AUSTRALIAN
Anaesthetist
THE MAGAZINE OF THE AUSTRALIAN SOCIETY OF ANAESTHETISTS • JUNE 2022

DOCTORS WITH DISABILITY

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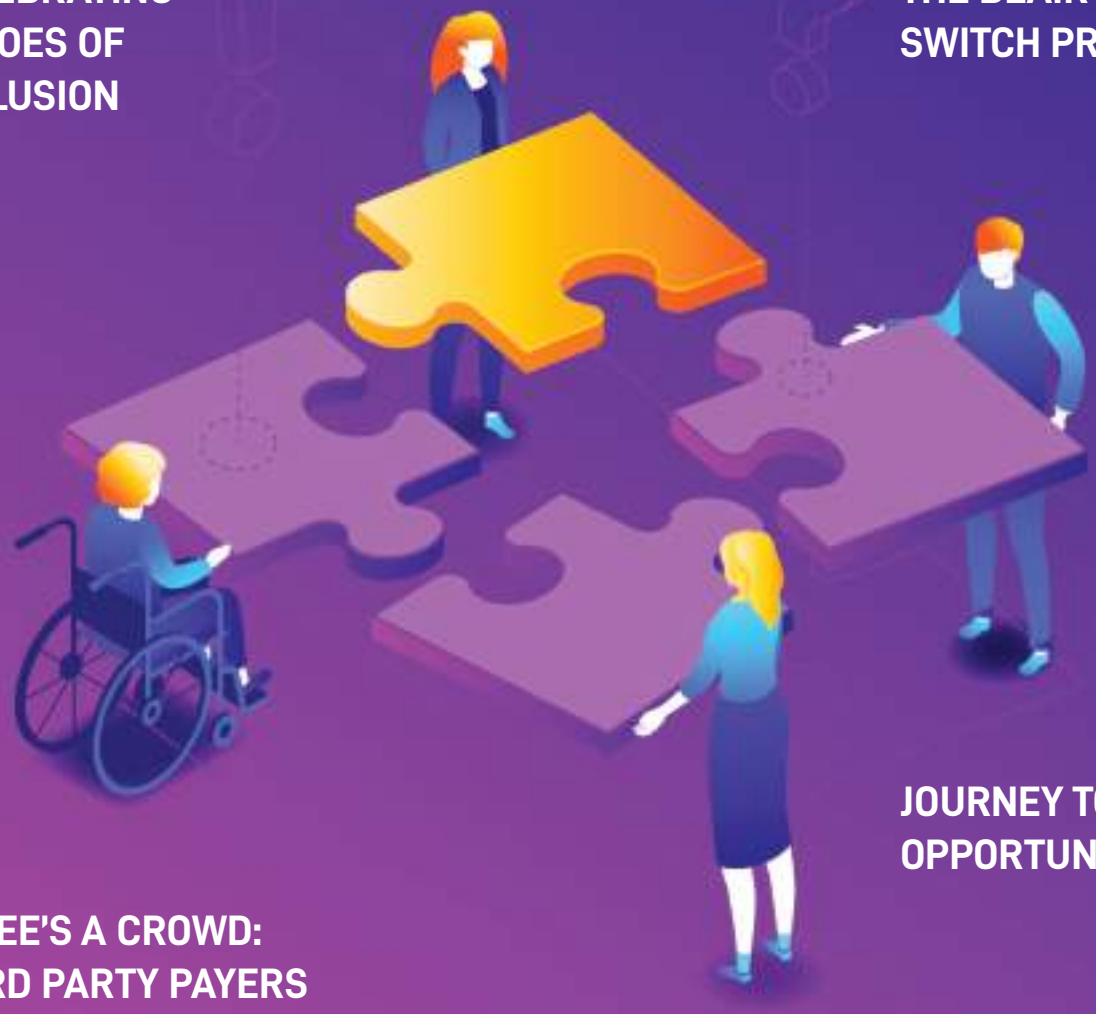

JOURNEY TO OPPORTUNITY

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Australian Society of Anaesthetists®

CSC2022

COMBINED SCIENTIFIC CONGRESS

NZSA & ASA - WELLINGTON NZ

21-24 OCTOBER 2022

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Keynote Speakers

Prof. Denny Levett

Prof. Kate Leslie

Prof. PJ Devereaux

Prof. Steven Shafer

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Dr. Leona Wilson

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2022 Combined Scientific Congress

Hybrid (F2F and online) conference jointly co-hosted by the NZSA and ASA

Tēnā koutou katoa,

It is our great pleasure to invite you to register for the premier Australasian anaesthesia conference of 2022, to be held in Wellington, the "coolest little capital in the world" (and virtually). Join us in October to reconnect with your colleagues and to hear from our outstanding line up of speakers – engaging talks which will explore stimulating, thought-provoking and challenging topics to enhance your clinical practice.

Keynote speakers:

- **Professor P.J Devereaux** is the Director of Cardiology and the Scientific Leader of the Anesthesiology, Perioperative Medicine and Surgery Research Group at McMaster University, Canada.
- **Professor Denny Levett** is an Anaesthetist at Southampton University Hospital NHS Foundation Trust in the United Kingdom, and the clinical lead for perioperative medicine and the surgical high dependency unit. On Twitter: @denny_levett
- **Professor Steve Shafer** is the Professor of Anesthesiology at Stanford University School of Medicine, California, United States. On Twitter: @StevenLShafer
- **Professor Kate Leslie** is a specialist Anaesthetist and head of research in the Department of Anaesthesia and Pain Management, Royal Melbourne Hospital, and honorary professorial fellow at the University of Melbourne and Monash University.

If you're able to join us in person, you can enjoy the many delights of our compact capital city – the stunning waterfront within an easy stroll of major hotels, restaurants, boutique shopping, as well as our vibrant arts and culture. For the more active, you can try out the many Wellington walks and biking trails.

Our conference will be located at two sites, only a few minutes' walk from each other: the TSB Arena (ideally placed for the trade exhibition and adjacent to the main Congress session rooms) and the Intercontinental Hotel (which will host the workshops and small group sessions).

View the scientific program on the CSC website (https://www.csc2022.co.nz/) along with other information including regular updates and FAQs. Bookmark the site to keep up-to-date and follow us on the CSC Twitter account @CSC_2022 and @NZSA and @ASA Twitter accounts.

The CSC Organising Committee is currently planning an incredible social program so you can relax and socialise, enjoying the best local cuisine and beverages. Don't miss our signature gala dinner on the Saturday evening, which we promise will be a major highlight. The HealthCare Industry reception take place on the Friday evening, and a family event on the Sunday night.

It goes without saying that the last couple of years have been tough on all of us professionally and personally. We have all faced uncertainty and disruption, and for some this will have taken its toll. We want to help you end 2022 on a high note of collegiality, conviviality, and connection – join us at the CSC to support this excellent educational and social event. See you in Te Whanganui-a-Tara, Wellington or virtually, on what will be an engaging and interactive online platform.

Register now and take advantage of our early bird registration rate.

We appreciate your support and look forward to welcoming you to CSC 2022!

Ngā mihi nui

Drs Mark Featherston and Cathy Caldwell
CSC2022 Co-Convenors

Dr Mark Featherston

Dr Cathy Caldwell

AUSTRALIAN
Anaesthetist
THE MAGAZINE OF THE AUSTRALIAN SOCIETY OF ANAESTHETISTS

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

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

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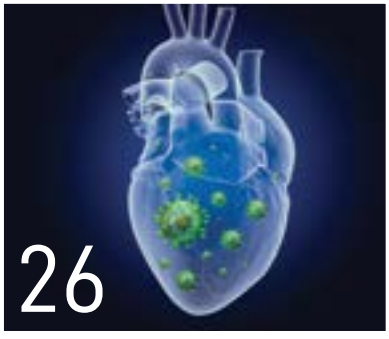

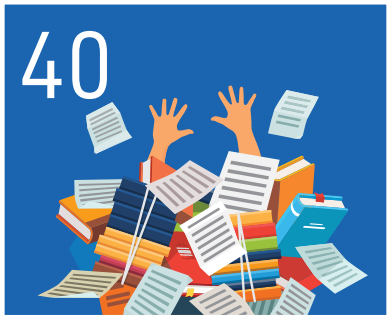

Would you like to contribute to the next issue?

If you would like to contribute with a feature or a lifestyle piece all articles must be submitted to editor@asa.org.au

September issue: submission by July 20

Image and manuscript specifications can be provided upon request.

Australian Society of Anaesthetists®

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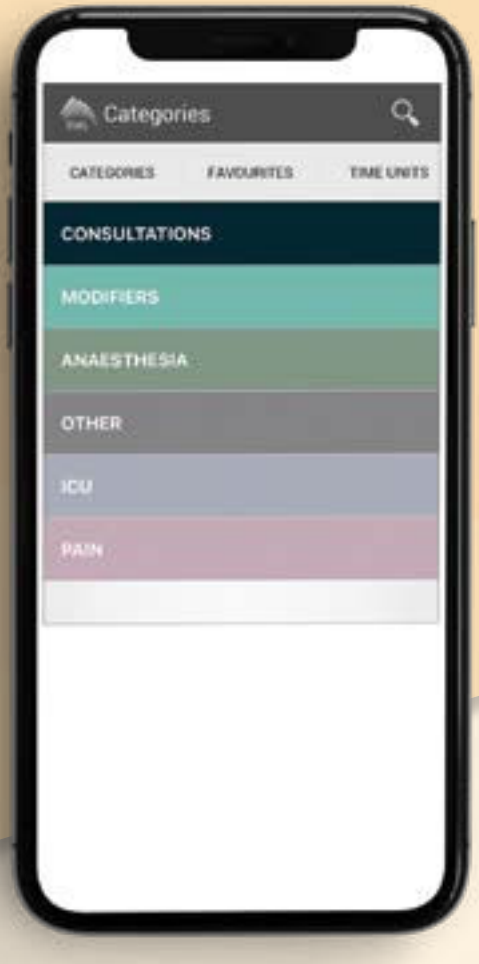

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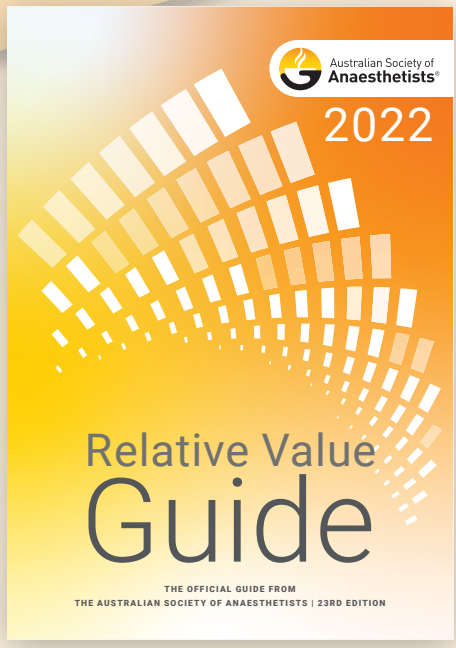
RVG



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FROM THE ASA PRESIDENT

ANDREW MILLER
PRESIDENT OF THE ASA

Here on the COVID-19 plateau members are facing ongoing impacts to their practice in both public and private.

There is an overwhelming desire to "get back to normal" from governments, without acknowledgment that a chronically underfunded public system was already struggling with waitlists and access to emergency care in pre COVID-19 times. Private hospitals were mostly running hot without public work in addition.

