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Anaesthetist
THE MAGAZINE OF THE AUSTRALIAN SOCIETY OF ANAESTHETISTS • JUNE 2021

WELLBEING

- Long Lives Healthy Workplaces
- Personal Reflections of a Catastrophe
- Mindful Based Stress Resilience
- The Welbeing Based Special Interest Group

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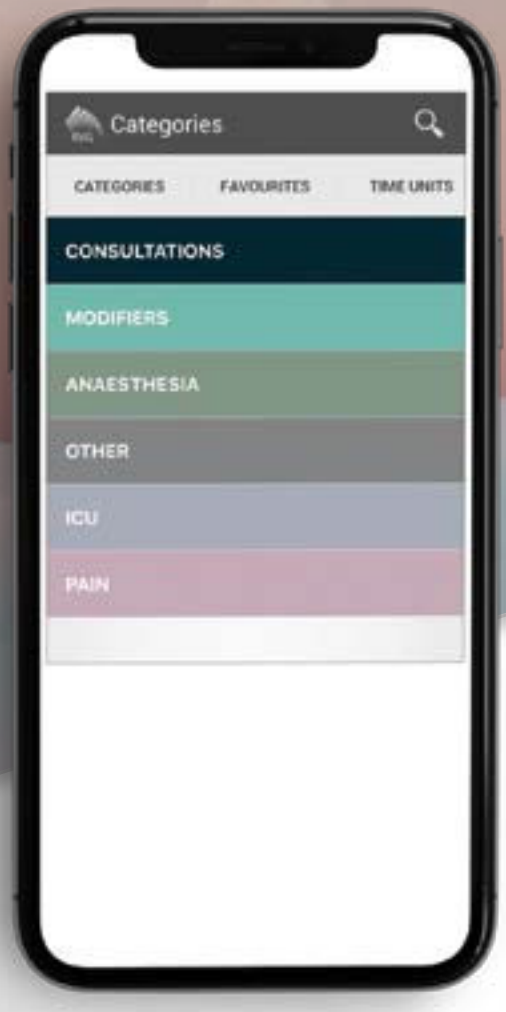

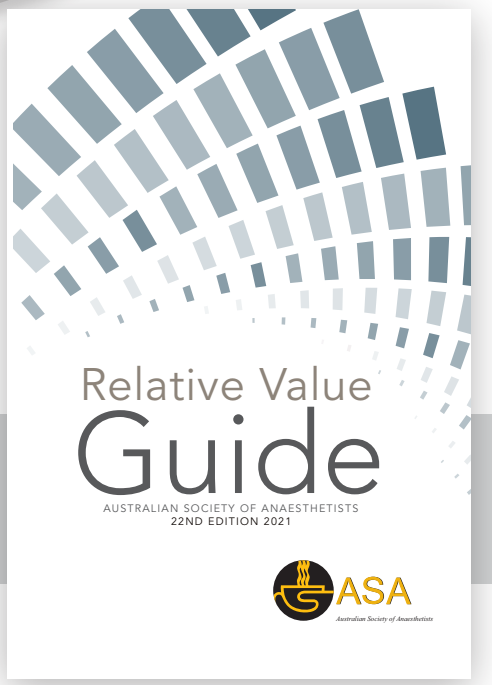

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REGULARS

FEATURES

WELLBEING

INSIDE YOUR SOCIETY

WOULD YOU LIKE TO CONTRIBUTE TO THE NEXT ISSUE?

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

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

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

REGULAR

EDITORIAL FROM THE ASA PRESIDENT

DR SUZI NOU
ASA PRESIDENT

It's true 2020 was a tough year for many and we at the ASA have used the start of 2021 as an opportunity to refresh and renew whilst still remaining committed to the founding goals of the Society developed 87 years ago.

Part of that process has been to finalise the 2021–2023 Strategic Plan. Thank you to all who contributed. It provides a roadmap which will guide our activities over the next few years, and I am pleased to share the final version with you here. One of the new strategic priorities is to proactively support wellbeing. The need for this was highlighted last year and I am proud that it is also the focus of this edition of Australian Anaesthetist.

The ASA has always informally supported our members, be it through social gatherings, developing resources that help us to navigate the health system in which we practise or by direct representation in the handling of complaints. We hope by prioritising wellbeing as a strategic priority we further embrace formal support structures and resources. One example of this support is the formation of the Trainee Members Group (TMG). Former National TMG Chair Richard Seglenieks writes about the 20-year history of the TMG, from its original name of Group of ASA Clinical Trainees, or GASACT, through to developing trainee focussed welfare resource documents and making Mental Health First Aid training available to TMG members.

In this edition, Wellbeing Advocate Divya-Jyoti Sharma writes about developing mindfulness to modulate our stress responses. She encourages us to be in the zone and to stop and smell the coffee, something that is often associated with anaesthetists. Another 'coffee cup' that is associated with the ASA is that of our logo. Did you notice the refreshed logo appearing on the cover? To me, the logo embodies the mission of the ASA: Support, Represent and Educate. In it, some see a supporting hand. Others see the beloved coffee cup. What does coffee do? It brings us together, it makes us stronger or gets us going, which is what occurs when we amplify our voices and advocate together. To learn what the logo actually represents and some of the thoughts behind its first refresh in over 40 years I refer you to the article written by David Borshoff, Chair of the Communications Committee.

Speaking of the ASA mission of Support, Represent and Educate brings me back to the Strategic Plan. In it, as well as in this edition of Australian Anaesthetist, I hope you enjoy finding out about how the ASA is here to support you so that you can function at your best. And of course, we couldn't do it without your support.

Thank you!

Suzi Nou
ASA President

CONTACT

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

OVERSEAS DEVELOPMENT AND EDUCATION COMMITTEE

Australian Society of Anaesthetists

Myanmar: how to help?

Members of the Overseas Development and Education Committee (ODEC) of the ASA (Australian Society of Anaesthetists) have been working with medical colleagues in Myanmar for over ten years. We are extremely concerned for the safety of our friends in the MSA (Myanmar Society of Anaesthesiologists), MMA (Myanmar Medical Association) and the PTC (Primary Trauma Care) fraternity. The people of Myanmar are in perilous danger, both from the immediate military violence, and also from the ensuing chaos and rupture of civil society.

We are distressed and helpless as we watch handheld phone videos captured through windows onto the streets. We hear the gunshots and see the clubs striking defenseless protestors and citizens. This is infinitely more disturbing than the de-sensitized sixty-second news "grabs" can ever be.

Numerous Facebook feeds with their translations and Twitter hash tags tell the story of the brutal violence with which the illegal Military government is trying to intimidate the people of Myanmar and crush the Civil Disobedience Movement.

We are temporarily reassured by messages:

"Thanks for your kindness. I am still safe. But we cannot say what happen tomorrow and next days. Our people need your support. With respect," VK

But what can be done?

Eloquent editorials, such as the recent Lancet "Myanmar's democracy and health on life support"[1] and letters to the editor[2, 3 4] are helpful in informing and motivating.

But geopolitical maneuverings have so far frustrated an effective collective global response.

In 2020, Covid 19 curtailed much International Development work especially by small NGOs (like the ASA ODEC). But now more than ever, the people of Myanmar need friends, organisations and institutions to recommit to rebuilding anew once this assault on their lives and to their democracy has been overcome.

In the meantime, we must look for every way to express our solidarity with their struggle, our outrage at their oppression and our compassion with their suffering and the suffering of those who cannot receive healthcare at this time.

We declare no competing interests.

Haydn Perndt, Amanda Baric, David Pescod, Michael Cooper, Chris Bowden, Suzi Nou

Faculty of Medicine, University of Tasmania, Hobart, Tasmania, Australia (HP); The Northern Hospital, Melbourne, Epping, Victoria, Australia. (AB, DP); The Children's Hospital at Westmead & St. George Hospital, Kogarah, Sydney Australia, School of Medicine and Health Sciences, University of Papua New Guinea, Port Moresby Papua New Guinea (MC); Peninsular Health, Frankston, Victoria, Australia, College of Medicine, Nursing and Health Sciences, Fiji National University, Suva, Fiji (CB), President, Australian Society of Anaesthetists 121 Walker street, North Sydney, NSW 2060, Australia (SN).

1 Lancet Vol 397 March 20, 2021 https://doi.org/10.1016/S0140-6736(21)00656-5
2 Lancet February 19 https://doi.org/10.1016/ S0140-6736(21)00457-8
3 Lancet March 12 https://doi.org/10.1016/S0140-6736(21)00621-8
4 Lancet April 7, 2021 https://doi.org/10.1016/ S0140¬6736(21)00780¬7

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REGULAR

ASA UPDATE FROM THE CEO

MARK CARMICHAEL, ASA CEO

"I can't wait to put 2020 behind me!" was how I opened my article for the March edition of Australian Anaesthetist. Noting of course that all of us were looking forward rather than back as far as 2021 was concerned. With the shadow of COVID-19 still hanging over our lives, I wondered what the future might look like. Clearly the answer remains uncertain. While the vaccine rollout is now underway, our instances of community transmission remain low (or they were at the time of writing) and many of the restrictions that we have lived with over the past year have thankfully been removed, there is still, understandably, some level of unease.

Small breakouts, such as the one experienced in Brisbane at the end of March, served as a reminder to everyone that the virus is far from gone. I recall in April of 2020 the then Chief Medical Officer Professor Brendan Murphy, commenting that we would get the virus under control but would need to learn to live with small outbreaks from time to time, until a fully effective vaccine was available. Quite possibly that is the phase we are currently in, and hopefully the methods employed over the past 15 months will continue to protect the Australian population from any deterioration in the ongoing battle with COVID-19.

So while we all continue to live our lives with the virus as part of it, other issues still require attention. One of those is indeed what appears to be the movement towards the corporatisation of medicine in Australia. Often the phrase 'managed care' is used to describe this phenomena, however, it is possibly somewhat more complex than that. It is certainly an issue the ASA is focussing on at the moment. That is why the March edition of Australian Anaesthetist devoted its full attention to this issue. It is hoped that those articles drawn from a variety of perspectives provided an informed view of what this may mean within the Australian medical landscape. Subsequently, a series of webinars has been staged to further inform members of the real implications of what a threat this initiative represents.

ASA intends to continue its focus on this matter and has kept in close contact with other groups such as the AMA and the Council of Procedural Specialists (COPS), in order to present a unified position on a matter it believes threatens patient care in Australia.

By the time you are reading this article the National Scientific Congress (NSC) for 2021, which has also undergone some significant changes, will be only a matter of weeks away. Members will be well aware that due to COVID-19 the 2020 Combined Meeting scheduled for Wellington New Zealand was put on hold until 2022. With the uncertainty surrounding COVID-19 carrying forward into 2021 the Organising Committee made the wise decision to modify its plans for this year's NSC. As a result, it moved quickly to relocate the Congress from Cairns to Brisbane and to stage it in conjunction with the ANZCA Queensland Regional Committee meeting, from July 23- 25. The Congress is planned primarily as a face-to-face event, with certain sessions streamed live. This combination of face to face and virtual may well be a thing of the future, however, for the moment it represents the best opportunity to offer members a high-quality educational meeting during 2021. I would very much like to thank all involved from both ANZCA and ASA who have and are continuing to work closely to make this opportunity available. If you haven't yet registered please do so by visiting www.asansc.com.au

Being a membership-based organisation, the Board and myself are acutely aware of retaining and gaining members. As such it is particularly pleasing to report that as of the end of March over 81% of members had renewed (this figure will no doubt have risen since the time of writing), which is in excess of 5% of what would be expected for this time. During this same period we have welcomed some 392 new members, many as a consequence of the online educational offerings that have been made available.

There is no doubt that the efforts of Dr Suzi Nou ASA President during 2020 positioned the ASA squarely at the forefront of the COVID-19 debate and decision making. With that in mind it is most satisfying to see the number of former members rejoining the Society, with the ASA's COVID-19 advocacy recognised

by multiple people as the reason. Let's hope this resurgence in membership continues!

Many of you will notice that this edition carries a refreshed ASA logo, and I direct you to the article by ASA Communications Committee Chair Dr David Borshoff which takes you through the thinking and the process around this refresh. I believe the Committee has done an extremely good job in retaining the integrity of the logo, while simply providing a refresh. In early 2020 the Society purchased a building in Naremburn a suburb of northern Sydney. That building which is a short walk to the Royal North Shore Hospital is rapidly being converted into the new Head Office of the Society. If all goes to plan the relocation should take place in late July. Members will be kept updated on this most significant development in the history of the ASA.

In closing I once again remind you of the National Scientific Congress in Brisbane July 23-25, it would be fantastic to see you there.

Mark Carmichael

CEO

CONTACT

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

BRISBANE, SOUTHBANK

REGULAR

LETTERS TO AUSTRALIAN ANAESTHETIST

With our autonomy significantly threatened by managed care, the ASA has highlighted this excellent letter from Dr David Olive because our professionalism and public perception is of utmost importance in navigating this challenge. It behoves us to remember we all carry the reputation of our profession every time we interface with patients and specialist colleagues.

Dr David Borshoff

Chair, ASA Communication Committee

OUTRAGEOUS FEES

I met the anaesthetist in the operating theatre reception five minutes before my major surgery. She informed me that I would be charged an out of pocket fee of $350 for her services. What options did I have? At this late stage I was not in a position to say that I didn't agree and wish to employ the services of another specialist. On receipt of the invoice I note that she had charged Medicare and my private health fund a total of $1949. Still she demands a further $350. My surgery lasted 215 minutes, her total fee was $2299; not bad for a little more than three and a half hours work. Who else gets paid more than $656 an hour? I consider this outrageous.

(letter to the Editor, Melbourne Age, 30 March)

I acknowledge that this is only one side of the story, and the anonymous colleague involved has not had a right of reply. All the same, we, as a profession, should take this sort of poor publicity as a learning opportunity to collectively improve what we do. We don't know if this was an after-hours emergency or an elective procedure, so the exact number of RVG units generated is unknown. Prima facie, however, it would appear that the fees are less than AMA rates, and can therefore be supported as being reasonable. The informed financial consent (IFC) process, on the other hand, was lacking. The patient is quite right to point out that he had little option but to accept the fees when they were presented immediately pre-operatively in the theatre reception. This is not genuine IFC, and the patient's very reasonable point highlights the importance of written pre-hospital IFC. Even for emergency cases, a generic written document describing the derivation of fees, with a reference to rebates (in percentage rather than dollar terms, so that it is applicable to a wide range of cases) is preferable to an off-hand comment that they'll be $350 short.

Secondly, the pre-anaesthesia consultation would appear to have been inadequate, or at least was perceived that way. A 3.5h procedure with an anaesthetic fee of $2299 warrants a formal consultation, not one en passant in the anaesthetic bay. I'm sure the anaesthetist involved gleaned all the relevant information from the patient, applied it expertly and gave excellent intra-operative care. Unfortunately, the patients often have little idea what we do after induction. They do, however, recall the consultation, and those who have an even cursory look at their bill know that they've paid for it. The pre-anaesthesia consultation should be so much more than simply gaining information from the patient. It is also about imparting information, establishing rapport, allaying anxieties, checking that regular medications that should have been taken have been taken, prescribing analgesic pre-meds, discussing post-op analgesia. Aside from being good medicine, a thorough pre-anaesthesia consultation represents an opportunity for good PR for our specialty. Too often, I overhear consultations for relatively major procedures (joint replacements and the like) taking place behind curtains with patients on trolleys in the theatre holding bay, conducted by anaesthetists who didn't want to get to work early enough to allow for a formal meeting in a consultation room, ideally in professional attire.

Patients don't mind paying a reasonable fee if they're happy with the service. Problems arise if the service is not perceived to match the fee. I have little doubt that, if the IFC and consultation had been better, this patient would not have considered the fees to be "outrageous".

I'm sure that most anaesthetists don't need to be told any of this. For the remaining minority, I'd encourage you to reflect on how you represent the profession so that you don't generate

publicity like this. Failure to do so does a disservice not only to your patients, but also to your colleagues who are tarred with the same brush.

Regards,

Dr David Olive
ASA member

MANAGED CARE

May I commend the excellent collection of articles entitled the Corporatisation of Medicine in the last issue of Australian Anaesthetist.

I fear the community does not fully appreciate the excellent health care system we have in Australia. Very high standard health care at a reasonable price compared to say the USA. The key to that excellent system is the balanced relationship between doctors, hospitals and health insurers. That balance is lost if health insurers can dictate to patients which doctors they can see, which procedures they are permitted to have done and which hospitals they can attend.

The key to private health care in Australia is the ability of patients to choose their doctor, their hospital, what they have done, in conjuction with their doctor and when it is done. If patients lose these choices and become dependent instead on the dictates of multinational health insurers then our private health system loses its most important features.

I well remember talking to an Australian anaesthetist who was living and working in California in the 1990s. He needed a corneal graft, without which he couldn't practice anaesthesia. The surgery was performed but was unsuccessful and needed to be repeated. His health insurer refused to approve the repeat surgery. He needed to undertake legal proceedings against his health insurer which were both time consuming and costly before the repeat corneal graft was finally approved and could be done. Another patient who did not understand the system and/or could not afford the legal expenses would have to simply live with poor vision.

We do not want such scenarios, which are common in the USA, occurring in Australia. Our largest health insurers are no longer not for profit Australian organisations. They are listed companies, often international, with one intention and that is to earn money for their shareholders. To this end they are trying to control the hospitals, the doctors and the patients so as to maximise profits through bundled care, preferred provider agreements and the owning of hospitals.

To counter this scourge, which will do so much to damage our excellent health system, medical practitioners through their professional associations, private hospital owners and consumers must together form a united front to inform the Australian community and our politicians about the huge problem of allowing health insurers to become so powerful as to dictate to patients, doctors and hospitals what can be done, where it can be done, when it can be done and by whom it can be done.

Yours sincerely,

Gregory J Deacon

REGULAR

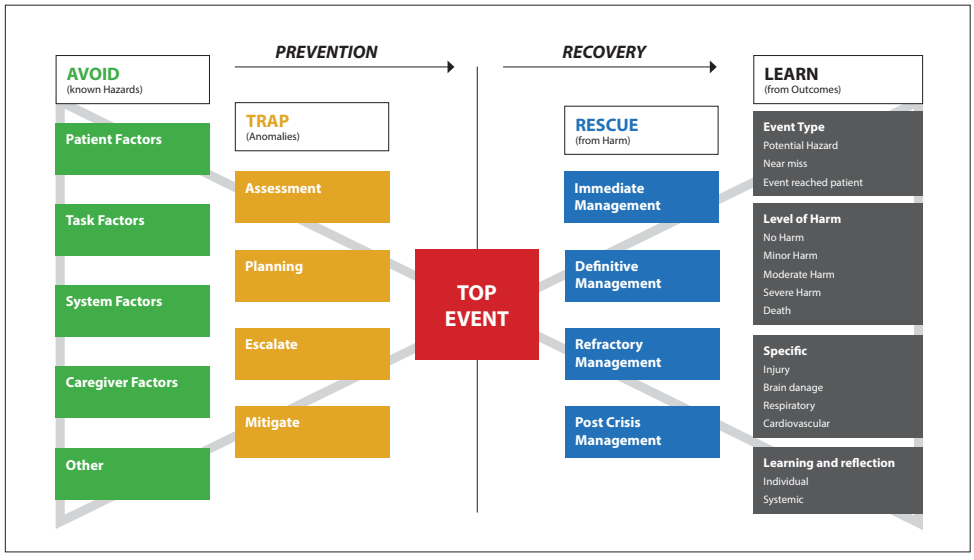
WEBAIRS NEWS

A BOWTIE ANALYSIS OF ASSESSMENT AND DOCUMENTATION INCIDENTS

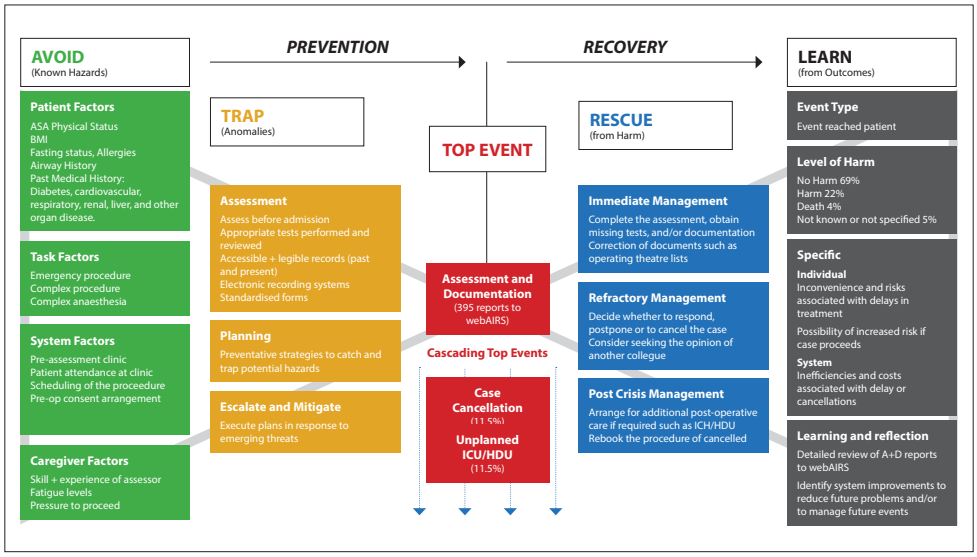
There have been 398 reports in the category for 'Assessment and Documentation' (A & D) amongst the first 8,000 incidents reported to webAIRS. In this article we present an overview of how these might be analysed using the Bowtie Diagram Method. A Bowtie diagram based upon the generic diagram shown in Figure 1 will be created to visually present the overview of these findings. The use of Bowtie analysis in anaesthesia has been described in multiple articles from 2016 onwards (Ref Anaesthesia and Intensive Care (1) and Current Opinions in Anaesthesiology (2). The Bowtie diagram represents a fusion of a Fault Tree and an Event Tree, connected by the Top Event in the middle, thereby creating its distinctive shape.

