesthesia

o. T1: Recommendations on Minimum Facilities for Safe Administration of Anaesthesia in Operating Suites and Other Anaesthetising Locations

p. T3: Minimum Safety Requirements for Anaesthetic Machines for Clinical Practice

2. ASA Position Statements and other documents (accessible online at http://www.asa.org.au/anaesthetists/position_statements)

These include:

a. ASA-PS04 Informed Financial Consent

b. ASA-PS07 Credentials and Clinical Privileges

c. ASA-PS13 Anaesthesia for Gastroenterological Procedures

3. Other resources

a. Guidelines for Office-based Anesthesia: American Society of Anesthesiologists (2009) (accessible online at http://www.asahq.org/publicationsAndServices/standards/12.pdf)

b. Office based anesthesia guidelines: Considerations for providing anesthesia in the office setting: American Physicians Insurance Company (accessible online at http://www.api-c.com/documents/OfficeBasedAnesthesiaGuidelinesNew_000.pdf)

Date of draft: 22 May 2010 – for review over 12months

Consent Revisited

Dr James Bradley

Many of us are currently dealing with the introduction of the so-called 'final check' or 'time out' before the commencement of surgery. This process has been driven by a number of activities, including emerging statutory requirements as well as the promotional efforts of the Royal Australasian College of Surgeons and various health care facilities, some of which (following dissemination of the World Health Organization Surgical Safety Checklist) have more than one checklist to be satisfied! The timing of these checks is not always optimal, and there is the potential to distract anaesthetists at a particularly busy time of anaesthesia, especially when the process is initiated by the nursing or surgical staff.

Given this focus on what is both institutional and patient risk containment, it's not surprising that a re-consideration of the process of 'consent' for anaesthesia as distinct from consent for surgery is occurring.

The Society has had a particular interest in the consent process and the means by which this might be effectively achieved for anaesthesia since the disturbing days of what we called the 'medical indemnity crisis'. The Society's Professional Issues Advisory Committee in fact arose out of the need to address 'consent' in the context of 'negligence' in the context of 'failure to warn'.

The issue was further addressed in a legal sense in the last issue of the *ASA news* and further comment intended to address professional practicalities follows.

Patient 'consent' has long been needed before the administration of anaesthesia. Consent is necessary to avoid a liability for trespass (battery), with the exception being an inability to give consent. For the consent to be 'informed' (and valid), there is a need to address the significant (or 'material') risks of a procedure. These significant or material risks, which might prompt a patient to change his or her mind about having anaesthesia (or surgery for that matter), were explored in Australia in the seminal Rogers v. Whitaker case.

Arising out of the common law, which includes a body of law that addresses and provides remedies for various 'civil wrong doings', a person who suffers damage may be able to receive compensation from someone who is found to be responsible or liable for those injuries. The law defines what constitutes a legal injury and establishes the circumstances under which one person might be held liable for another's injury. One of the main elements is determining the 'standard of care' and whether or not this was breached: in Australia, 'failure to warn' was judged to be a breach of that 'duty of care', and became negligence through Rogers v. Whitaker.

In addressing the need to warn as a component of the 'consent process', the ASA and Australian Medical Association, the various medical indemnifiers and Australian and New Zealand College of Anaesthetists have all given advice. ANZCA PS 27 provides guidelines which include a discussion of the elements of valid consent, the documentation of consent, advice about consent forms and information sheets and comments in relation to what is required of the persons involved in the consent process.

Valid consent requires that the patient has a clear appreciation and understanding of the facts, implications and future consequences of what is planned, for the surgery and for the anaesthesia. The patient has to be in possession of adequate reasoning faculties and in possession of all the relevant facts.

Anaesthetists appreciate that an optimal consent process is problematic when patients are met for the first time minutes before their anaesthesia. This has become increasingly the norm with day-of-surgery and staggered admissions.

There is a wide variation in how consent for anaesthesia is obtained in various institutions around the country. A default position accepted by some anaesthetists is that specific written consent for minor or 'low risk' anaesthesia is not required if consent for surgery which mentions, say, 'routine' anaesthesia is obtained. However, specific consent might well be addressed for 'non-routine', higher risk and more invasive anaesthetic procedures. This might be signed or unsigned. Some practitioners will, however, obtain written consent for all anaesthesia. This may be optimal, or it may not be: it will certainly add time and will be more an issue when patients are met for the first time immediately before their anaesthesia. We have been advised that the only time written consent is not required is when time is critical, there is an

emergency situation involving a child, there is a court order or when the treatment is authorised by statute.

In short, it is appropriate that a re-consideration of 'consent' for anaesthesia and how it is documented occurs, and the Professional Issues Advisory Committee is addressing the issue, including the practice of delegation of the consent process to junior members of staff.

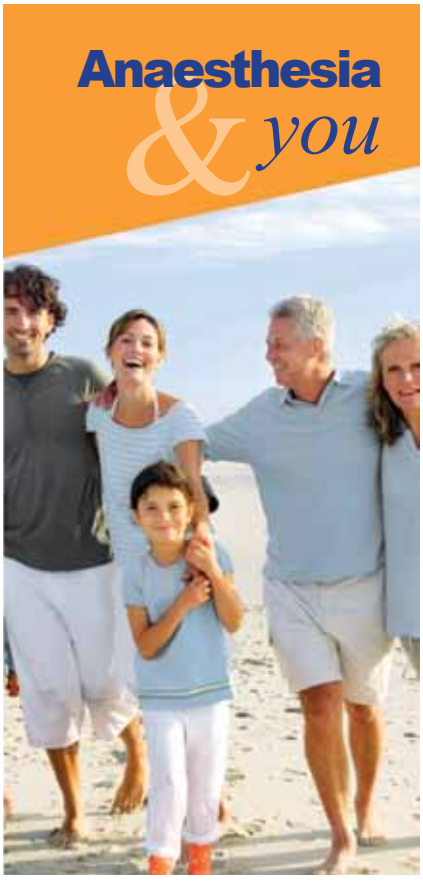
In the interim, members are reminded that the Society has produced a number of documents for the use of patients and practitioners. These documents can be provided in advance of the anaesthetic consultation and are designed to facilitate the consent process. The use of these documents will, if documented in the anaesthesia records, assist in any defence that might need to be mounted in the context of 'failure to warn' but cannot substitute for the actual explanation and advice of the anaesthetist.

Anaesthesia & you is available in both electronic and hard copy formats, and the Mi-Tec range of documents (which deal with 'risk' in more detail in the more contentious [and less routine] areas of practice) are available as hard copies and for purchase by anaesthetists and health care facilities, with many practitioners and facilities making them available to patients as part of the preoperative process. Further, 'Online Patient Advisories' (which are abridged versions of the Mi-Tec documents) along with *Anaesthesia & you* are available on the website and members are encouraged to highlight the 'Patients' area of the Society website (www.asa.org.au/patients) in their correspondence with patients.

Effective communication with patients has always underpinned a good doctor/patient relationship.

And a reminder – a competent person has the right to refuse treatment on any grounds and can withdraw consent at any time. You are obliged to respect these wishes!

James Bradley
Chair, Professional Issues Advisory Committee



Anaesthetising a child for cleft surgery, Lautoka Hospital

Island Anaesthesia

Suva, Fiji

Living in the Fijian islands normally conjures up idyllic tropical-island images: sunshine, endless beaches, crystal-clear water, great seafood and a lazy lifestyle.

And while that may be true for holidaying among the beautiful beaches of the Mamanuca and Yasawa Islands or on Viti Levu's Coral Coast, life as a medical volunteer in Suva, Fiji's capital, is an equally rewarding but altogether different experience.

From August 2009 to January 2010, I spent six months working and teaching at Fiji's main hospital in Suva and the affiliated Fiji School of Medicine as one of the 2009 ASA Pacific Fellows. I was joined by my wife, an obstetrician/gynaecologist, and our two preschool-aged children.

Fiji is one of the most populous South Pacific countries, home to almost 900,000 people among the 110 inhabited islands. Despite being a popular tourist destination, poverty is a major challenge for many Fijians. Fiji is placed 92nd on the Human Development Index and has a Gross Domestic Product per capita of US$4121. The nation has an infant mortality rate of 16 per 1000 births, four times greater than Australia, and a maternal mortality of 75 per 100,000 births.

Suva serves as the centre for medical training and receives tertiary referrals for the entire Fiji Islands. The Fiji School of Medicine (www.fsm.ac.fj) has now been training doctors for Fiji and many other South Pacific nations for the last 150 years. Suva also serves as the largest provider of healthcare in the South Pacific through the Colonial War Memorial Hospital (CWMH). My role was with the Fiji School of Medicine as a lecturer and clinician at CWMH.

The Colonial War Memorial Hospital is a large tertiary referral hospital with a diverse and challenging case-mix that will appeal to many anaesthetists. CWMH is effectively three hospitals in one, with a busy obstetric and gynaecology service (6500 deliveries per year) and a heavy paediatric load, in addition to general medical and surgical patients.

The four operating theatres provide regular elective general surgical, orthopaedic, paediatric, ear nose and throat surgery, urological, obstetric and gynaecology lists. Visiting

Tropical boardwalk along side the Colonial War Memorial Hospital

An interesting on-call case: knife wound to the thoracic spine

surgical teams from Australia and New Zealand also provide regular neurosurgical, plastic and cardiac surgical services that are satisfying to be involved with in such a unique and resource-limited environment.

Emergency and semi-elective procedures comprise more than half the theatre case-load, with a significant amount of injury and road trauma presenting after-hours. Because primary care facilities in Fiji are limited and medical retrieval is frequently delayed, anaesthesia issues in these patients are complex and challenging.