A perfect storm of lack of immigration, burnout and ongoing COVID-19 in the community has delivered a staffing crisis in all sectors, including significant numbers of nurses being away from work for various reasons, which leads to further system stress. Omicron reinfection, long COVID symptoms lasting more than 30 days in around five percent of triple vaxxed personnel and drug and equipment shortages compound the situation.

This is not the time to devalue the contribution of specialist anaesthetists. We have delivered efficiencies and safety that allow efficient day and short stay surgery on a scale that would have been unimaginable even ten years ago. The practice of outsourcing public work must not undermine the value proposition of private health cover for those who pay their premiums in expectation of timely care from the doctors they choose in the location they prefer.

The ASA will continue to respectfully argue that the central role of anaesthetists is deserving of recognition and support. When taking into account private practice disruption, lack of sick leave, superannuation, COVID leave, workers compensation, general leave and other conditions the appropriate remuneration for public work in private is no less than the ASA recommended fee.

While individuals may be prepared to accept less than this rate for local reasons, they should do so in the knowledge of the full costs of providing that service, and in comparison to public sector conditions including access to IT systems and junior staff and ICU support perioperatively. We will continue to liaise with all AMAs and governments on these.

The ongoing discussion around bundled care and other commercial arrangements has been fruitful, with the ASA gaining valuable insights and experience, and relationships in order to ensure we have an ongoing voice in these important discussions. If you are affected at all by these arrangements, we can help you to understand them and be sure of what contracts mean. There are some excellent members-only podcasts by Immediate Past President Dr Suzi Nou that anyone contemplating these arrangements should listen to.

Our new CEO Matthew Fisher has hit the ground running and has a remit from the Board for change. We have a great asset in this Society and we must apply it to solving the problems of our members in the contemporary workplace. If there is an initiative you think we should be onto, let us know, it is your Society.

Dr Andrew Miller

MBBS LLB(Hons) FANZCA
FACLM FAICD FAMA

Contact

You can contact me at drajm@me.com or @drajm on twitter any time.

FROM THE CEO

MATTHEW FISHER
CHIEF EXECUTIVE OFFICER, ASA

When I announced to the social media world of my appointment, I wrote a very simple statement – "I feel privileged and enthused to have been appointed CEO of the Australian Society of Anaesthetists (www.asa.org.au) and am looking forward to getting my "boots" under the desk. The ASA has a proud history of Supporting, Representing and Educating Australia's anaesthetists since 1934 and through their work and that of the members, provide critical and quality care to Australians in fulfilling a significant role in the healthcare system. I look forward to working with the Board, staff, members and stakeholders to advance the interests of the ASA". Since the process of engagement commenced, I have been excited by the opportunity and have felt that there is a great values match which is important for all. Andrew and Suzi, as the point people on behalf of the Board and membership, were open and engaging which enabled us to progress and I do appreciate those great indicators of openness, intelligence and a passion for the ASA.

I am a great believer that there is a story behind a person and it is important to understand it so I will aim to give you an insight into mine as the person chosen to add further value to the great work already done. From a professional perspective, I am described by colleagues as an astute and transformational leader of people and organisations. My experience is in sectors including professional association (dentistry and chiropractic), health (public and private), and tertiary education sectors. I am described as an inclusive leader with personal integrity who makes considered decisions and has an ability to be effective under challenging circumstances. I have worked extensively with governments and their agencies to improve the understanding and recognition of the professions I have worked with and the contribution they have with the broader Australian society. My direct and indirect networks into the business, education and community sectors are broad, and I have been acknowledged for being able to provide a public face for the organisation I represent and create networks in government, business, and community agencies for mutual benefit.

My qualifications include a Bachelor of Science (Honours), Graduate Diploma of Dietetics (yes I once was a dietitian) and a PhD. Charles Sturt University also awarded me a Doctor of Health Studies (honoris causa) in 2013, in recognition of my contribution to the development of the University and in improving regional health services plus the title of Adjunct Associate Professor in 2009. I have worked in Broadmeadows Community Health Services in Child & Family services; Epworth Hospital and Westmead Hospital as the department manager; Western Sydney Area Health Services as an area health planner; Mayne Health Corporate Health Programs as NSW Manager; and through Victoria University as high-performance advisor to what is now the Western Bulldogs AFL team. I have also attended both Harvard Business School and London Business School for professional development.

As a CEO, I worked for the Australian Dental Association (NSW Branch) Ltd for 13 years and then the Australian Chiropractors Association for seven years where I restructured the business from a federation to a national entity whilst focussing on improving professionalism within a regulated healthcare environment. This included being part of two ministerial reviews and being a member of AHPRA's professional reference group, apart from dealing with many media issues in that time. Both organisations experienced growth and members expressed high satisfaction which is what I hope to bring to the ASA. A couple of achievements I reflect on include a sustainable dental program in supporting asylum seekers at ADANSW and a Reconciliation Action Plan at the ACA; leadership development and inclusiveness were underpinning strategies.

From the person behind the title, I am a Geelong, Stawell, Ballarat, Melbourne and Sydney person who values his family of Donna, two boys (Beau who is in Vermont in the USA who I haven't hugged for three years but will do so in August; and Sam who is the youngest at home and training to be a helicopter pilot) and a menagerie of cats and dogs. Ocean swimming is a lifelong passion, however the recent shark attack at one of my swimming spots has curtailed how far out I go, but the Sydney rain also made the water quality poor (my excuse), and my SUP is another outlet. There are many other layers however I am guided by some basic values of honesty, integrity, inclusiveness, enjoy experiences and egalitarianism (my beach background). I look forward to engaging with you and as I announced at the start, advancing the interests of the ASA.

Matthew Fisher

PhD DHlthSt (honoris causa)

Contact

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

Australian Society of Anaesthetists®

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WEBAIRS

ANZTADC Case Report Writing Group

Lingual Nerve Injury

WebAIRS recently received a report of lingual nerve (LN) palsy associated with a dual lumen supraglottic airway device (DL-SGA). The patient woke with a bilateral lingual nerve neuropraxia, described as numbness in the front half of tongue. There was no motor involvement, with normal speech, tongue movement, and eating. They had not noticed less taste until they were asked. It was unchanged three days later. A search of the webAIRS database using structured query language revealed that a further 15 cases have been reported making 16 in total. In the webAIRS case series, five were associated with the use of a standard single lumen SGA and 11 with a DL-SGA.

A Google query to gain general information regarding LN palsy revealed that a well-known Australian singer, songwriter, and actress, Delta Goodrem, had also suffered a similar complication in 2020 and subsequently had to relearn how to both speak and sing. It happened that in her case it was a known complication of the surgery performed rather being related to anaesthetic management[1].

Lingual nerve (LN) injury or neuropraxia is a potentially serious but rare complication following general anaesthesia[2,3,4] or surgery involving the oral cavity or neck [4]. Causes of LN injury after general anaesthesia are multifactorial with possible mechanisms including difficult laryngoscopy [2,3], prolonged anterior mandibular displacement, oropharyngeal airways, macroglossia and tongue compression[2]. Airway manipulation[3] pressure from an endotracheal tube (ETT) [2], and pressure from SGAs[4] are also all implicated as causative factors for LN injuries. Any dental or surgical procedure near the LN might also cause trauma to the nerve either directly, or by pressure, or by stretching the LN during tissue retraction[5].

Estimated frequency

The overall incidence rate of postoperative lingual neuropraxia in a retrospective matched case-control study was 0.066%, 6.6 cases per 10,000 (36 patients over 4 years), in patients receiving general anaesthesia with an airway device. Risk factors associated with postoperative LN injury in this study were head and neck surgery, ASA 1 to 2 and young age[2].

Incident Management

Recommended management of lingual neuropraxia includes supportive psychotherapy in conjunction with medication administration of steroids, antidepressants, and anticonvulsants. Expected recovery is within 3 months without special treatment and frequently within days or weeks. However, some injuries are reported as permanent. Microsurgical reconstruction of the LN could provide improved sensation when lingual neuropraxia does not spontaneously improve[2].

Outcomes

All the cases in the webAIRS case series were reported as temporary harm. However, some of these were assumed to be temporary as the patient had not phoned back to report ongoing symptoms. Some of the cases took several weeks to resolve and some cases had reported substantial improvement when followed up but still had some minor numbness. This is in keeping with the literature reviewed[2-5]. In Delta's case it was a slow road to recovery, taking almost a year[6]. However, in her case it was surgical trauma and a known risk for the type of procedure rather than pressure from an airway device[1].

Conclusion

In conclusion, future research could be considered regarding the relationship of SGA cuff volume, pressure, and position within the oral cavity to prevent lingual nerve injury[5].

However, it should be noted that SGAs are not the only cause of LN palsy and that any anaesthetic or surgical device used in the oral cavity has the potential to cause this type of injury.

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THE JOURNEY TO OPPORTUNITY

Richelle Pellegrini chats with Dr Bruce Powell

Dr Bruce Powell was at the top of his game with a career spanning 30 years as a specialist endocrine anaesthetist and Head of Department of the ICU at Rockingham Hospital in Western Australia when, in 2018, his world and career came literally crashing down around him.

Dr Powell suffered catastrophic injuries, including a broken neck and back, ruptured kidney and lung, shattered jaw and a severe Traumatic Brain Injury (TBI), after colliding with a street sign at 65 km/h when competing in a charity cycling race in Victoria.

And so began a journey which has been both a "nightmare and a unique opportunity."

The Nightmare Begins

"Returning home to WA after ten weeks in hospital in Melbourne, saw the beginning of a lengthy rehabilitation journey, often confronting and upsetting," said Bruce.

"My rehabilitation consultant told me bluntly that she didn't know if I would ever work again. I was so angry and upset. How could any of the rehab team know whether I was fit to practice? Who even knew what us gassers did?"

''Before the crash, I felt like I was just getting to the peak of my powers, an influential clinician and health administrator. It was 6 months after that sunny September day, when I came to the realisation that I did not recall what had happened, nor who I was. The loss of identity was terrifying.

"No medicine, no cycling, who was I now? All the things that had defined me since I was 18-years-old just disappeared. My 'normal' life, 8-14-hour days in theatre as well as being Australia's longest-serving State Director of Organ Donation (Donate Life), now reduced to no more than an hour of focus each day, before an overwhelming feeling of absolute exhaustion.''

Return to work?

Bruce, determined to return to the operating theatre, experienced sleepless nights as his starting date approached.

"I was forced to admit to myself that I was afraid of the huge responsibility that us anaesthetists bear. I realised how often I would have to hide my own anxieties to facilitate others doing their jobs. Anaesthetists lot is not to take centre stage but to quietly keep everything in order," said Bruce.

"Naturally it can be daunting to be a leader and anaesthetists often have to step up. We are relied upon, trusted with command of the ship and when the storm breaks, deliberately calm and precise. For all the time I had fought to return to work, I had subconsciously belittled my role, I am only an anaesthetist I would say to myself."

Acknowledging and accepting his new normal was terrifying, disappointing and confronting. Bruce was compelled to accept the trauma's consequences and his responsibilities as a professional to admit some tough truths to himself and his employers.

"My rehabilitation consultant told me bluntly that she didn't know if I would ever work again. I was so angry and upset. How could any of the rehab team know whether I was fit to practice? Who even knew what us gassers did?"

"You have to be mindful of your own state. I had to say that I couldn't do this anymore. I couldn't look after patients anymore. I had to tell the AMA that I wasn't sure I could be a doctor anymore. For all the deep and proud instincts that had me desperate to go back to my old life, I knew I couldn't,'' said Bruce.