Risk factors are known as Hazards in Bowtie terminology. To suit anaesthetic practice, the terminology has been modified to 'Avoid Known Hazards'. These hazards may be divided into patient factors, task factors, system factors, caregiver factors and other.

Patient factors that might be associated with A & D incidents include higher ASA PS grades, higher BMI, as well as diabetes, cardiovascular, respiratory, airway, renal, liver, and other organ disease. Task factors include complex or emergency surgery and complexity with the delivery of anaesthesia. Caregiver factors can include the skill level and experience of the person making the assessment. System factors include the availability of a pre-anaesthetic



(Figure 1) Generic Bowtie diagram (Curr. Opinions 2020)



(Figure 2) Bowtie diagram showing Assessment and Documentation as the Top Event

assessment clinic, the patient's ability to attend a clinic, and the scheduling of the case.

In many circumstances, hazards cannot be avoided, but the risks are nevertheless managed, to reduce the development of a 'Top Event'. The second column in the Bowtie diagram therefore depicts examples of processes which might 'Trap' the progression of hazards to prevent them from progressing to the 'Top Event'. Displayed in amber, these barriers can be compared to Reason's well known Swiss cheese diagram (Ref). In Assessment and Documentation events, Traps to prevent incidents might include Assessment, Planning, Escalation and Mitigation.

Assessments ideally should happen before the patient is admitted to hospital, or the latest before the patient arrives at holding bay for their surgery. Factors influencing this might be emergency cases, where it is not always possible to assess the patient in a timely manner. Legible, electronic records which are easily accessible on standardised forms might prevent or reduce the risk of Top Events from happening.

The second box, 'Planning' is a useful way to determine a strategy in advance to prevent an incident from occurring should a latent factor in the hazard column start to manifest itself. This set of preventive strategies could be called plan A, B, C and D, in a similar way to planning for the management of other potential incidents such as airway problems. 'Escalate' is where these plans are executed in response to emerging problems and 'Mitigate' has the actions taken just prior to an inevitable incident. Examples of mitigation in the A & D category of webAIRS A & D reports might include rearranging the order of an operating list, either earlier, for example, to facilitate improved diabetic management or later, to allow time to perform extra tests.

Top Events reported to webAIRS in the A & D category include:

- Clinical or risk assessment inadequate (42.3%)
- Documentation or tests (missing, delayed, or illegible; 14.6%)
- Problems with the operating theatre list (incorrect patient, incorrect list, or list changes; 2.8%)
- Miscellaneous (40.3%).

In the 'Rescue' column, we can envisage several options related to management. Immediate and definitive management might include completing the assessment, obtaining the required tests or documentation, correcting documents such as operating theatre lists, or arranging for additional post-operative care. Refractory management, where the incident cannot be corrected with simple measures, might involve a decision to proceed, postpone or to cancel the case. An opinion could also be sought from another, if possible, more senior colleague. Finally, post-crisis management might involve observation in an intensive care (ICU) or high dependency unit (HDU).

In the final column, 'Learn from Outcomes', the analysis of the first 8,000 reports revealed that most of the cases reported in the A+D category were associated with no harm (69%), harm occurred in 21.7%, and death in 4.3%. The balance (5.1%) did not specify the level of harm. However, it should be noted that harm or death might not have been causally related to the A & D incident. The case was cancelled in 11.5%, prolonged length of stay in 7.2%, and unplanned ICU/HDU in 11.5%.

In summary, although incidents involving A & D are not commonly published, they do form a sizeable number (398 reports) of the first 8,000 reports. In addition, they are associated with harm, death, case cancellations, increased length of stay, and unplanned ICU or HDU admissions. However, further, more detailed analysis is required to identify if this association is a direct casual effect.

There will be presentations relating to the Bowtie method at both the ANZCA ASM 2021 (On Demand virtual format) and at the ASA NSC 2021.

References

1. MD Culwick, AF Merry, DM Clarke, K Taraporewalla and NM Gibbs. Bow-tie diagrams for risk management in anaesthesia. Anaesth Intensive Care 2016, 44:712-718.
2. The Bowtie diagram: a simple tool for analysis and planning in anesthesia. Culwick M, Endlich Y and Prineas S. Current Opinion in Anaesthesiology: December 2020 - Volume 33 - Issue 6 - p 808-814

FEATURE

INTRODUCING OUR NEW BRANDING

Australian Society of Anaesthetists

Readers will have noticed the new look of the ASA logo on the cover of this issue. Communications Committee Chair David Borshoff explains the change.

The ASA is pleased to present its new logo with a more contemporary look, brighter colours and modern typography. It comes as part of a review into the ASA brand identity to create a united, integrated look and feel for our organisation across all media platforms. Given the affection held for the longstanding cupped hands and vapour bowl image, the new design pays homage to ASA logo history.

The brief for the previous design stated it must: refer to some aspect of anaesthesia; not be entirely divorced from the Faculty badge (which used the Royal Australian College of Surgeon's coat of arms); show some regard to Societies and Faculties in Great Britain and Ireland(!), and be unique but easily recognised.

A Brisbane-based firm presented design ideas to a committee making the decision at the time (1970s), consisting of Michael Bryce (architect and Associate of Industrial Design Institute of Australia), David McConnel (Federal ASA President) and John Hains (QLD Chairman ASA).

Ultimately the 'pot and vapour' peculiar to anaesthesia (and opium), and the hand as a symbol of caring and friendship, were favoured. The black and gold colours acknowledged the Faculty (the colours of its gown) and the design was accepted in October 1978, remaining unchanged for nearly 43 years.

The Communications Committee decided it was time to support exciting new changes in the digital communications sphere of the ASA with a more contemporary design. In view of the previous logo's success, as well as its instantly recognisable colour scheme, we opted for a modern, minimalist and slightly softer interpretation of the enduring image.

Despite the inevitable reservations that come with change, there was support from the ASA Council in this review and ultimately it felt change could be achieved without losing the positive characteristics of the much-loved ether bowl.

Regardless of the alternative image explanations continuing to circulate throughout the membership (the 'coffee cup' being a favourite) we prefer to promote it as part of the anaesthetist's role as peri-operative physician. Not only does it represent our sleep agents and caring hands, but it could just as easily convey the 'all round' caring component of our specialty - a more holistic image of feeding 'chicken soup' to the unwell.

The new logo and branding will be adopted across a range of ASA publications, communication tools and merchandise this year as the organisation continues to modernise for our members. We hope you will all embrace it as the instantly recognisable symbol of our organisation and all it stands for.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FEATURE

ASA WORKING FOR YOUR WELLBEING

The COVID-19 global pandemic put a spotlight on the mental health and wellbeing of the healthcare workers and the ASA continued supported a growing number of wellbeing initiatives designed specifically for anaesthetists.

It is well established that medical professionals, in particular anaesthetists and critical care physicians suffer significantly higher rates of psychological distress and burnout than the general population. Our specialty faces a number of unique challenges which can result in poor mental health and poor general health. The ASA recognises the importance of keeping anaesthetists well at work and supporting those who need assistance.

What became very clear over the past year has been the need to prioritise mental health and wellbeing of our members. We are devoting this edition of Australian Anaesthetist to this important issue as we launch a new strategic priority 'Proactive Wellbeing' - to foster the personal health and welfare of members, associates and their families.

This is not a new focus for the ASA, but endorsing wellbeing as a strategic priority sends a strong message of support to anaesthetists. Last year we expanded the range of resources provided to members and renewed our commitment to the Long Lives Healthy Workplaces (LLHW) toolkit which has now been relaunched.

Early in the pandemic we explored the potential for COVID-19 to influence the wellbeing of anaesthetists with specific questions included in our member survey, along with questions from the Kessler Psychological Distress Scale. The majority of responders reported some impact on wellbeing with a small percentage experiencing high levels of distress.

This survey was conducted in June, only three months after the pandemic declaration and almost 60% of respondents felt their wellbeing had declined over those three months. It was reassuring to see significant numbers of members using a range of strategies to lessen the impact of the pandemic on their wellbeing and we were proud to expand the support offered to anaesthetists around the country.

Some of the key initiatives we have undertaken over the past year include:

- **Wellbeing Advocates** – supporting a network of advocates
- **Wellbeing webinars** – check the ASAEd page if you missed any
- **Supporting LLHW** – read the update on the toolkit in this issue
- **Wellbeing resources** – check the ASA website for resource links
- **Member surveys** – results in September 2020 Australian Anaesthetist
- **Subsidised counselling** – links to anaesthetists trained in counselling available
- **Peer support** – Victorian Committee piloted new support program
- **Mental Health First Aid** – online courses offered through ASA
- **DHHS Healthcare Worker Infection Prevention and Wellbeing Taskforce** representation
- **Australian Anaesthesia podcast**

SPOTLIGHT ON CONSENT

The future of the law of consent

The law of consent has developed along similar lines in the US and Australia, although with a difference on the issue of materiality. However, in both jurisdictions the question of what is considered to be a material risk is often at issue between the doctor and patient. In a number of recent cases in the US, patients have argued that all information that was available was material to their assessment. A look at some of the recent US cases gives some indication of where the law of consent maybe heading in Australia.

Cameron Leaver, Hicksons Lawyers

Noteable legal findings

Case 1: Patient not fully appreciating risk

In Byrom v JH Hospital, a woman with severe preeclampsia was advised to proceed with a caesarian section. However, she refused due to concerns about pain and potential future caesarians. The baby was born profoundly disabled and the mother sued the hospital for failing to properly consent her. She argued the material risks of the caesarian were conveyed in an unduly pessimistic manner, and she would have consented to surgery if they had been explained more sensitively. Her experts gave evidence that considering the condition of the mother and fetus, it was a breach of care even to have offered an induction of labour.

The court accepted the way the information regarding risks was presented meant she failed to properly appreciate the risks to herself and the fetus. She was awarded $225 million in damages.

Case 2: Doctor's failure to disclose "life factors"

In the case of A Urology v Cleveland, the patient sued his doctor for failing to disclose the doctor's recreational use of cocaine.

The patient argued that had he been informed of the doctor's use of the drug he would not have proceeded with him as the surgeon.

The patient lost at trial, but the Georgia Court of Appeal found in his favour.

Ultimately the Supreme Court held that physicians do not have an obligation to reveal "life factors" which do not impact the physician's performance.

The decision leaves open the argument that there is an obligation to disclose information which may affect the patient's risk, including issues personal to the physician.

Similar issues have already been raised in Australia, particularly in complaints to the HCCC, such as practitioners appearing to be affected by drugs and alcohol.

Case 3: Doctor not explaining revised surgery

Finally, the matter of Burchell raises the difficult question of how far a surgeon should proceed with surgery when tests and scans have shown something different.

In that case, the patient was diagnosed with a small mass on his scrotum which was thought to require a local excision, but during surgery the mass was found to extend to the penis.

The surgeon removed the mass, which required removing part of the penis.

The patient sued his urologist for failure to obtain his consent for the revised surgery and as a consequence, for battery.

The court held in favour of the patient and awarded him $9.25million for pain and suffering.

While the amount of damages in Australia would likely be less, an outcome in favour of the patient in those circumstances is likely.

Where Australia is headed

While the awards of damages in the US remain breathtaking, and judgements of similar amounts are unlikely to be followed in Australia, there is no doubt that patients' vigorous pursuit in the US of failure to consent claims will eventually follow in this country.

Cameron Leaver is a partner at of legal firm Hicksons Lawyers, which acts for hospitals and private health insurers. He has been practicing in medical negligence matters for over 25 years and currently manages a medical negligence team of 25 people.

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FEATURE

LONG LIVES HEALTHY WORKPLACES

MAKING MENTAL WELLBEING BAU

Dr Joanna Sinclair chairs the Long Lives Healthy Workplaces (LLHW) Committee and re-launched the wellbeing toolkit at the recent ANZCA ASM. She shares why she is so passionate about this initiative.

In April 2020 my health service conducted a Wellbeing Index survey with data collected over a four-week period, mostly during the Level 4 lockdown in New Zealand. This was a time when we were preparing for a flood of COVID-19 patients which did not eventuate so our hospitals were quieter, elective surgery was on hold and as no one was taking leave, there were more staff on the floor. Interdepartmental co-operation increased and senior medical officers were involved in planning and decision making.

All these things feed into the autonomy, purpose and mastery that are so important to the meaning and satisfaction a doctor derives from their job. It came as no surprise that we found a significant improvement in wellbeing over that month.

Unfortunately, that didn't last. The second set of data, collected when we were back to 'business as usual', suggested a return to the usual state of wellbeing. Sadly, this usual state tends to come with high rates of burnout, fatigue and mental health concerns.

We are all aware of the explosion of research into and publications about the impact of the COVID-19 pandemic on the mental health of healthcare workers. Whilst we have been very focussed on strategies to relieve stress in the acute setting, it has really highlighted how much more work there is to do on embedding long-term strategies in our workplaces so that we don't have to scramble quite so much when faced with a crisis.

The Long Lives Healthy Workplaces (LLHW) toolkit is a fantastic place to start so we can focus on long-term strategies for wellbeing and for this to become the new 'business as usual'. The return on investment in staff wellbeing programs has also been well established so the timing could not be better for you to promote the toolkit in your own workplace.

> The medical profession has a high level of stigma around mental health in the workplace and this is often compounded for anaesthetists.

BAU BURNOUT

Physicians have high levels of burnout, anxiety, depression, suicidal thoughts, and they are typically unlikely to seek professional help. Many do not have the time or flexibility to see a therapist during office hours, and the stigma attached to psychological problems leads many to suffer silently.

A range of risk factors can impact health professionals' mental health and wellbeing at work with anaesthetists facing a number of unique risk factors which can result in mental ill-health, poor general health and an increased risk of suicidal behaviour. The medical profession has a high level of stigma around mental health in the workplace and this is often compounded for anaesthetists.

- Anaesthetists work in a highly stressful occupation and are exposed to trauma and death
- Anaesthetists have high work demands and may or may not feel a sense of belonging to a particular team in the health service where they work
- Anaesthetists work long hours, experience fatigue and are exposed to on-call stress

The LLHW toolkit is designed for anaesthetists to help create mentally healthy workplaces so they can: reduce risks and stress load in the workplace; improve mental health and general wellbeing; build social connections among peers; and develop action plans to support good mental health and the prevention of suicide.

We know that one in two New Zealanders will likely meet the criteria for a mental illness at some stage in their lives and I'm sure the same is the case for Australians. Doctors are very good at hiding personal distress and not talking about personal struggles. But it is usually not possible to keep these behaviours hidden for long from family, friends and co-workers. When a co-worker recognises that someone is in trouble, it is important to break the code of silence.

LONG LIVES HEALTHY WORKPLACES (LLW) TOOLKIT STRATEGIES AND ACTIVITIES

Improve the culture of medicine to increase wellbeing and reduce stigma

- Implement strategies to improve the health and wellbeing of all staff
- Increase connectedness and peer support
- Address stigma associated with mental ill-health and suicide directly
- Create a workplace where bullying, harassment and discrimination are not tolerated

Improve the training and work environment to reduce risk

- Ensure job design, rosters and individual workloads are reviewed to reduce risks for mental ill-health
- Design and manage a work environment that minimises harm
- Ensure adequate and structured access to training and professional development opportunities

Improve capacity to recognise and respond to those needing support

- Improve the capacity of staff to recognise and respond to mental ill-health and suicide
- Improve pathways to care for those who need support

Better support anaesthetists and trainees impacted by mental ill-health and suicide

- Ensure effective processes to manage staff to stay at work or return to work
- Ensure the department has policies and services available to support those impacted by suicide

Improve leadership, coordination, data and information on the health and wellbeing of our profession

- Improve leadership capability
- Improve data collection on the health and wellbeing of the profession

TOOLKIT TOOLS

The LLHW toolkit is a locally designed, open access wellbeing framework that was developed with the Wellbeing of Anaesthetists Special Interest Group. It was funded by the Australian Society of Anaesthetists (ASA) and The Prevention Hub. The toolkit was progressed by Everymind, who have the expertise to develop such mental health frameworks for specific industries.

I am currently chairing the implementation group for the toolkit and we have developed a range of summary documents with action points from the toolkit because we know the full version

FEATURE

with all the evidence, all 90-something pages, has been a bit overwhelming for our wellbeing advocates and Heads of Departments. ASA President Suzi Nou has also developed a roadmap to help people conceptualise a possible pathway to achieving change in their departments using the toolkit.

My own journey in the past couple of years has been a broader approach to senior medical officer wellbeing across our organisation, but I still started with a needs-assessment. This helped us lobby our executive leadership team for their support to establish a formal role to look at wellbeing, and I was proud to be appointed the first SMO Wellbeing Officer in March of last year.

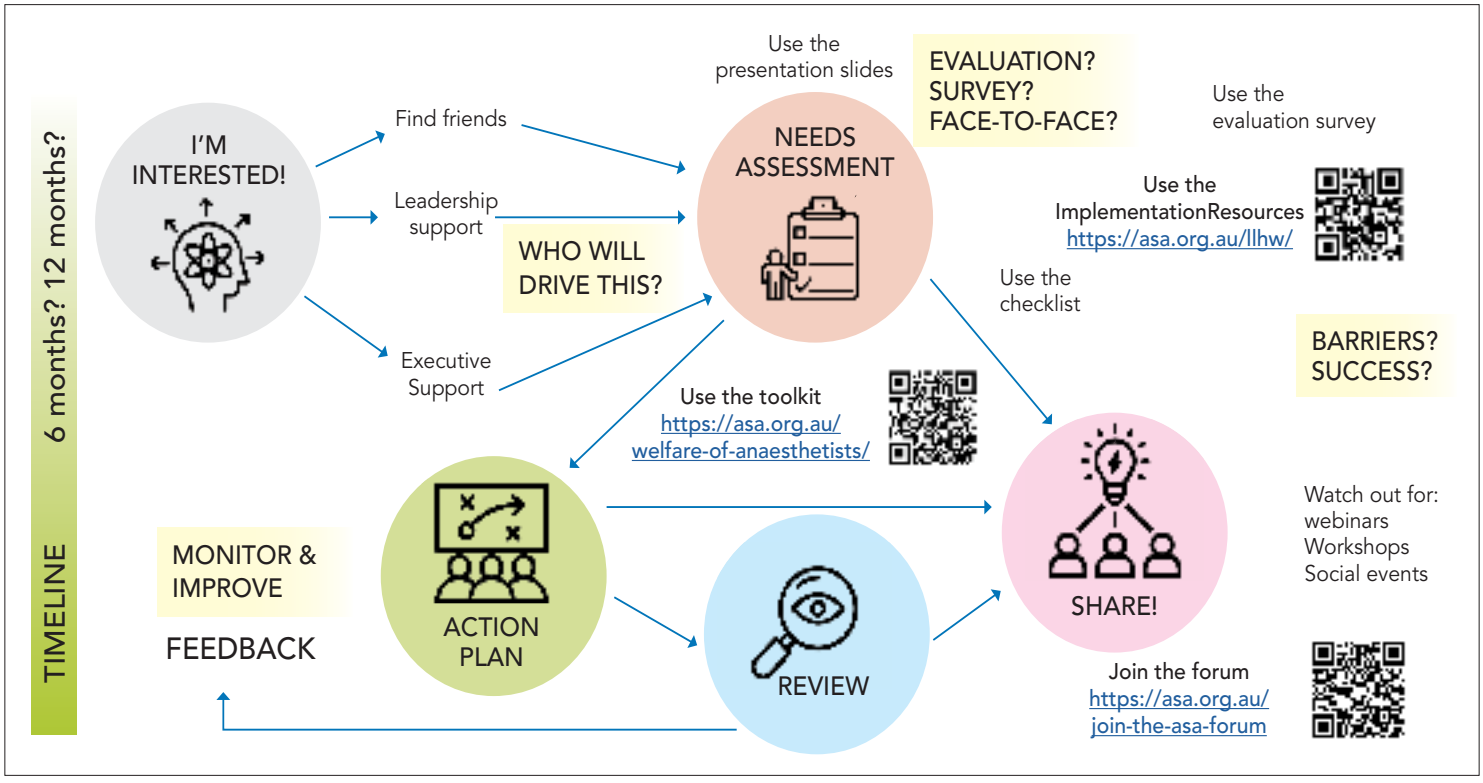
It's really important to engage with managers and executive leadership on matters of staff wellbeing. Many of us find this challenging. Individual wellbeing advocates may not feel equipped to negotiate this terrain solo, so accessing change-management expertise of an executive sponsor may be useful. They can help you identify stakeholders and collaborators, help you find work already being done that you can piggyback onto and they understand funding cycles and how the timing of your proposal might be important.