In addition, many surgical patients suffer complex medical problems impacting both surgery and anaesthesia. Diabetes and coronary artery disease are growing problems in Fiji and, among the younger obstetric population, rheumatic heart disease was not uncommon. Obstetric and gynaecology challenges were frequent, with cases of maternal Eisenmenger's, ruptured uterus, ectopics and advanced gynaecological cancers. Sadly, there were six maternal deaths in our short six-month time in Fiji alone.

The anaesthesia department also managed the six-bed intensive care unit (ICU), frequently needing to close elective theatres in order to use anaesthesia monitors for ICU patients. In order to assist the sole expat FANZCA/Joint Faculty of Intensive Care Medicine intensivist at CWMH, expat anaesthetists regularly cover the ICU roster. ICU admissions were as diverse as the anaesthesia case-mix, with infectious diseases (typhoid, leptospirosis, H1N1, dengue fever), trauma and severe asthma featuring prominently.

Anaesthesia equipment, monitoring and drug shortages were a common problem, sometimes requiring cancellation of elective theatres. Many of the drugs available were those no longer commonly used in Australian anaesthesia – nonetheless it was immensely satisfying to be able to deliver a safe and effective anaesthetic using only these foundational agents, away from the distracting allure of more modern volatiles and ultra-short acting opioids. The resourcefulness and skill of the local anaesthesia trainees was impressive, working in an environment far outside the comfort zone of a typical Australian anaesthetist.

Teaching was both the primary focus and most satisfying aspect of our time spent in Fiji. The Fiji School of Medicine trains both undergraduate and postgraduate doctors for the entire South Pacific. Standards are comparable to Australia and New Zealand for undergraduate teaching, while postgraduate teaching relies heavily on expat doctors from Australia, New Zealand and other countries to assist in specialist training.

In addition to formal tutorials, assignments and exams, a large component of teaching was clinical: on the wards, in ICU or in theatre. The Fijian and Pacific trainees have a strong thirst for knowledge and excellent clinical skills on which to build. The Damocles sword often hanging over Pacific trainees was the looming responsibility of returning once qualified to their native country as the sole anaesthetist

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Propofol- Lipuro has the same Pharmacokinetic properties as standard Propofol with rapid onset and quick recovery for optimal control of Anaesthesia.

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Before prescribing please review the full Product Information available on request from B. Braun Australia.

MINIMUM PRODUCT INFORMATION – PROPOFOL- LIPURO 1%: Composition: 1ml emulsion for injection or infusion contains Propofol 10 mg. **Excipients:** Soya-bean oil, medium-chain triglycerides, glycerol, egg lecithin, sodium oleate, water for injections. **Therapeutic indications:** Propofol- Lipuro 1% is a short-acting intravenousgeneral anaesthetic for: – induction of general anaesthesia in adults and children aged one month and older. – maintenance of general anaesthesia in adults and children aged 3 years and older. – maintenance of general anaesthesia in children aged from one month to 3 years for procedures not exceeding 60 minutes, unless alternative anaesthetic agents should be avoided. – for sedation of adults receiving intensive care. – for monitored conscious sedation of adults for surgical and diagnostic procedures. **Contraindications:** Propofol- Lipuro 1% must not be used: – in patients with a known hypersensitivity to propofol or to any of the other ingredients contained in Propofol- Lipuro 1%, namely soya oil, medium chain triglycerides, glycerol, egg lecithin, and sodium oleate. – in patients who are allergic to soya or peanut. – in children younger than 1 month for induction and maintenance of anaesthesia. – in patients of 16 years of age or younger for sedation during intensive care and for monitored conscious sedation for surgical and diagnostic procedures. **Use during Pregnancy and lactation:** Propofol- Lipuro 1% crosses the placenta and may be associated with neonatal depression. It should not be used in pregnancy or for obstetric anaesthesia. Propofol enters breast milk in small amounts. Therefore, mothers should stop breast-feeding and discard breast milk for 24 hours after administration of propofol. **Adverse effects:** Hypotension and transient apnoea may occur depending on the dose of propofol, the type of premedication and other concomitant medication. Account should be taken of the possibility of a severe drop in blood pressure in patients with impaired coronary or cerebral perfusion or those with hypovolaemia. During general anaesthesia bradycardia has occurred, occasionally with progressive severity (asystole). During induction of anaesthesia spontaneous movements and myocloni are likely to be observed. During maintenance of anaesthesia and the recovery period coughing occasionally occurs. During the recovery period, nausea, vomiting, headache, shivering and sensations of cold have seldom been reported as well as euphoria and sexual disinhibition. Very rarely, pancreatitis has been observed (causal relationship unclear). Very rarely, after long-term infusion of high doses (more than 5 mg/kg body weight) for sedation in the ICU the so-called propofol infusion syndrome has been observed with the following symptoms: rhabdomyolysis, metabolic acidosis, hyperkalaemia, and cardiac failure. Rarely, epileptiform convulsions including opisthotonus may occur, in isolated cases delayed by hours or days. In isolated cases, after administration to epileptic patients, convulsions have been observed. There have been reports of rare cases of postoperative fever and discoloration of urine following prolonged administration as well as severe cases of hypersensitivity reactions (anaphylaxis), which may include bronchospasm, erythema and hypotension. Isolated cases of pulmonary oedema have also been reported. Local pain may occur during the initial injection. Thrombosis and phlebitis are rare. After co-administration of lidocaine the following undesirable effects may occur: giddiness, vomiting, drowsiness, convulsions, bradycardia, cardiac arrhythmia and shock. There are isolated reports of severe tissue reactions after accidental extravascular administration. **Interactions:** When propofol is given with central nervous system depressants, such as potent analgesics, alcohol, or general anaesthetics, the sedative effect may be intensified and the possibility of severe respiratory or cardiovascular depression should be considered. Concomitant use of benzodiazepines, parasympatholytic agents or inhalation anaesthetics has been reported to prolong the anaesthesia and to reduce the respiratory rate. Intramuscular or intravenous premedication particularly with narcotics (e.g. morphine, meperidine, and fentanyl, etc.) and combinations of opioids and sedatives (e.g. benzodiazepines, barbiturates, chloral hydrate, droperidol, etc.) may increase the anaesthetic or sedative effects of Propofol- Lipuro 1% . Additional premedication with opioids may cause a higher incidence and longer duration of apnoea. Inhalational agents can also be expected to increase the anaesthetic or sedative and cardiorespiratory effects of Propofol- Lipuro 1%. **Instructions for use/handling:** Propofol- Lipuro 1% is administered intravenously. Containers should be shaken before use. Propofol- Lipuro 1% contains no antimicrobial preservatives. Therefore, Propofol- Lipuro 1 % (200 mg/20 ml) is to be drawn up aseptically. Before use, the neck of the ampoule should be cleaned with medicinal alcohol (spray or swabs). The contents are for single use in one patient. Any portion of the contents remaining after use must be discarded. Please see package leaflet before application. Store below 25 °C. Do not freeze. **AUST R 142906**

The Product Information is available on request from B. Braun Australia by calling the Customer Service team on 1800 251 705.

PBS Information: This product is not listed on the PBS.

(1) Larsen B, Beerhalter U, et al. Less pain on injection by a new formulation of propofol? A comparison with propofol LCT. Anaesthesist 2001; 50(11): 842-5.

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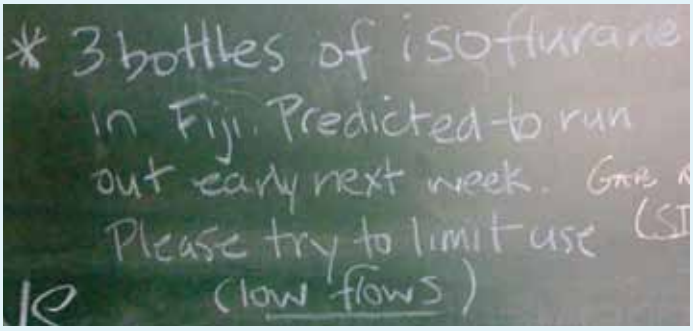
for an entire island nation. While resource scarcity is an ongoing challenge for Fiji, much has and can be achieved through further education and training. It is easy to forget that many of the advances in modern anaesthesia care are the result of changes in practice, knowledge and skills rather than the result of expensive new drugs or equipment. We plan to regularly return to Fiji to continue this journey, as well as build upon the valuable relationships forged with local doctors, and further foster links between medicine in the South Pacific and in Australia.

Daniel Jolley
Royal Womens' Hospital, Parkville and
The Northern Hospital, Epping, Victoria

Daniel is returning to Fiji in August to run an Obstetric Anaesthesia workshop.



Department blackboard notice of critical nation-wide volatile shortage

Working in Kathmandu, Nepal

Machhapuchhre and prayer flags

Sunrise beside Machhapuchhre

I was very fortunate to spend the last month of my provisional fellow year in Nepal, as part of an exchange program between the Royal Hobart Hospital and the Society of Anaesthesiologists of Nepal (SAN). This is the third year we have provided speakers for the SAN refresher course, the second year of sponsoring a Nepalese anaesthetist to come to Hobart and the first year the exchange included a Hobart anaesthetist working in Nepal.

I was keen for an introduction to the differences and challenges of anaesthesia in a developing country. Nepal was an easy choice because our department was seeking participants for the SAN refresher course and this also presented an opportunity to strengthen the link between Hobart and Nepal.

Kathmandu Medical College is a 700-bed teaching hospital which performs most surgery except cardiac, neuro and transplants. It has six main theatres staffed by five consultant anaesthetists.