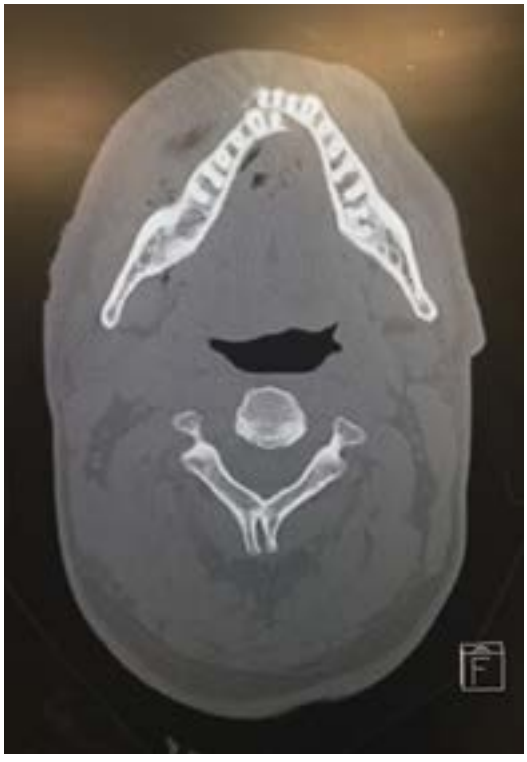
"It was crippling and hard to accept. I had been a bloody good anaesthetist, the 'go-to-guy'. I didn't feel that way anymore. I was deluded to think I could go back to what I was before. I could never forgive myself if anything went wrong and affected a patient."

Opportunity Knocks

As hard as it was to accept he could no longer practice as an anaesthetist, Bruce found that apart from the awful aftermath and trauma his accident caused, it also opened up many opportunities for him to explore.

"If the accident hadn't have happened, I never would have found the courage to step out of my role. As much as I miss being a clinician and will always love it, I now have so many other passions and interests I actually have the time to pursue."

Those passions and interests involve exploring his creative, strategic and communication skills and leveraging them to advocate on behalf of other traumatic brain injury survivors and their families.



"If the accident hadn't have happened, I never would have found the courage to step out of my role. As much as I miss being a clinician and will always love it, I now have so many other passions and interests I actually have the time to pursue."

"Being on the radio, talking about wellness, organ donation and other health care issues, writing about them, is really important to me. It is wonderful to still feel part of the conversation," Bruce said.

"It's all about thinking outside the box and learning about how I might help use my experience as a clinician and an administrator, as well as a survivor and patient."

A regular spot as both interviewee and panelist on ABC Radio Perth, podcasts and articles on his website and presentations to conferences are vehicles for improvement. Bruce advocates for survivors of traumatic brain injuries and the crucial role of the community in organ donation.

He has also been approached by the Western Australian State Head Injury Unit to work with them.

"I am in a unique position as a former head of a department and as a traumatic brain injury survivor to help bring together key players in the field to address the needs of survivors and their carers.

"We need scientists to find solutions to problems experienced by the brain injury community, understand what the needs and wants of the community are."

Bruce is exploring how, using his connections and strategic skills, the State Head Injury Unit might partner with universities to partner PhD research students to the community (giving access to survivors as research subjects) to facilitate the development of projects that will deliver long-term in positive outcomes for survivors.

''I want to be an inspiration to others - I'm not done yet. It is a privilege to still be involved in the medical community and to share ideas with people.''

Lessons Learned

As a long-time clinician and administrator, as well as a patient and survivor, Bruce is acutely aware of the systemic changes that need to happen to improve outcomes in our health care system.

> "A physically and mentally exhausted person will make mistakes, and that of course includes clinicians. If you're a surgeon or an anaesthetist working on me, I really would rather you weren't if you are exhausted and genuinely distressed because of your level of exhaustion

One of the biggest issues and hurdles in his view is the push and pull between clinicians and administrators to ensure budgets are met, surgical lists are completed and patient safety is maintained – often to the detriment of overworked health professionals.

"Cognitive exhaustion – experienced by brain Injury patients – can also be related to the exhaustion experienced by many clinicians who work enormous hours," Bruce said.

"We all carry debits and unless a manager is open to the idea of flexibility regarding those debits, eventually those debits will sink you. The ethos that you work until you drop is just wrong. We as a culture need to accept the fact that well-rested, happy people make good decisions.

"A physically and mentally exhausted person will make mistakes, and that of course includes clinicians. If you're a surgeon or an anaesthetist working on me, I really would rather you weren't if you are exhausted and genuinely distressed because of your level of exhaustion.

"These are the conversations we as a profession and the health care system overall need to have. Looking after our health professional's mental and physical health is paramount and patient groups will back that up.

"I often suffer cognitive exhaustion that can lead to a sense of depression and even despair. I have learned how important this issue is and how important it is that we address these systemic issues of over-worked health professionals. At the same time, we also need to have a connect between the administrative side – funding and policy-driven decisions.

"So, it's all about shared leadership, not working in silos. Clinicians, while often not thinking they need to be a part of politically and policy-driven conversations, actually should be. There needs to be that connect and a shared common ground.

''With more leadership from the medical side we can be more involved in driving policy decisions.''

Dr Bruce Powell

Dr Bruce Powell will be a key note speaker at the 2022 Perth ANZCA Annual Scientific Meeting (ASM); ASSBI Annual Conference; North Queensland Work Well Conference; and is the consumer representative on the National AROC Committee (Australasian Rehabilitation Outcomes Centre).

Visit his website www.drbrucepowell.com

DOCTORS WITH DISABILITIES AUSTRALIA

In 2017, three pioneering Australian doctors, each with their own disability, joined together to set up Australia's first advocacy campaign group to represent established and aspiring doctors with disabilities – Doctors with Disabilities Australia (DWDA).

Each with their own unique story of working in the healthcare system while facing the challenges of disability, Dr Dinesh Palipana, Dr Hannnah Jackson and Dr Harry Eeman wanted to set up a body advocating for an inclusive profession, without regard to physical attributes. Their aim is to help break down the barriers still faced by many doctors and medical students with disabilities.

The field of medicine encompasses a wide range of specialties, each requiring different skill sets and physical requirements. Like every other doctor wishing to specialise, a person with a disability will seek a specialty that best suits their capabilities.

With one in five Australians identifying themselves as having some sort of physical impairment, DWDA takes the point of view that society is better served by having doctors with real-life experience of being patients themselves. This experience can produce doctors with greater compassion for their patients. It can also provide the medical profession with a boost in innovation and efficiency, both demonstrated to be among the benefits in having a diverse workforce.

DWDA brings together the people that have beaten the odds and have gone on to become successful doctors, as well as those aspiring to follow in their footsteps. With the aim of reducing physical, attitudinal and social barriers, DWDA provides advocacy and peer support on matters associated with medical study and doctors with a disability. They have contributed to work in countries such as the United States, United Kingdom, and India.

Dr Dinesh Palipana is a registrar in the emergency department – Australia's busiest - at the Gold Coast University Hospital in Queensland. He was a medical student when in 2010 he sustained a spinal cord injury from a car accident which left him a quadriplegic. He was the first quadriplegic intern ever to be appointed in Queensland.

Dr Hannah Jackson was born with the condition osteogenesis imperfecta and is a successful general practitioner in Hobart, Tasmania.

Dr Harry Eeman was diagnosed with the debilitating disease Guillain-Barre Syndrome while on holiday in France, and spent many months in the ICU and hospital wards, almost losing his life, before returning home to Canberra in 2004 to start his medical internship at Canberra Hospital. He is now a rehabilitation physician and pain specialist at St Vincent's Hospital, Melbourne.

For more information about DWDA please visit their website www.dwda.org.au

Richelle Pellegrini

BE A HERO

Dinesh Palipana OAM is an Australian doctor, lawyer, scientist and disability advocate. He was the first quadriplegic medical intern in Queensland, Australia. He is the second person with quadriplegia to graduate as a doctor in Australia and the first with spinal cord injury.

Dr Palipana currently works as a Principal House Officer in the emergency department of the Gold Coast University Hospital.

A doctor with quadriplegia?

After sustaining a spinal cord injury from a car accident in 2010, even I thought that this was a radical concept. My mind changed as the years went by, though. Coming back to medical school four years later, I figured out how to do many things to work as a doctor. In 2021, I was in my sixth year as a doctor working in the busiest emergency department in Australia. I've been grateful for every minute of it.

The evolving face of medicine

But, you know what? There are more like me. Around the world, there are doctors with disabilities. There's a paediatric surgery trainee who uses a wheelchair. An Orthopaedic Surgeon with a spinal cord injury. A Director of Rehabilitation Medicine with blindness. A General Practitioner with deafness. A Paediatrician with cerebral palsy. A director of Nephrology with Quadriplegia. A General Practitioner with osteogenesis imperfecta. A Rehabilitation Physician with Guillain-Barré syndrome. I'm even lucky to call the last two my friends.

In Australia, we have more medical students with disabilities coming through universities. We have medical students with neurodiversity. We have medical students thriving with chronic conditions. We have ones like Dr Ben Bravery, the author of 'The Patient Doctor', graduating from medical school after going through colon cancer. He knows so well what it's like to be a patient. The future of medicine looks rich. We are evolving.

We've needed to for a long time. The cardiologist Dr Eric Topol says that, "Medicine is remarkably conservative to the point of being properly characterised as sclerotic, even ossified." He calls for the Creative Destruction of Medicine, in the book so titled.

"Medicine is remarkably conservative to the point of being properly characterised as sclerotic, even ossified."

We are primarily thinkers

In our evolution, disability within medicine encourages us to think about who we are as a profession. A long time ago, Dr Harvey Cushing said that he

> "would like to see the day when somebody would be appointed surgeon somewhere who had no hands, for the operative part is the least part of the work."

While this statement can have different meanings, and maybe even suggest something else entirely, I think that one message is clear. Medicine is primarily an intellectual activity.

When I was a student, I was under a medical subspecialty for a time. There, we once consulted on a patient who had pre-existing heart failure and was experiencing sepsis. When the specialist physician asked me how I would manage this patient, I rattled off a number of steps from the sepsis guideline of that time. He was quick to correct me. Applying that guideline ignores the heart failure, potentially killing the patient. He told me that in medicine, this is where we earn our place. By thinking. Anyone can follow a guideline, he said. But, we need to think through problems. This is the privilege that we have.

So, I learned that Dr Cushing was right. In medicine, the primary activity before doing any intervention is to think.

The spectrum of attitudes

Not everyone feels that way. During a discussion with an emergency physician in New South Wales once, she told me that emergency medicine is primarily about things like intubating and inserting chest tubes. This requires your hands, she said. Not having the use of my fingers, I could never be an emergency physician, she concluded. To me, that reductionism shrinks the breadth of an entire specialty into a small window.

In 2020 to 2021, the Australian Institute of Health and Welfare reported 8.8 million emergency department presentations; 0.8% were assigned a triage category of 'Resuscitation', 14% were assigned to 'Emergency', 37% were assigned to 'Urgent', 37% were assigned to 'Semi-urgent' and 10% were assigned to 'Non-urgent'. In the most pessimistic scenario to support my argument, I can say with confidence that there would have been at least 880,000 patients that didn't require an intubation or a chest tube. Anecdotally, we all know that only a small handful would have required these procedures in an emergency department.

What do the large majority of these patients need? Someone with a brain and a heart.

I often overhear emergency medicine trainees vying for access to procedures as learning opportunities, as well. If someone like me is around to see the patient with chest pain, the other registrars can jump on any procedure that comes through the door. Everyone wins. These are the benefits which Dr Ian Rigby, a Canadian emergency physician with quadriplegia, told me during a conversation. After sustaining a spinal cord injury, he continued to work in the emergency department. There have been plenty of things for him to do, including seeing many of the right kind of patients as well as teaching trainees.