My approach has been to educate and inform and present possible solutions. Presenting a problem with solutions is often welcomed. The LLHW toolkit can help you provide those solutions.

I encourage you to check out the toolkit – through the ASA or ANZCA websites – and discover online tools, programs and initiatives to implement in the workplace along with references for mentoring and peer support training programs, best practice guidelines and all the tips and tools needed to show leadership in creating mentally healthy workplaces.

ABOUT THE AUTHOR

Joanna Sinclair is an ANZCA Wellbeing SIG Executive Committee member and a Consultant Anaesthetist at Counties Manukau Health in Auckland where she also holds a wellbeing advisory role, working on organisation wide initiatives to improve staff wellbeing.



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<< contents

FEATURE

WELFARE AND GENDER

DR BRIDGET EFFENEY

The ANZCA Gender Equity Subcommittee (GESC) is a group of high-calibre individuals championing equality for people of all genders.

The work is focused on five main pillars in the GESC Action Plan 2018 – 2022:

- Inclusive and equitable culture
- Diverse and representative workforce
- Flexible and empowering workplace
- Attention to closing gaps
- Strategic and accountable leadership.

So what about welfare?

Many fellows, mainly women, contact the group with frequently asked questions on a number of matters and occasionally about workplace grievances. These include questions about returning to work after parental leave, job sharing arrangements and flexible workplaces and equitable access to CPD.

The group has worked closely with anaesthesia and pain medicine event and conference convenors to ensure equal representation of female speakers. Eligibility criteria for prizes and awards for emerging researchers and leaders have been changed relative to opportunity to account for the career breaks new parents take. There has been a lot of work done to improve the culture of training, research, CPD, bias training, representation and leadership all of which improve the professional welfare of anaesthetists of all genders.

But what about equitable access to a safe workplace and culture in anaesthesia?

The *#MeToo* movement started when many young actresses finally spoke out about repeated sexual abuse by the famous movie producer Harvey Weinstein, resulting in a criminal conviction and jail term. This has triggered workplaces and organisations to introspect about the true nature of their occupational and professional culture, in general, and in particular towards women. Are our own workplaces safe?

Recently, we have seen two recent stories making front page headlines in mainstream Australian media. The first is the successful nomination of Grace Tame, a survivor of sexual assault as Australian of the Year and her compelling story of surviving sexual abuse.

The second is the shameful portrait of professional culture in Parliament House exposed by the Britney Higgins rape allegations.

We don't have to look to hard to find reported examples of stories of deeply entrenched bias and inappropriate treatment of women in professional life more broadly in Australia. There is the expose about sexual behaviour in private boys high schools, triggering federal education campaigns about consent. There is a report about sexual harassment and discrimination condemning the legal fraternity, describing sexual harassment as "an open secret".

RACS has established a strong gender policy and anti bullying campaign in response to widespread reports of discrimination towards female trainees.

So if we are to believe what we read, can we extrapolate that there may be a problem in our workplaces? In our hospitals and anaesthetic departments? Our private professional groups? Our tea rooms? Our staff christmas parties? Social events at conferences?

We know that the incidence of domestic violence in Australia remains shockingly high. In 2017 Australian Police recorded 25,000 sexual assaults 1 in 6 women and 1 in 16 men in Australia have experiences physical or sexual violence from a cohabitating partner, and 1 woman is killed every 9 days as a result of family violence. (www.aihw.gov.au).

Liz Broderick, the former Sex Discrimination Commissioner spoke recently to the Sydney Morning Herald in the weeks following the Brittney Higgins allegations.

She states,

> *"Leaders who believe there is no sexual harassment is happening in their workplace raises a huge red flag. If you're not hearing about it, it absolutely doesn't mean that it is not happening. Its just that you're not looking hard enough"*.

She reinforced that every organisation has a responsibility to ensure that its workplace is safe.

In 1998 Di Khursandi published a paper in Anaesthesia and Intensive Care entitled, *"Unpacking the Burden: Gender Issues in the Anaesthesia"*.

She describes the results of a survey entitled, "Does Gender affect the pursuit of a career in anaesthesia" of 298 female (67% response rate) and 190 male (50% response rate) ASA members. The survey covered many aspects of personal and professional life and general attitudes towards gender. At the time there seemed a sense of optimism that some of the stereotypical inequalities in the workplace were changing. It was clear that the shackles of domestic

responsibility lay firmly with women. It was womens' work.

"You shouldn't be working. You should be home looking after children" (male surgeon to female anaesthetist)

"Once you are known to be a mother you are regarded as less professional, less committed, and definitely discriminated against. If you have children you are some how expected to want less prestigious work, less pay and not to compete for more desirable positions" (female responder)

There was some other concerning comments:

"Female colleagues, with a few notable exceptions, are a considerable burden – no concept of equal effort or commitment for equal remuneration." (male responder)

I was told I would never pass the primary (examination) because I was married and female." (female)

And a deep sense of inequality with regard to access of high quality work in private practise

"I suspect that while each group desires the odd female anaesthetist, they prefer the majority to be male" (male)

"Women can undercut men because they don't need the money" (male)

Dr Khursandi also asked about sexual harassment . 21% of female respondents had experienced harassment but rarely from anaesthetists. She reports the American Society of Anaesthetists found a similar incidence of 20%. Interestingly 13% of male anaesthetists reported experience of harassment.

23 years ago many of us still in practise would have been registrars or junior consultants, a period of exponential learning and influence from senior colleagues. An estimated 23% of anaesthetetists in practise in Australia are in the over 50 age bracket.

It is clear that such overt bias against women does not openly exist in most

modern workplaces in health, hospitals or operating theatres. It would not be tolerated. But how much of these attitudes are still permeating through professional culture in medicine?

Do we work in cultures of equality?
Do we address our own bias?
Do we actively set the tone to eliminate sexism in the workplace?
Do we make unwanted comments about personal appearance or personal lives?
Do we supervise registrars with respect?
Do we tolerate borderline behaviour, jokes or language?
Do we give equal opportunities in leadership, research, and supervisory roles?
Do we experience sexual harassment in the workplace, or at social functions?
Do we have systems to inform and empower people to speak up and take action on this harrassment?
Do we listen to, empower, respect and support people who are impacted?
How tidy is our house?
Our department?
Our Hospital?
Our organisation?

The Champions of Change Coalition (previously the Male Champions of Change), mission statement is" Men stepping up besides women on gender equality".

The group has produced a handbook entitled Disrupting the System, outlining best practise for organisations to prevent and respond to sexual harassment in the workplace, inspired by the National Inquiry into Sexual Harassment in Australian Workplaces, led by Sex Discrimination Commissioner Kate Jenkins.

The report opens with

"By openly acknowledging the prevalence of sexual harassment and taking action to address its systemic drivers, leaders have the unique power to ensure their workplaces are safe respectful and inclusive. Their employees and the community expect no less from them." Not to mention our patients.

There are tools, guidance and frameworks for unpacking and managing sexual harassment in the workplace. It is mandatory reading for anyone in leadership.

These are the issues that interest the GESC, and many committees like it in other organisations. Recently the GESC called for expressions of interest for membership. Dozens of highly qualified female anaesthetists responded. But no men. We have shoulder tapped, personally requested, begged and implored our male colleagues to join us, but it seems that work in equity is women's work.

How will we tidy our house if we don't work together?

Welfare and wellbeing for all genders will be well in hand if our "house is tidy and safe and equitable workplace culture prevails.

FEATURE

PERSONAL REFLECTIONS OF AN ANAESTHESIA CATASTROPHE

ANTONIO GROSSI

There is no right or wrong way about how to feel regarding a major anaesthetic catastrophe such as an unexpected death in the operating theatre. This is a uniquely personal experience. There may, however, be more or less productive ways of dealing with this major life event. Here I share my personal experience and thoughts in the hope that others may find useful.

Many have written about the human factors in anaesthesia crisis and emergency situations.

[1] Stress in anaesthesia in particular has also been described. [2] There may be some common factors that can be anticipated and predicted to assist in the management of future cases. [3] The Association of Anaesthetists of Great Britain and Ireland has published detailed guidelines on 'Catastrophes in anaesthesia practice- dealing with the aftermath.' [4] These are useful for anaesthesia departments and anaesthetists individually to consider ahead of time to provide a framework for dealing with an acute event.

Several years ago, I managed an unexpected death of an elective surgery patient in the operating suite. Morbidity and mortality reports describe how safe anaesthesia in Australia has become; how death in theatre is a rare event.

[5] This may have a tendency to promote feelings of guilt and shame in the aftermath of a crisis as the individual anaesthetist questions, 'why is this happening to me?' In reality, over a career most anaesthetists can expect to have to deal with intra-operative death and other anaesthesia catastrophes as part of their job. [4] The immediate reaction for myself, was all about dealing with the clinical crisis. For this fortunately we are well trained and often assisted by our colleagues in the team response. In my case, a cardiac arrest was declared, surgery ceased, cardiopulmonary resuscitation ensued, protocols were followed. The patient received maximum therapy and after consultation with family, the treating doctors and other specialists, cardiopulmonary resuscitation was ceased,

and death declared. There was much for me to attend to including documentation of events, speaking to and supporting the family together with the surgeon as part of the open disclosure process [6] notifying the Coroner and organising an immediate team debrief. In consultation with the perioperative team, I made a decision to cancel the remainder of the scheduled elective procedures for that day to free up my cognitive space to deal with these important tasks. It was such a busy time dealing with these practicalities, that there seemed little opportunity for emotional reflection in this immediate period.

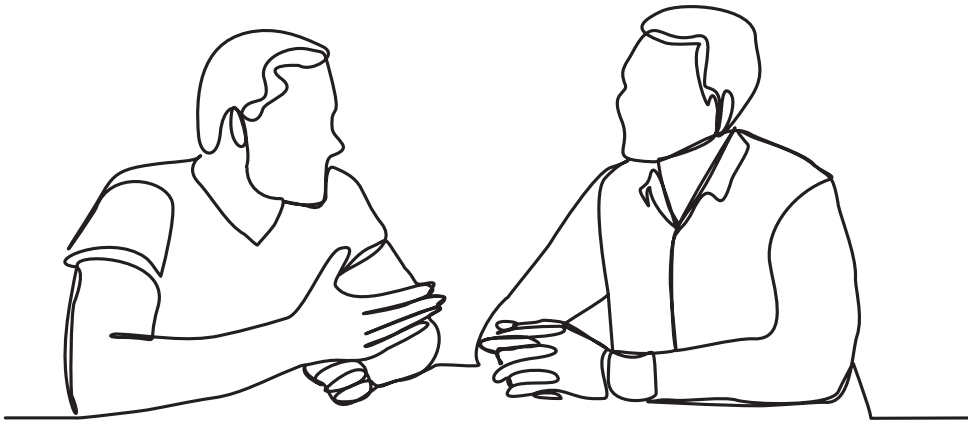
Going through the case with my mentor was helpful to clarify the sequence of events from a clinical perspective. He also provided me emotional support from a personal perspective.

In the following days, I did reflect in great detail. Firstly, I went through the events with my mentor and trusted senior colleague. If this is such a rare event, I asked myself what could I have done differently to avoid or prevent this catastrophic outcome? Were there any system factors here that may have contributed to this adverse event? We live and work in a just culture so whilst it is not appropriate to blame individuals, it is appropriate to ask questions, analyse and scrutinize what could have been done better. As anaesthetists, there may be some common personality traits such as perfectionism, a zero tolerance for error, a desire for control over our immediate working environment, risk aversion and attention to detail. To a greater or lesser degree, it is on this background that I was very hard on myself in those first few days scrutinizing every detail of the case as I completed my own reports for the files, medical indemnity company and consultative council on morbidity and mortality. Going through the case with my mentor was helpful to clarify the sequence of events from a clinical perspective. He also provided me emotional support from a personal perspective. This was equally important because I remember feeling incredibly sad that this patient had lost their life, the patient's family had lost their loved one and that outcome could not be changed. It may or may not be deemed by others to be 'my fault' but as a direct consequence of what occurred, this patient who had moments previously being talking to me about their rich personal life, was now dead. Forever dead.

This negative feeling of dread seemed inescapable for those first ten days. I had insight into the situation and was in close communication with my peers. The second person I discussed the case in detail was my anaesthesia department director. This was helpful to ensure there were no outstanding anaesthetic or clinical issues that required attention. I checked in daily to ensure I was functioning adequately. Ironically perhaps, I felt best when I was in theatre administering anaesthesia to other patients during this time. When in theatre, anaesthetists are substantively exclusively focussed on their patient. Outside of the theatre environment, one is susceptible to intrusive thoughts of recrimination and further paralysis in over analysis.

In retrospect I should have been more compassionate to myself. This is an important point to remember when advising others in future situations.

You cannot control the thoughts that come into your head, but you can develop productive and protective strategies on how you deal with those thoughts. For me cognitive behavioural tools were useful to reassure myself that the correct process was in place to deal with the aftermath of the case. I also derived great personal comfort from my family and contemplated on notions of gratitude for our daily lives, hope for positive outcomes in the future and compassion for others. In retrospect I should have been more compassionate to myself. This is an important point to remember when advising others in future situations. Interestingly, my partner is a medical oncologist whose practice involves daily discussions with patients about poor prognosis. There was a definite different contextual appreciation about this death. An unexpected death or catastrophe presents unique emotional challenges. The third person I discussed the case was the medical director and then a follow up conversation with the surgeon. This was important to clarify any clinical governance



issues and in providing appropriate feedback and support for the family.

Receiving the appropriate counselling and support is essential to avoid long term sequelae such as post-traumatic stress, chronic stress, burnout, self-harm and substance abuse.

As part of the open disclosure process, follow up with the family and demonstration of any clinical investigation is required. In this case we all anxiously awaited the Coroner's findings. One of the stressors in anaesthesia is how we are perceived by others and our reputational damage following a major incident.[3] For the next several weeks I remember being hypervigilant and probably a little more risk averse than usual. The notion of 'secondary victim'[7], describes the adverse impact on the health practitioner involved in a major clinical catastrophe. Receiving the appropriate counselling and support is essential to avoid long term sequelae such as post-traumatic stress, chronic stress, burnout, self-harm and substance abuse. Tertiary victims are subsequent patients that may receive inadequate treatment by an impaired practitioner. In an anaesthesia department it is helpful for colleagues to provide support and oversight if required. For solo practitioners and in private practice this may be more difficult. I found it useful to have regular contact with my peers during this period to restore personal and emotional integrity and ensure that my future patients were being cared for well.

I stopped discussing the case with anyone else. There is a temptation to keep retelling the story especially when prompted by the curious. This can lead to unhealthy rumination, reliving the experience and focussing on minute details which are often irrelevant. The next time I formally presented this case was several months later at a morbidity and mortality meeting with a literature review on the subject and the Coroner's findings. This provided personal productive closure to go through the process and present the learnings from this case.

When to ask for help? Anytime and always. This is a very personal journey that occurs on the background of our own personality and sociocultural characteristics. It occurs in a particular clinical and circumstantial context. Many of the emotional responses may be predictable as moving through phases of grief, dealing with the immediacy, managing intrusive thoughts, restoring personal integrity, coping with investigations and scrutiny, accepting emotional support and finally resolution.[8]

ABOUT THE AUTHOR

Dr Antonio Grossi has been active as an advocate for quality improvement, sustainability and advancing the professional and industrial conditions for anaesthetists. He has been actively involved in the ASA for a number of years, serving previously as the Victorian state chair.

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FEATURE

MINDFUL-BASED STRESS RESILIENCE

As we contemplate the last twelve months, we cannot help being overwhelmed by the barrage of wellbeing resources thrown at us. The very thought of this can activate our limbic systems to increase the sympathetic discharge and contribute to our stress response. The World Health Organization defines stress as "the body's reaction to a threat or demand or pressure that we perceive exceeds our knowledge and coping capability". As William Shakespeare's Hamlet says, "There is nothing either good or bad, but thinking makes it so". [1]

With a little training, we are very much able to control our perception of stress, which in turn modulates our physiological and subsequent psychological response to our stressors.

Stephen Covey, in his book, The 7 Habits of Highly Effective People, speaks about viewing life through the lens of three circles [2]:

1. **Circle of Control:** e.g. my actions, my words, my spiritual focus, my time management.
2. **Circle of Influence:** e.g. my community of family, neighbours, co-workers.
3. **Circle of Concern:** e.g. actions of others, the weather, corporate decisions.

Those that can concentrate their inner green Circle of Control save time and energy. They also save themselves considerable incidental stress.

How can this be achieved? Can we modulate this in a scientific way? Turns out we can.

Our response to stressors was programmed within our reptilian mid-brain during human evolution. Now, those stress reactions have modern interpretations, so Fight becomes frustration; Flight becomes avoidance; Fright becomes anxiety; Freeze becomes procrastination; Frantic becomes poor decision making; and Fatigue becomes lacking motivation.

When faced with these modern threats, our mid-brain limbic system, with the amygdala and hippocampus, becomes activated and showers our body with its sympathetic discharge. This is also known as the amygdala hijack. [4]

So how are we able to combat this?

Mindfulness is a term coined by Jon Kabat-Zinn in 1979. "It is the **awareness** that emerges through **paying attention** on purpose, in the **present**

moment and **non-judgementally** to the unfolding experience". [3]

This statement is better understood when we explore the concept of 'unmindfulness'. We can waste time when we get distracted in conversation on our phones, during emails or even when we do both whilst watching television; we can have instruction bombardment and not understand complex emails; we can have a fixed mindset and not be willing to explore our blind spots; we may suffer poor emotional wellbeing when our thoughts control our moods, or suffer poor sleep when we replay past events or plan for future; we can have poor communication whilst trying to do two things at once (send an email to the wrong person for example).

Since the inception of the Mindful-based Stress Reduction course, there has been extensive scientific evidence to show that by practising mindfulness we can train our forebrain – specifically, the anterior cingulate gyrus and the ventromedial prefrontal cortex – responsible for our attention and emotional regulation, to be activated and give a top-down regulation of our emotional responses to stress. This calming of the limbic system, once embedded within our habits, can modify our response to stress physiologically.

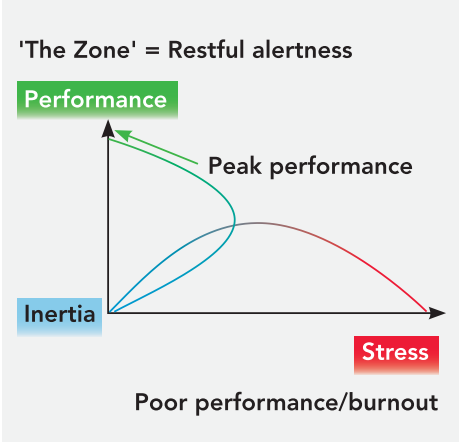

Figure 1: The Alternate Stress Performance Curve. Craig Hassed 2014.

Being mindful is not all about meditation or escaping to a retreat. It is possible to practise being mindful and calm our limbic system in our day-to-day activities. The gateway back to the present moment is through our senses. When we train our senses by practising mindful techniques, we can cause structural changes in our prefrontal cortex. Simply put, mindfulness is a metacognition skill that can be learnt.

So how can we apply this without having to invest in yoga pants? We have the tools at our fingertips.

1. Being in the zone

Providing clinical anaesthesia is surfeit with opportunities to concentrate solely on the task at hand. When we are intubating, our whole focus is passing the endotracheal tube through those vocal cords. In that moment, we are alert, we are calm, and we are at our peak performance. We are also not thinking about the past or planning for the future. We are fortunate to be able to concentrate on these tasks whilst caring for our patients – e.g. IV lines, regional techniques, drawing up drugs. The same applies to when we are cooking, playing music or sport. Associate Professor Craig Hassed from Monash Medical School calls this restful alertness and has modified the Yerkes Dodson Curve to reflect the change in performance whilst in "the zone". [5]

2. Mindful eating

Even the act of stopping to mindfully eat our food can help slow that racing heart or the feel of our shoulders hunching up. It requires no additional time to appreciate our hot tea or coffee. We can stop and notice the sound of the cup filling, notice the colour of the beverage, the smell, the temperature, the taste of the beverage and the act of swallowing.

Through the engagement of our five senses, we can bring ourselves into the present moment and quieten our minds. There is some evidence to suggest that mindful eating can help increase our internal awareness of our cues to eat. By doing so, it may address binge eating, emotional eating or eating in response to external cues. [6]

3. Single breath/diaphragmatic breathing

Anaesthetists are acutely aware of breathing mechanics. If we turn this awareness inwards, we can bring ourselves back to the present moment simply by being aware of the inspired breath as it enters our mouth or nose, travels down the oropharynx, trachea and into our lungs as we feel the diaphragm flatten and our chest expand. If we hold this position for a moment, we can appreciate the chest expansion. Upon expiration, the reverse process can be noticed. The longer the expiration, the slower the heart rate. [7]

Any variation of this technique can be performed surreptitiously before an IV insertion, difficult intubation, or even a difficult conversation. Another useful time to practise this is between episodes of patient care, brushing off concerns from the last patient, to be able to focus on the next one. This technique is particularly useful before entering the home and interacting with family or friends. It creates a mental and physical reminder of the different spaces we inhabit and move between in our lives.