The lists I was involved with ranged from the familiar (laparoscopic cholecystectomies, caesarian sections and prostate resections) to the not so familiar (thoracotomies and bowel resections for tuberculosis abscesses). For cases under general anaesthesia, there was a steep learning curve with using halothane in the absence of end-tidal agent monitoring or capnography.

Cases in Australia which would normally be performed under general anaesthesia, such as appendicectomies and hernia repairs, were done with spinal anaesthesia and selected laparoscopic cholecystectomies were also being done under spinal. Regional techniques such as ankle blocks and brachial plexus blocks were often used as the sole anaesthetic technique. The benefits of regional anaesthesia in this setting were its safety over general anaesthesia, as well as reduced pressure on recovery. The recovery unit did not have the same level of staffing or monitoring to which we are accustomed, which meant that a patient who had received a general anaesthetic had to be partially recovered in theatre between cases.

Some of the more interesting cases I assisted with included electroconvolsive therapies using the isolated forearm technique to judge seizure duration and the setting up of transvenous pacing for a woman in second degree heart block prior to an elective hysterectomy.

While I was at Kathmandu Medical College I was also involved with teaching the residents. This was very much a two-way stream and I learnt a great deal from the trainees about the practicalities of working in their hospital system. We had two to three formal teaching sessions per week, as well as informal teaching in theatre where I mostly demonstrated regional techniques.

My experience in Nepal was a good introduction to developing country anaesthesia. The infrastructure was limited and provision of anaesthesia more challenging than in a Western country, but I still had the luxury of a hospital environment. Indeed, the hospital where I worked was quite well resourced compared to theatres in other hospitals I visited. I think this is a good foundation for people interested in working in more challenging environments.

At a departmental level, this has strengthened relations between our hospitals. It is very useful to understand the perspective of Nepalese anaesthetists who visit Hobart by experiencing their normal work conditions. It also provided useful feedback on how techniques and concepts learnt during the Hobart rotation were applied in the Nepalese setting, such as ultrasound-guided regional techniques.

The major benefit for me was gaining a new perspective on the functioning of our own theatres. I hope that working without the equipment and services we take for granted has made me more flexible and I admire the dedication of our Nepalese colleagues in providing safe anaesthesia under these challenging circumstances.

Roger Wong
Royal Hobart Hospital

Sunrise on Annapurnas

End of Financial Year Preparations

With the end of the financial year approaching, it is timely to review your practice financials in order to ensure you are able to meet your financial obligations and have all information ready to provide to your accountant to complete your tax returns.

If, as can often be the case when running a busy practice, you have fallen behind with the preparation of your financial reports, now is the time to get those reports underway and your accounts in order.

Take the time to:

- Ensure your bank statements and receipts are in order.
- Check whether you have met your statutory obligations, including the payment of compulsory superannuation contributions for your employees and PAYG instalments.
- Reconcile your payroll.
- Reconcile your accounts receivable and accounts payable.

Give consideration to whether there are any legitimate business expenses that might be paid for in the current tax year to help reduce your overall tax bill.

Speak with your accountant in relation to whether any small business tax concessions may be claimed by your business.

At the end of the financial year, in addition to providing all relevant documentation to your accountant for the preparation of your annual tax return, you will need to complete your final Business Activity Statement for the year. It is also a good idea to review your business expenses and where you may be able to make savings next year and identify areas where there may need to be an increase in expenditure (either ongoing or as a one-off basis) so these can be budgeted for in advance. Also take the time to review your staffing arrangements and make sure that all staff, be they employees or contractors, are appropriately engaged, including a review of the terms and conditions of employment or appointment and remuneration arrangements.

The review of insurance arrangements is often a matter that can be overlooked in the day-to-day running of your business. Often these matters are overlooked until there is the need to call on a policy and the realisation that levels of cover have not been varied over the years to take into account the changes in your business. Take the time to ensure you have the appropriate insurances in place and the necessary levels of cover.

Superannuation Update

Preliminary recommendations on self-managed superannuation funds (SMSF) have been issued by the Panel overseeing the Super System Review. The Panel's final recommendations on SMSF will be made by 30 June, 2010. A summary of the preliminary recommendations are:

- support for trustees control over SMSFs,
- the introduction of member identity requirements as part of the SMSF registration process,
- prohibiting investment in collectables and personal-use assets such as artworks, wine collections, exotic cars and yachts,
- prohibiting the acquisition of in-house assets and imposing restrictions on transactions between related parties and an SMSF,
- expanding the Australian Tax Office's enforcement powers.

In addition, the Government has released its response to the Henry Tax Review. The key Government proposals include increasing compulsory superannuation from 9 to 12% by 2019.

The contribution will be staged in the following way:

Table 1

Contribution

Year	Increase	Total % contribution
2013 to 2014	0.25%	9.25
2014 to 2015	0.25%	9.5
2015 to 2016	0.5%	10.0
2016 to 2017	0.5%	10.5
2017 to 2018	0.5%	11.0
2018 to 2019	0.5%	11.5
2019 to 2020	0.5%	12.0

In addition, it is proposed that the super guarantee age limit will be raised from 70 to 75 years.

Professional Advice and Assistance

Always remember to avail yourself of professional advice and assistance as the end of financial year approaches, to ensure you are complying with your obligations, maximising your returns and to ensure that your business is in great financial shape for the coming year.

Dominique Egan
Partner, Trescox Lawyers

GPALS Placements Begin

"My initial response to the General Practitioner Anaesthetists' Locum Scheme (GPALS) was that it seemed too good to be true!", exclaimed Dr Michael Schien, a Newcastle based GP anaesthetist who is also a GPALS locum and provides intermittent relief at Kempsey Hospital, New South Wales.

GPALS is the Australian Government-funded initiative designed to maintain access to anaesthesia services for rural and remote communities by providing locum support to the GP anaesthetist workforce.

"This is a Scheme linking many of the overworked anaesthetists out there with appropriate locum support, and rewards them financially for doing so", says Dr Schien. "Hopefully, it will flourish in the long-term and encourage more and younger doctors to develop, practise and maintain anesthetic skills in rural and remote areas, in the knowledge that locum relief will be easier to obtain in the future."

Dr Schien's services were directly arranged by Kempsey Hospital, which was still able to take advantage of the GPALS financial benefits by registering with the Scheme. That's one of the good things about GPALS – as long as the eligibility criteria are met by both the host and the locum, rural practices and hospitals can use the Scheme simply to access the subsidies. Per GP anaesthetist seeking relief, these include: $750 per day locum service fee for up to 14 days (i.e. up to $10,500) per financial year, and up to $1500 for travel costs per placement.

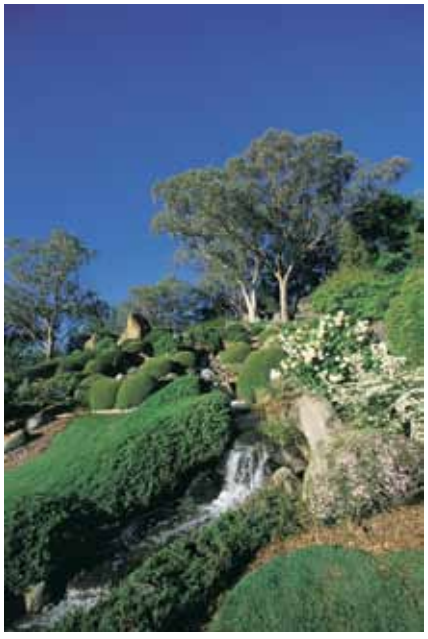
The subsidies were welcomed by Dr David Richmond of Cowra, where the first facilitated GPALS placement occurred. "Both my colleague and myself received a subsidy. The Scheme was subsidised very effectively and so, due to the generous support, we incurred no cost outlay for the locum placements," said Dr Richmond. "GPALS provided an excellent service. It arranged the GP anaesthetist locum who was most welcome and provided some desperate relief for the procedural GPs in the town."

The practitioner who provided locum cover at Cowra, Dr Siew-Lee Thoo, is usually the District Medical Officer of anaesthetics at Kununurra District Hospital, Western Australia. What she really liked about the Scheme was the interesting opportunity it offered her. "GPALS enabled me to see both another part of the country and to work at a different site. The latter provided me with a comparative experience that gave me greater insight in to my usual workplace to see what's working well and what may be done differently. I also appreciated that GPALS gave me the opportunity to help out my rural colleagues who invariably have great difficulty in finding locum relief, particularly for an extended period of time."

If you'd like to know more about GPALS or to apply, visit the ASA website at www.asa.org.au, call the Project Coordinator on (02) 9327 4022, or send an email to gpals@fed.asa.org.au.

Dianne Bennett
GPALS Project Coordinator

Sunset at Cowra



Cowra's Japanese Gardens

CONSULTANT (SPECIALIST) ANAESTHETIST

The Fiji Ministry of Health invites applications for two (2) positions of **Consultant (Specialist) Anesthetist.**

Position Title: **Consultant (Specialist) Anesthetist**

Location & Term: **CWM Hospital – 6 months**
Lautoka Hospital – 2 years

Minimum Qualification: Registered Specialist or able to be registered in the Fiji Specialist Roll. Consistently good peer assessment and ability to supervise staff.

Salary & Condition: The Consultant will be recruited under the standard terms & conditions of Service offered to Fiji Government Expatriates with AUSAID supplementation (the details of which to be negotiated with the successful candidate for this position).