In contrast, when I was talking about radiology training with the Royal Australian and New Zealand College of Radiologists and the Princess Alexandra Hospital in Brisbane, their position was that since I'll never perform the interventional procedures outlined in the curriculum anyway, a reasonable adjustment will be for me to understand them, know their indications, and observe them.

The reason I tell you these two contrasting anecdotes is to demonstrate differences in thinking. One attitude is not only contrary to inclusion, but it reduces the scope of a specialty. The other is inclusive, while celebrating the breadth of work that the doctors in its specialty does.

Not only that, this approach allows doctors to better fit into their areas of strength. And, that's important. For anaesthetics, there are pain rounds and pre-admissions clinics. For medical specialties, there are many options. General practice has numerous niches. The options are only limited by our imagination.

We all need to know our limits

Having a different conversation again, this time with a medical regulator, I was told that the most important thing for a doctor is to understand their strengths and weaknesses. Similarly, the lawyer friend in medical negligence tells me that the most difficult cases are from doctors who don't have the insight into the error that they've made. Insights into our limits are the most important thing. Thinking about that, we can take the safety argument to task.

Who's safer? A doctor with quadriplegia, who knows that they can't use their hands to perform surgery inside the skull, not attempting it at all; or the doctor who was criminally prosecuted in a particular country for attempting the same thing without being adequately trained to do so?

Who's safer? A doctor with quadriplegia who clearly knows the indication for a certain procedure, understanding who to best engage for it; or the doctor who attempts it unnecessarily, causing harm to a patient then faces a disciplinary panel?

We've all heard the stories. Who would you rather have as your treating doctor? Whose boundaries can you assess best?

How to progress inclusion?

Hopefully, I've encouraged you to think about the breadth of work that we have in medicine to have a place for people with all different abilities. We know that there's enough work to go around as well. We can do it safely, maybe even minimising the usual risk to patients.

How do we do it?

One answer is technology. When I came back to medical school, our hospital had an electronic medical record. No more piles of folders. I found ways to

be efficient with these tools, seeing 24% more patients than the average intern in our emergency department in my first year. Since then, I have started using more tools as well. These include digital otoscopes that connect to my phone, voice recognition, and portable ultrasound. We have enough technology today that can bridge physical gaps, benefiting not just doctors with disabilities, but all doctors.

However, there's the bureaucracy. In the 2017 Harvard Business Review article by Kenneth T Segel titled, 'Bureaucracy Is Keeping Health Care from Getting Better', the author notes that

> "Bureaucracy is destroying value in innumerable ways, including slowing problem solving, discouraging innovation, and diverting huge amounts of time into politicking and 'working the system.'"

Bureaucracy is a barrier for inclusion.

During two instances where I was advocating for medical colleagues with disabilities, the bureaucracy noted that using a wheelchair in their hospital is a safety risk. For example, what if they fall out of the wheelchair? Think about that. A person in a wheelchair has four contact points with the ground. They won't run. They won't trip. They won't climb stairs. They won't slip over. I'd argue that they are safer than their bipedal colleagues.

There's some innovation to be had here. My partner is a doctor as well. Sometimes, we roll around with her sitting on my lap. I've suggested to her that we do the same at work, doubling our efficiency. She can examine the patient while I take the history, or vice versa. To my disappointment, she has declined this plan to date.

Back to the point. We roll beds and wheelchairs around the hospital constantly. They are rolled in and out of operating theatres. They are taken in and out of the emergency department. They are moved in and out of radiology. In these arguments, commonsense goes out the window. Instead of using highly trained people to do much-needed work in a hospital, we prefer to relegate them to a life on a disability support pension. Is this fiscally efficient or socially just, if someone wants to go back to work?

Workplaces are heavily supported by disability schemes to bring people back to work. JobAccess for example, a federal government scheme, pays for a variety of modifications including physical infrastructure and equipment that can benefit entire departments.

But, the only way we can navigate the bureaucracy is with people. In this whole equation, people are the most important part. If we don't have allies, this is difficult to progress. Sometimes, those allies need to be heroes.

Heroes of inclusion

Dr Cliff Reid defines who heroes are. He says,

> "Heroes do the right thing in difficult circumstances, often weathering personal risk to help others with no expectation of personal gain. They are guided by a strong moral compass, and persist despite setbacks, often overcoming fear to achieve a goal, accepting the consequences of their actions."

"Heroes do the right thing in difficult circumstances, often weathering personal risk to help others with no expectation of personal gain. They are guided by a strong moral compass, and persist despite setbacks, often overcoming fear to achieve a goal, accepting the consequences of their actions."

I talk about Dr Reid's definition a lot, because it's had a deep impact on me. For inclusion, we need heroes.

After I graduated from medical school, I struggled to secure an internship. At that time, many people stood up for me. Some emergency physicians from my emergency department, where I work today, offered up their salaries to pay for mine. Let's take money off the table, they said. Give this person a chance to work. Today, they continue to encourage me and support my career. They are heroes.

I've been heartened to see that there are heroes scattered around our profession. Over the last few years, I have come across four Australian anaesthetists who sustained spinal cord injuries. I've watched as doctors like the anaesthetist Dr Tracey Tay worked hard to support some in getting back to work.

I've also been heartened over the years to note that anaesthesia is a unique specialty that thinks outside the box, eager to talk about inclusion. In 2018, the Chicago anaesthesiologist Dr Christine Park invited me to talk at Stanford Medicine X on inclusion. Run by Dr Larry Chu, another anaesthesiologist, I had the fortune to share a message about inclusion there. Back in Australia, Dr Scott Ma invited me to share some thoughts at the Combined SIG (Special Interest Group) meeting in 2019. Around the world, anaesthesia has taken a lead in inclusion.

Inclusion requires heroes, but our profession broadly requires heroes more than ever. It's the heroes that will take the reins back, to position medicine as a leader for society to look to.

Disability is a national conversation today. We have the National Disability Insurance Scheme. The Disability Royal Commission happening. Consistently, we note that disability representation across all professions is important. This allows us to better reflect the society that we serve, be innovators, create efficiency, and be a beacon.

More than anything in these words, I ask that you be a hero for inclusion, for your colleagues. To create a big change, it's our individual actions that matter collectively.

Dr Dinesh Palipana OAM

A VIEW FROM BOTH SIDES

THE GOOD, THE BAD AND THE UGLY OF THE JOURNEY FROM DOCTOR TO PATIENT AND AT LEAST PART WAY BACK.

DR BLAIR MUNFORD, FANZCA

Two days before the end of 2016 my life as I knew it ended when what I initially thought was a minor tumble off a bicycle left me completely unable to move and barely to breathe. I initially expected to die at the roadside – and considered this a preferable alternative to life as a ventilator dependent quadriplegic. That neither outcome occurred is a tribute to the ICU & Spinal Unit at RNSH in Sydney.

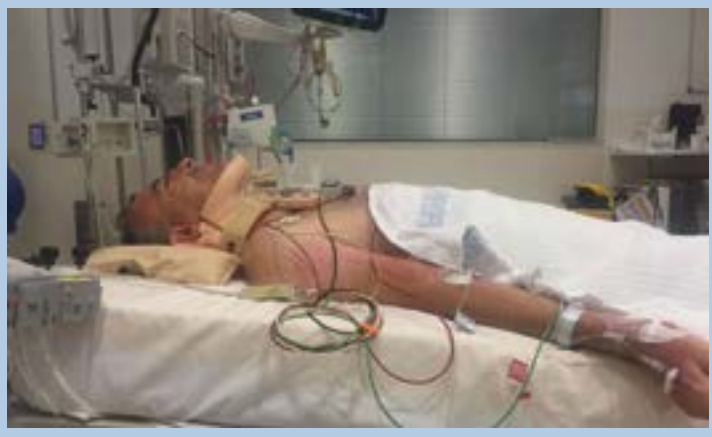
Lying flat in bed for days on end, contemplating a grim future and the terrible blow I had dealt to my wife and family, left my brain searching for some sort of outlet. As I was having frequent ABGs taken, I started by asking the nurses and junior medical officers to tell me any two of the pH, pCO2 and HCO_3 and I would calculate the third. This morphed into giving impromptu physiology and pharmacology tutorials to registrars sitting the CICM Primary Examination. This did something to reassure me that there might still be some useful role for me going forward.

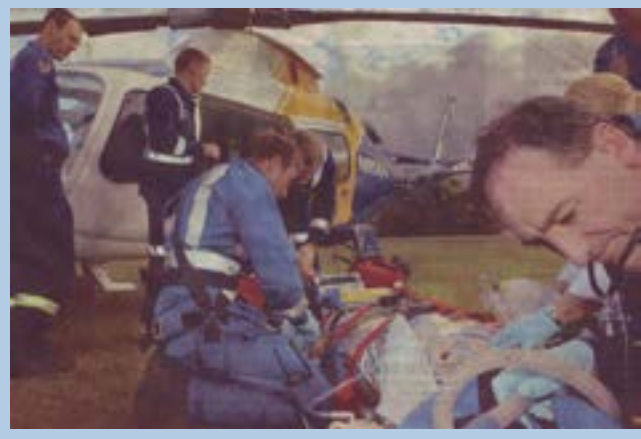
The other thing that sustained me through this dark period was the number of visits and messages of support, tributes and thanks from former students, registrars and also many from the surgical side. The latter surprised me, because I had always thought my surgical colleagues considered me overly pedantic and slow – a perception that led me to avoid private in favour of public practice plus teaching and collegial activities. I suspect most of us never realise that we are valued by others; such tributes so often only coming in eulogies.

After nearly three months, I was transferred to Royal Ryde Rehab Hospital, where I remained for the best part of a year. There I was able to intermittently continue teaching for both ANZCA and CICM Primary candidates, plus some medical student groups; both in person when they were able to come to Ryde, and by becoming an early adopter of conferencing software before COVID19 forced it upon everybody.

At this stage, I was becoming independently mobile in a powered wheelchair and had recovered some arm function, enabling me to write a little, albeit slowly. I could also use a

> I had no illusions of returning to procedural anaesthesia, but was confident that I would be able to work and make a real contribution in areas such as perioperative clinics, pain rounds and of course teaching – all of which I had established experience in.





computer with a combination of some keyboard use, a trackpad and dictation software. I had no illusions of returning to procedural anaesthesia, but was confident that I would be able to work and make a real contribution in areas such as perioperative clinics, pain rounds and of course teaching – all of which I had established experience in. I expected that I would be supported by the hospital where I had worked for over twenty years (the identity of which I will leave unspecified) in returning to such a role.

The first indication I had that this was definitely not going to be the case was when I attempted to attend a QA/M&M meeting, having received an invitation via a departmental group email. This resulted in my being told to leave the hospital – on the grounds that I was not permitted to enter the hospital until a formal workplace safety assessment had been done. I attempted to argue the point that a single-level ground floor meeting room in a hospital was presumably intrinsically wheelchair-friendly by design and also precedent. I was then threatened with forcible removal by hospital security.

Unfortunately, this was not just a misunderstanding, but rather only the start of a protracted struggle where it seemed that every conceivable obstacle and excuse was thrown up to interdict my attempts to return to work. It culminated in a meeting with Medical Administration and Human Resources where I was told I would have to complete a formal assessment of my abilities to perform the full range of duties expected of a specialist anaesthetist. When I enquired what possible purpose there could be in this, other than setting me up to fail, I was told (direct quote, burned into my brain to this day): "You have no right to question what we propose to do. It is sufficient for you to know that is what we require of you."