4. Mindful communication

Whilst sounding obvious, communication is a flow of understanding that has three components: [8]

1. Receptive element: listening
2. Expressive element: speaking
3. Primary element: presence or self-awareness.

Presence is actually the bedrock of communication. It offers reliable information about our own and another's experience through observation, intuition and feeling. Presence creates a choice point for speaking and listening, serves as a meter for our reactivity and provides the container for intensity.

FEATURE

In short, when you notice yourself and your feelings, you can choose when to speak and when to listen. Our intentions are the vectors or motivation for our communication. We have all learnt communication habits from our family, our culture, our society, and our life experiences. When our needs are not met, or unacknowledged, it can block our understanding.

Mindful communication is about cultivating an openness or a curiosity to fundamentally shift our perspective to the needs of the speaker and be intent on listening for them. (Fig. 2)

Power dynamics are always present in any communication. To communicate effectively we need to be aware of these relationships and adjust how we engage accordingly. How we are speaking can be as important as what we say. When we understand that all communications occur to meet a need, we can step back and become curious about the other person's needs, rather than just our own. When we connect with the need of the other person, then there is mutual understanding. Once there is understanding, solutions will follow.

This mindset of using mindfulness in all forms of communication – personal, email, text – can really help in de-escalating many interactions, in turn, decreasing our limbic discharge. Try it with your next 'difficult interaction'- be that with a patient, staff member or family member.

5. Clinical mindfulness and patient safety

Mindfulness can be seen as a de-biasing strategy for reducing diagnostic and other medical errors. This is based upon the idea that bias is characterised by a lack of awareness and responsiveness by the individual to their own cognitive or affective processes. Again, by cultivating an attitude of openness and curiosity, it may help us to become aware of our metacognition. For example the cognitive disposition to respond to representativeness restraint bias where, if it walks and talks like a duck, it must be a duck, can lead to a failure to recognise atypical variants. This can be countered by fostering a mindset of curiosity and non-judgement. This is especially true with affective heuristics bias, where 'gut feel' of the clinician can be moderated with an open mindset. [9]

Mindfulness is a metacognition skill which employs our prefrontal cortex to regulate our limbic system discharge during times of stress. This physiological modulation can help us to navigate our stressors in a measured way. There are many ways to practice mindfulness in our daily lives. The key is to give it a go.

Unexamined View	**Leads to:**	**Conditioned Intentions**
Difference as problem, gone wrong		Blame / Judge
Conflict as win/lose		Protect/Defend
Others as objects in relation to our needs		Coerce/Manipulate
Re-examined View	**Leads to:**	**Cultivated Intentions**
Difference as natural , Okay		Curious, interested
Conflict as win/win ground for learning		Collaborate
Inherant value in others		Connect

Figure 2: Intentions changing with mindful communication

About the author

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WA representative, Wellbeing SIG
Department of Anaesthesia,
Sir Charles Gairdner Hospital, Perth

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<< contents

FEATURE

THE WELLBEING SPECIAL INTEREST GROUP

The Wellbeing SIG is one of our earliest SIGs, having its origins back in 1994 when a group which included trailblazers Dr Di Khursandi and Dr Genevieve Goulding met to discuss how to manage issues of mental ill-health amongst our fraternity. They met at Onions restaurant in Melbourne and initially adopted that name, given its connotations. With the subsequent support of the college, it became the Welfare SIG and now the Wellbeing SIG. But … "What's in a name? That which we call a rose by any other name would smell as sweet."

The concerns of the group were largely related to the perceived high incidence of suicide, depression and stress, poor physical health and long working hours, and the inability to work effectively if impaired or distressed. At the time it was considered normal to bat on despite these problems and to some extent, probably still is. There was a huge stigma associated with any suggestion of inability to cope which, although improving, persists today. Those who noticed these problems according to Dr Khursandi, were unable to intervene because they were frightened to do so, or felt incapable of doing so.

Another major issue was gender related, particularly the need of women to care for children and working part time. In some fraternities, women were loath to inform their department heads of pregnancy for fear of losing their traineeship. The number of women joining the specialty was steadily increasing and many felt disadvantaged in a culture which was very male dominated.

Many will have heard of the SIG but I suspect the number who are aware of what we do is significantly lower. Our activities include provision of a listening ear to those who feel their voice is not heard, to lobby for better conditions for our fellows and trainees and to provide advice on areas of concern to many.

As a result, there is now greater support for flexible working hours for women (and men) due to a recognition of the importance of parent-child interaction and shared family responsibilities. Return to work programs are available for those returning from parental leave or illness.

The stigma around mental ill-health and suicide, although still present, is decreasing. We recognise the need to support not only the family and close associates of victims, but whole departments and allied health members who know the individuals affected.

There is wider recognition of the need to understand and apply wellbeing practices, not the least evidenced by the inclusion of wellbeing questions in the examination.

Many departments now have strong wellbeing groups and wellbeing advocates who provide education on physical and mental health, mentorships or peer support for trainees and for fellows. They can assess and provide input into departmental activities and set up suitable physical and emotional supports.

The SIG has over many years developed guidelines on a range of topics including depression and anxiety, bullying, discrimination and sexual harassment, financial issues, retirement, breaking bad news, substance abuse, and mentoring. There are 30 resource documents in all, which provide a frequently updated, referenced and easy guide on a range of issues which may occur.

However, in recent years the SIG has taken on a more active role in providing programs for departments to adopt in a kind of 'prevention is better than cure' strategy. One such program involves the soon to be mandatory access to a wellbeing advocate as part of college accreditation. Another major step is the development of the Long Lives Healthy Workplaces (LLHW) toolkit.

LLHW was developed by the SIG in conjunction with the ASA and Everymind to enable departments to assess their wellbeing needs, to enact protocols and activities to address those needs, and to ongoingly reassess them. The object of LLHW is to proactively reduce the incidence of suicide, depression and substance abuse amongst us.

More recently, the SIG has developed a document to advise and support fellows and trainees during the COVID-19 pandemic, as well as providing an extensive library guide.

Yet despite the above, we still have a long way to go. Gender equity is improving but the discrepancy between female and male leads in most departments and the persistent issue of sexual harassment would indicate that there is still a lot to be done. Careful fostering of an environment where women are encouraged and equipped to further their careers is needed. It is up to all of us, and particularly we men, to be alert to anything that threatens that environment. However, excellent role models such as the president of the ASA, Dr Suzi Nou and president of ANZCA, Dr Vanessa Beavis, plus past female ANZCA presidents, are helping to provide that safe environment.

Many of the SIG's resources are being enacted at training sites. But the rollout to smaller public hospitals and particularly to private hospitals is exceedingly poor. This may be for a number of reasons. My attempt to commence support networks, mentoring and assessment of needs at the private hospital where I work was met with blank stares and comments such as "we're only here to make an income" and "most of our colleagues are fine, so we can put up with the surgeons and other staff who treat us poorly". Additionally, many private anaesthetists persevere with rushed lists and long hours, presumably because they feel there is no other option. This may work well, until they have a near miss or a patient morbidity/mortality, or a family disruption or disaster. If despite this, they continue to work under a cloud of anxiety and stress it can devolve into a cycle of depression and possibly alcohol or other substance abuse. We need to find a way to engage those working in private settings, and support them too.

We continue to need accurate data on the needs of our fellows and trainees, the effects of the pandemic and other traumas and the incidence of mental ill-health. Some data is already available, and it is hoped that with the development of the new Professional Practice Research Network (PPRN), future investigators will be encouraged to further that data collection.

The future is bright for the SIG with a strong membership and hard-working executive, the rollout of LLHW and the increasing presence of wellbeing advocates.

Dr Greg Downey

Chair – Wellbeing SIG

NSC 2021 SPEAKER ABSTRACTS

2021 BRISBANE CONVENORS REVEAL ALL

Convenors Dr Peta Lorraway and Dr Ed Pilling speak to Monique Wells about the 2021 conjoint ASA NSC and QLD ACE meeting Brisbane July 23 – 25

EXCITING NEWS!!

Brisbane will play host to an extraordinary meeting combining the ASA NSC 2021 with the QLD ACE meeting. This will be a rewarding and mentally nourishing meeting filled with opportunities to learn, improve, collect CPD, and yes, to socialise! That's right, this is a face to face meeting! How wonderful to catch up with intra- and inter-state colleagues whilst enjoying a fantastic educational program.

We also have a rewarding program for our registrars including exam preparation, navigating private practice and managing work life balance. In addition, the ACE Tess Cramond Prize session will recognise trainee-led research with $1000 up for grabs; so please encourage your trainees to submit their audit or research projects (details available asansc.com.au).

This wonderful collaboration has been orchestrated by two of our finest: Dr Peta Lorraway and Dr Ed Pilling, both from the Princess Alexandra Hospital and in Private Practice in Brisbane, as well as Dr Steve Bruce (Scientific Convener). Dr Monique Wells, (Social Convener) sat down with Peta and Ed to find out what drives them and what we have to look forward to!

Thanks for joining us to tell us more about the upcoming meeting! Firstly, give us a bit of background about how you ended up as anaesthetists and where you trained?

Ed: I'm originally from the UK where I completed my medical degree, but I've done all my anaesthetic training here in Queensland. My home in North-West England, is a very beautiful, green place but it rains a lot too, and that, coupled with 4 years working in the NHS during the GFC as a physician trainee, was enough for me to look for somewhere sunnier! In 2010 I took a job as an Emergency Registrar in Newcastle (NSW) for a year and soon after moved to Queensland to start anaesthetic training. Certainly, when I arrived here with 2 bags planning to stay for a year, I never imagined I would still be here and practising anaesthesia a decade later!

Peta: Like Ed I'm no stranger to the UK, as after medical school in Brisbane, I did the typical Aussie thing of the 90's and moved to the UK to work for a few years before coming back to Anaesthetic training in South East Queensland. I finished off with a neurotrauma fellowship in Toronto. I would highly recommend training in a variety of places to broaden your experience if you are able.

Monique: What are your special interests in and out of anaesthetics?

Peta: My enjoyment of critical care has probably translated into my anaesthetic interests being cardiothoracic, neuroanaesthetics and trauma work (although I don't do so much trauma now), but I'll tackle just about any kind of adult anaesthetics. Kids and obstetrics scare me.

I'm often one of those 'too busy' people but try and spend as much time as I can with family, friends, cooking, eating, hiking, and travelling (not necessarily in that order)!

Ed: I'm with Peta: cooking, eating, and travelling are where it's at (especially when shared with friends and family!). I can't wait to reorganise the trip we had planned in Mexico, which that fell victim to COVID-19 (although I'll have to go via the UK or risk

being excommunicated). I'm also well known for keeping active and I love being outdoors on my bike, hiking, swimming or beside the pool with a good read.

Work for me is mainly in a public adult teaching hospital, which meaning I get lots of exposure to trauma, transplant, and tumours, and some exposure to a lot of interesting sub-specialities. I've developed an interest in colorectal and am lucky enough to be involved with the brilliant cytoreductive surgery team at the Princess Alexandra Hospital here in Brisbane. I'm also interested in peri-operative medicine and I'm keen to see us adopt more of the ERAS principles across all surgical specialities including opiate-minimisation strategies for anaesthesia.

Monique: How did you get roped into convening the 2021 CONJOINT ASA NSC and Qld ACE meeting?

Peta: I'm not sure if this was being in the right place at the right time, or the reverse! I'd been involved in a previous NSC in a much smaller capacity, and I like being a bit of an organiser so when approached I said yes! It's a huge job over a few years so I think you need to be conscious of how much time you need to commit and whether you're willing to take this on. But it's an opportunity to help shape an educational event and feel like you're contributing to your specialty which I like. When I knew that Steve was our scientific convenor that sealed the deal!

I hope that people will notice that there are a lot of Queensland-based clinicians who are practicing world-class anaesthesia here in the Sunshine State and I'm certain that they will learn something valuable to take back and apply to their own practice.

Ed: Much like Peta – wrong place, wrong time! I'm the chair of the regional Queensland Anaesthesia Continuing Education (ACE) Committee – which is a joint committee with representation from the ASA. We're responsible for organising the regional ACE events which including a regional conference which that was pulled last year due to the pandemic. This year we were approached by the NSC organising committee to join forces to put on a face-to-face event with the idea of using mainly local Queensland contributors to make it as COVID-safe as possible. Given the committee is a team of can-do, collaborative people we decided we had to say yes!

Monique: What challenges has COVID presented in regard to the conference organisation and how is this conference different due to this?

Ed: From the looming threats of border closures, lockdowns and how and when to use technology, there are many extra things to consider, most of which change constantly including restrictions on gatherings and social distancing requirements. We also anticipate that there will be a reluctance to book ahead until people know for sure that they will be able to come (but I warn you: the great restaurants in Brisbane book out well in advance, so don't leave that until the last minute!)

The other difference will be the amount of local talent we are drawing on. Whilst Queensland often gets overlooked in favour of our more populous neighbours to the south, I hope that people will notice that there are a lot of Queensland-based clinicians who are practicing world-class anaesthesia here in the Sunshine State and I'm certain that they will learn something valuable to take back and apply to their own practice.

Peta: Yes, COVID certainly has thrown (and continues to throw) a few challenges, but the same can be said for everybody both professionally and personally; and you just have to work with what you've been dealt. One of the biggest things to try and navigate was the uncertainty; planning for these meetings starts nearly 3 years in advance, so there was a real sense of disappointment that the large NSC we were hoping to deliver in Cairns, could not be guaranteed to happen.

By late 2020, we knew we had to contingency plan as lockdowns were still an ever-present threat. Hence the Qld ACE committee were approached about a possible collaboration, with the idea we move the location of the NSC to somewhere that seemed a bit more achievable for a Brisbane based committee, and to hold it on the weekend of the planned ACE CME meeting. Fortunately, Ed and his committee were willing to work together, and we hope that this meeting brings you the best of both. Timing was challenging and I realise that this has impacted on other state meetings, so I thank those involved for being flexible in regard to this. We've built in a limited virtual component so that people still have access to some education should they be unable to travel. I still hope these have been the right calls to make!

Monique: Why would you encourage people to attend this meeting?

Brisbane in the winter. End of list.

No really - Brisbane's winter weather is hard to beat (congrats if you got the 30 Rock reference). Just watch out for the people cracking out the scarves when it's still 20 degrees out – quite amusing

NSC 2021 SPEAKER ABSTRACTS

STREETS BEACH IN SOUTH BANK PARKLAND, BRISBANE

for an Englishman to see! Also, with the 'beginning of the end' of the pandemic in sight and most of the medical workforce vaccinated, I think that we need to try and get back to life as normal. Virtual platforms have been a lifesaver over the last year, but nothing can replace ability to network with one's peers at face-to-face meetings.

Our original Queensland ACE conference was going to be themed on the future of anaesthesia and in a nod to this there is a session entitled the 'ACE Futures Session' on Saturday. This session features A/Prof John Loadsman, Editor of Anaesthesia and Intensive Care, speaking on: 'Disruptors in Scholarly Communication: Do medical journals have a future' - very current given our reliance on online communication to receive and deliver information during the pandemic. This is followed by Mr Sean Lowry, Directory of Green Cup Consultancy and a specialist in healthcare planning and reform (and partner to an anaesthetist) who will talk to us about 'The Current and Emerging Trends in the Australian Healthcare Market' – preceding COVID there were concerns about the ongoing pressures of an ageing population and burgeoning cost of healthcare in Australia, so what does the post-COVID future hold? In addition, ACE are running CICO training, an M&M meeting and an Acute Severe Behavioural Disturbance workshop. This last item is something that's been in the pipeline for a while – wonder how you would deal with an aggressive patient on a pain round, in clinic, on denial of opiate medication? Come along and find out (but places are limited so don't delay).

We also acknowledge the ongoing need for CPD – especially those colleagues mainly in Private Practice and those with an approaching triennium date – not simply to tick the box but as a genuine requirement to ensure our practice is up to date and our knowledge current. In addition to having CPD points available in every category, we will be providing opportunities for accreditation in every single emergency response activity – so get in early to avoid disappointment.

Peta: Ed has articulated beautifully a lot of what I would say! But However, I would reiterate the opportunity to see colleagues again, to get back to some hands on and face to face learning, and visit Brisbane at what is arguably the best time of year to be here.

Dr Steven Bruce, our NSC scientific convenor, has put together a fantastic program. You won't want to miss the Kester Brown lecture this year as we're fortunate to have Professor Eddie Holmes, an expert on the origins of SARS CoV-2, which really has turned our world upside down. We've got the majority of our invited speakers from both meetings still able to present, with the fabulous Vern Naik beaming in live from Canada, along with Queensland based Kerstin Wyssusek and Jo Rotherham live in Brisbane. There's a strong contribution from our SIGs, along with our usual emergency response workshops so that people can get along to areas that most interest them. We've also tried to include a large QA component, and a lot of wellbeing activities, because if COVID has taught us anything, it's that we need to look after ourselves and each other and that social interaction is good for us. We hope you can join us!

Monique: Thank you Peta and Ed for organising what sounds like a stimulating and enriching meeting. Peta and Ed, along with the entire organising committee, look forward to welcoming you to Brisbane July 23rd to 25th for this wonderful opportunity to learn and engage with colleagues.

2021 SPEAKER ABSTRACTS

DR JOANN ROTHERHAM MBBS FANZCA FFPMANZCA

Jo is an Anaesthetist and Pain Medicine Specialist, currently working as Director of the Acute Pain Service and Deputy Director of the Department of Anaesthetics at the Princess Alexandra Hospital in Brisbane. She also works privately as a Pain Medicine Physician and Anaesthetist at St. Vincent's and St Andrew's Hospitals.

Jo has had a varied career starting in the UK, through New Zealand to Australia including general medicine, paediatrics, obstetrics, gynaecology, geriatrics, psychiatry and palliative care.

MEDICINAL CANNABIS WEEDING OUT THE ANAESTHETIC ISSUES

Whether you are reviewing a patient in preoperative clinic, dealing with a patient with acute pain on the ward, managing a patient with persistent pain or just at a dinner party where the subject comes up; it will be useful for you to know the truths and myths surrounding medicinal cannabis and where the evidence stands since the Australian federal government passed the Medicinal Cannabis Bill in 2016.

You will learn what medical cannabis is and is not and the important pharmacokinetics and pharmacodynamics. I will discuss the current formulations available and what their indications are.

I will summarise and interpret what the professional bodies have to say on the subject as well as the influence of social media.

What are your options? What are your duties of care? What are the implications for the anaesthetist?

Has legalising medicinal cannabis changed anything?

This will be an interactive and lively session where the wheat will be sorted from the chaff.

SESSION TIMES

Medical Cannabis – Weeding out the anaesthetic issues!

DATE: Sunday 25 July
LOCATION: M1 & M2
TIME: 15:30 – 17:00

NSC 2021 SPEAKER ABSTRACTS

ASSOCIATE PROFESSOR KERSTIN WYSSUSEK MD PHD FANZCA

Director Department of Anaesthesia and Perioperative Medicine at the Royal Brisbane and Women's Hospital (RBWH) and Associate Professor at The University of Queensland

SUSTAINABILITY IN ANAESTHESIA

Healthcare in Australia contributes to around 7% of Australia's global CO2 emissions. Many healthcare related environmental activities are promoted by clinicians. Anaesthetists have long been on the forefront to address environmental sustainability acknowledging the detrimental effects of climate change on human health.

Sustainability in Anaesthesia encompasses a broad range of activities to undertake or to avoid. This ranges from engagement in broader hospital waste management strategies to individualised anaesthetic practice.

Anaesthesia contributes to waste generated in the hospital. Operating theatres (OT) produce around 30% of all hospital waste and about 25% of the OT waste is recyclable. Waste prevention strategies such as 'avoid, reduce, reuse and recycle' have been promoted and are practiced to various degrees in Australian hospitals and operating theatres.

Anaesthetic practice contributes to the globally increasing CO2 emissions. Anaesthetic gases are considered Greenhouse Gases and carry a considerable Global Warming Potential (GWP).

Sustainability in Anaesthesia is a choice we have as clinicians. Adapting sustainable practices and making informed decisions will decrease the impact of anaesthetic practices on the environment and human health and help fight climate change.

SESSION TIMES

Sustainability in Anaesthesia

DATE: Sunday 25 July
LOCATION: M1 & M2
TIME: 15:30 – 17:00

PROFESSOR VIREN N. NAIK MD MED MBA FRCPC

Director of Assessment, Royal College of Physicians and Surgeons of Canada; Professor, Department of Anesthesiology and Pain Medicine and R.S. McLaughlin Professor of Medical Education, The Ottawa Hospital and University of Ottawa, Ontario, Canada; Medical Director, MAiD Program, The Ottawa Hospital and Champlain Region, Ontario, Canada

MEDICAL ASSISTANCE IN DYING (MAID) IN CANADA: 5 YEARS LATER – WHERE WE'VE BEEN AND WHERE WE'RE GOING

Medical assistance in dying (MAiD) became a right for every Canadian in June 2016, when the Supreme Court in Canada amended the criminal code prohibiting the assistance of clinicians in hastening death for a person with a grievous and irremediable medical condition, whose suffering is intolerable, and who clearly consent to the termination of their life. In Australia, voluntary assisted death was made lawful in certain circumstances in Victoria, and will become legal in Tasmania in March 2021 and Western Australia in July 2021. New Zealand has ratified a referendum to make assisted dying legal, planned for November 2021.