Terms of Reference: May be sought from Mrs Jennifer Turaga, Recruitment & Appointment Unit, Ministry of Health, Fiji on telephone number (679)3221422 or (679) 3306177 or through email address jturaga@govnet.gov.fj

Application: Applicants should provide their completed curriculum vitae with a covering letter and forward applications by post to:
The Manager, Recruitment & Appointment Unit
Ministry of Health, P.O.Box 2223,
Government Buildings, SUVA
FIJI
Or email application to Mrs Jennifer Turaga on the above given email address.

Closing Date: **1st August 2010**

2010 Combined Special Interest Group Meeting

Sheraton Mirage, Port Douglas, Queensland
Friday 24 to Sunday 26 September, 2010

The meeting will follow the successful format of previous years which includes sessions and workshops under the four Special Interest Group areas. A number of concurrent sessions will be run to allow a mix of workshops and themed presentations. In addition, breakfast sessions and free paper sessions will be included in the program.

Following the success at past meetings of speakers from areas of interest outside the field of anaesthesia, TRIAD Consulting Group, founded by members of the Harvard Negotiation Project, will be the main speaker in 2010. They are world renowned as experts in negotiation techniques and communication training. As well as taking part in the meeting, there will be optional workshops also available.

The preliminary program and registration brochure will be available shortly.

The Sheraton Mirage, Port Douglas is situated on Four Mile Beach. It is an easy distance to the centre of Port Douglas and a good base for visiting the Great Barrier Reef and the Daintree Rainforest.

Gay Hopgood
Combined SIG Meeting Coordinator
ANZCA Continuing Professional Development
Tel: +61 3 8517 5322
Email: ghopgood@anzca.edu.au

Sheraton Mirage Port Douglas Resort

Medicine in Australia: Balancing Employment and Life
Focus on Anaesthetists

About MABEL

The aim of this short article is to present some initial findings from the Medicine in Australia: Balancing Employment and Life (MABEL) longitudinal survey of doctors.

The MABEL survey has been funded by the National Health and Medical Research Council for five years until 2011, and has been endorsed by key medical colleges and organisations, including the ASA and the Australian and New Zealand College of Anaesthetists (ANZCA). The strength of MABEL is the longitudinal design, range of questions and strong potential to influence medical workforce policy. MABEL has a Policy Reference Group whose members comprise key stakeholders in the medical workforce policy area. The Policy Reference Group has been involved from the inception of the survey and meets twice a year.

In 2008, 10,498 doctors responded to Wave 1 of the MABEL survey and data from Wave 2 (2009) is currently being processed. The Wave 1 survey was sent to all specialists and specialists registrars listed in the Australian Medical Publishing Company Medical Directory (19,579 and 4214 respectively), of which 4311 (22%) specialists and 864 (20.5%) registrars responded. A number of these and other doctors had changed their doctor type and filled out a different version of the survey, which provided 4596 specialists and 1072 specialist registrars for analysis. This included 617 anaesthetists and 145 anaesthetist registrars. The analysis below is based on data from these anaesthetists and registrars. According to the 2008 ANZCA Annual Report, there were a total of 3629 (3448 old and 181 new) Australian anaesthetist fellows registered in 2008.

Demographic Characteristics

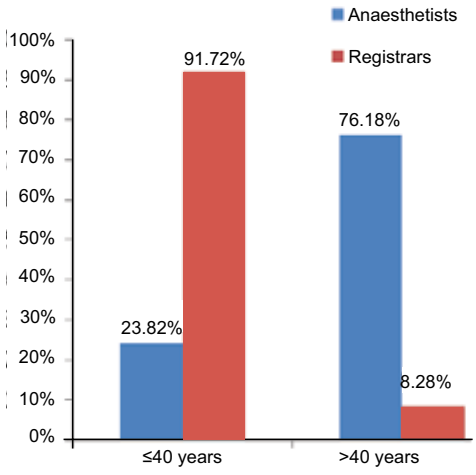


Figure 1: Age distribution.

The average age of the anaesthetists was 49 years (male 49.84, female 45.52 years) while that of registrars was 33 years (male 33.21, female 32.71 years). As shown in Figure 1, almost three-quarters of the anaesthetists were aged between 41 and 70 years, while 92% of registrars were between 26 to 40 years of age. The percentage of females was much higher among anaesthetist registrars (40%) than anaesthetists (27%). According to ANZCA 1995, as mentioned in AMWAC report 2001, the percentage of female anaesthetists at that time was 17%. This percentage rose to 24% in 2008 as per the 2008 ANZCA Annual Report.

Hours Worked

Table 1 below compares measures of workload between anaesthetists and registrars of different genders. In general, registrars worked longer hours (six additional hours) than anaesthetists. Gender differences were strongest amongst anaesthetists. Female anaesthetists worked 10 hours less than their male counterparts. Such a difference did not exist between male and female registrars. The total percentage doing on-call was higher amongst female than male registrars. The pattern was opposite for anaesthetists. A higher proportion

Table 1

Comparison of work characteristics by gender

	Anaesthetists			Registrars		
Work characteristics	Male	Female	Average	Male	Female	Average
Average hours worked	45.88	35.37	43.04	49.44	48.41	49.03
Working more than 50 hours per week, %	45.11	13.17	36.47	44.83	41.38	43.45
Doing on-call, %	86.89	82.04	85.58	88.51	96.55	91.72

of male than female anaesthetists reported doing on-call. In line with this, more than half of the female registrars wanted to reduce their work hours (Figure 2).

The average number of hours worked seems to have fallen from 52.4 hours in 2001 as reported in the Australian Medical Workforce Advisory Committee report cited earlier. Interestingly however, the pattern of females working less than the males (10.4 hours lower) has remained unchanged.

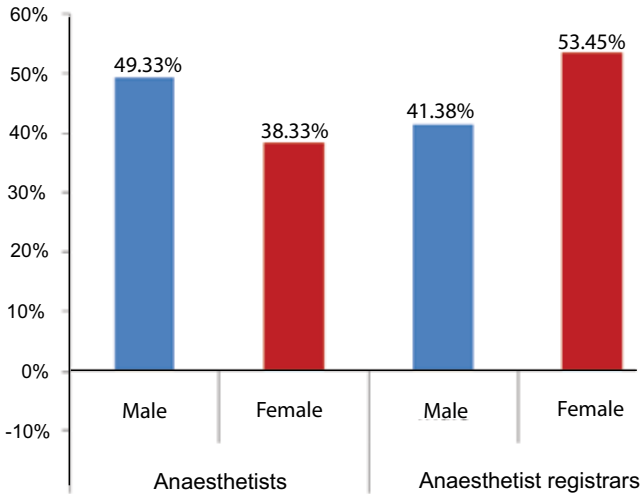


Figure 2: Percent wanting to reduce hours worked.

Figure 3: Job satisfaction by gender and doctor type.

Perceptions on Job Satisfaction

In general, anaesthetists and registrars were satisfied with their jobs. As shown in Figure 3, 89.1% anaesthetists (89.8% male, 87.0% female) and 84.1% registrars (83.9% male, 84.5% female) felt either moderately satisfied or very satisfied with their jobs. The difference between males and females were small. Female registrars were the most dissatisfied (10.3%), followed by female anaesthetists (9.0%), male anaesthetists (7.1%) and male registrars (5.8%).

Perceptions on Work-Life Balance

A greater percentage of registrars reported poorer work-life balance compared to anaesthetists. About 50% of the registrars (49.4% male, 50% female) and 29% of the anaesthetists (31.6% male, 23.4% female) disagreed with the statement that the balance between their personal and professional commitments was about right. These are slightly higher than figures for all specialists (49%, with 48% male, 51% female) and slightly lower than for all specialist registrars (36%, with 39% male, 32% female). Further, female anaesthetic registrars reported poorer work-life balance compared to the female anaesthetists. Only 33% of the female registrars reported optimal work-life balance while the corresponding proportion in female anaesthetists was 65%.

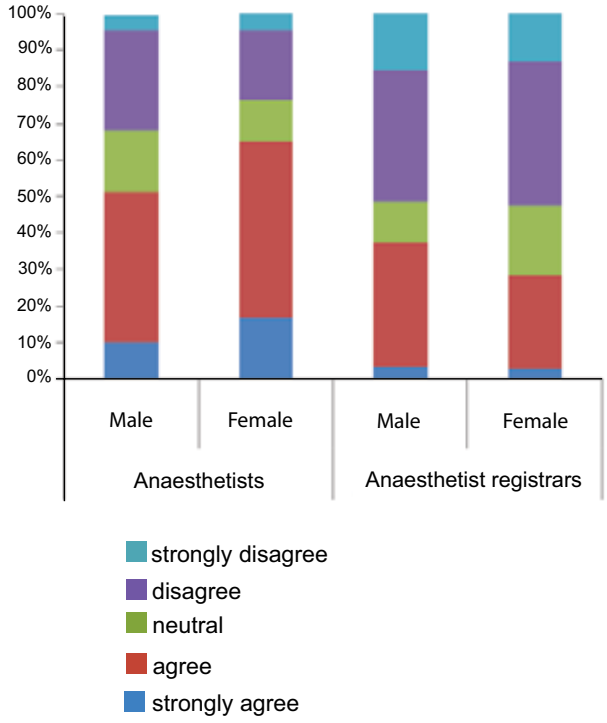


Figure 4: Work-life balance by gender – agreement with the statement "The balance between my personal and professional commitments is about right".

Intentions to Leave Direct Patient Care

For those aged under 55 years, when asked about the likelihood that they would leave direct patient care within the next five years, roughly 7% of anaesthetists and 2% of registrars reported that they were likely to do so (Figure 5). Female anaesthetists were more likely to quit than their male counterparts.