What I found gut-wrenching though was the outright adversity from the medical hierarchy, even though many anaesthetic, surgical and intensive care colleagues were individually supportive.

I was not entirely surprised at the attitude of the health bureaucracy, having long held the view that the title 'Human Resources' is entirely appropriate. Staff are no longer regarded as valuable team members whose knowledge, experience and dedication are to be cherished; rather they are just another supply like hospital linen that can be changed if a cheaper or more convenient alternative can be found. What I found gut-wrenching though was the outright adversity from the medical hierarchy, even though many anaesthetic, surgical and intensive care colleagues were individually supportive. I had been assisted by an occupational therapist who specialised in assisting people and their employers in developing return-to-work programs. She had expected a health facility to be right at the top in terms of support and was shocked to find, as she eventually stated, the most uncooperative and obstructive attitude she had ever encountered. Eventually we just gave up, because as she summed it up: "If they are this hostile, do you really want to work here?"

While I had expected support from my own facility, I never believed that any other hospital would want me especially when my own did not. I was coming to terms with being classified as damaged goods not fit for purpose. What happened next I struggle to find a term to describe – overwhelmed is perhaps the closest I can come up with. Almost simultaneously, several colleagues from other hospitals reached out to me in support with offers of work, in particular to become involved again in teaching for the Primary exam. Even though some of what was offered would be pro bono work, this in no way diminished the sheer joy of being affirmed as still having something to offer.

Most exciting of all was the proposal by two colleagues from John Hunter Hospital in Newcastle, Tracey Tay and

Ross Kerridge, to develop an assistance program and assessment process to enable me to participate in perioperative clinic services. This program, christened 'The Blair Switch Project' by Tracey, and her poster presentation about it at the 2020 ANZCA (virtual) ASM is described by her separately. After completing the program, I have now been working there once a fortnight for two years as well as contributing to their Primary tutorial program.

At the same time as this program was getting underway, another colleague, Dr Rob Turner at Prince of Wales Hospital offered me a role assisting with their Primary program, combined with an appointment as a clinical tutor for UNSW medical students. This involved teaching basic clinical science to third year students, which is their first clinical year. This apparently caused some disquiet amongst the cohort of tutors who were all physicians, as they had never previously had an anaesthetist as a tutor. So my first few tutorials were supervised by one of these physicians who pronounced himself happy with my standard of teaching – I was pleased to hear later via the grapevine that he was surprised how much medicine anaesthetists seem to know! I was sorry to have to leave this position after only a year only because it ended up clashing with my clinic commitments.

Again concurrently, yet another colleague and former registrar Dr Jo Tan, Director of Anaesthetics at Campbelltown Hospital offered me a part-time position involving initially administrative and teaching duties, including again running a Primary teaching program, but this time for CICM trainees across the area health service, as well as teaching UWS medical students. More recently, I have also started working in the perioperative service. Subsequently, during the COVID19 pandemic, I was able to contribute both educationally and clinically – by contributing to the Assistant in Medicine program put in place to fast-track final year medical students into the clinical workforce, and along with other anaesthetists providing additional clinical support in COVID wards during the peak patient load.

> … five years after my injury, I want to pay tribute to those who saw ability not disability and gave me a sense of purpose in life and the chance to make a worthwhile contribution. I trust, or at least hope, that I have repaid them by fulfilling the latter.

So, five years after my injury, I want to pay tribute to those who saw ability not disability and gave me a sense of purpose in life and the chance to make a worthwhile contribution. I trust, or at least hope, that I have repaid them by fulfilling the latter. In the wider arena, I hope that my saga and the telling of it will prevent future instances of what happened to me at my original workplace. A couple of years ago, while my roles above were still in development, I was privileged to be asked to speak at a Welfare SIG meeting, along with an inspiring junior doctor, Dinesh Palipana, who became a quadriplegic in a car accident. He was still a medical student and had to fight to be allowed to complete his medical training and then internship and RMO years. One of the things I was able to bring up was that I was fortunate to have my Fellowship and some established roles to fall back on. It would have been much more difficult had I been a trainee. Between accidents and medical conditions, e.g. multiple sclerosis, it is unfortunately inevitably something that our College/specialty will occasionally need to confront: to try and support such an individual into a meaningful role. I leave you with that as a challenge to think about.

Dr Blair Munford

ACKNOWLEDGEMENTS

There are so many people I am grateful to in this journey that I could not possibly thank them all individually. But within the medical community, as well as those already mentioned, I would like to specially thank Rob Thomas, Paul Healey, Rhys Thomas and Claire Armstrong at John Hunter, Shona Chung & spinal specialist Bonne Lee at PoW, Praha Sellappa and Michael Ayling at Campbelltown and Deepak Bhonagiri at Campbelltown and SWSAHS. And from the rehabilitation and occupational therapy sphere: Rachel Harper, David Simpson, Allie DiMarco and Adrian Byac. Finally, but most of all, none of this would have been possible without the almost infinite work, support and love of my wife Bronwyn, who has carried me through everything since the day of my accident.

Dr Blair Munford, March 2022

THE BLAIR SWITCH PROJECT

"I was struck by the ordinariness of the day preceding the moment of the fall and the utter transformation of his world and that of his family and friends that followed. The universal possibility that anyone of us could suffer a devastating injury should drive us all to actively support those for whom this becomes a reality."
Dr Tracey Tay

On hearing Blair Munford's account of the day he suffered his devastating cervical cord injury, I was struck by the ordinariness of the day preceding the moment of the fall and the utter transformation of his world and that of his family and friends that followed. The universal possibility that anyone of us could suffer a devastating injury should drive us all to actively support those for whom this becomes a reality.

Currently, doctors living with disability face a wide range of experiences in returning to work. In their 2016 study, Smith et al identified a number of issues for doctors with chronic illness and disability who wished to continue working in some capacity. The main barriers were lack of support from workplaces to adapt the physical environment, and the attitudes and behaviours of staff, including bullying. By contrast, enabling workplaces were described as "supportive and imaginative" and "adaptive and positive". Blair's experience traversed this range of responses as he attempted to return to work.

In the best interpretation of the reasons for why one workplace actively obstructs return to work, while another seeks to support, there is a dearth of practical approaches to guide the return to work of highly trained, motivated professionals who wish to continue to use their skills to improve the lives of others. This article describes a simulation-based approach to identifying ability and what is needed in the workplace to ensure the community continues to benefit from their expertise.

What is the size of the problem?

The most recent Australian labour force participation rate data shows that 53.4% of people with disability were in the labour force, compared with 84.1% of people without disability (ABS, 2018).

The 2009 National Disability Strategy Report 'Shut Out' noted that 34% of submissions received referred to barriers to employment for people with disabilities. These included discrimination and stereotyping, the physical environment and assumptions made about occupational health and safety. It was noted that employment is not only essential for economic income, but also for a person's health and well-being.

These findings are reflected in the interim findings of the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability (Commonwealth of Australia, 2020)

What is the current policy environment?

In 2008, the Australian Government became a signatory to the UN Convention on the Rights of Persons with Disabilities and developed the National Disability Agreement. The latest national policy is Australia's Disability Strategy 2021-2031 (Commonwealth of Australia, 2021).

In NSW, the Disability Inclusion Act 2014 was passed and the most recent NSW Disability Inclusion Plan 2021-2025 outlines four Focus Areas:

1. Positive community attitudes and behaviours
2. Creating liveable communities
3. Employment
4. Systems and Process

With regard to Focus Area 3 - Employment, the Outcome defined is that, as a Premier's Priority, the NSW Government ensures that 5.6% of all Government sector roles are held by people with disability by 2025. This is still a long way from the approximately 16.9% of the NSW population that lives with disability (NSW Health, 2020).

The NSW Health Disability Inclusion Action Plan 2016-2019 (not yet updated) latest report states that in June, 2019, 1.7% of NSW Health staff were recorded as having a disability.

It was also clear that this identification of ability would need to be objective, measureable and reliable if it were to break down the focus on disability

While government policy would appear to support the return to work of a disabled doctor, current experience suggests that this support has been variable. Anecdotally, a number of disabled doctors are currently employed, but the process by which organisations assess and support these doctors is not documented. As a result, interpretation of current policy is dependent on the experience of disability, or lack thereof, of the managers involved.

The Blair Switch Project

Following Blair's injury, and during his recovery and rehabilitation, there was a significant outpouring of concern and offers of support in terms of meeting immediate needs.

However, the negative response from his workplace suggested that there was little in the way of formal guidance to assist the hospital management in returning Blair to work. There was, of course, a fitness for work assessment provided, which reflected that Blair had reached a stage in his recovery and rehabilitation where he was ready to return to some form of employment. The yawning gap was the identification of Blair's abilities and the matching of these with roles that made use of this knowledge and skill.

It was also clear that this identification of ability would need to be objective, measurable and reliable if it were to break down the focus on disability that had been demonstrated with disheartening regularity by those with the power to make a difference. To this end, a multidisciplinary team hatched the Blair Switch Project.

In partnership with Blair, a project was designed to:

- Describe the components of work in the Perioperative Clinic/Telehealth consultation
- Demonstrate Blair's physical abilities in the Perioperative Clinic, John Hunter Hospital, Newcastle
- Describe the gap between job requirements and Blair's physical abilities, and other barriers (technological/environmental/policy/social etc)
- Investigate how to fill the gaps/describe solutions (technological/environmental/policy/social etc) to work in Perioperative Clinic

The team consisted of Blair, his occupational therapists, an occupational therapy academic, simulation experts, anaesthetists, nurses, junior doctors, a communications student, his carers and his ever-supportive wife. We were also very fortunate to have the involvement of Dr Dinesh Palipana, a doctor living with quadriplegia, who provided real-time advice.

Three scenarios were developed by expert faculty from the Hunter New England Simulation Centre:

1. Patient with no comorbidities for minor surgery
2. Patient in a wheelchair with complex comorbidities for preoperative assessment
3. Patient who requires a rapid response call in the course of a preoperative assessment.

Using a novel assessment tool, the occupational therapists observed anaesthetists without disability enacting the scenarios with simulated patients. The physical actions were documented in detail.

Next, Blair carried out the same scenarios. Where there was a variance between the requirement and Blair's effort, the team paused and discussed solutions to bridge the gap. These may have been physical aids such as splints, technology such as voice recognition software, or changes to the environment, for example.

The initial assessment demonstrated that, with simple accommodations, Blair achieved a 91% mastery score for work in the Perioperative Clinic. Subsequently, further accommodations were developed and the final score was 96% -a stunning demonstration of ability!

The initial assessment demonstrated that, with simple accommodations, Blair achieved a 91% mastery score for work in the Perioperative Clinic. Subsequently, further accommodations were developed and the final score was 96% - a stunning demonstration of ability!

Based on this objective report, Blair was offered a position as an anaesthetist in the John Hunter Hospital Perioperative Clinic where he continues to work part-time. He couples this with invaluable teaching for Primary candidates.

What does this project add?

If nothing else, this project was a triumph for Blair and for the team of volunteers who saw ability and valuable contribution where others did not.

Importantly, it has demonstrated the usefulness of simulation-based scenarios to support independent assessment of a person's ability to return to work. It allows for a range of roles to be tested for suitability and for accommodations to be identified and developed. It builds confidence for the doctor with disability who may doubt they can return to work and it validates the actions of managers who support their return.

The approach could be used to support the return to work of doctors in a very wide range of situations whether it is from injury such as Blair's, or following significant physical or mental illness or disability secondary to chronic disease.