In Canada, assisted death is offered to patients in two forms: 1) self-administered assisted dying - where a patient is prescribed an oral medication to ingest which induces death; and 2) clinician assisted death - where medications are administered to a patient intravenously to induce death. Less than 0.1% of assisted deaths in Canada are from self-administration. While self-administration is provided as an option to mitigate clinical atmosphere, it is not preferred by patients and practitioners because of issues of palatability, volume and patient disease that can impact the efficacy and speed in inducing death. Clinician administered medications intravenously to induce death is 100% effective in the presence of working vascular access.

Anesthetists have emerged as a key provider of assisted dying in Canada (after family physicians and palliative care specialists). Their early participation stemmed from their knowledge of the medications used to induce death which are routinely used for anesthesia. Our skills with vascular access, peripheral and central, are also key assets in delivering this service to patients. Vascular access and familiarity with the medications are identified as key pain points for clinicians considering becoming involved with assisted death. In most jurisdictions in Canada, best practice in clinician administration of medication to induce death requires the clinician assess the patient's eligibility. The assessment of eligibility is often not complex, can be learned, and is within the competencies, medical and non-medical, of an anesthetist. Importantly, conscientious objection to participate in assisted dying is respected, but clinicians must never abandon a patient and/or make an appropriate referral to any request.

SESSION TIMES

Medical Assistance in Dying (MAiD) in Canada: 5 Years Later – Where We've Been and Where We're Going

DATE: Sunday 25 July
LOCATION: Q1 & Q2
TIME: 10:45 – 12:15

INSIDE YOUR SOCIETY

PROFESSIONAL ISSUES ADVISORY COMMITTEE

DR PETER WATERHOUSE
PIAC CHAIR

DR PETER WATERHOUSE

PROFESSIONAL WELLBEING

Personal wellbeing is essential to the safe, enjoyable and sustainable practice of medicine. Patients rely upon anaesthetists to be calm and attentive. Intrusive worries and distractions can make this task difficult.

Sleep, diet, exercise and a harmonious home-life undoubtedly promote wellbeing, facilitating the calm and focus required in the practice of anaesthesia.

In addition to these fundamentals, several other issues influence the mindset of busy professionals. Simple problems, such as regularly finishing a morning list late and rushing to an afternoon session in a different facility, create an insidious background of mental stress. Workplace conflict, disharmony or staff turnover at your practice, patient complaints and financial worries add to this background. Attention to these stressors contributes to what might be called "professional wellbeing".

A professional health check might include review of:

Medical indemnity cover

Is your cover appropriate for your current practice? Have all serious incidents and complaints been discussed with your medical indemnity provider? Many matters will not be raised by patients until well after your memory of the inciting incident has dimmed.

Life and income protection insurance

What will happen to your family if you or your spouse are injured or sick? Adequate insurance frees you from material concerns and allows you to focus on the health and happiness of your loved ones.

Estate planning

Reviewing your will obliges you to consider all possibilities, including the sudden death of both yourself and your partner. In addition to such practical arrangements, financial considerations including testamentary trusts ensure that your financial legacy is maximised for the beneficiaries of your will.

Practice review

Do you still enjoy all of your work commitments? How would you like your diary to look in five years from now? Regular assessment of your practice will put you in control of your workload, ensuring you can continue to work on your own terms.

The above list is by no means exhaustive. There are many other considerations

within the professional domain worthy of regular review. Each can enrich your working life and keep you feeling positive about your career.
They include:

Continuing Professional Development activities

Hospital committee work

Education of students, junior doctors and hospital staff

Regular engagement with colleagues in large departments or group practices

One can never be immune to life's ups and downs. However, regular attention to professional wellbeing will help you remain calm, confident, and in control.

PIAC ACTIVITIES

Contract guidance

The evolution of health insurance towards managed care in Australia continues. Anaesthetists are frequently being presented with contracts for bundled care, especially for arthroplasty surgery. An email alert has been sent to members, and can be accessed on the ASA website.

Managed care webinars

ASA webinars continue to examine the issues surrounding managed care. Thank you to all who participate in these. Without broad engagement by all stakeholders, health fund initiatives would go unchallenged, potentially damaging our world-class health system.

Public-in-Private guidelines

The number of public patients offered surgery in private hospitals continues to increase. Without careful attention to process, this type of work is likely to be associated with a higher risk of complications than traditional private practice. The ASA has prepared a paper discussing this issue, including suggestions to increase safety. It can be accessed on the website.

Thank you to all who take an interest in the broad issues affecting our specialty and indeed the whole healthcare system.

I hope to see you at the NSC!

INSIDE YOUR SOCIETY

ECONOMICS ADVISORY COMMITTEE

DR MARK SINCLAIR

DR MARK SINCLAIR
EAC CHAIR

MEDICARE BENEFITS SCHEDULE (MBS) AUDITS

As reported in previous editions of *Australian Anaesthetist*, a number of ASA members have been subject to audits of Medicare claims made in their name. In particular, the situation where anaesthesia claims are lodged with no matching surgical claim have been investigated.

To reiterate, the Health Insurance (General Medical Services Table) Regulations 2019 (commonly referred to as 'The Regulations'), which contains the laws governing Medicare eligibility, states:

> *"Items 20100 to 21990 (other than item 21965), 22060, 23010 to 24136, 25200 and 25205 apply to a service only if the service is provided in connection with a service that:*
>
> *(a) is a professional service within the meaning of subsection 3(1) of the Act; and*
>
> *(b) is mentioned in an item that includes, in its description, "(Anaes.)"."*

Point (b) is crucial. As can be seen from a brief glance at the MBS book, there are many hundreds of procedural services which contain the term "(Anaes)". The Regulations also specifically exclude items 22900 (anaesthesia for dental extractions) and 22905 (anaesthesia for dental restorations) from this requirement, as there is virtually never an eligible MBS item for these dental procedures.

Several ASA members have been subject to audit due to a number of unmatched claims for item 20170 (anaesthesia for intraoral procedures, not otherwise specified). In two cases of which the ASA is aware, the anaesthetists had many hundreds of such claims, as they believed that the use of an item for oral surgical procedures more accurately matched the services of an oral maxillofacial (OMF) surgeon, as opposed to a dentist. The OMF surgeons were however using dental items for their billing, as there is no Medicare item for the operations performed.

MBS Item 20170 is most definitely subject to the requirement for a 'matching' surgical service with "(Anaes)" in its descriptor.

It is essential that item 22900 is used for all anaesthesia claims for dental extractions, regardless of the qualifications of the surgeon.

The ASA has highlighted this fact in the hard copy and electronic versions of the Relative Value Guide (RVG) and has asked the Department of Health to make a similar entry in the MBS.

Unfortunately, as the claims for 20170 were incorrect, the Department of Health has advised these anaesthetists that they may have to repay the claims.In two cases of which the ASA is aware, the amount in question is approximately $40,000. The ASA and our legal advisors at HWL Ebsworth have written to and met with members of the Department's Audit and Compliance sections, and highlighted a number of issues:

- The financial loss to these anaesthetists will be close to 100% of this figure, as the process of re-billing and re-claiming the correct Medicare items is so difficult as to be practically impossible, some 18-24 months after the date of the actual services.
- Medicare has sustained no financial loss whatsoever, as the rebates for items 20170 and 22900 are exactly the same
- A penalty of $40,000 or more for nothing more than an innocent clerical error is entirely unreasonable.
- The Department has stated in its correspondence with HBL Ebsworth and the ASA that

> *"… the Department will conduct a broader targeted letter activity to support early intervention and awareness raising, and to prevent the likelihood of providers being subject to more intensive compliance activity. MBS item 20170 will be excluded from this activity, however the letter will be accompanied by a factsheet which includes information about the correct claiming of items 20170, 22900 and 22905."*

The result of this is that some anaesthetists who have incorrectly claimed item 20170 may be penalised tens of thousands of dollars, while others will merely be advised

on the correct use of the item(s). These totally opposite approaches will depend only on the date on which the Department decided to analyse each individual anaesthetist's claim patterns.

The ASA has also pointed out that the Compliance and/or Audit sections could reasonably be expected to have detected this anomaly well before many hundreds of cases built up, and made some attempt to educate the specialty in the correct use of such Medicare items, as required by the Regulations.

ASA Immediate Past President, A/Prof. David M. Scott, developed an excellent working relationship with senior public servants, up to and including the Minister for Health himself, during the 'business end' of the MBS Review. A/Prof Scott has discussed the matter with senior Departmental officials. There appears to be agreement that pursuing refunds and reclaiming old accounts would be not only be an administrative and financial burden for the anaesthetists involved, but also for the Department.

PRIVATE HEALTH INSURANCE (PHI)

As members will be aware, Medibank Private (MBP) has purchased a 49% stake in the East Sydney Private Hospital, and has also bought into a corporatised general practice. MBP has now joined with a group of 42 doctors (mostly surgeons, but we believe there are also a few anaesthetists in the group) with the aim of developing a new short-stay surgical facility in Melbourne.

Key aims of the venture are to "reduce unnecessary time spent in hospital" and "reduce out of pocket costs", with OOP costs being a "big part" of addressing "affordability" of private healthcare. We are already aware that OOP expenses, while an important issue, are only one issue affecting "affordability". Close to 90% of all doctors' fees for inpatient services are "no gap" and a further 4-5% are billed as "known gap", where there are terms and conditions in place, notably a limitation on the actual OOP. Nevertheless, PHI companies and others continue to portray doctors' fees as being the core issue affecting "affordability".

Again, it must be noted that MBP is a for-profit insurer, and in all initiatives in which it is involved, financial profit is its aim. Certain aspects of the initiative will be beneficial, for example nobody would argue against reducing unnecessary hospital time. However, anaesthetists who wish to be accredited at the facility will almost certainly have to sign a contract regarding fees and charges, and it can be expected that these contracts will contain terms and conditions more favourable to the insurer than the doctor.

As previously advised, another for-profit PHI (nib, via its separate entity Honeysuckle Health (HH)) has applied to the Australian Competition and Consumer Commission (ACCC) for

> *"authorisation for 10 years … to form and operate a buying group to collectively negotiate and administer contracts with health care providers … on behalf of participants."*

PHI companies are identified as one of the potential "participants".

HH has engaged the services of a USA health insurer Cigna to assist. This company has a long history of concerning practices, regarding USA-style 'managed care'. In 2016, Cigna was sanctioned for

> *"widespread and systemic failures, including the denial of health care coverage and prescription drugs to patients who should have received them".*

And in 2020 Cigna was sued by the USA Department of Justice, as it had allegedly, over five years, inappropriately benefitted by USD $1.4 billion. The accusation was that Cigna had

> *"… falsified the health conditions of its Medicare Advantage plan members to coax CMS* into making larger payments to the insurer on behalf of beneficiaries".*

The ASA thanks A/Prof Scott, who also serves as the Chair of the Council of Procedural Specialists (COPS), for providing information in this regard. Useful links include the following:

https://www.usatoday.com/story/money/2016/01/22/cigna-medicare-sanctions/79160738/

https://www.healthcaredive.com/news/doj-cigna-medicare-advantage-fraud-lawsuit/583023/

The ASA, along with a number of other bodies, has expressed significant concern to the ACCC. The various submissions can be viewed on the ACCC website (accc.gov.au) by following the link 'Public Registers', then 'Authorisations Register' at the left of the screen.

Again, all initiatives pursued by such PHI companies must be viewed in the light of their prime motive – financial profit.

* Center for Medicare and Medicaid Services

INSIDE YOUR SOCIETY

LIFEBOX IN LAOS

INTRODUCTION OF AN ONLINE PILOT PROGRAM WITH THE LAO SOCIETY OF ANESTHESIOLOGY

DR TOM MOHLER
ROYAL HOBART HOSPITAL

DR TOM MOHLER

Lifebox was introduced to Laos Anaesthesia and Surgical services in February 2021, piloting a new online delivery method via the almost ubiquitous platform: Zoom. Previous surveys as early as 2010 suggest that district hospitals had limited access to functional pulse oximetry. For various reasons the Lifebox programme was not able to be implemented in perioperative services. The Covid pandemic highlighted the very real need for increased pulse oximetry requirements, in particular in provincial areas of Laos. Members of the Lao Society of Anaesthesiology led by their president Dr Traychit Chantasiri, Lifebox and myself approached the Ministry of Health and after significant negotiation, gained permission to allow the delivery of oximeter units into the country under the usual Lifebox terms, including free customs access and implementation of an educational package. The package consists of four modules, a pre- and post-course MCQ and evaluation delivered as a day-course. The modules include basic physiology of oxygen transport, practicalities of using the pulse oximeter, introduction to an Hypoxia action plan with associated scenarios as well as familiarisation to the WHO Surgical Safety Check list. Usually on the subsequent day, a Train the Trainer (TOT) course is offered, which discusses concepts of adult learning, preparation, facilitating lectures, workshops and small group discussions. This equips local practitioners with that ability to deliver Lifebox material and training.

The inability to travel to Laos due to Covid presented a significant hurdle in delivering any form of education along with the hardware. As with many other programs consideration was given to moving the program online.

The inability to travel to Laos due to Covid presented a significant hurdle in delivering any form of education along with the hardware. As with many other programs consideration was given to moving the program online. Throughout 2020, Lifebox had been working towards uploading its educational program onto an online platform called LearnWorlds, which also facilitated access to Covid orientated specific material. Lifebox was also keen on developing and trialling an online delivery of course material and TOT

Left:
Presentation of Lifebox oximeter by Ministry of Health representative Kham District Hospital (central Laos)

Presentation of Lifebox unit in Northern Laos province.

Vientiane, Laos, Southeast Asia

for its pulse oximetry program. The recent delivery of pulse oximeters and my 15-year collaborative program with a network of local anaesthetists in teaching residents in anaesthesia, usually good internet access, the challenge of some language barriers provided an ideal opportunity to trial a pilot in this country. Earlier online attempts in teaching resident anaesthetists had shown that teaching through interpreters was much more challenging than face-to-face teaching. Through the hard work of Program Coordinator of Lifebox Dr Tara Mansi in the UK, local coordination by Dr Traychit Chantasiri, joined by Assoc. Professor Robert McDougall of Lifebox ANZ, Dr Simon Morphett a fellow long term visitor assisting anaesthesia teaching in Laos and myself, we formed a team including six local anaesthetists. These local anaesthetists were from a number of hospitals in Vientiane, were the most proficient in English and many, as part of their work, travel to remote district hospitals to provide teaching, best placing them to be future Lifebox educators. The two-day program was contracted down to 2 hours on consecutive days, juggling time zones between the three countries. Prior familiarity with the LearnWorlds platform was encouraged.

Day 1 on the 1st of February 2021 consisted of demonstrating the four main modules of the Lifebox program in a necessarily contracted form. In addition to the seven local anaesthetists, we were joined by a local biomedical engineer. Day 2 consisted of a limited form of TOT course that included preparation, facilitating case studies and workshops, and a Q and A session.

Overall, the sessions ran surprisingly smoothly, keeping reasonably to time and maintained a stable internet connection via Zoom throughout. The course material was condensed to focus on essential concepts and how to effectively present the material taking into account the difficulties presented by the language barriers. It was recognised by local participants that the slides presented in English will need to be translated into the Lao language for use on a practical basis, in particular in provincial centres where English proficiency is minimal amongst many medical and nursing staff.

I would like to thank Lifebox for their ongoing interest in this project over the past year. Dr Tara Mansi as Programme Manager and Dr Traychit Chantasiri as the coordinator in Laos contributed greatly to the success of this two-day online pilot program. I personally found the project enriching; the enthusiasm of the participants was heartening and showed the endeavour of mankind to adapt and carry on. It cannot replace the tactile dimension through face-to-face contact. However, for now, until this crisis becomes somewhat controlled, the 2D version provides an option to continue contact and support our medical friends and colleagues in other countries and to improve the healthcare and safety of their people.

INSIDE YOUR SOCIETY

TRAINEE MEMBERS GROUPS UPDATE

DR ALEX COURTNEY

DR ALEX COURTNEY
ASA TMG CHAIR

Hello again!

My my, this year is absolutely flying past. There I was, enjoying my January, thinking it would be a while before I have to think about starting my study for sitting the final exam next year, and then … BAM! … March rolls around and away we go. I have been grateful not to spend any significant amount of time confined to a 5 km radius around my house though, there's not much to do here!

EDUCATION

We are still seeking expressions of interest from trainees who would like to be part of the ASA Online education committee. The new ASA Ed section of the website has been launched (https://asa.org.au/asaeducation/), and this committee is tasked with its implementation, relevance and future directions. You will join some incredible anaesthetic educators in curating and producing some earth shattering, ground breaking content for your fellow trainees to expand their minds. Do not be shy! Expressions of interest to: vidav@goape.com.au

March finished with a bang! On the 31st Dr Suzi Nou and I hosted the first (annual) ASA Prevocational Medical Education and Training Event. We were joined by Dr Lynn Hemmings, a Medical educator from Tasmania, Dr Vida Viliunas and Dr Lan-Hoa Le as well as so many of your colleagues from around the country (Thank you to Julia, Hannah, Gihan, Andrew, Jingjing, Eileen, Kelly and George). Lynn's video on interview tips had so many pearls of wisdom it made me want to go back to my original interview and re-do my answers! We then had an amazing session of questions and answers from HMOs around the country on what trainees have done to get on the program. It was so exceptionally popular we had to close registrations due to the sheer number! We plan on hosting further state specific events, so please let any budding future anaesthetic trainees know about these!

Vida has prepared an extensive document about CV tips, preparing for job interviews and the questions often asked – email Vida on vidav@goape.com.au

Regular Practice VIVA sessions for both the Primary and Final exams are held for ASA Trainee Members, these are always well received and honestly one of the best resources we provide to trainee members of the ASA, well worth joining just for this!

At the recent meeting of the ASA Council, changes were made to the eligibility criteria for application to the Common Interest Group scholarships which have made the membership requirements clearer. A reminder that despite these scholarships being for international meetings of our partner associations, they are more flexible at the moment due to COVID related issues, so please do apply via the ASA website!

ANZCA has advised that EMAC courses are currently at capacity with a large backlog of applications to work through (Thanks COVID!), they are working to increase capacity in line with restrictions on density quotients. If you are nearing the end of your training and need to get EMAC qualified, please liaise with your SOT and keep your ears tuned.

The ASA NSC is now being held as a conjoint meeting with the QLD ACE in July (23–25) with a trainee day to start it all off, please do register! There will be both a physical and on-line presence.

ADVOCACY

Due to an unexpected vacancy, we are seeking expressions of interest for an ACT based trainee member to join our TMG committee. We meet regularly to discuss trainee specific issues and events and have regular communication with the ASA Council and other relevant committees. We are supremely supported by the association and regularly plan, run and facilitate some amazing trainee-centric

events! Please apply by sending your CV and a one page covering letter to mwade@asa.org.au.We continue to be a voice in ANZCA, AMA and ASA based committees to advocate for the wellbeing of trainees. ANZCA recently announced some substantial changes to both primary and final exam procedures, specifically related to carrying over pass marks from written to future sittings of Viva exams as well as making clarification to the special consideration process. The college is looking for further trainee input in a variety of areas, some of which ASA trainee members are in the thick of it making sure you voice is heard.

Managed care is going to be a part of our future careers and is an incredibly complex and potent topic of discussion at many levels. ASA committees are extensively involved in the discussions around this topic. I would encourage any AT/PFT members to educate themselves about this issue, the ASA has webinars and documents explaining the relevance to your practice on the website. A section on managed care will be incorporated into Part 3 courses soon to ensure that when you become a consultant you have all the information you need at your disposal to navigate the complexities of this issue!

The 2020 Medical Training survey results were released recently, it showed that accredited anaesthetic training is generally well received. There are some ongoing issues with how trainees are communicated with and how involved they feel with the college. This shows that the advocacy the ASA undertakes on our behalf with ANZCA and other bodies is important. Worryingly, there are still a number of trainees experiencing or witnessing bullying/harassment in their work place and many from within their own team. The ASA has a strong culture of support and I would encourage anyone who feels they need to, to not hesitate to contact us – trainees@asa.org.au

SUPPORT

On the topic of exams, a reminder that ASA members can make use of a corporate discount for the Accor hotel group for their exam related accommodation. Please contact mwade@asa.org.au for information.

Trainee membership in the ASA is strongly growing. We now have over 700 trainee members across all categories including the newest "Prevocational medical education and training". This category is for junior doctors who have a future in anaesthesia but are not yet on an accredited training program. Please keep this in mind when you are stopped in the corridor by a keen HMO wondering how they become you!

The ASA has kindly carried over membership fees from 2020 to 2021, including if you were a BT and are now an AT member. So please use this opportunity to update your membership category if relevant as AT/PFT membership comes with loads of great presents!