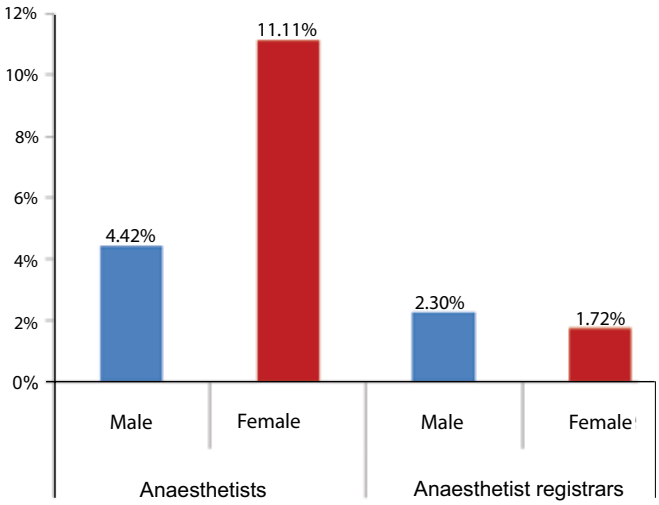


Figure 5: Intention to leave direct patient care for those aged less than 55 years by gender.

Conclusion

The MABEL baseline data presented above provide a solid foundation for examining changes over time in workforce participation and attitudes to work. The results suggest that anaesthetists are less likely than registrars to perceive a work-life imbalance. Almost 89% of the anaesthetists and 84% of the registrars were satisfied with their jobs.

Notable gender variation was seen in the average number of hours worked among male and female anaesthetists, with the males generally working 10 hours more than the females. Female registrars worked 13 hours more than female anaesthetists. This group (female registrars) is the most dissatisfied among the anaesthetists and registrars. About 10% of female anaesthetists reported dissatisfaction with their job and 50% reported that their work-life balance is not optimal. Although half of the female registrars wanted to reduce hours worked, these were the group who were the least likely to want to quit.

These patterns might change however, with the increasing proportion of females in the anaesthetic workforce over time. For example, the longitudinal nature of MABEL will allow us to monitor how hours worked for female registrars change over time relative to males. These results also provide an important baseline to examine the impact of future changes to the medical workforce. Further results and details are available for download from our website www.mabel.org.au.

Acknowledgements

This work was supported by a National Health and Medical Research Council Health Services Research Grant (454799) and the Commonwealth Department of Health and Ageing. We thank the doctors who gave their valuable time to participate in MABEL, and the other members of the MABEL research team.

Ms Durga Shrethsa
Dr Catherine Joyce
Department of Epidemiology and Preventive Medicine, Monash University.

Professor Anthony Scott
Melbourne Institute of Applied Economic and Social Research, The University of Melbourne.

News from WFSA – Obstetric Committee Report 2010

The past year for the Obstetric Committee has been one of forging links with sister organisations and attempting to build the bridges by which we may collaborate on future multidisciplinary projects.

Late in 2009, following an earlier introductory meeting in London, the Chair, Dr Paul Howell, travelled to Cape Town as a guest of the International Federation of Gynecology and Obstetrics to participate in their World Congress. There he joined round-table panel discussions devoted to the International Federation of Gynecology and Obstetrics initiative on maternal and newborn health supported by the Bill and Melinda Gates Foundation. He made clear to parties who habitually forget to include anaesthetic involvement in the planning of maternity projects (e.g. obstetricians, midwives, health planners) how pivotal we are in improving obstetric surgical outcome in resource-poor areas.

The World Federation of Societies of Anaesthesiologists (WFSA) has now become a partner in the World Health Organization Partnership for Maternal, Newborn and Child Health, a multidisciplinary alliance of interested parties who are working to improve the health of mothers and children worldwide. This will hopefully improve our international profile and our ability to liaise with like-minded organisations on joint future projects – all too pressing since it is now clear that Millennium Development Goals 4 and 5 are far from being met.

Links with the Obstetric Anaesthetists' Association (OAA) and Association of Anaesthetists of Great Britain and Ireland continue to grow and the WFSA has joined forces with them on several interesting ventures. Thanks to a generous grant from Baxter and collaboration with the OAA and Elsevier, publishers of the *International Journal of Obstetric Anesthesia*, a two CD set of useful obstetric anaesthetic resource material is being produced for distribution in resource-poor countries. This set, which comprises a variety of different tools including a webcast of the 2008 OAA Three Day Course with slides and abstract book, video of how spinals work and back copies of the journal *Update in Anaesthesia* and the Anaesthesia Tutorial of the Week, is almost ready for circulation through usual WFSA routes.

Cape Town

Image: Courtesy of Cape Town Tourism

In addition, an exciting new handbook of obstetric anaesthesia, specifically targeted at anaesthetic providers in resource-poor areas, has just been completed and is ready for shipping. This handbook is a collaboration between the Publications Committee, the OAA and the Association of Anaesthetists of Great Britain and Ireland. Already in hardcopy, it is hoped to make it available in electronic format at some point in the future.

As and when these two new educational tools are received, please do feed back to us with your comments, including what is useful, what is not and what else would you like included (for the next editions).

Around the world, individual members of the Obstetric Anaesthesia Committee continue to make significant contributions to the practice of obstetric anaesthesia and analgesia in their own regions and beyond. Everyone plays their part, but special mention should perhaps be made of Dr Medge Owen who heads Kybele, an organisation that takes multidisciplinary teams into transitional level countries and shows how obstetric (anaesthetic) care can be improved through a combination of formal lectures and hands-on practical tuition. Recent publications[1,2] show that this approach can make a lasting impact, with sustained changes in practice – an excellent example to us all.

Finally, in the not-too-distant future, our 2012 World Congress in Argentina approaches. There will, of course, be an obstetric anaesthetic component to the meeting – always popular sessions – so put the dates in your diary and we hope to see you there!

Paul Howell
Chair, Obstetric Anaesthesia Committee, WFSA

References

1. Kopic D, Sedensky M, Owen M. The impact of a teaching program on obstetric anesthesia practices in Croatia. Int J Obstet Anesth 2009; 18:4-9.
2. Howell PR. Supporting the evolution of obstetric anaesthesia through outreach programs (Editorial). Int J Obstet Anesth 2009; 18:1-3.

ASA Strategic Planning Workshop

The ASA Council, together with the Chairs of the Professional Issues Advisory Committee and the Economics Advisory Committee, spent Sunday, 23 May ensconced at Edgecliff in a strategic planning workshop. The workshop was externally facilitated to keep us out of deep rabbit holes!

The workshop complements other Board Development sessions. Recent sessions have focused on governance and financial reporting.

The session reviewed the ASA's situation and sought to clarify its role in relation to ANZCA. The outcomes of the workshop will be refined by Council and a précis will be presented at the ASA's Annual General Meeting in October as well as in the next *ASA news*.

Peter Lawrence
Executive Director

Drs Richard Clarke, Andrew Mulcahy and Mark Sinclair

Drs James Bradley and David Brown

Drs Richard Grutzner, Guy Christie-Taylor, Reginald Cammack and Phillip Morrissey

69th National Scientific Congress 2 to 5 October 2010

The Organising Committee would like to invite all readers to attend the 69th ASA National Scientific Congress! It has been almost three years of planning and organising and we now have a spectacular meeting to present. There will be a little of the old and a lot of the new.

So what's new? The venue, for a start! It is being held at the expansive and majestic new Melbourne Convention and Exhibition Centre on Southbank. It is the first convention centre in the world to achieve a six green star environmental rating.

Right next to this is the old Exhibition Centre, known to the locals as "Jeff's shed". And what a shed! Equally as expansive, it has been generously and avidly subscribed to by the healthcare industry, encompassing variety and diversity.

The program is full and broad in content, with overseas and local speakers and non-anaesthetic presenters. Delegates will have to be prepared to make choices between sessions. On some days, five high quality concurrent sessions are on offer, including Super Sunday. Check the details on the website, www.asa2010.com.

The Organising Committee would also like to extend a special welcome to all trainees and GP anaesthetists, as well as the members of the Retired Anaesthetists Group. We have had enthusiastic and very capable representatives for GASACT, RAG and GP anaesthetists on our committee with great results. Academic and social sessions have been organised with these groups particularly in mind.

We have shouldered four simulator sessions, so you can attend on the Friday before or the Wednesday after the meeting, complementing your National Scientific Congress attendance and allowing CPD points aplenty. And let me remind readers that the first triennium of the current Continuing Professional Development expires in 2010.

There are several workshops, problem-based learning and question and answer discussions, including a mock hearing at the County Court.

On Sunday morning we have a session on teenagers, which partners and delegates alike will find interesting and stimulating. We have been incredibly fortunate to secure the services of Mr Bernard Salt, world renowned demographer, Ms Paula Kotowicz from The Butterfly Foundation for eating disorders and high profile youth worker, Mr Les Twentyman OAM, who will speak to us about 'Our Troubled Youth'. Sometimes it's not easy being the children of high achieving parents and we think this is an important issue facing all of us. We have therefore decided to open this plenary session on Sunday to all partners as well (including non-registered accompanying persons). On that

day only, the partners will be invited into the trade area for morning tea following the session.

I could go on and on about the academic program content because there is so much of it, but it's easier if you just log on to the website and find out for yourself!

The social program has not been forgotten. It too has attracted significant attention from our Organising Committee and will not disappoint. It includes a family night at Science Works, where both children and adults are sure to be educated and entertained. The committee has selected choice Victorian wines and have been maturing them in our cellars in anticipation of the Gala Dinner. Of course, to ensure that the accompanying persons are not unoccupied, there are several optional activities available.