Government policy promoting equity, formal inquiries identifying discrimination and aspirational action plans have proven necessary but not sufficient for doctors like Blair and others as they strive to continue to contribute to society and to ensure their financial security. Clear and practical approaches such as that described in the Blair Switch Project are needed to objectively and emphatically demonstrate ability and to

We must amplify the voices of our friends, colleagues and loved ones who live with disability and continue to find very practical ways to ensure their valuable contributions to our communities.

allow managers to partner with doctors with disability, removing barriers to return to work.

We must amplify the voices of our friends, colleagues and loved ones who live with disability and continue to find very practical ways to ensure their valuable contributions to our communities.

Dr Tracey Tay

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Tracey Tay recently took up the role of national Chief Medical Advisor for Calvary Health Care following a long career in anaesthesia, most recently at John Hunter Hospital in Newcastle. In recent years she has also been the Clinical Executive Director, CATALYST, at the NSW Agency for Clinical Innovation, with responsibility for over twenty statewide clinical networks of clinicians, managers and consumers redesigning healthcare across NSW. Tracey has also had a career-long passion for supporting the well-being of healthcare workers.


CANADIAN ANESTHESIOLOGISTS' SOCIETY
Mark your calendars!
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ANNUAL MEETING
June 24 - 26
Halifax, NS
Book your time off now!
Registration information and virtual options available soon
Check our website for regular updates
www.cas.ca/annual-meeting

MY COVID ENCOUNTER

DR SUZI NOU
IMMEDIATE PAST PRESIDENT
CHAIR COMMUNICATIONS

In early February, I, like many Victorians, caught SARS-CoV-2, the virus that causes COVID. It was no surprise when I saw the two lines light up on my rapid Antigen Test (RAT). Exactly 72 hours prior, our 5-year-old's test had done the same thing.

The night before her RAT was positive, she had climbed into our bed. My husband had the good sense to realise the bed was too small for the three of us and had gone to find somewhere more spacious, and as it turned out, less infectious. It was only in the morning when I woke to her burning foot in my ribcage that I suspected it wasn't a bad dream that had caused her to seek our company. The thermometer confirmed a fever, the RAT confirmed COVID and with that, we confirmed the end of our holiday.

For the duration of my incubation period, we assumed that I was suspected to have COVID, or sCOVID, as we might label people here in Victoria. I had to assume that I both had received an infectious dose and that I may have been lucky enough to not be infected. It made mealtimes and anytime we entered shared spaces a bit of a dance, so in a way, the positive result came as a bit of relief. I hoped that as someone who is relatively young, fully vaccinated and with no comorbidities that I would be at best, mildly symptomatic and at worst, that it be no more than the flu.

I recall one night trying to cook dinner. It certainly was not an elaborate affair, perhaps a simple pasta and salad, but creating and timing all the elements to be ready at approximately the same time took a new level of concentration that was exhausting. Thankfully this symptom and the others resolved quickly, and I considered myself quite lucky.

In terms of symptoms, I had the full hand, although all thankfully mild. I had minimal respiratory symptoms, a little gastrointestinal upset, loss of taste and mild dehydration. Perhaps the most challenging symptoms for me were the neurological ones: fatigue, difficulty concentrating, slight loss of visual acuity and sleep disturbance. I recall one night trying to cook dinner. It certainly was not an elaborate affair, perhaps a simple pasta and salad, but creating and timing all the elements to be ready at approximately the same time took a new level of concentration that was exhausting. Thankfully this symptom and the others resolved quickly, and I considered myself quite lucky. Compared to some of my patients that I had met in my role as a COVID community doctor, I'd had a good run, probably only taking two doses of paracetamol throughout the whole infection. I was back at work well within a few weeks.

During my COVID stint, I rested mentally and physically. Exercise for me is an important part of my life. I am more energised, sleep better and eat more healthily when I exercise regularly. So I kept moving, only by way of gentle yoga until I was back at work. Once back at work, I started to increase the intensity of my workouts. I had read a few guidelines on returning to exercise following COVID and used these to guide me[1–3].

About a week after I had been back at work, I noticed mid workout, that I felt a slight discomfort in my chest. In describing it to myself, I sounded like many patients we have all probably met. "No, its not a pain, doc, more like a heavy feeling. It's not bad. I certainly wouldn't take a Panadol for it". I did the mental scan: no radiation to the jaw or arm, no associated symptoms in someone at low risk. Probably nothing. Once I stopped exercising, the discomfort ceased, as did my concern and I went about my day as usual.

However, a few days later, after I arrived at work, I noted that the discomfort (about a 0.5 out of 10 on a pain scale) was still

One afternoon, when I realised that the discomfort had been present all day, I finally followed their advice. What I thought would be a quick stop in the ED to do an ECG that would be normal, ended up being an overnight admission to a coronary care unit for telemetry and further investigations.

there. That morning's workout had not been particularly onerous, especially compared to what I was doing before COVID. I had been diligently limiting myself to low intensity steady state (LISS) exercise; a brisk walk or slow jog on the flat but certainly no sprints or hill climbs. With that slight niggle continuing at rest and more out of curiosity, I did an ECG, which was essentially normal.

The next few weeks rolled on, I was back in the swing of things at work and the chest discomfort came and went. It was there most days, as I was exercising most days. Sometimes it would start mid workout, especially on the odd occasion when I pushed it too hard (two weeks of LISS is hard to maintain) but often it would start a few hours after I had stopped exercising. Whilst I was cognisant of it, I was reassured by my ECG.

During these weeks, friends asked how my recovery from COVID was progressing. "All good except for this funny chest niggle" would be my reply. A few voiced their concern and particularly the general practitioners and emergency physicians, requested I go to be assessed properly in an Emergency Department (ED). One afternoon, when I realised that the discomfort had been present all day, I finally followed their advice.

What I thought would be a quick stop in the ED to do an ECG that would be normal, ended up being an overnight admission to a coronary care unit for telemetry and further investigations. My ECG showed widespread changes and although my troponins were negative, I learnt that this was not uncommon in post-COVID myocarditis[4]. The other differential diagnosis was pericarditis although my transthoracic echo and CT coronary angiogram (CTCA) were normal.

From there I was booked for a cardiac MRI and advised to only exercise within limits. I went back to the return to exercise guidelines and picked the most conservative one I could find[5]. This involved progressing to the next level of exercise after seven asymptomatic days, rather than two. As symptoms mainly occurred after exercise, rather than during, assessment was difficult. I went back to only doing yoga and my only goal was to achieve seven days without symptoms. When I started to build up my workouts, I found I had to halve almost every aspect of exercise: the duration, the intensity and the frequency.

With the potential diagnosis of myocarditis lingering over me, I started to doubt every niggle. I could see why patients with coronary artery disease are started on anti-reflux medications. I found correlation between my chest pain and an increased resting heart rate. I also found it would recur during high pressure moments and not so high-pressure moments in theatre, interestingly more often when I was working solo. A laryngeal mask airway that didn't sit perfectly, an epidural in a labouring patient with a past history of an inadvertent dural tap, a child who partially obstructs during the excitement phase of an inhalational induction. These experiences occur commonly enough in anaesthesia for them not to be alarming but the heavy feeling in my chest didn't necessarily agree. Soon after discharge from hospital I attended a few neonatal 'code blues' (cardiac arrests) and an obstetric 'code green' for emergent delivery without noticing any symptoms, despite mentally scanning for them. Attending a resuscitation can be stressful but the patient has already deteriorated and our role, although at times quite significant, is as part of the resuscitation team. Perhaps the recurrence of my symptoms during elective surgery cases reflects the gravity of the responsibility we carry when we start with healthy patients and make that commitment that we will return them safely to recovery or their pre-procedural state.

With that realisation, I made the difficult decision to step back from clinical duties. A study published whilst I had COVID that showed that people were almost twice

as likely to have a significant cardiac event in the twelve months following COVID[6]. Shane Warne died the day I was discharged from CCU and Labor Senator Kimberley Kitching not long after. I found the chest pain distracting and I didn't want it to impact patient care. Fortunately, this decision was well supported by my public hospital departments, my private practice group and the surgeons with whom I work. I was particularly supported by my family. My husband confessed that on the night I didn't come home from work our 5-year-old daughter asked him outright if I was going to die.

At the time of writing, it has been two and a half months since I had COVID, and my symptoms have eased significantly. I can exercise with more intensity but am still not able to achieve what I could do pre-COVID. I have some objective measure as the week I had COVID I was booked for my physical assessment, a requirement of being a Reservist in the Royal Australian Air Force and back then, knew I would have passed easily. My cardiac MRI result thankfully showed pericarditis rather than myocarditis and I have returned to full clinical duties.

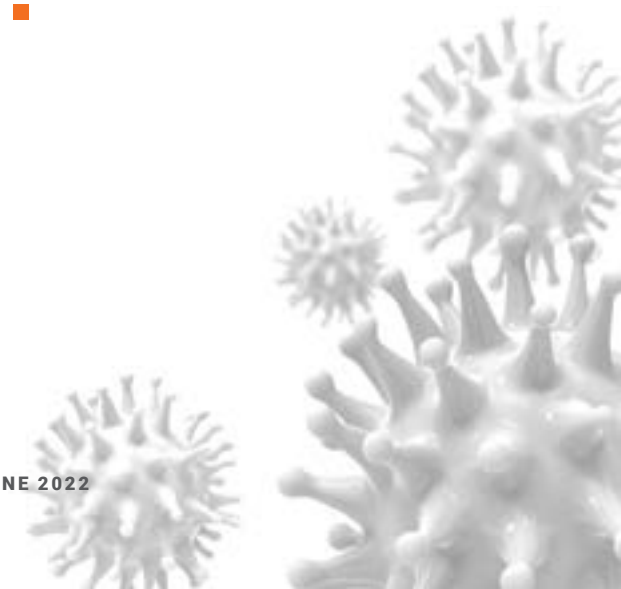
I really do count myself fortunate with my clinical course. People reached out to me about their experiences with post-COVID and Long COVID symptoms such as fatigue and myalgia. I also heard from people diagnosed with myalgic encephalitis/chronic fatigue syndrome (ME/CFS) after other viral infections. They often mentioned their frustration in being misdiagnosed and in a way, I felt grateful that I had the 'concrete' sign of an abnormal ECG and that I didn't have to try to convince anyone of the significance of my symptoms. I acknowledge with gratitude those who have shared their experiences in this issue of Australian Anaesthetist and feel that my experience pales in comparison.

I was not keen to be infected with SARS-CoV-2 in the first place and this experience has made me even more reluctant to catch it again. I do not accept that (re)infection is inevitable. I have been able to meet friends and family, travel, and not live the life of a hermit. Community level public health measures to reduce spread have started to ease, travel is increasing, and people are meeting in greater numbers. I am glad that people have started to socialise in person again and we are starting to regain a sense of normalcy.

Taking COVID precautions at a population level to reduce transmission has been the subject of debate and strong opinion over the last two years. This experience has highlighted to me the importance, not only of implementing measures to reduce transmission, but also publicising what they are, in order to be inclusive and improve participation. With the easing of many mitigation strategies, it is up to us as individuals to assess risk and decide which activities we attend and how we might participate. Knowing ahead of time whether air quality has been addressed and other measures, such as whether testing and masking are required, assists people in making their own risk assessment. Those who are able bodied, younger, with 'no comorbidities' and not living with vulnerable people in their household may not value that information, but many others, such as myself, will.

Dr Suzi Nou

I was not keen to be infected with SARS-CoV-2 in the first place and this experience has made me even more reluctant to catch it again. I do not accept that (re)infection is inevitable.