The theme of this issue of Australian Anaesthetist is Wellbeing. I'm sure there are several mentions already in this issue, but I wanted to encourage trainee members to avail themselves of the resources on the ASA website: https://asa.org.au/welfare-of-anaesthetists-2/. There is a huge list of websites and groups that cover everything from providing support to repositories of resources on training, techniques and strategies for mental health and welfare. These resources are so extensive that I'm sure every one of you could find something helpful for yourself or colleagues and friends.

As we have seen, 2020 was a challenging year at every level. Exam stress took personal tolls on many, including myself! I spent a large part of 2020 in a perpetual state of heightened anxiety, intermittent despair and self-doubt. Sometimes, these feelings could be overcome by chocolate and ice cream (which when enjoyed in "moderation" I totally support as a coping strategy!). But I very much relied on the oft mentioned "personal support network" of my friends and family. Without whom the year would have been substantially more challenging. I also heavily relied on some 'disconnection' strategies like outdoor exercise and hobbies (TV is also a hobby, right?), which often just provided a bit of defusing and recharge.

I think there's been a monumental shift in opinion on the importance of trainee mental health in the past 12 months. And I would encourage you all, even if you think "Ah, I'm doing alright! I'm just a bit tired because I'm always studying/working." Take a moment to reflect on life and you. Utilise whatever you have available, close friends or loved ones, to take stock of how you are doing and how they think you're going; sometimes a 3rd-person view is necessary! And make time for a walk, a run, a kayak … whatever it is that gets you out of the artificial light of indoors. And please, if I have learnt one thing, don't be afraid to seek help early!

By the time this issue is in your hands, the year will be almost half way done. Here's hoping that we've crept a little bit closer to normality, the vaccine rollout has gone smoothly and the first 2021 sitting of the exams is behind us!

And remember - do not hesitate to reach out to your local TMG committee member if you need our help!

Until next time.

INSIDE YOUR SOCIETY

TIPS FOR JOB INTERVIEWS

Dr Vida Viliunas is a specialist anaesthetist currently working in public and private practice in Canberra.
As ASA Education officer, she hosts primary and final exam practice vivas via Zoom. Those vivas are edited and appear in the trainee resources section of the ASAEd website. She is a past examiner for the final fellowship exam and a past Chair of the Final Examination Subcommittee. Dr Viliunas is the convenor of the annual Final Exam Boot Camp in Canberra. 2021 dates are set for July 10 and 11 registration details are in the Professional Development and Events e-news and under the trainee events tab on the website.

Aaron Pym is completing a provisional fellowship at The Canberra Hospital, and draws on a prior career in recruitment and management consulting.

DR VIDA VILIUNAS AND DR AARON PYM

Preparing for job interviews and CV writing are two important components for successful job interviews addressed by this article. Hope is not a strategy.

FIRST IMPRESSIONS

The objective facts on your CV are important, but they are not everything.

There are studies which claim that nonverbal communication contributes a great deal to charisma, credibility and intelligence ratings (and therefore to job appointments). There is no denying that your grooming, presentation, hand gestures, voice- modulation and the amount that you smile or frown all make a difference to the impression you make on your audience. That applies for both an in-person or a virtual interview. A first impression occurs in nanoseconds. You only have one chance to make it.

When thinking of your presentation

- Dress for success; it is simplest to wear a professional, classic suit such as the one you wore to the exam. That sends a signal about the effort you are prepared to make in order to succeed
- Be mindful of good nonverbal communication – sit straight, make eye contact, connect (whether in person or virtually) and listen
- Use professional language, do not be too familiar
- Aim to be punctual or early
- Bring a well composed, well-presented, current curriculum vitae for the interviewers to scan. Consider preparing several copies of a short resumé that you can leave with the interview panel. This resumé should set out how your CV dovetails with this particular role

For a video interview, check that you

- Have the latest version of the platform
- Have high speed internet
- Are charged and connected to a power source
- Have done a sound and video check
- Set up in a quiet room with a locked door
- Get a diffuse light on your face (not behind you)
- Have the camera at eye level (not from below)
- Expect a glitch: have a plan for when things go wrong (have the mobile or email of a contact to call on)

There are many videos describing "How to look good on Zoom" – including "Look better on zoom" on the ASA website in the trainee resources section. Dress, grooming and body language for video is just as important as it is for an in-person interview.

LOGISTICS AND INTERVIEW PREPARATION

Make sure that you are fully aware of

- The details of the job advertisement
- The hospital and departmental website
- The membership of the interview panel and their individual interests
- Other applicants and vacating appointees
- How your past experience relates to the position

TOP TIP: Work through each element of the job description and predict the possible interview questions you might be asked. Practice your answers in a mock interview or on video.

Be polite and nice to the gatekeeper. Never mess with the staff. You have probably already learned this as a life lesson. If you want to succeed at anything, start by choosing your enemies carefully. It's a small world. While the person who answers the phone may not be the final decision-maker, s/he may very effectively and persuasively have the ear of the person who is.

BEHAVIOURAL QUESTIONS

There are a number of high-quality resources on medical behaviour-based interviews. There is a sandwich construct for the interview: the "putting you at your ease question", the actual questions and conclusion chat.

Just as you practised scripts for the vivas to prepare responses to questions, so you can anticipate some questions and rehearse the answers to make the job interview easier and less intimidating. This will assist to portray your qualities and skills more persuasively and accurately.

"Tell us about yourself"

This is not about your golf handicap, hobbies or book club. Unless you are specifically asked for your star sign, this question is about the job. It calls for you to talk about the skills, experience and qualities that you bring that fit for the specific position for which you are applying.

Avoid a general answer such as you might give at a nightclub. You should be specific and link how your education, previous employment and experience in training are related to the specific skills required for the particular job at hand and not your personal life. Doing so allows you to showcase your communication skills and ability to anticipate: a real performance winner!

So: what are the contents of a good response for an anaesthetic job?

All the candidates for a Provisional Fellow or consultant position have a FANZCA

or equivalent so how was your training distinguished? A prize or prizes? Relevant volunteer work? A particular departmental contribution? Relevant Subspecialty work? Special interests, non-technical skill development/ research/ teaching opportunities? What particular skills did you hone during training?

"What are your strengths?"

You need to be specific and detailed for this one. Divide your skills list into Knowledge-based (education and experience), Transferable skills (communication, IT, people management) and Personal Traits.

(Your choice of) academic/ leadership/ teaching/ niche (informatics/IT/ subspecialty etc) and how they apply to improving your contribution to the job (when you get it) and to the organisation.

If you have already achieved or mastered something outstanding in the spheres of education, employment or skills, say so! Show that you are proud of it by saying that you are proud of it. However, no-one likes a show-off. It can be tricky to point out your strengths and convey humility, curiosity and a desire to learn and contribute. Develop this by explaining how that achievement can improve your contribution to the job/ team/ organisation.

Something relevant to the particular academic/community service/teaching/ departmental/global interests of the particular job description or something you intend to do in the future. This demonstrates the strength of your vision and a plan for growth in the job.

TOP TIP: For the questions that you are likely to get, make sure you script a positive statement that you can say with confidence that will match your strengths to the job description.

"What are your weaknesses?"

Having anticipated the strengths question, the "weakness" question is the next obvious place to go. Yes, you have to have some weaknesses. It is too cheesy and can come across as arrogant, to reply that you are a perfectionist or similar.

This is not about you or your personality. Avoid the temptation to present a strength in disguise. This should be an issue that has occurred (often in a specific context) and which you have corrected. This question is an opportunity to show that you have powers of insight, have taken corrective initiative and have the discipline to implement a remedy. Your response shows that you have a track record of reflection, flexibility and the ability to respond to changing requirements and different organisations. Thus, you will not need much beyond basic orientation in a new place.

In its disassembly, this is a Hollywood movie: Likeable hero (you) encounters an obstacle (weakness), takes action and emerges renewed/transformed/ improved (result). The STAR construct (Situation, Task, Action, Result) is another helpful way to structure a response. Be brutally honest with yourself about this one. Spend time reflecting on and composing a response.

An example of a weakness is difficulty in accepting criticism that results in impaired communication and lost opportunities to improve skills and knowledge at many levels. You strive to achieve the best possible outcomes for your patients but find it very challenging to be criticised by your colleagues. The remedial action might be to seek the advice of your senior mentors and peers, attending a "taking criticism without crying" course where

INSIDE YOUR SOCIETY

you learned to deal with acute situations as well as maintain skills that you refresh every six months online. Result? Plusses all round:

- You have improved relationships in your workplace (remember, the question is about the job).
- You have realised many more opportunities to learn from all levels of medical and non-medical staff.
- You are vigilant about not falling into old habits.
- You have taken on mentoring of your peers and juniors in this sphere.
- Recognising this fault early in your training allowed you to take full advantage of your basic and advanced training and to spread that particular joy to others.

Accepting or receiving criticism is a significant issue for many registrars and other humans. The above analysis allows a job candidate to demonstrate insight and an ability to recognise and implement solutions. The results provide an opportunity for self-improvement as well as contribution to the greater good by way of patient care and improved relationships with colleagues.

The realisation that there are other areas where you can improve may well have enabled you to develop in those as well. If there is a follow-up question about another area, be ready for that one e.g., fear of public speaking.

For other ideas search "Mayo Clinic's behavioural interview"

"List of greatest strengths and weaknesses monster.com"

"How to answer the weakness interview question monster.com"

"Why do you want to work here?"

Honesty and research are required here. Find out about the institution, its past work, research interests, culture, reputation and people. Prepare something which addresses how the opportunities for you might be mutually beneficial or serve a higher purpose. Use specific examples which demonstrate the excellence of the match of you for this job. Information from a vacating registrar for a Fellowship position or another consultant is very valuable here. Acknowledging your source signals that you are someone who does their homework.

"Why should we hire you?"

You should be answering this question from the moment you started to research the job description, the institution, panel members and outgoing job holders as well as your polite and respectful dealings with the staff. Having done all that work, tell the panel that you have made yourself aware on those fronts. The fact that you arrived early, the way you walked into the room (or Zoom), the way you presented yourself, your CV, resumé and your confident greeting to the interview panel, should all be persuasive.

By the time this question comes up, you might feel that you are repeating yourself. That might not be a bad thing. You can prepare a summary of your excellence as

- A colleague – positive feedback in previous roles, reputation for reliability
- A departmental team player – value-adding as a teacher/ researcher/ mentor/ roster creator or fill-in
- A soft-skill superhero including leadership, communication, interpersonal skills, stress management, time-management, empathy, self-confidence, endurance, respect for others.

Your specified and special skills which you have matched to the particular needs of the job and the added value that you would contribute, should make the panel beg you to stay.

"Do you have any questions?"

Prepare some questions so you can leave a strong impression on the panel. Again, this is an opportunity to signal your preparedness and motivation. Your questions should be credible and not just Dorothy Dixers or questions to which you already know the answers.

Search "The secret to acing behavioral interviews: be a great storyteller". A lot of the information is from American websites, thus the spelling.

TOP TIP:
Prepare some answers to questions that you can anticipate from your research for the job

THE INTERVIEWERS

It is interesting to reflect on the interview process, its structure and to spare a thought for the interviewers.

Interviewers are trained, not born.
Be prepared for an interviewer who:

- Has not read your CV
- Gets aggressive to see how you react under stress
- Seems distracted
- Makes remarks about your previous bosses
- Asks questions but does not listen to the answers.

Interviewers may also be nervous, aggressive, unprepared, disorganised or ask inappropriate questions.

It is always better to be prepared for, rather than outraged by "forbidden" questions about family plans, religious beliefs or ethnicity. They may be simply deflected by a statement such as "My (religious beliefs/ sexual orientation) will not interfere with my ability to fulfil my job obligations." If the situation shows signs of developing into an unpleasant one, you can choose to use it as an opportunity to display a well-mannered composure.

Make a decision at a later time regarding whether you want to work in a place where inappropriate questions are asked. Remember that there is no point in alienating anyone in this (or any) process. You never know where or when members of this interview panel might turn up on the yellow brick road of your professional life.

CV WRITING

"Preparing your medical CV" in the BMJ 29 October 2018 by Kathy Oxtoby

"Polishing your Curriculum Vitae in Australian Anaesthetist June 2019 p42

NON-BEHAVIOUR-BASED SKILLS QUESTIONS

You should anticipate questions relating to anaesthetic career choice, why the panel should hire you and where would you like to be in five years' time. These are questions about direction, ambition and growth. You cannot know how your plans will be shaped (or controlled) by circumstances, but an interest in knowledge and skill maintenance or improvement is a good place to start. You could show curiosity in or research how the anaesthetic career plans of your mentors have reconciled with reality.

Be prepared for a clinical question. Rely on your exam preparation for this: identify the issues and how your choices address those. Refer to relevant evidence for your response. Where evidence does not exist, your response should be based on sensible, defensible judgement with an emphasis on the best interests of the patient and their safety. Where the clinical question raises competing physiological interests or personal conflict, there is often no "right" answer. Acknowledge this and explain your answer.

THE ODD QUESTIONS

Sometimes panels ask uncategorisable questions. Some examples are:

- If you were a hamburger, would you prefer to be the hamburger or the bun?
- Which superhero would you be?
- What would you take to a desert island?

Such questions test your flexibility and response to novelty. Anaesthetists are trained to anticipate the expected and to be prepared for the unexpected. Use humour cautiously. Take a deep breath and give an answer. However, if you are confident about the way things are going, your answer to such a question might provide a good opportunity to display something of your personality.

For other weird interview questions and why they are asked search "Great answers to awkward interview questions monster.com".

SOCIAL MEDIA

Clean it up.

Consider going a step further and build a benign social media presence so that a name search generates non-controversial content.

Review your presence on social media: Linkedin, Facebook, Twitter, Instagram, University/school/community website, AHPRA, personal blogs.

Decide what you wish to make public.

The most dangerous component in a motor car is the 'nut behind the steering wheel'. In the online world, the most dangerous vulnerability just might be the careless individual behind a keyboard.

QUESTIONS THAT YOU SHOULD ASK

This marks the closing of the interview – but not quite. Fight the urge to get out of the room having survived the experience. Take the opportunity to distinguish yourself as a candidate to the panel and to learn more about the job and demonstrate your interest for it.

Questions such as the following:

- Of the research interests of the department, given my background in 'x' how can I best contribute?... or phrase this as stating that you have spoken to 'y' (vacating the position) who completed project 'z' and ask/state how you can build on this work
- Pick an 'omission' in the job description and ask if you can undertake that task: rostering/mentoring/teaching
- How do you evaluate success in this position? Is there a formal process?
- Asking when you can expect to know the decision of the panel is a simple way to close.

Frca.co.uk has some useful material

"Consultant Interviews" https://www.frca.co.uk/SectionContents.aspx?sectionid=237

"Consultant interview tips" https://www.frca.co.uk/page.aspx?id=118

From the AAGBI "Preparing for the Consultant interview" at https://www.frca.co.uk/documents/august05.pdf

TOP TIP
- Be honest
- Be yourself
- Be prepared.

The harder you prepare, the luckier you will be.

INSIDE YOUR SOCIETY

CLINICAL PRACTICE FOUNDATIONS FOR INTRODUCTORY TRAINEES

DR MICHAEL ROBBINS

We are proud to report on the successful completion of the first 3-day RIAACT course (Readiness for the Initial Assessment of Anaesthetic Competencies Training); aiming to provide a solid foundation for our Introductory Trainees' (ITs') clinical practice.

The 'RIACT course' was designed in the Oxford Education Deanery, United Kingdom, to supplement the teaching and training received by new anaesthetic trainees during their first placement. It aims to help trainees achieve the standards stipulated in the Initial Assessment of Anaesthetic Competencies (IAAC).

WA has a valuable primary examination tutorial programme for all 'pre-primary' trainees. These start from the first month of training and are, understandably, heavily exam orientated. With no centralised training on clinical anaesthetic practice, along with the 'intimidation factor' the examination holds, ITs focus much of their early enthusiasm and effort on exam preparation rather than developing clinically safe anaesthetic practice. The revised (and slightly renamed) 'RIAACT' course, aligned with the ANZCA curriculum, contributes towards the primary purpose of the IAAC - to provide a solid clinical foundation so ITs can "safely work beyond Level 1 supervision for suitable cases".

COURSE STRUCTURE

The aim of this 3-day course was two-fold:

- To provide a structured overview of core topics for ITs to 'pin' their daily experiences on.
- To provide a safe environment to encourage open discussion and facilitate applying new skills, knowledge and experience to clinical situations in both case-based discussions and simulation scenarios.

We prioritised interactive, small-group sessions to ensure trainees felt empowered to speak up, ask questions and reflect. Each day followed a similar format, with care to reinforce previously taught material during simulation sessions.

Following a set of short lectures in the early morning session, trainees moved onto group-based interactive rotating sessions with 4-5 ITs in each group. We utilised a variety of teaching techniques to maintain engagement, including reflection on past experiences, case-based discussions using cases from ANZCA's Networks, quizzes and hands-on skills stations.

RESOURCES

The faculty requirement for running these small group programs is high and therefore we split the content over three sites, with each day run at one of Perth's three major tertiary hospitals; Royal Perth Hospital, Sir Charles Gairdner Hospital and Fiona Stanley Hospital. Faculty from smaller teaching hospitals in the area also volunteered to help. For various reasons, the three days were split throughout March, rather than the start of the academic year in February.

The reciprocal benefits each hospital had in sharing education between their trainees enabled us to use all the facilities free of charge. We are indebted to the faculty for their contribution of non-clinical hours, PDL or their own personal time. Sponsorship was kindly provided by Avant Pty Ltd for refreshments over the entire course, and we thank the AMA (WA) for assistance in supporting the Sir Charles Gairdner simulation facility through donation of equipment.

Feedback from the trainees was collected each day and was overwhelmingly positive. In addition, independent feedback was sent to SOTs by the IT group, which highlighted the need for more of this form of teaching.

WHAT THEY ENJOYED:

- Reflecting on individual's experiences or using fictional cases to discuss different topics.
- Theatre-based simulations that provided ample time for feedback.
- Faculty with high energy and who related lesson content with their own experience.
- Niche topics that aren't covered so easily/commonly in theatres e.g. machine check.

WHAT WE WILL IMPROVE:

- Some sessions felt rushed -adequate time spent on less material is higher yield than skimming a higher volume.
- Some lessons were a little more didactic than others, making it difficult to remain engaged, especially during small group sessions.
- Much of the content would have been very useful in the first few weeks of training – in future, we will try to bring the sessions into the first month of training.

LESSONS LEARNT

FACULTY: Splitting the course over three sites worked very well. Recruiting faculty from each site wasn't too difficult and the feedback from each department was very positive. We hugely appreciated everyone's effort in developing their lesson content as well as donating their time. Now developed, less preparation time will be required for subsequent courses.

SIMULATION FIDELITY: The first day had trainees in casual clothes. This significantly reduced 'buy-in' during the scenarios and was improved by wearing scrubs on subsequent days.

INTERACTIVE TUTORIALS: There was a clear trend in the feedback with high praise for the more interactive sessions. We accept that 'less content' may be covered, but the course is not designed to cover all the IAAC curriculum. Instead it aims to provide a mental framework which trainees can use to help focus their future study and clinical practice. Ultimately, more interaction, more engaging, more enjoyable, better retention of content!

FOOD & DRINK = VITAL: We were very lucky to have fantastic refreshments to fuel participants and faculty. Finding a generous sponsor to organise and fund this is key in keeping people happy and thereby improving their experience.

MOVING FORWARD

We aim to run this course twice a year in WA. Hopefully the course will keep its current format; however, our mid-year cohort is smaller and further trainees will need to join to make it viable. They could be independent ANZCA trainees, or trainees from other specialities on placement with the respective anaesthetic departments.

Alternatively, depending on faculty availability, we may consider running a modified format in which groups are not split and have morning tutorials followed by afternoon simulation. This would reduce the faculty and facility requirements.

We have already had interest expressed by anaesthetists in other states, who agree with the principles of the course. We will happily share material and provide support to those interested in setting up a similar program.

For more information contact:

Dr Michael Robbins
Course Coordinator
Michael.robbins@health.wa.gov.au

Dr Archana Shrivathsa, Medical Lead
Archana.shrivathsa@health.wa.gov.au

INSIDE YOUR SOCIETY

20 YEARS OF THE TRAINEE COMMITTEE

DR RICHARD SEGLENIEKS

A strong, independent voice for trainees is vital. It ensures that this vulnerable group is not ignored or forgotten, and that trainees' interests are protected. It provides a two-way channel for communication between trainees and leaders in anaesthesia. It gives us a say in the future of the profession – which is our future too.

This article looks back through the history of the ASA's trainee committee, focusing on its formation and some more recent achievements.

Gestation of the Trainee Committee

In 1998, during the presidency of Dr Rod Westhorpe, the ASA Council was approached about the development of a forum for Australian trainees in anaesthesia to meet and express their opinions. Council agreed in 1999 and Dr Dave Fenwick, Chairman of the South Australian Committee of Management (SA COM) and Council Member was tasked with taking the first steps.