We will be trying to reduce paper at this meeting, choosing not to distribute hard copy registrations. However, for those with difficulties with online registration, emails with a PDF version will be sent around. And if you're really stuck, there will be a phone number where you can 'phone a friend'. Also, in keeping with

the trend, we shall not be distributing hard copy abstract books to everyone, though for those who cannot let go of their security blanket, we have compromised so that a copy can be ordered (please note the deadline when registering). Abstracts will be electronically available to all registrants. This option is much lighter to carry and occupies less room in the home office.

So log on and join us at www.asa2010.com. We look forward to seeing you at the Congress!

Renald Portelli, Convener
David A. Scott, Scientific Convener

69th NSC brought to you by:
Jean Allison
Michael Boquest
Antonio Grossi
Richard Grutzner
Jenny King
Simon Reilly
Mark Sandford
Andrew Schneider
Peter Seal
Michelle Spencer
Quentin Tibbals
Andrew Wyss

Images: The Melbourne Conference and Exhibition Centre

The vital question that successful investors and wealthy entrepreneurs ask before they invest

When investing, the vast majority of investors focus on achieving the highest investment return – as if they can somehow influence the return. It's absolutely crazy! The return will be what it will be. My advice is to forget about returns. Instead, focus on investment risk, because that's what you *can* influence.

Genius investor Mr Warren Buffett purchased preference shares in Goldman Sachs in September 2008 in the heart of the Global Financial Crisis. The preference shares pay an income stream of 10% p.a. and are exercisable at a share price of $115. At the time of writing this article, Goldman Sachs' share price was $177. I estimate that Warren has already made a profit of US$2.6 billion. This is a prime example of considering your downside. Warren mitigated this risk of 'zero capital growth' by structuring the deal with a 10% income stream – so at least he had earned an income if nothing else. This is a perfect example of how smart investors think about the downside (risk) first.

Risk ***and*** return make up your total return

Investors are often blinded by return. Greed is probably the second most powerful motivator behind fear. This has been proven many times in history, with disasters like Storm Financial, the US sub-prime crisis and the list goes on. Dangle a double-digit return in front of most people and they'll immediately start calculating the profit in dollar terms.

The correct way to consider an investment opportunity is to first consider the return. Next, you need to assess the risk associated with the investment – is it low, medium or high? Finally, you need to decide if there is anything you can do to mitigate or eliminate some of the risks, to bring the residual risk down to an acceptable level. However, many people forget the last two steps. Instead, they look at the gross return and get excited. Interestingly, seasoned and successful investors tend to reverse the approach. I recall reading Sir Richard Branson saying that when looking at an investment opportunity, he first considered his 'down side'. The first thing Sir Branson thinks about is his risk. Interesting!

What can we do to minimise risk?

The answer to the above question is a separate article in itself. However, here are a few comments:

- **Time** – the longer your planned investment period, the lower the risk. For example, if you have 30 years until retirement, you do not have to take many risks at all. However, someone with only 10 years from retirement with a relatively low asset base has a much higher investment risk.
- **Experience and advice** – consider a doctor who wants to buy an investment property. He has two choices. He can search for the 'right' property himself or he can engage an expert to do it for him. Which option do you think carries more risk?
- **Strategy** – the way you go about investing can change your risk. For example, something as simple as buying a property (that you plan to sell in 15 years time) in a super fund, instead of owning the property in personal names will minimise (or eliminate) capital gains tax thereby increasing your 'after tax' return. This correct strategic decision increases the chance of achieving retirement goals.

The single most important thing

Probably the single biggest way of mitigating or reducing investment risk is through financial planning. The financial planning process allows us to develop a smart strategy. The next step is then to go through the strategy with a fine-tooth comb and identify all the possible things that can go wrong and develop a strategy of how to address them. This can only be achieved through astute and diligent planning which ultimately reduces your risk.

Stuart Wemyss

Stuart Wemyss is a qualified Chartered Accountant, financial planner and mortgage broker. Stuart founded financial advisory firm ProSolution Private Clients which helps anaesthetists maximise their net worth through proactive and strategic asset and liability management. Contact: swemyss@prosolution.com.au

News from the States

TASMANIA

Political Landscape

Tasmania has recently had an election which resulted in a hung parliament with 10 Liberal, 10 Labor and five Green seats. An agreement has been made between the Labor and Green Parties, resulting in the current leader of the Greens being given a seat in cabinet. This is the first time in Australia that this has occurred. We have a new Minister for Health, Ms Michelle O'Byrne, who was previously involved in community development and local government.

Hospitals

Funding has been made available for the recruitment of additional anaesthetic staff specialists at the Royal Hobart Hospital. This should allow for all operating theatres to be fully utilised, and should improve throughput of cases. The Private Practice Scheme for staff specialists is currently undergoing an independent review.

Meetings

Dr Ben van der Greid organised a Paediatric Anaesthesia Day meeting which was held on Saturday, 17 April, in Hobart. The speakers comprised both local and mainland paediatric anaesthetists. It attracted about 100 delegates, including a number of nursing staff, registrars and interstate anaesthetists. The comments were uniformly highly positive. There are a number of additional meetings planned for the rest of the year, including a Part III course in November.

National Registration

Once the legislation passes through parliament it will result in a 60% increase in the cost of medical registration to $650. Tasmania plans to have its own health practitioners' tribunal, allowing for the majority of cases to be dealt with on a local level.

David Brown
Chair

QUEENSLAND

Registrars Meeting

The registrars' meeting which was cancelled in November was held on 24 April 2010. There was a good turnout with nine papers presented. Entries were of a high standard. Dr David McCormack awarded the ASA prize to Dr Louise Munro for her paper "An audit of blood transfusion practices in primary elective hip arthroplasty at Logan Hospital for 2008". Congratulations to Louise and thank you David for standing in on my behalf.

Combined CME NSC

This meeting is scheduled for 10 July at the Victoria Park Golf Club. The theme for the meeting is "Acute Pain and What's New in Anaesthesia". Registration forms have been distributed and we expect a large turnout.

Surgery Connect

The Surgery Connect contract was extended by the Director General until 30 June 2010. The new plans and agreements have been written but not yet released. Surgery in the meantime has continued with the four current brokers. Dr Tim Wong has continued his sterling work on our behalf and is pushing for the anaesthetists to be paid at the same level as the surgeons (hopefully no less than QComp rates).

Visiting Medical Officer Contract

Once again negotiations are at a standstill. QHealth took the Visiting Medical Officers to the Industrial Commission where the Commissioner advised QHealth to rethink their approach. QHealth then attempted to persuade Visiting Medical Officers to accept the old agreement. (A meeting was meant to be held in early May but unfortunately the Commissioner had to cancel at the last minute.) The AMA apparently has a contingency plan if needed.

QHealth Pay Debacle

This is an ongoing fiasco which QHealth are trying to sort out! Queensland rail apparently are using the same system as QHealth and, despite a phased transition, Queensland rail are still experiencing problems over a year down the line! We can only advise all public anaesthetists and Visiting Medical Officers to examine their payslips closely, especially super contributions, salary sacrificing, fringe benefit tax, leave entitlements etc.

GASACT

The Part Zero course which was held in January was very successful. Of note is that the Part Zero Booklet written and compiled by Dr Chris Breen is now being used by other states. Well done Chris!

The Part III course was held on 26 June. My thanks to Drs Chris Breen, Rob Miskeljin and their team for their excellent organising efforts.

New ASA Premises Queensland

I would like to inform all ASA Queensland members that we have relocated our offices to the AMA offices on

L' Estrange Terrace, Kelvingrove. On behalf of myself and my committee, I would like to thank the ANZCA office and staff for all their help in the past. The new ASA contact number is 1800 806 654.

Finally, I would like to report that, as the Chair of the Queensland Committee, I have been asked (and have accepted) to stand as the State Representative on the ASA Executive Committee.

Gerry Turner
Chair

AUSTRALIAN CAPITAL TERRITORY

I would like to thank Dr Linda Weber, who retired as Chair in early May (her second term as ACT Chair). Society members in Canberra are very grateful for her tireless contributions over the last three years in what has been a time of great industrial and medico-political unrest in the ACT.

Branch Council and Premises

The ACT has a new Branch Council, consisting of Drs Guy Buchanan, Michael Wilson, Andrew Hehir, Mark Skacel and myself. An agreement has been finalised with the ACT AMA for provision of premises and secretarial support for the Society.

Continuing Education

The 2013 National Scientific Congress Committee, led by convenor Dr Mark Skacel, has been formed with various roles delineated. The actual dates for the conference will be finalised shortly.

Visiting Medical Officer Contracts

There have been prolonged negotiations over the upcoming renewal of public Visiting Medical Officer contracts. The work of the Visiting Medical Officer Association in this matter is greatly appreciated, with special thanks to Dr Nicola Meares for providing a valuable anaesthetic input to discussions.

Rosters

The on-call arrangements at Calvary Private Hospital (Bruce) continue to be of great concern. Despite the private hospital being effectively 'free-standing' for almost a year now, at the time of writing there is still no official on-call roster, instead relying on the goodwill of the on-call public anaesthetist providing a (free-of-charge) service. This situation is unlikely to be sustainable in the long-term, and is compounded further by the lack of a Director of Anaesthetics in the private hospital.

Phil Morrissey
Chair

WESTERN AUSTRALIA

Membership

It has been a good period for membership with five new Ordinary Members, 22 new Trainee Members and one new Associate Member. The efforts of GASACT representative Dr Joe Ng should be acknowledged for the success in recruiting trainees.