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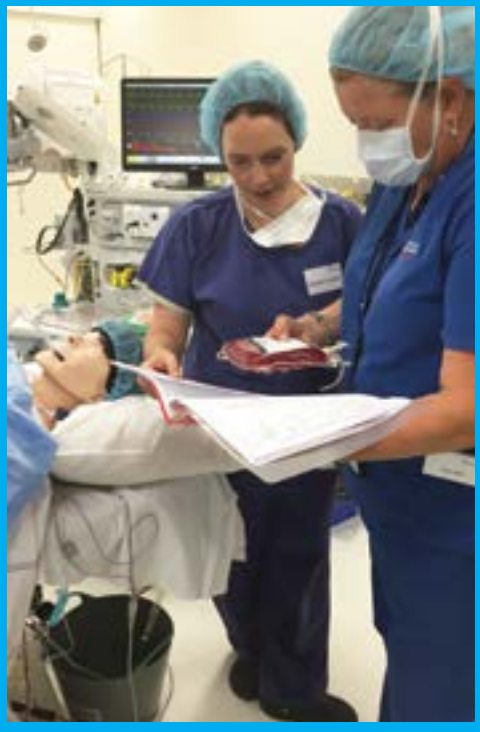


Getting back to work can be a big challenge after a period away. 'CRASH' is a course designed to restore your confidence and support your return.

The ASA has 20 CRASH scholarships a year available for members

The Australian Society of Anaesthetists recognises the importance of ensuring that anaesthetists returning to work after a period away can do so with confidence. To this end, the ASA is offering scholarships to members who are returning to work after a period of leave to undertake the *"Critical Care, Resuscitation, Airway Skills: Helping You Return to Work* - CRASH Course."

What is CRASH?

1. CRASH has been designed by critical care specialists and educators to form part of a structured return to work process after a period of leave.
2. It is facilitated by a dedicated faculty, with a high faculty: participant ratio
3. CRASH meets the ANZCA requirements for two emergency responses plus additional Continuing Medical Education (CME)
4. CRASH is recommended by CICM as part of a return to work process, providing simulation (face-to-face), emergency scenarios, skills practice and clinical decision-making support to refresh knowledge, as well as practical tips on returning-to-work.

CRASH face-to-face (which may be half or full day) has two emergency responses.

CRASH virtual is accredited for one emergency response.

What is the ASA CRASH Scholarship?

The scholarship is a contribution designed to partially offset the registration costs of undertaking the CRASH Course. CRASH Virtual $200 CRASH face-to-face $400.

Who can apply for an ASA CRASH Course Scholarship?

Any ASA member returning to work after a period of leave be it parental (including maternity and paternity), overseas fellowship, cross-specialty training, research, or wanting to refresh their skills after a break in practice, may apply for a scholarship.

Applicants must have been a financial ASA member for a minimum of one year to be eligible for the scholarship.

How do I apply?

Book and pay for your CRASH Course online. Save your registration receipt.

Complete the online ASA CRASH Course Scholarship application and attach your receipt.

Should your application be successful, you will be informed by the ASA and scholarship funds will be paid into your nominated bank account. All successful applicants must use the scholarship within one year (12 months) of it being awarded.

Please note that the financial scholarships are dependent on applicants attending the CRASH Course. Therefore, if you are unable to attend the course for any reason, you'll be expected to refund any monies received from the ASA.

For course information, dates and scholarship application please log in to the members website and go to **www.asa.org.au/membership-crash**

www.thermh.org.au/health-professionals/continuing-education/anaesthesia-and-pain-management-courses/crash-course

"The CRASH course was invaluable for my confidence on returning to work after leave and I am grateful to the ASA for supporting me with a CRASH Course Scholarship. The best part was meeting other participants and realising that you're not alone in the 'return-to-work' transition.

Dr Georgie Cameron
ASA member

THREE'S A CROWD: THIRD PARTY PAYERS AND BUNDLED MEDICAL CARE

DR PETER WATERHOUSE
PIAC CHAIR

Private practice places the doctor-patient relationship at the centre of clinical medicine. The involvement of third party payers disrupts this individual focus by introducing another key decision-maker.

'Bundled' care describes a system in which multiple aspects of medical treatment are centrally controlled by a third party payer. Individual providers of care enter into an agreement with the payer. The patient's primary relationship in bundled care is with the payer, rather than an individual doctor or other healthcare provider.

This article explores two bundled-care models emerging in the Australian private healthcare industry. In each case the individual nature of private healthcare is disrupted by the introduction of a third party with a financial motivation for controlling the delivery of treatment.

Bundled arthroplasty: The St Vincent's JointCare scheme

In March this year, anaesthetists at a private hospital in Queensland were notified of a new bundled arthroplasty scheme affecting their lists. Patients insured by a particular health fund would undergo hip or knee replacement with no out-of-pocket expense. Participating doctors were required to enter into an agreement to this effect, with one business day allowed for consideration of the offer.

Unfortunately many aspects of the proposed scheme had not been sufficiently worked out. This is not surprising given that the scheme was not presented to the Medical Advisory Committee of the hospital, nor to affected craft groups apart from the surgeons to whom the bundle would refer patients.

The role of anaesthetists, perioperative physicians, surgical assistants and allied health practitioners had not been given much consideration. Rather it was assumed that each of these independent professions would accept the terms of the proposed scheme.

Anaesthetists responded quickly, disseminating information about the proposed scheme and arranging meetings both locally and at a national level, facilitated by the ASA.

There was remarkable agreement amongst anaesthetists regarding the dangers inherent in the proposed model. It represented a major departure from the existing model of highly individualised care provided within the hospital. The specific concerns included:

Diminishing the doctor patient relationship

Patients' primary relationship would be with the insurer providing the bundle, rather than a particular medical specialist.

Disruption of perioperative teams

The excellent outcomes enjoyed by private patients are the result of teamwork. Surgeons, anaesthetists, assistants, physicians and others contribute to overall results. Bundled care schemes restrict team membership to contracted providers. Such a system transfers ever more power to the insurers. Most Australian health insurance is provided by public companies whose primary function is to generate profit for shareholders.

Loss of identity

Hospitals participating in bundled care could be perceived by referrers and patients as the insurer's hospital, and participating doctors as the insurer's doctors. This could diminish the reputation for independence and excellence which private hospitals strive for.

Creation of preferred provider networks

Bundled care schemes divide the medical workforce into networks of preferred providers. Health fund rebates to patients may vary widely depending upon their doctors' participation in the insurer's network. This undermines the principle of universal access under Medicare, which pays rebates equally irrespective of provider. Preferred provider networks deliver power to insurers, who can influence medical care offered to patients by adjusting rebates.

Overall, anaesthetists and others were concerned that the proposed bundle could facilitate a transition to an insurer-dominated healthcare system, similar to that of the United States.

Fortunately the hospital has withdrawn the proposed bundle, for now at least. However, while insurers are permitted to assemble networks of preferred providers by manipulating patient rebates, such schemes will continue to emerge in various guises.

Private surgery for uninsured patients: Assessing the risks

There has been a recent increase in the number of uninsured patients accessing elective surgery in the private sector.

Uninsured patients seek private care for procedures which are not available in the public sector or for which long delays are common. Examples include bariatric surgery, arthroplasty, knee reconstruction and cosmetic surgery.

Financial uncertainty

Given the number of providers involved in elective surgery, an accurate estimate of cost is difficult to generate. Factors including facility fees, prostheses and professional fees from surgeon, anaesthetist, assistant and allied health practitioners need to be considered. Even if an estimate can be obtained from each provider, a surgical complication would result in higher costs than anticipated.

This inherent financial uncertainty may discourage patients from undertaking self-funded surgery. They may be paying for their treatment using borrowed money or retirement savings. An exact figure facilitates easier planning.

Brokers for self-funded surgery

The desire for financial certainty has led to the emergence of brokers for self-funded surgery. They provide a total fee for a bundle of care.

Brokers find a venue for surgery, and assemble the perioperative team required to perform it. They also undertake a number of administrative tasks, from booking appointments, to facilitating payment plans or access to superannuation savings.

Transfer of risk

The purpose of a firm quote for elective surgery is to eliminate financial risk for the patient. This is achieved by transferring the risk to the providers of care.

Every provider involved in the proposed episode of care must forward a quote to the broker. An unplanned increase in the cost of care is then borne by providers.

Magnitude of risk

While any surgery can lead to unexpected complications, risk is likely to correlate with the magnitude of the proposed intervention. For example, major complications are more likely following gastric bypass surgery than knee reconstruction. Financial risk is linked to the need for additional services not accounted for by the bundle price.

Considerations for anaesthetists

Anaesthetists invited to participate in bundled care of self-funded patients need to consider the implications of this model before making a commitment. Most obviously, a fee estimate will need to take account of the financial risks inherent in this model, as discussed above. Doctors remain responsible for the delivery of appropriate care irrespective of the financial details of the bundle. It may therefore be prudent to make provision for complications when setting a fee.

Beyond purely financial considerations, anaesthetists need to consider other aspects of bundled care of at least equal importance.

As is always the case in bundled medical care, the patient's primary relationship is not with a doctor but with a non-medical third party. In this case, the broker. This means that the broker, rather than the primary medical specialist, is responsible for assembling the team providing care to the patient. Of course the team assembled may be satisfactory, but membership of the team is restricted to those agreeing to the terms of the bundle. All participants are responsible for ensuring that they are happy to work with other providers in the bundle.

Finally, a doctor's livelihood depends upon the preservation of a good reputation. Involvement in bundled arrangements exposes all participants to both good and bad perceptions of the overall package. It is therefore important to be comfortable with the reputation of the broker and other providers in the bundle.

Understand the motivation behind the bundle

The above scenarios provide two examples of bundled care. In each case, a third party payer is introduced, displacing the doctor-patient team from its central place in the direction of medical care.

This is not to say that there is no place for centrally controlled or bundled care in our medical landscape. In the public hospital system, patients' primary relationship is with the state health department, which undertakes to provide treatment. Choice of doctor and hospital is left to the payer.

Traditional private healthcare gives more discretion to the individual patient, who is free to choose doctors and healthcare facilities. In this model, the doctor-patient relationship is central to medical decision-making.

The bundles considered in this article have different motivations behind them. In the first example, a health insurer aims to assemble preferred provider networks in order to take control of healthcare funding. Rebates to patients will be better when treating doctors are part of the network.

The self-insured bundle aims to provide a fixed fee to patients funding their elective surgery. Financial risk is transferred to healthcare providers.

Understanding the motivation behind bundled care schemes enables doctors to make informed decisions when invited to participate. Bundled care is fundamentally different to traditional private practice. Doctors must satisfy themselves that the benefits of any proposed bundle outweigh the risks.

Dr Peter Waterhouse

INSIDE YOUR SOCIETY

AROUND AUSTRALIA

Queensland

Dr James Hosking

Chair of the Queensland Committee of Management

The Sunshine State Wellbeing of Anaesthetists Network

We talk a lot about supporting our colleagues, especially with respect to wellbeing advocates and supervisors of training with trainees. A lot of this puts emphasis on public departments of anaesthesia whilst private anaesthetists are often left out. Also, who supports those who provide support to their colleagues?

In Queensland we have set up the Sunshine State Wellbeing of Anaesthetists Network (SSWAN) which is a peer support network for wellbeing advocates, supervisors of training and anyone interested in looking after their colleagues. The network is in no way therapeutic but through online meetings we support each other by confidentially discussing difficult situations, comparing ideas and sharing knowledge about support services which are available to us and our colleagues.