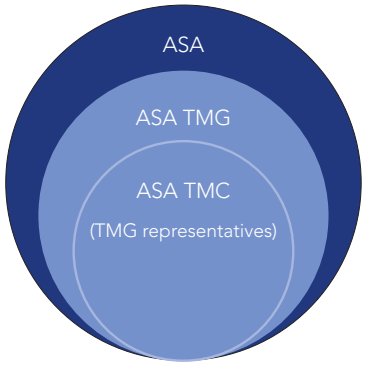
The 'ASA Doctors-in-Training Forum' was convened by the SA COM on 29 July 1999 in North Adelaide, providing anaesthetic trainees the opportunity to share their opinion on issues important to them including how the trainee committee should function. It was convened by Dr Fenwick and attended by ASA Treasurer Dr Peter Lillie and nine trainees.

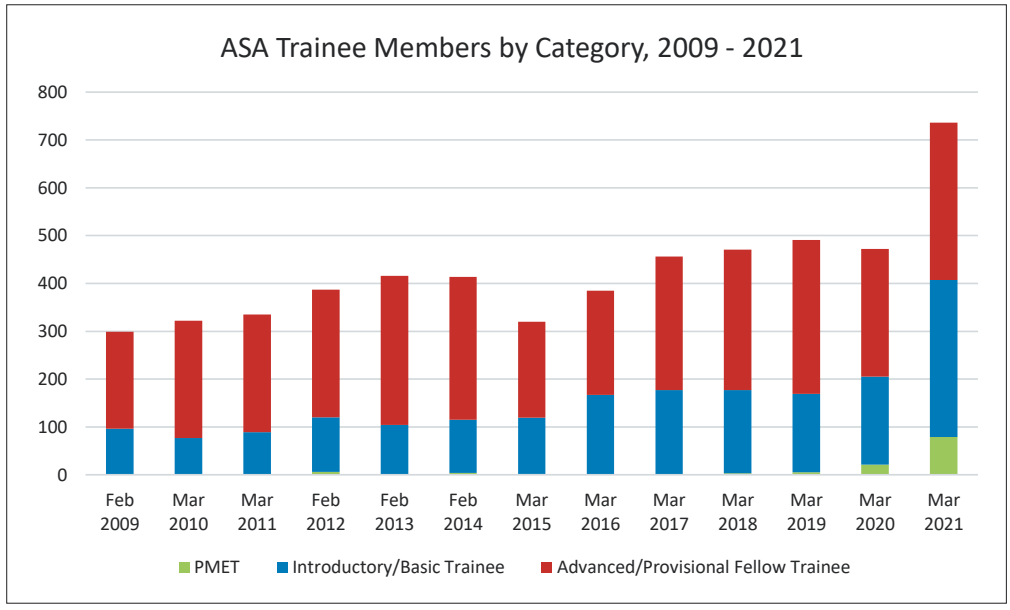
At the forum, Dr Julia Coldrey (a trainee at the time) highlighted the important role of the ASA as a link for trainees with ANZCA given the lack of trainee representation within ANZCA at that point. Trainees expressed the need for feedback regarding political issues, and expressed interest in the publication of a newsletter for circulation amongst trainees and in communication of important matters via email. Key issues were identified as the promotion of the importance of anaesthetists as specialists within the medical profession and the wider public, and the AMA Safe Hours campaign including conditions for overnight accommodation.

Dr Coldrey was elected as State Chair of the new group and asked to make a report to Council on the feasibility and format of the organisation. The full report, outlining the need for a trainee group with the ASA, how it should be structured, the format that meetings of the group should take, and the progress made, is retained within the ASA Archives. This report highlighted that "trainees need an avenue to express their needs and concerns" and "to ensure its survival, the ASA needs to have a group of anaesthetists interested in taking part in the Society's running and acting as advocates on behalf of the whole profession … Trainees are the office bearers of the future".

Genesis of the Trainee Committee

This year, 2021, marks 20 years since the inaugural meeting of the trainee committee within the ASA. Formed a year earlier in 2000, the group was initially known as the Group of ASA Clinical Trainees (GASACT).





The formal process of establishing GASACT was outlined in *A Working Paper on the Formation of a Trainee Organisation Within the Australian Society of Anaesthetists* – a document also retained in the ASA archives. This paper was produced by the delegates from each state of Australia and from all levels of anaesthesia specialist training attending the 'Future Directions Meeting of the ASA' at St John of God Hospital in Perth, 27–29 September 2000, convened by Dr Dennis Haywood and Dr Jim Bradley.

There was unanimous support at this meeting for "the establishment of an anaesthetists in training group under the auspices of the ASA". This group was to "report to and act under the guidance of the [ASA] Council"; "to work within and to contribute to the strategic plan of the ASA"; and "to identify issues, review developments, advise Council, and initiate and support strategies … to achieve the aims of GASACT".

Membership was open to all trainees in anaesthesia and intensive care who were ASA members. At the time, intensive care medicine was yet to break away and establish its own college (College of Intensive Care Medicine est. 2008). Now, all trainee members must be registered with ANZCA, except prevocational members.

The group's aims were established at this meeting in 2000 as:

1. To give trainees an official independent voice.
2. To provide a forum for discussion on matters of concern to trainees.
3. To seek opinion and advice from trainees.
4. To determine and attempt to satisfy the needs of trainees.
5. To inform trainees of developments in anaesthesia and medicine in general.
6. To develop a representative network for trainees.
7. To provide a forum where trainees with future career options and advice on entering practice.
9. To assist trainees industrially, socially, with health and lifestyle issues, educationally, scientifically, with practice matters and politically.
10. To establish a communication network, including similar organisations overseas.
11. To develop a large membership base of trainees within the ASA.

In 2016, GASACT rebranded. All trainee members of the ASA now comprised the ASA Trainee Members Group (TMG), with the representative committee known as the Trainee Members Committee (TMC). This distinction is a little blurred and the committee is often referred to as the TMG or TMG Committee.

The committee membership consists of two trainee representatives each for: Victoria, New South Wales, Queensland, South Australia/Northern Territory, Western Australia, Tasmania, and the ACT. There is also a Chair, who is elected through an open competitive application process, with any ASA Trainee Member eligible to apply. The TMG Chair is invited to ASA Council meetings and ANZCA Trainee Committee meetings, and the committee has representatives on several other ASA committees (including the Economics Advisory Committee (EAC) and Communications Committee).

As far as I could find, there is no clear record of the past GASACT/TMG committee members. I was fortunate pre-pandemic to have visited the ASA Headquarters in North Sydney and delved into the archives. This provided a great deal of interesting material, including the previous GASACT Handbooks (2005 First Ed, 2008 Second Ed, 2010 Third Ed) that inspired the new ASA Trainee Members Handbook. Based on minutes of past meetings, the list below is my best determination of past Chairs of GASACT/TMG – apologies for any inaccuracies!

INSIDE YOUR SOCIETY

Past Chairs (dates approximate)

GASACT

2001	Julia Coldrey
2001-2002	Douglas Fahlbusch
2002-2004	Amanda Curo
2004-2005	Waleed Alkhazrajy
2006	Peter Devonish
2007	Michael Farr
2008	Mark Suss
2008-2012	Michelle Horne (nee Spencer), Rob Miskeljin
2012-2013	Natalie Kruit
2014-2016	Ben Piper

TMG

2016-2017	Scott Popham
2017-2019	Richard Seglenieks
2020	Emily Munday
2021-current	Alex Courtney

ASA Trainee Membership numbers have, on average, seen a steady growth over the last decade, from 299 in 2009 up to 472 last year. The definition of the PMET (Prevocational Medical Education & Training) category was recently broadened to include all medical graduates with an interest in pursuing a career in anaesthesia (e.g. interns and residents) – a change initiated in 2019 and implemented in 2020. This, together with strong growth in the introductory/basic trainee category, has seen a surge in membership over the past year, up to 736 in March 2021!

Committee Achievements

Much of the work undertaken by GASACT/TMG flies under the radar and is difficult to fully appreciate from outside the committee. In particular, the regular input of a trainee voice to ASA Council and committees is invaluable to ensure that trainee issues are understood and addressed. The ASA's strong support for trainees and growing trainee membership are a testament to the strength of this dialogue.

The overall aims of the TMG's efforts are to support, represent and educate trainees. The committee has been active in promoting awareness and driving advocacy on workforce issues over the years – particularly regarding trainee numbers and new fellow positions. While there is geographic and temporal variability, we are fortunate that thanks in part to these ongoing efforts, the anaesthesia workforce supply and demand in Australia is reasonably well-balanced. Feedback is also regularly provided on a number of ANZCA matters including TPS, curriculum changes and AMC accreditation reviews.

In 2017, the TMG coordinated trainees across Australia collecting data for the Epidemiology of Critical Care Provision after Surgery Study (EPICCS). This is, to my knowledge, the first project undertaken by an anaesthetic Trainee Research Network (TRN) in Australia and has played a key role in the subsequent development of a number of formal TRNs around the country. More than 2,600 patients were recruited across 21 sites – an impressive feat for a network formed de novo for this project. The study has resulted in several journal publications[1-3].

In recent years, the TMG has advocated on COVID-19 issues, trainee welfare, critical incident debriefing, fatigue and rest facilities, and electronic examinations. We formed a working group which produced two welfare resource documents to help trainees and fellows with working while pregnant and returning to work after leave; created a new Trainee Handbook; expanded membership for prevocational doctors; secured access to the RVG for advanced trainees and provisional fellows; continued to assess and award valuable annual CIG Scholarships; helped organise a number of events including Part 3 Courses; enhanced our communication with trainee members; and helped members access Mental Health First Aid training.

Future

I hope that the TMG continues in its role as an independent voice for trainee anaesthetists across Australia. This is a complementary role to that played by the ANZCA trainee committees and there is close collaboration between these groups.

The current elected TMG Chair, Dr Alex Courtney, commenced in the position in January 2021. His focus is on "continuing to grow the presence of the TMG as a voice of advocacy for trainees". This is particularly important in the context of the tumultuous past year which had significant impacts on many trainees in terms of training, exams, and life in general. Alex is keen for the TMG to promote flexible training pathways, to continue developing wellbeing initiatives, and to provide ongoing exam and career support.

To get in touch with the TMG, email trainees@asa.org.au or speak to one of your state/territory representatives.

Dr Richard Seglenieks

Chair (2017-2019), ASA TMG

Co-Chair (2021), ANZCA Trainee Committee

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1. Wong DJN et al. Cancelled operations: a 7-day cohort study of planned adult inpatient surgery in 245 UK National Health Service hospitals. Br J Anaesth 2018 Oct;121(4):730-738.
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*Analgesia not solely derived from opioid agonism.

Strong pain relief as effective as oxycodone IR with significantly less constipation, nausea and vomiting[1,4†]

†Non-inferior efficacy (5-day Sum of Pain Intensity Difference); secondary endpoint, primary endpoint was met. Nominal p<0.001 for constipation, nausea and vomiting. PALEXIA® IR 50mg vs. oxycodone IR 10mg.

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BOXED WARNING: PALEXIA® IR should be limited to patients for whom other treatment options are ineffective, not tolerated or otherwise inadequate. There are risks of hazardous and harmful use leading to overdose and death; life-threatening respiratory depression; and profound sedation, respiratory depression, coma and death resulting from concomitant use with benzodiazepines, alcohol and other CNS depressants. See Boxed Warning in full Product Information for further details.

Before prescribing, please review Product Information available at www.seqirus.com.au/products

MINIMUM PRODUCT INFORMATION: PALEXIA® IR (tapentadol hydrochloride) INDICATION: For the short-term management of severe pain for which other treatment options have failed, are contraindicated, not tolerated or are otherwise inappropriate to provide sufficient management of pain. **CONTRAINDICATIONS:** Known hypersensitivity to tapentadol or any component of PALEXIA® IR (contains lactose); severe or acute respiratory disease or respiratory depression; confirmed or suspected paralytic ileus; acute intoxication with alcohol, hypnotics, centrally acting analgesics or psychotropic drugs; patients who are receiving MAO inhibitors or who have taken them within the last 14 days. **PRECAUTIONS:** Risk of abuse, misuse, addiction, tolerance, dependence and withdrawal – monitor for signs/symptoms, taper gradually to avoid abrupt cessation; risk of life-threatening respiratory depression, accidental ingestion/exposure and hyperalgesia; risks from concomitant use with benzodiazepines, alcohol and other CNS depressants; not recommended in chronic non-cancer pain, in patients with increased intracranial pressure, impaired consciousness, coma or severe renal or severe hepatic impairment; caution in patients with sleep-related breathing disorders, head injury, brain tumours, a history of seizures or any condition that increases risk of seizures, moderate hepatic impairment or biliary tract disease, including acute pancreatitis. May impair ability to drive or operate machinery. Use in pregnancy (Category C). Should not be used during breastfeeding. Not recommended for children < 18 years old. **INTERACTIONS:** Take care when combining with other opioid agents; additive CNS depression with concomitant administration of other mu-opioid receptor agonist analgesics, general anaesthetics, phenothiazines, other tranquilisers, sedatives, hypnotics or other CNS depressants (including alcohol and illicit drugs); isolated case reports of serotonin syndrome when used in combination with serotoninergic drugs. **ADVERSE EFFECTS:** *Very common (≥1/10)*: dizziness, somnolence, headache, nausea, vomiting; *Common (≥1/100 to <1/10):* Decreased appetite, anxiety, confusional state, hallucination, sleep disorder, abnormal dreams, tremor, flushing, constipation, diarrhoea, dyspepsia, dry mouth, pruritus, hyperhidrosis, rash, muscle spasms, asthenia, fatigue, feeling of body temperature change. **DOSAGE AND ADMINISTRATION**: Take whole tablet, orally, approximately every 4 to 6 hours, with or without food. Usual recommended dose 50 to 100 mg every 4 to 6 hours and should be adjusted to maintain adequate analgesia with acceptable tolerability. Total daily doses >600 mg not recommended. *Discontinuation:* taper dose gradually to prevent symptoms of withdrawal. *Special populations:* Not recommended in severe renal or severe hepatic impairment. Initiate at 50mg every 8 hours (maximum three doses in 24 hours) in moderate hepatic impairment. Use care in dose selection for elderly patients (likely decreased renal and hepatic function). Based on approved Product Information.

REFERENCES: 1. PALEXIA® IR Approved Product Information. **2.** Raffa B *et al. Curr Med Res Opin* 2014; 30-12: 2579–2584. **3.** Pergolizzi JV *et al. Expert Opinion on Drug Discovery* 2018; 13 (10): 965–972. **4.** Hartrick C *et al. Clin Ther* 2009; 31(2):260–271. Date of preparation: April 2021. ANZ-PALX-21-0081. 000819-PRINT-ASA.

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INSIDE YOUR SOCIETY

MUSEUM OBJECTS OF THE QUARTER

John Mudge (1721–1793)

Two of the four Mudge inhalers in the museums collection

There are four pewter four beer tankards in the Harry Daly Museum, but they were probably never used to consume alcohol. In fact, they represent nifty medical ingenuity and improvement to the treatment of coughs, colds and consumption. The design of these objects lives on in modern metered dose inhalers, and yet came from traditional vapor treatments dating back to ancient times.

John Mudge (1721–1793) was a surgeon who primarily practiced in Devon and the greater West Country region. Educated at Plymouth and London, Mudge had a strong belief in bringing new and effective medical treatments to his local patients. He was a man of innovation, always interested in new approaches and methods.

He described the Mudge inhaler in 1778, a year after he became a Fellow of the Royal Society, in his influential work *'A Radical and Expeditious Cure for a Recent Catarrhous Cough'*. The device was simple: a modified beer tankard with a lid and breathing tube into which was placed a mixture of hot water, herbs and/or opium was used in the treatment of inflammation in the lungs and pain relief.

The main modification to the tankards was two-fold: the additional air inlet holes in the hollow handle and an air valve in the lid. Together with the breathing tube, these changes allowed the patients to breathe fresh air without the need to remove the breathing tube from their mouth.

Aerosolised medicine is not itself ground-breaking – inhaling vapours is a practice stretching far back into pre-history – but the Mudge inhaler marks an early piece of equipment which was deliberately designed for more precise control over the delivery of the medicine into the airways. Mudge patented the device and entered a partnership with pewterer William Barnes of London to sell and distribute the inhaler. The inhalers ease of use, price and portability made it a success. It was sold in its original design for over 160 years.

Mudge was very specific in his recommended uses of the device, primarily emphasising it's use to treat the aforementioned catarrhous cough through an 'elixir paregoricum'. This mixture included camphor, benzoic acid and opium.

When not repurposing beer tankards for medical use or undertaking further study to become a physician, Mudge devoted his time to astronomy and mirror making, including making early advances in reflecting telescopes for which he won the Royal Society's prestigious Copley Medal in 1777. He was married thrice and had ten children.

LIBRARY – BOOKS OF THE QUARTER

One of the larger tomes in the Richard Bailey Library is a leather bound, exquisite reprint of Andreas Vesalius's (1514–1564) *De humani coprporis fabrica*. First published in 1543, Vesalius's magnum

Andreas Vesalius (1514–1564)

Illustrated cover page of *'De humani coprporis fabrica'*.

opus documented his work advancing the study of human anatomy, inspired by but also building upon the work and theories of Greek scholar Galen.

Even at the time of its publication, the work was renowned for the level of detail in more than 250+ wood block print illustrations. The illustrations were a product of his unusual teaching method: dissecting corpses of executed criminals during his lectures, without the aid or use of a barber surgeon. Much of the work is based on his lectures from the University of Padua, Italy.

One of the renowned wood block illustrations in *'De humani coprporis fabrica'*.

The work is divided into seven books as Vesalius sort to methodically document and examine the structure and organs of the human body. He corrected some of Galen's errors, realising that Galen had made his interpretations from animal cadavers rather than humans, but still subscribed to the belief that different types of blood ran through veins and arteries.

De humani coprporis fabrica was met with great acclaim, laid much of the foundation for anatomy to become an academic discipline in its own right, and led to Vesalius being appointed physician to the Holy Roman Emperor, Charles V.

The model sailing ship presented to the ASA by the Mauritius Society of Anaesthetists in 1996.

ARCHIVE – AUGUST 1996

The first newsletter after ASA hosted the 11th World Congress of Anaesthesiologists, included over seven pages of colour photographs showcasing the event (and the fun run!) as well as this glowing review of the event by the then President, Gregory Wotherspoon:

> *"In almost perfect Sydney weather, a record number of delegates, accompanying persons and industry personnel took advantage of the many activities including the high standard scientific program. During the Congress, several presentations were made to the ASA … Dr Abdool Carim Jackaria, President of the Mauritius Society of Anaesthetists presented the ASA with a carved model sailing ship.."*

Kate Pentecost
ASA Museum Curator,
Librarian and Archivist

INSIDE YOUR SOCIETY

NEW AND PASSING MEMBERS

The ASA would like to welcome all new members from March to May 2021.