Collaboration with ANZCA in Western Australia

The ANZCA Regional Committee have promulgated a set a guidelines for future collaboration, to replace the previous Anaesthesia WA structure which was foundered as a result of uncertainty within ANZCA WA as to its authority to participate. We are confident that the relationship will continue to be a positive one under whatever arrangements are agreed upon over the next few months.

Simulation Committee

The purchase of a high fidelity simulator has been approved by the Health Department. Currently, the process has been delayed by processes associated with negotiating who is responsible for approving expenditure and any shortfall, given it is to be located with the Royal Perth Teaching Hospital.

Continuing Medical Education In collaboration with ANZCA WA

Autumn Meeting 6 March

This meeting was well-attended (160 delegates), with positive feedback from the delegates. Final finances are yet to be confirmed but a reasonable surplus is anticipated. Thanks go to Dr Prani Shrivastava for convening a very successful meeting.

Winter Meeting 31 July

Planning is well-advanced for the winter meeting. The working title is "Current Challenges in Anaesthesia". Dr Eric Visser will give the Dr Ian McGlew lecture and will present on the perioperative management of patients on methadone and buprenorphine. A colleague of the late Dr McGlew will be asked to give a brief overview of his contribution to anaesthesia at the start of the first session. Other sessions include an update on management of diabetes and optimal management of patients undergoing colorectal and joint replacement surgery. There will be a workshop on "Dealing with an impaired colleague", a panel discussion and several problem-based learning discussions. In response to feedback from the previous meetings, these learning discussions will have a practical focus and should fulfil Category 3 for continuing professional development.

Bunker Bay 29 to 31 October
'Emergency! Stand back!'

The scientific program is progressing well. Professor Paul Myles will be the visiting speaker and will speak on Pulmonary Hypertension and run a problem-based learning discussion. Other topics will include updates in resuscitation and defibrillators, metabolic emergencies, ear, nose and throat emergencies, transferring an unstable patient and an obstetric session. There will be a Saturday afternoon on practical echo with concurrent learning discussions.

To allow more sponsors to attend the trade display, morning and afternoon tea and lunch will be held in a marquee. The social program will include whale watching and a visit to a fauna park. The conference dinner will be held at Vasse Felix winery.

Andrew Miller
Chair

VICTORIA

Time For Talking – Time for Action

Inadequate Transport Accident Commission/WorkSafe Rates in Victoria

Dr Renald Portelli and I have been talking to the Transport Accident Commission/WorkSafe authority about the recent audit of anaesthesia services and the gross discrepancy between fees paid in Victoria compared with other Australian states. While we await a formal response, Victorian members should be aware that both authorities, unlike interstate counterparts, consider themselves rebate systems, not dissimilar to private insurance. Members should consider what they value their individual service to be worth, and charge a co-payment to the patient providing the necessary informed financial consent, if they feel it appropriate.

Salaried Anaesthetists in the Private Sector

A private hospital in Melbourne is seeking to exploit anaesthetists by offering to bill patients on their behalf and pay them back a small portion of the total billings as a salary. I would urge all anaesthetists to enter into any contracts with caution and consider their own circumstances carefully. A contract which limits the service provider's right to charge an appropriate fee undervalues that service. A hospital which takes a portion of your fee is stealing your income. You should also consider potential difficulties in providing substitute service providers when you cannot attend, when such fixed contracts have been signed. The Victorian committee welcomes any contractual enquiries from members.

Medical Referral is the Basis of Quality Practice

The referral system in medicine has ensured the highest quality of service to patients over a number of years. Hospitals which seek to erode the usual referral patterns for their own financial gain are on a slippery slope of decreased productivity, decreased quality of care, increased risk of complications to patients and steady regression to mediocrity.

Education

A reminder that the ASA/ANZCA Combined Meeting is scheduled for 24 July 2010. The ASA 69th National Scientific Conference "Skills and Technology" is to be held in Melbourne at the Melbourne Convention and Exhibition Centre from 2 to 5 October 2010. Visit www.asa2010.com.au for information. The call for papers is out and we encourage those of you interested in research, or who have completed research recently, to log on to the site and consider presenting.

Antonio Grossi
Chair

The new ASA office in Queensland

American Society of Anesthesiologists

ANESTHESIOLOGY 2010

AMERICAN SOCIETY OF ANESTHESIOLOGISTS ANNUAL MEETING

DON'T MISS OUT ON THE WORLD-CLASS EDUCATION

AT THE ANNUAL MEETING OF THE AMERICAN SOCIETY OF ANESTHESIOLOGISTS

OCTOBER 16-20, 2010

San Diego, California

For more information, please go to **www.asahq.org** or e-mail: **annmtg@asahq.org**

Anaesthesia in the News

Games distract from pain

Virtual reality games are being used in America as anaesthesia for pain management. The technique, which is proving to be extremely successful for burns patients, aims to distract users from the pain of painful procedures such as debriding.

One popular game, SnowWorld, which is set in the Arctic, has been reported by patients to reduce pain between 30 and 50%. Creators have found that virtual reality is an extremely good tool for separating patients from their actual environment and because users wear a helmet, they are not easily able to turn their attention back to wound care. The technique is also being trialled to treat mental illnesses such as post-traumatic stress syndrome.

Sydney Morning Herald, 13 May 2010

Dentists may be dropping needles

Dentists may be moving away from using needles to administer local anaesthesia after research found that an inhalable nasal spray may be more suitable. When sprayed into the nose, common anaesthetics like lignocaine travel down the face's primary nerves to the mouth faster and more effectively that injection into the gums.

According to studies, when administered this way, drugs travel down the trigeminal nerve and are pooled in the jaws and teeth at levels 20 times higher than in the brain or blood.

Popular Science, 14 May 2010

Return of significant anniversary loan

The Gilbert Troup silver mug loaned to the ASA for its 75th anniversary celebrations, and which, for the past year, has been on display in the Society's headquarters at Edgecliff, has been returned to its owner Dr Anne Nichols with many thanks.

The Society is always grateful for loans of this nature, or for gifts of historic anaesthetic equipment, specialised reference books or other items of intrinsic value relating to the Society's interests. If you are making space in your home or rooms, please ring 02 9327 4022 or fax 02 9302 2708 before disposing of them in another way. The Society is happy to pay modest transport costs for such objects!

Peter Stanbury
Curator, Harry Daly Museum & Librarian,
Richard Bailey Library
Australian Society of Anaesthetists, Sydney

The Gilbert Troup mug (centre). The inscription reads: "Presented by / His Fellow Members / to / Dr Gilbert Troup/ Perth W. A. / President Australian Society of Anaesthetists / 1939-1945"

History of Anaesthesia Library, Museum and Archives News

The Richard Bailey Library

Cataloguing of the vast majority of the historic books, including our Mesmerism Collection, is now nearing completion, thanks to the sterling efforts of Dr Peter Stanbury, our Librarian and Curator. Cataloguing is a considerably more complicated procedure as we endeavour to comply with the very much more detailed classification established by the National Library of Medicine.

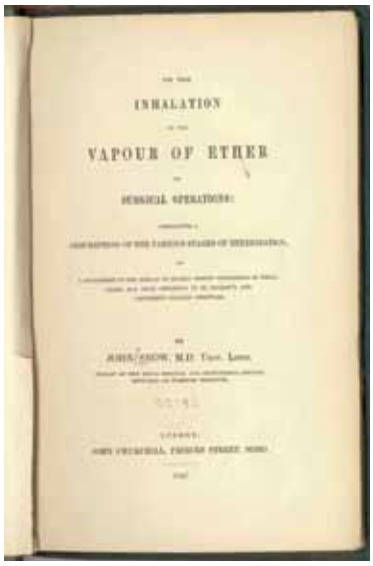
We are fully aware of the value of our rare books, some of which need professional repair work and this will be commenced in the new financial year. In the meantime, an additional unit of bookshelves with lookalike glass-fronted doors is being built to match the existing elegant bookcases. This unit will provide secure storage and display, but allow ready access for researchers.

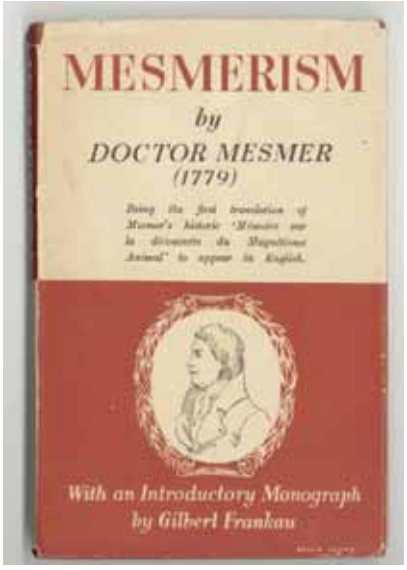
New brochures are being prepared for both the Library and Museum, to advertise our existence and invite visitors to enjoy the collections.

I recently attended a full-day seminar at the National Library in Canberra, organised by Blueshield Australia and DISACT. Security of historical collections was discussed in detail, focussing on disaster preparedness for both large and small libraries and museums.

New international standards for collections in terms of temperature and humidity were presented. The possible salvage of rare books and valuable documents which have been severely water-damaged was also presented, using a technique involving freezing and thawing which can at least allow separation of pages and render text legible.

Jeanette Thirlwell
Honorary Librarian and Curator





Two of the Library's oldest books: Dr J. Snows's *On the Inhalation of the Vapour of Ether* printed in 1847 (left) and a translation of Dr F. Mesmer's *Mesmerism,* first printed in English in 1949 (right).

iPhone Attack!

With the increasing popularity of such devices as the iPhone, the standard anaesthetic practice is under pressure to improve processes to meet the demand of this technology. Anaesthetists now want access to online calendars, accounting data and informed financial consent (IFC) information via the web and patients are expecting online services such as online credit card payment options along with patient preoperative information and quotes.

Today's society revolves around the online experience. Consider online banking, web email and online media such as newspapers, books and journals, online shopping and online courses for students. The shift to the web has made daily tasks simpler and convenient to complete. The demand for web technology is now so large that software companies are selling computers that run purely online applications. Google and Microsoft now provide versions of their Word, Excel and office applications via the web.

There are two options for the anaesthetic practice in these times. One is to try and add applications to the existing (non web-based) practice software. This leaves the already stretched practice manager trying to manage more manual processes and increases the inefficiencies, costs and stresses of running a practice. The other option is to embrace the technology shift and upgrade practice software to a platform that is designed to manage the current web demands. One such company providing this software and service is MediTrust.

Utilising the latest web technology, MediTrust software enhances and simplifies practice management by providing a single, web-based solution for scheduling/diary management, account management and IFC. Its hosted approach means there is nothing to install in-house and no upgrade or management requirements. All software is accessed via the web and all software updates and back-ups are managed by MediTrust and not by practice staff. This leaves staff to the job of running the practice, not the technology.

MEDITRUST MEETING THE DEMANDS OF ANAESTHETISTS, PRACTICE MANAGERS AND PATIENTS

Anaesthetist: "*I want to be able to gain access to my surgeons' lists, accounts data and quotes when it suits me.*"

The MediTrust application is 100% web-based. Anaesthetists have their own login which gives them access to only their data. They can login at anytime, anywhere and gain the information they are looking for on a self-serve basis. Quote information, surgeon lists, patient preoperative survey responses and patient prepayment summaries are just some of the information available to access

Practice manager: "*I spend significant time trying to manage health fund updates, servers and different applications, not to mention the worry of backups and taking them offsite.*"

There is nothing to install or manage for the practice when using MediTrust. The application is 'zero install'. The means the only thing required for use is an internet browser. It is 100% MAC and PC friendly. The MediTrust staff manages all the health fund updates, servers and the system is automatically backed up every three hours to an offsite location. All new software upgrades are automated by MediTrust staff and users are not responsible for installing upgrades

Patient: "*I expect to know who my anaesthetist is, their professional experience, if I can take my mediations, treatment risks and what it is going to cost me – before I go to the hospital*"

Patients receive their IFC quote (along with anaesthetist profile and photo and anaesthetic guidelines) via the web without burdening staff time. Ring-in patients receive the same information in less than two minutes. Patients receive accounts and can self-service payments directly via the web or can call rooms to complete payment over the telephone. Staff completes this payment quickly using web payment gateway within the MediTrust software.

1. 100% web-based, 'zero install' and able to run on MAC or PC.

2. Patent protected IFC solution and outsourced service. Patients access quotes without staff involvement.

3. Web-based accounting package. Staff and anaesthetists can access reporting and data from any location. Supports multiple office locations.

4. Online calendar and list management. Accessible from any location.

For more information please contact MediTrust on 1300367540 or info@meditrust.com.au

Advertorial

Retired Anaesthetists Group

Christchurch ANZCA ASM Meeting 2010

A luncheon for retired anaesthetists was held at the Limes Room, Christchurch Town Hall on Tuesday, 4 May. It was attended by an enthusiastic company of 15 members of the Retired Anaesthetists Group and their guests. New Zealand, Victoria, New South Wales, Australian Capital Territory and Queensland were represented at the luncheon. We were especially pleased to welcome Dr Clement Yuan, a member who had travelled from Malaysia to attend the Australian and New Zealand College of Anaesthetists Meeting. The participants were well known to each other and most had been involved in College affairs, either as examiners or supervisors of registrar training. The function was very enjoyable and on behalf of those attending I have been asked to thank the College of Anaesthetists and the ASA for arranging the facilities, venue and the very pleasant meal.

David Gibb
Chair

Dr Trevor Dobbinson and Professor Barry Baker

Front row (left to right): Mrs Kathleen Dobbinson, Dr Di Khursandi, Mrs Mary Rechtman, Dr Michael Allam
Back row (left to right): Dr Trevor Dobbinson, Professor John Gibbs, Dr Bob Boas, Dr Jane Baker, Dr Michael Davis, Dr Ian Rechtman, Dr Clement Yuan, Dr Richard Rawstron

WFSA Book and Journal Donation Scheme

Many anaesthesiologists in poorer parts of the world work without access to modern books or journals. In contrast many other anaesthesiologists have access to considerable amounts of educational material which is used for a short time and then discarded. If anaesthesiologists in one part of the world sent their books and journals to colleagues overseas, we could do much to reduce this imbalance.

The wfsa publications committee wishes to put anaesthesiologists who are willing to donate books or journals in touch with anaesthesiologists in developing countries who have requested this type of assistance.

- Donors who are willing to send (by surface mail) current journals and/or recent textbooks (published after the year 2000) to anaesthesiology departments in the developing world should send an email to the address below with details of what you wish to donate.
- If your department would like to receive books or journals please email or write to us and we shall do our best to help. Please give details of yourself, size of hospital and department, how many anaesthesiologists work in your department and which books or journals you have available.

Contact for WFSA Book and Journal Donation Scheme
worldanaesthesia@mac.com Alternatively write to World Anaesthesia, Pound Cottage, Christow, Exeter, EX6 7LX, United Kingdom.

New ASA Members

The ASA welcomes all new members from 5 February 2010 to 17 June 2010

Dr C. Aase	Tas	Trainee 2
Dr E. Alfredson	NSW	Ordinary
Dr I. Arhanghelschi	Vic	Ordinary
Dr D. Alcock	Tas	Trainee 1
Dr S. Aziz	Qld	Trainee 1
Dr A. Badenoch	SA	BTY1
Dr C. Bain	Vic	Ordinary
Dr D. Banda	Qld	Trainee 1
Dr S. Bhattacharya	NSW	Trainee 2
Dr J. Blackshaw	Qld	Trainee 5
Dr D. Borshoff	WA	Ordinary
Dr B. Brabin	ACT	BTY2
Dr T. Branson	SA	Ordinary
Dr D. Brouwer	Vic	Ordinary
Dr J. Burke	Vic	Ordinary
Dr I. Cheung	Vic	Trainee 4
Dr J. Cameron	NSW	Ordinary
Dr Z. Clark	Qld	Associate
Dr F. Collingwood	SA	BTY1
Dr S. Collins	NSW	BTY1
Dr K. Cooke	Qld	Ordinary
Dr R. Cooray	SA	BTY1
Dr T. Corcoran	WA	Ordinary
Dr J. Cummins	Qld	BTY1
Dr J. Cotter	Qld	BTY1
Dr P. Dahal	Tas	BTY1
Dr H. Daly	WA	Ordinary
Dr A. D'vaz	NSW	ATY1
Dr K. Elms	Qld	Ordinary
Dr J. Evans	Vic	BTY1
Dr K. Figueiredo	WA	Associate
Dr M. Fortuin	NSW	Ordinary
Dr B.Freeman	Vic	Ordinary
Dr A.Hapgood	Qld	Ordinary
Dr S. Keynes	SA	BTY1
Dr J. Kok	Vic	Ordinary
Dr J. Koziol	Vic	Trainee 5
Dr P. A. Krishnan	SA	BTY1
Dr K. Jeffrey	NSW	BTY1
Dr M. Joseph	Vic	Ordinary
Dr C-W. Lee	Vic	Trainee 2
Dr K. Lee	Qld	Trainee 1
Dr T-S Lee	SA	BTY1
Dr G. Lethbridge	Vic	Ordinary
Dr J. Lim	SA	PMET
Dr C. McMahon	Qld	Trainee 1
Dr N. MacCormick	Qld	BTY1
Dr A. MacKinlay	Tas	Ordinary
Dr N. Malek	NSW	ATY1
Dr P. Mamo	NSW	Associate
Dr E. Moloney	Qld	Trainee 1
Dr M. Moore	WA	Ordinary
Dr C. Morgan	Vic	Ordinary
Dr B. Moser	Qld	Trainee 4
Dr A. Parameswaran	Qld	ATY1
Dr S. Pathy	Vic	Ordinary
Dr W. Pavey	WA	Trainee 5
Dr A. Perez-Smith	Qld	Trainee 1
Dr J. Pincus	Qld	ATY1
Dr L. Neale	Vic	Ordinary
Dr B. Newman	Tas	Trainee 1
Dr H. Smith	Qld	Trainee 1
Dr E. Tiong	NSW	BTY2
Dr C.Y. Teoh	SA	BTY1
Dr J. Trumble	SA	BTY1
Dr B. Weitkamp	Vic	Ordinary
Dr D. Whybrew	Qld	Ordinary
Dr M. Williams	WA	Ordinary
Dr L. Willington	SA	BTY1
Dr W. Wilson	SA	Ordinary
Dr T. Win	Tas	Trainee 1
Dr N. Woodall	Qld	Trainee 1
Dr N. Woollard	Qld	BTY2
Dr R. Wong	Tas	Ordinary
Dr K. Wyssusek	Qld	Ordinary
Dr J. Yen	Qld	Trainee 1
Dr L. L. Yeow	Qld	Trainee 1
Dr J. Zois	Vic	Ordinary

In Memoriam

The ASA regrets to announce the passing of ASA member Dr I. Selvadurai, Tasmania.

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