TRAINEE MEMBERS

Dr Laura Staples	ACT
Dr Samantha Jane Lambe	ACT
Dr Alice Xinyue Sun	NSW
Dr Andrew R Owen Phillips	NSW
Dr Deniz Tat	NSW
Dr Dushyant Iyer	NSW
Dr Faith Fenella James Dyer	NSW
Dr Georgina Natalie Prassas	NSW
Dr Glen Abbott	NSW
Dr James Bulman	NSW
Dr Joanna Buchan	NSW
Dr Justin William Payne	NSW
Dr Kelly Teneile Stallard	NSW
Dr Leah Meron	NSW
Dr Lucy Cameron Sutherland	NSW
Dr Matthew Sean Doherty	NSW
Dr Michael Shaun McLellan	NSW
Dr Navid Aminian	NSW
Dr Oscar Wen	NSW
Dr Paul Sochor	NSW
Dr Phoebe Court	NSW
Dr San-Rene Tan	NSW
Dr Simon Ellis	NSW
Dr Simon Ting	NSW
Dr Sjorjina Crowther	NSW
Dr Spencer Hon Lam Wan	NSW
Dr Stefan Lang	NSW
Dr William Yip	NSW
Dr Henry Bear	NT
Dr Abraham Petrus	QLD
Dr Angus Loraine	QLD
Dr Ankitha Hakeem	QLD
Dr Ari Isman	QLD
Dr Eliza Louise McDougall	QLD
Dr Elizabeth Parkinson	QLD
Dr Emma Jennifer Walker	QLD
Dr Erica Mae Barton	QLD
Dr Ethan Mar	QLD
Dr Hamish Raniga	QLD
Dr Ioana Arhanghelschi	QLD
Dr Jeremy Sin	QLD
Dr Jessie Wang	QLD
Dr Jimin Kang	QLD
Dr Justin Lim	QLD
Dr Ka Lo Chan	QLD
Dr Katarzyna Maria Nowak	QLD
Dr Kate Elizabeth Sewell	QLD
Dr Kate Engelke	QLD
Dr Lachlan Horton Young	QLD
Dr Lewis Michael McGahan	QLD
Dr Lisa Stevens	QLD
Dr Louven Bing Menzies	QLD
Dr Marissa Lee Woodburn	QLD
Dr Mark Moll	QLD
Dr Maryam Khalil Cassim	QLD
Dr Mathew Judd	QLD
Dr Matthew Jacob Black	QLD
Dr Michelle Liu	QLD
Dr Nathan Yan-li Yii	QLD
Dr Nicola Ellen Doogan	QLD
Dr Amelia Steel	VIC
Dr Amy Shenyuan Dai	VIC
Dr Andrew Lim	VIC
Dr Andrew Martin	VIC
Dr Bridget King	VIC
Dr Bryan Yip	VIC
Dr Carina Hadden	VIC
Dr Carolina Radwan	VIC
Dr Carrington J Morwood	VIC
Dr Cassandra Lee Roberts	VIC
Dr Charlotte Anne Russo	VIC
Dr Chris Zi-Fan Zhao	VIC
Dr Christine Vien	VIC
Dr Christopher E Etherington	VIC
Dr Chun Ling Chan	VIC
Dr Clare McCann	VIC
Dr Cliff Ngai Tin Wong	VIC
Dr Dan Xu	VIC
Dr Emily Anne Traer	VIC
Dr Fayzah Mutlib	VIC
Dr George Yi	VIC
Dr Grace Breanna Hollands	VIC

Dr Hamish Brown	VIC
Dr Harrison Yao	VIC
Dr Ifrah Khan	VIC
Dr James W C Ballantyne	VIC
Dr Jennifer Lay	VIC
Dr Jessica Jing Zhang	VIC
Dr Kavi Manektalla	VIC
Dr Larissa Jayne Kasian	VIC
Dr Liam Joseph O'bryan	VIC
Dr Lillian Coventry	VIC
Dr Luke Alastair Perry	VIC
Dr Manon Rhys Jenkins	VIC
Dr Michael Zidao Wang	VIC
Dr Mihindu Jayasuriya	VIC
Dr Naomi Jane Hughes	VIC
Dr Nicholas John Piper	VIC
Dr Nicholas Yat Cheung Lui	VIC
Dr Nicholle Yau Wen Sim	VIC
Dr Patrick Hamilton	VIC
Dr Reubban S Muthusamy	VIC
Dr Richard Buckley	VIC
Dr Richard George Horton	VIC
Dr Ru Dee Chung	VIC
Dr Sarah Louise Allen	VIC
Dr Saras Anil Mane	VIC
Dr Sean A. Harris	VIC
Dr Sean Ezekiel Seow	VIC
Dr Shahad Emad Al-Badri	VIC
Dr Shervin Tosif	VIC
Dr Simone Martonhelyi	VIC
Dr Victoria Ann Moulson	VIC
Dr Wison Vien Khoi Le	VIC
Dr Ahmed Samy El-Batanouny	WA
Dr Alex Wright	WA
Dr Alexandra Carle	WA
Dr Elsie Lyons	WA
Dr James Preuss	WA
Dr Jonathan Richard Hills	WA
Dr Kiran Bharath Venkatesulu	WA
Dr Laura M Wisniewski	WA
Dr Michael J Edward Robbins	WA
Dr Olympia Samolis	WA
Dr Pramod Vasantharao	WA
Dr Ronithung Ovung	WA
Dr Werner Christian Jaeger	WA

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Dr Raphael Weidenfeld	QLD
Dr Rochelle Patane	QLD
Dr Ruth E. Coward	QLD
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Dr Sharmini Michelle Punitham	SA
Dr Ella Mary Margaret Flecker	TAS
Dr Helen A Harkness Browne	TAS
Dr Kamal Kishore	TAS
Dr Keith William Paul	TAS
Dr Nicholas Reeve	TAS
Dr Adam Guilfoyle	VIC
Dr Ainsley Lorych	VIC
Dr Alexander Linden Clarke	VIC

ASSOCIATE MEMBERS

Dr Nicholas A Barnard Duce	NSW
Dr Nicholas John Roberts	NSW

IN MEMORIAM

The ASA regrets to announce the passing of ASA members:

Dr Rosemary Coffey, NSW

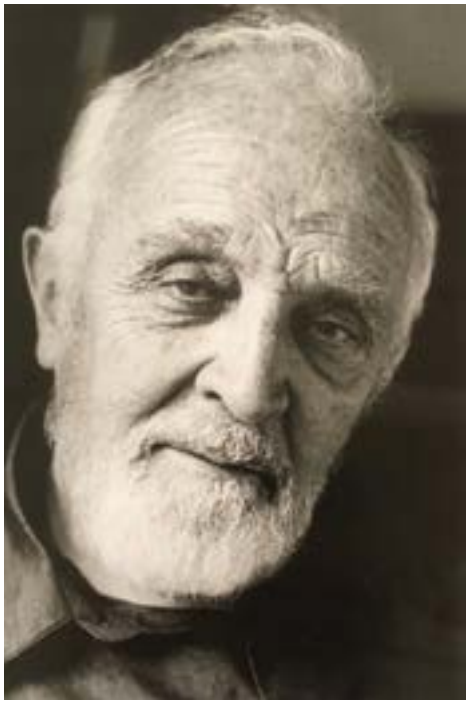
Dr Michael Richard John Claxton, TAS

Dr George Henry Tippett, AM, VIC

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

INSIDE YOUR SOCIETY

DR GEORGE TIPPETT AM 1927 – 2021



DR GEORGE HENRY KING TIPPETT AM FAMA KStJ DA (Lon) MB BS (Mel)
1/9/1927 – 20/3/2021

Dr George Tippett's principal legacy to anaesthesia and surgery was the establishment of the first purpose-built Day Surgery Clinic in the Australia in 1982, heralding the progressive change in medical practice that now sees some 70% of surgery performed as "day stay".

A great raconteur, George modestly downplayed his role in many other pioneering activities in medicine and the community, describing himself as having "spent a lifetime doing the right thing for the wrong reasons".

George's parents were of modest means, his father a publican, and his mother a telephonist. He attended Caulfield North State School, and being clearly exceptionally bright, a friend of his father recommended secondary schooling as a boarder at Geelong College. At the end of first term, his father was unable to continue paying the fees. Despite this, the school supported George with a scholarship for the remainder of his schooling. It was only when he graduated that George learnt of the school's generosity, and in typical fashion, he later endowed a bursary at the school to support students in similar circumstances. Although not inclined to sports, but tall and strongly built, he managed to talk his way into a vacancy in the first rowing crew, whereupon Geelong College won its first "Head of the River" after many years.

In 1945, George commenced studies in engineering at Melbourne Technical College, now RMIT University. In his third year, he went to BHP in Wollongong for work experience. He saw the site manager going to work at 7am with his lunch in a paper bag, and thought one day that would be him, so he decided to transfer to Medicine at Melbourne University (and ended up going to work at 6am).

At that time, many ex-servicemen were enrolling in Medicine, and the first year was conducted in Mildura. Although George had secured a Queen's College scholarship to continue his studies, ex-servicemen had priority on entry to second year back in Melbourne, and George spent the year driving buses, trucks and skinning rabbits in order to help fund his education. He continued to intersperse work and study, married Helen, an architecture student, and graduated MB BS in 1956.

He and Helen proceeded to Wollongong, where George did his residency and gained some early experience in anaesthesia. George was keen to travel to Europe, to gain further experience in radiology, and "to buy a Mercedes Benz duty free". This was the time of the 1950s immigration scheme, and George figured that joining the Commonwealth Department of Health would be a good way to be sent overseas to do assessments. Instead, they were short of medical officers in Darwin, so they sent him there until a European vacancy might arise. Ultimately, he never got his wish because he had come under the notice of ASIO as a member of the communist party (he had inadvertently paid a subscription during a university party, when he thought he was contributing to the cost of the barrel of beer!)

The Department of Health offered him a longer stay in Darwin, but George, who had found that the practice of anaesthesia in air-conditioned operating rooms was to his liking, sought a position closer to home. The nearest job available was in Alice Springs, as the newly created

Medical Officer in Charge of the Commonwealth Aerial Medical Service, and Medical Officer, Native Survey. He decided it might be a challenge.

He more or less wrote his own job description, there being few records when he arrived. He travelled by plane to outlying aboriginal settlements and stock stations, returning each day. There was a five week rotation, with four weeks using the plane and one week travelling by landrover while the plane was serviced. He soon realised that there were problems in both primary care and in public health. He began instituting public health measures and vaccinations in remote areas, and transporting patients with more serious conditions to Alice Springs for treatment or surgery. He set up radio consultations for remote settlements and radio contact for the aborigines who were in hospital.

"He changed my attitude towards people, my handling of people and my respect for them …

There was initial reticence by many of the station owners and settlement managers, who didn't see why anyone would want to do anything for the aborigines, but by gaining their trust and support, along with developing a rapport with the aborigines, they saw that everyone could benefit.

George had to overcome his own pre-conceived thoughts about indigenous Australians, and many encounters led him to admire their integrity and intellect. On one occasion, he was encouraged to visit an elder in his creek bed humpy, having previously visited the settlement several times to treat members of the tribe. The elder had observed the young doctor as he went about his work.

"He changed my attitude towards people, my handling of people and my respect for them … I came away highly diminished and much improved I think, and I was never really quite the same again after that."

Outback medicine can be very different. While stopping overnight at a remote station, the manager said, "We've got someone for you - he's got a boil on his bum or something." George went down to the shed where an aborigine was laying on the tailboard of a ute under the light of a hurricane lamp. As George describes it, "his need of analgesia was greater than my need of a rubber glove". He goes on. "I suddenly felt ridiculous and I giggled. The aborigine got very offended and he tried to get away, and I hung on and burst the abscess, he felt better. He took off at great guns and came back the following day and said, Thanks very much!"

"I was asked by an Aboriginal family if I would take part in the circumcision of their son, to make sure he didn't bleed too much. They had a problem there in that they used to cut the foreskin with pearl shell, which being jagged would cause almost an immediate shut down of the bleeding. But then they got on to razor, gem razor blades, and scalpels from the hospital, if they could get them, that made a very clean cut, which didn't retract so well and they had a couple of very serious cases of post surgical bleeding. And because there had been a case recently, this family asked if I could go there for their son's circumcision. And I was amazed, I was ushered into the hut in which it was being done and told to stand in the corner until I was asked for. And I stood there and watched the whole procedure, which was carried out with gentleness and kindness and very serious discipline, and when one of them did bleed I was summoned over to stop the bleeding. I had to wear a special belt that was made of human hair and... but it was very clear that I should know my place in the organisation, and I was pretty adaptable and I was very, very lucky to be in it."

On one occasion while travelling in isolated country between settlements, he came across a white man who was stranded and severely dehydrated. The man was William Ricketts, the artist and sculptor. George and he became life long friends.

After three years in the Northern Territory, he moved with his family to Leichardt in western Sydney and entered General Practice. After another four years, he decided to "become a serious anaesthetist". He first travelled to London to obtain his Diploma in Anaesthetics, and then secured a Clinical fellowship in Anaesthesiology at the American University of Beirut, led by Bernard Brandstater. In the two years he spent with Bernard (another life-long friend), he was involved with pioneering work on continuous epidurals and prolonged intubation. His time in Beirut coincided with Six Day War in 1967, so it was with some trepidation and bravado, that George decided to return soon after by landrover, with his wife and three young daughters, to London.

In 1969, after a year gaining more experience in epidural anaesthesia, George, Helen and their family returned to Australia. Shortly after, George and Helen divorced, and George was reacquainted with his childhood girlfriend, Naomi, whom he had known from the age of 14, but to whom marriage had been precluded by family religious traditions. Both George and Naomi had married and raised families independently. They rekindled their friendship and were devoted to each other as husband and wife for the next fifty years.

He joined a practice based in Frankston, but found that general practitioners gave the "straightforward" anaesthetics "in hours", while he was called for the "out of hours" cases. He decided to specialise in dental anaesthesia, carrying his own equipment to hospitals and dental surgeries, leading to a practice that extended from "Rosebud to Deer Park". He established a group of anaesthetists

INSIDE YOUR SOCIETY

willing to give anaesthetics in dental surgeries and manufactured 15 portable anaesthetic machines.

Recognising the shortcomings of private dentists' rooms, and that early ambulation, especially after cataract surgery, was becoming an important feature of new developments in surgery and anaesthesia, George decided that it would be best to establish a dedicated centre and invite the dentists to bring their patients there.

Dentists initially showed no interest, so he went to Phoenix, Arizona to look at the "Surgicenter", the first successful free-standing day surgery facility established by Wallace Reed and John Ford in 1970. Overcoming many initial "external" obstacles, by 1976 they had successfully treated more than 33,000 patients without a single death.

Returning to Melbourne flush with ideas for a similar centre, George found that there were major restrictions to the building such a facility locally. Opposition came not only from bureaucrats, but also came from many other quarters. Dentists did not want to travel out of their offices; surgeons, "who were resistant to discipline of any kind, found that they had to cope with punctuality and accurate prediction of outcome"; patients, who could not claim a facility fee from their health insurance; and hospitals, "who could see us getting a slice of their cake".

George attended a medical meeting where the President of the College of Surgeons claimed that day surgery was "just a fad", and that in the US, 20% of patients required readmission to hospital. George was able to stand up and quote the 1977 Orkand Report, citing 0.3%!

The response from the Heath Department is best told in George's own words:

> *"Three of our submissions for registration were claimed to have gone astray, without which there would be no rebate or insurance for the patients. Almost a year passed and in desperation I sought assistance from some friends and a public relations advertising director came to my aid. He introduced me to an investigator who asked if I knew the meaning of a 'manila envelope'. I said 'I have been around the block'. He then issued instructions for the exact contents, and the handing over of such an envelope at a certain place and time. Having prepared the envelope, I met a man at 8am on an outer suburban street corner, who said 'is that for me?' A month later, I received a call from the investigator, asking 'Have you got your registration?' When I said 'No', he said 'You should have, it will come straight out.' Within an hour, a government car arrived with an envelope and we were registered!"*

He was asked by the Dalai Lama to investigate the high incidence of stomach ulcers and cancer in monks.

The Dandenong Surgicentre opened in 1982, the first free-standing day surgery facility in Australia, pioneering a major change in surgical and anaesthesia care. There were visitors from all over Australia to see what George and his colleagues had created, and they gladly shared their information. Soon, a second stand-alone facility opened in South Australia. In 1984, the first public sector day surgery unit opened in the grounds of the Campbelltown Hospital in NSW, after George had a done functional brief for the NSW Health Minister Laurie Brereton, to show that 40% of the hospital's surgical cases could be undertaken as day cases.

> *"The surgeons eventually had to show it was all their idea and the College appointed someone to lead the belated charge and bring out a booklet of how to do it all - a masterpiece of plagiarism of what we had plagiarised!"*

George continued to manage and work at the Surgicentre until retiring from clinical work at 71. During that time he regularly took time off to establish and engage in various aid programs in South Asia and the Northern Territory.

He had joined Rotary in 1981, and much of his aid work was done with the support of that organisation. While visiting Naomi's son in Dharamsala in northern India, he found that the children of the Tibetan refugees there had very poor dental health. With Naomi, he persuaded a group of Melbourne dentists to go there and perform dental care, while he instructed the families in dental hygiene. He was asked by the Dalai Lama to investigate the high incidence of stomach ulcers and cancer in monks. Aided by a gastroenterologist, he biopsied 250 monks, without anaesthesia, and after testing himself first. There was a high incidence of helicobacter pylori infection, facilitated by contaminated water and poor nutrition. By adopting the principles of hygiene that had been used by Melbourne's Pentridge Prison, he instituted local programs to address the health issues.

This aid work was repeated in many places, in Vietnam, Thailand, Cambodia, Borneo, Indonesia and the Northern Territory, primarily directed at improving local hygiene, establishing immunisation programs, and treatment of cataracts. In one project in Vietnam, he and the gastroenterologist did faecal analysis on 250 malnourished children, gaining for himself, the title "Prince of Poop". Returning a few months later, after treatment of the endemic roundworm infestation, they were met by healthy children with improved school attendance and cognitive development.

George's international work was recognized by the award of the Member of the Order Of Australia in 1990, and the "Service above Self" Award, by Rotary International in 1992. Among numerous other awards, he received the Sir Edward 'Weary' Dunlop Asia Medal in 1996.

George maintained his connections with healthcare of indigenous Australians through the Victorian Division of the Royal Flying Doctor Service, spending ten years on the board, three as President. He and Naomi made regular trips to central Australia in their highly modified Series 1 Landrover, fitted out with every conceivable accessory for survival in the desert.

In the 1990s, George joined the executive of the National Forum on Child Welfare, and the Medical Benevolent Association of Victoria. During more than twenty five years service to the Medical Benevolent Association, he served as president for ten years and represented the association on the Victorian Council of the AMA. He was elected to Fellowship of the AMA in 2007. He served for ten years on the board of the Melbourne Lord Mayors' Fund, retiring in 2015. He had recently achieved fifty years as a member of the ASA, which included several years on the Victorian committee of the Retired Anaesthetists Group.

In his spare time, George indulged in his passion for engineering and mechanical things. Over the years, he owned a wide variety of cars and motorcycles, including vintage Citroens and a Rolls Royce. His home workshop included a mechanic's "pit" enabling him to carry out his own service and repairs.

His love of engineering led him into a long association with Geoffrey Kaye, and they spent many hours together in Geoffrey's workshop. George acted as Geoffrey's carer in the six months before he died in 1986. As George bathed the diminutive Geoffrey each evening, he recalled being told repeatedly "Tippett, I resent these unsolicited ministrations on my person!"

George was a student of Kashmir Shaivism, a philosophy that embodies idealism and a respect for each individual as an equal. He was not driven by ambition, he just "had the flexibility and the confidence to say 'yes'."

In his 93 years, George enriched many peoples' lives, physically and emotionally, and left the world in a better place.

Rod Westhorpe OAM

Acknowledgements:

Naomi Tippett AM, Personal communication.

George Tippett interviewed by Gordon Dowell in the Bringing them home oral history project. May 2000, Trove: https://nla.gov.au/nla.obj-218323204

Club "Champion" George Tippett. Interview by Dorothy Gilmour for Rotary Club Bulletin, 2017.

"The Beginning of Day Surgery in Australia" Presentation By George Tippett to the Medical History Society of Victoria. March, 2009

INSIDE YOUR SOCIETY

UPCOMING EVENTS

JUNE 12 2021

VIC MEDICAL VIVA BOOTCAMP

June 12, 2021

Venue: TBA

Contact: Rhian Foster
rfoster@asa.org.au

Not yet ready for the medical viva? Register for the full day workshop and learn everything you need to know to pass lectures, demonstrations and practice vivas.

JUNE 19 2021

ASA SA/NT PART 3 COURSE

June 19, 2021 8:30am – 5:00pm

Venue: AMA (SA), Office L1,
175 Fullarton Road, Dulwich

Contact: Rhian Foster
rfoster@asa.org.au

Designed for trainees who have completed their Part 2 exam and offers non-clinical advice and guidance in commencing their anaesthetic career.

JUNE 23 2021

WA NEUROANAESTHESIA JOURNAL CLUB DINNER

June 23, 2021

Venue: Kailis Bros, Leederville

Register: drpaulkwei@gmail.com

Please join us for an evening of discussion, collegiality and Continuing Professional Development on some interesting neurosurgical cases with an obstetric twist. Presented by Dr Colm Quinn, Dr James Preuss and Dr Nicole Somi

JULY 3 2021

BOOT CAMP PART 1 MOCK WRITTEN EXAMS

July 3, 2021 9:00am – 4:00pm

Venue: Virtual

Contact: Rhian Foster
rfoster@asa.org.au

Learn everything you need to know to pass – 'money maker' tips and tactics.
Hosted by the ASA NSW Committee

JULY 10–11 2021

EPIC EXAM PERFORMANCE IMPROVEMENT CLINIC

July 10, 2021 9:00am
July 11, 2021 4:00pm

Venue: Virtual - Trainees Only

Contact: Rhian Foster
rfoster@asa.org.au

JULY 23–25 2021

CONJOINT ASA NSC & QLD ACE MEETING

July 23 – 25, 2021

Venue: Brisbane Convention and Exhibition Centre

Contact: Denyse Robertson
drobertson@asa.org.au

Website: asansc.com.au

PRACTISE EXAM VIVAS

FINAL ANAESTHETIC VIVA & SAQ

June 4 & 25 | Aug 6
7.30 – 8.30pm AEST

FINAL MEDICAL VIVA

Sept 10 & 24 | Oct 8
7.30 – 8.30pm AEST

PRIMARY ANAESTHETIC VIVA & SAQ

June 7 & 21 | Aug 2
7.30 – 8.30pm AEST

PRIMARY MEDICAL VIVA

Aug 23 | Sept 27
7.30 – 8.30pm AEST

SIMG ANAESTHETIC VIVA & SAQ

June 18 | Aug 16
7.30 – 8.30pm AEST

SIMG MEDICAL VIVA

Sept 17 | Oct 15
7.30 – 8.30pm AEST

Contact: Rhian Foster rfoster@asa.org.au

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BRISBANE

Dr Viren (Vern) Naik
CANADA

Dr Jo Rotherham
BRISBANE

QLD ACE

A/Prof. Laurence Weinberg
MELBOURNE

Mr Sean Lowry
BRISBANE

Dr Suzi Nou
MELBOURNE

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