ANZCA have helped by hosting our Zoom meetings and we hope to have a face-to-face meeting at the Combined SIG meeting in September. If anyone in Queensland, in either private or public practice, has an interest in wellbeing and would like to meet with like-minded anaesthetists to exchange ideas and support, please contact Mairead Jacques mjacques@anzca.edu.au at the College, Usha Gurunathan usha.gurunathan@health.qld.gov.au or Anna Hallett anna.hallett@health.qld.gov.au.

ACT

Dr Vida Viliunas

Chair of the Australian Capital Territory Committee of Management

COVID-19

We are at the grind stage of the pandemic. Compared with other jurisdictions, the ACT has been largely spared the devastating effects of the pandemic. The disruptions continue: delays in communicating the need to delay surgery after COVID-19 infection to surgeons and hospitals has resulted in delayed operations, sometimes at short notice. In addition, quarantine requirements for nurses and anaesthetists is having significant flow-on effects.

Elective public surgery waiting lists in the private

Waiting list reduction surgery continues in the private: for joints, ophthalmic surgery and others. These are covered by staff specialists in the course of their normal staff specialist hours or by other anaesthetists at standard VMO rates (with paid pain rounds the following day where applicable).

Managed Care

As elsewhere, contracts have been offered to anaesthetists in the ACT by insurers. Considerations of short-term gain but long-term disadvantage (due to non-indexation, loss of autonomy in patient care etc) have figured in discussions. The US-style model has so far been unpopular. It is hoped that lessons learned in the US are not ignored.

Art of Anaesthesia meeting

With the resumption of live meetings, the events calendar is getting full! The popular Art of Anaesthesia meeting is set for 8 + 9 October this year. Meanwhile, it's autumn.

ECONOMIC ISSUES ADVISORY COMMITTEE REPORT

DR MICHAEL LUMSDEN-STEEL
EAC CHAIR

Are you sure about "GapSure"?

Dr Peter Waterhouse covered in his article the dangers of new type of managed care – bundled care, in addition to that there has been an increased number of attempts of insurance companies trying to gain back that market share. NIB GapSure trial scheme is one of them. NIB has been losing its market share and now in an attempt to attract more members they are trialing this new scheme. Once joined, all NIB patients are billed as per the network (i.e. NIB members have financial certainty when using GapSure).

On the face of things, the scheme seems to be quite attractive for anaesthetists which will use a flat base unit rate of $41 across all item numbers (exceeding current earnings of a significant number of providers). For more complex procedures, a $500 discretionary known gap can be applied (Procedure items with Base units of five and above). So far, the scheme is being trialed in Newcastle but will be rolled out nationally in May.

NIB told the ASA that they have started with anaesthetists because anaesthetists are involved in nearly every single surgical procedure and the associated out of pocket expenses have the biggest impact to NIB member experience. Our concern is that this move towards the preferred provider network could undermine the quality and integrity of the Australian Healthcare system. The feedback that we have been receiving from members was that NIB are being quite selective in terms of who joins the trial - they seem to only offer GapSure programme to select practitioners who are not high billers. The scheme will probably be coming on offer to surgeons and other specialists in the near future. We would like our members to take caution when signing up to such schemes and talk to the ASA if you have any concerns.

Medicare compliance activity has been on the rise

Another issue that's been dominating the Economics Advisory Committee's time as of late is the increased Medicare compliance activity. Medicare recent compliance activity has impacted many anaesthetists. With the election coming up and changes that were introduced as the result of the MBS review gave Medicare a push to increase the checking to ensure doctors comply with the new rules. Under this year's compliance round, a group of anaesthetists that have been particularly impacted were cardiac anaesthetists. Over the past month, we have responded to dozens of queries regarding the co-claiming of 55135 (Intraoperative transoesophageal echocardiography (ITOE)) in association with open heart surgery anaesthesia (20560). Members have received very distressing letters asking them to review all cases that warranted such co-claiming. It was particularly strange because all of the cardiac anaesthetists that approached the ASA have been using this item number for years and there has never been an issue. It seemed that all claims have been made 'in good faith' based on previous negotiations and discussions with the Department many years ago. These anaesthetists have

been claiming for a service which is not only safe and effective, it is absolutely essential to the successful undertaking of the surgery.

From the ASA perspective, it looked like the funding (for 55135) has been withdrawn overnight. The MBS compliance team has sent letters to dozens or even hundreds of anaesthetists that used 55135 instead of 22051 (22051 - ITOE in association with non-cardiac valve surgery) the value of which is half of 55135. The ASA has urgently written to the Department of Health (DOH) with Dr Andrew Mulcahy leading the negotiations. After several meetings between the ASA and representatives from the Department of Health's Medical Benefits Division, the Department of Health has decided to suspend its compliance activity regarding co-claiming MBS items while considering the information the ASA has provided them.

History of TOE item numbers

The ITOE number 55135 was introduced in 2003/2004 following the MSAC review of all ITOE services. In May 2004 the DOH made changes to TOE items by introducing new item "non-valve" TOE 55130 - $170 and "valve" TOE item 55135 - $353.60. The 55135 was effectively introduced for the use of cardiac anaesthetists with the full knowledge of its use by the Department. The DOH intended to undertake a TOE study to understand the impacts of withdrawing funding for TOE services on the safety and standards of Australian cardiac surgery. However, the ASA is still not sure whether the study was completed. In November 2006 further formal discussion with the DOH resulted in a formal proposal from the ASA for new ITOE item to be included in the MBS with deletion of 55130, which has subsequently been accepted by DOH (verbally).

The DOH then seem to have backtracked on this and the new item has not been introduced. In 2021 at the meeting between the ASA and DOH, the DOH flagged general concerns regarding co-claiming of RVG and non-RVG items by anaesthetists.

In 2022 DOH wrote to many cardiac anaesthetists listing episodes of co-claiming 55135 and 20560 (open heart procedures) over a 12-month period from 1st Aug 2020. The DOH stated in letter that such co-claiming is not permissible in Medicare and asked anaesthetists to explain and verify their claims.

Next steps

Shortly after that the ASA had a meeting with the DOH compliance department explaining the history of the item. Despite a different recollection of the events that happened over the years, common sense prevailed and the compliance activity regarding the co-claiming has been stopped for this year.

The suspension of the compliance activity for co-claiming a 55135 with 20560 has created the opportunity to work with the Department of Health to address the long overdue requirement to have appropriate therapeutic and diagnostic item numbers in RVG.

The ASA formed an ITOE working group to make a submission for new MBS item numbers into the RVG including but not limited to ITOE (55135) and 55118 (TOE not in association with an operation). The working group will share insights and data regarding clinical information on the current uses and effectiveness of the ITOE and related services. The working group will also review the existing ASA and MBS cardiac surgery and interventional cardiology procedure numbers and other numbers which anaesthetist may be co-claiming including 13400 (DC reversion), and performing ITOE for non-cardiac surgery.

This submission will be evidence based, and give detailed clinical benefits and explanation for ITOE, and will address DOH concerns regarding increased costs. If successful, such precedent can be used as an example of how we should go about getting new item numbers in the MBS. I would like to thank our members for being proactive in letting us know about the increased compliance activity but also the expertise of the EAC committee members and the methodical approach that was used to make the case plausible.

POLICY MATTERS

Jason Alam
Policy Manager
Professional Affairs

Katya Sadetskaya
Policy Manager
Economic Affairs

Patrick Gifford
Senior Policy
Administrator

Introduction

The Policy team has had a busy couple of months from the RVG APP update to compliance and managed care issues cropping up across both EAC and PIAC areas.

Advocacy and engagement

We have been actively engaging with stakeholders across the health sector on those issues including various hospital groups (Ramsay HealthCare, Healthscope), health funds (BUPA, NIB and Honeysuckle) and other specialist organisations (RACs, AMA and ANZCA). As the result of our president's and state committees' work with the help of the policy team, we have had a number of wins this quarter:

- HBF's proposed cuts anaesthesia item rebates for patients have been withdrawn
- BUPA st Vincent's Bundled Care arthroplasty scheme has been paused indefinitely and completely in Victoria and Queensland
- Collective bargaining class exemptions approved for St Vincent's Northside Private Hospital in Queensland and Wagga Wagga Hospital in New South Wales
- MBS compliance activity regarding Intraoperative TOE claims has been suspended.

The next quarter looks as busy as ever with the election coming up. We will continue our advocacy efforts to minimise the negative impacts of the bundled care scheme on both doctors and patients. And we will continue liaising with the Department of Health to ensure MBS compliance activity is reasonable and fit for purpose; and developing proposals to introduce new item numbers to align with anaesthetic modern practice.

Policy resources page is under development

The policy portal is currently under development. We are updating the policy resources tab which will include resources for members related to ACCC exemptions, Informed Financial Consent, and information about insurance fees and health fund premiums paid to medical professionals. We are also hoping to include library resources and useful academic articles to help you with your practice and stay up to date with the latest innovations. Watch this space and let us know if you want anything else to be included on the policy resource page – members' contribution is always welcomed.

We are responding faster to your queries

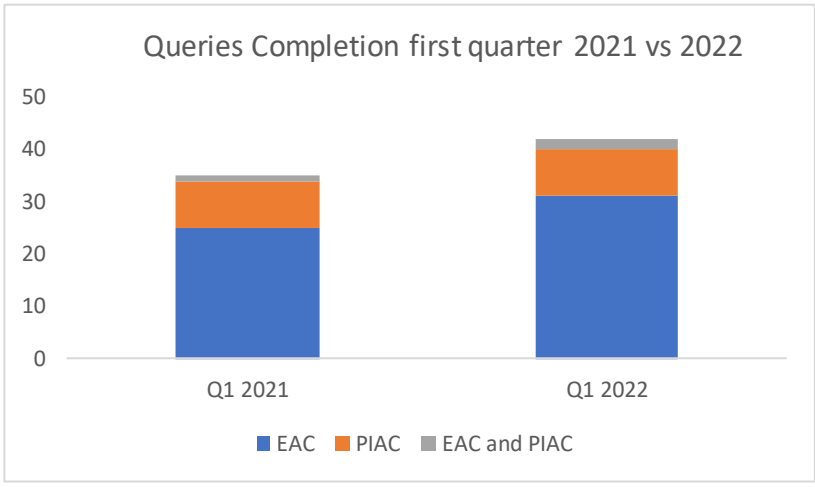
Policy team work is often happening on the background. We facilitate communication between members and committees and help progress the policy issues as they appear. We receive queries from our members which are then escalated to state chairs and committees. The policy team then facilitates any action that needs to be undertaken to resolve the query. One query sometimes becomes a common query and affects several members (such was the case with MBS compliance increased activity).

Across the Q1 of 2022, the ASA Policy Team has handled 43 member queries via email and phone. These queries have covered a range of subjects, from notifying us and seeking assistance for Medicare audits on TOE item billings, to correct billing practices, to advice on how to navigate attempts at managed and bundled care. Thanks to the new structure of our team, we've been able to reduce the standard query response waiting time from two business weeks to a matter of days, getting your inquiries to our Professional Issues Advisory Committee and Economics Advisory Committee Chairs, and their responses back to you, at our quickest rate yet.

We are also grateful to have received some positive feedback for helping our members to resolve their queries.

The ASA Policy Team is ever open to feedback from you, the members, on how we can improve and target our advocacy efforts on the issues that most affect you.

ASA Policy Team



"Many thanks indeed for all your hard work and for such a good interim outcome! I know that many of my colleagues are very pleased and we have gained members." — Member

"I really appreciate the ASA involvement in this issue. Thank you for your advocacy." — Member

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ANAESTHESIA TRAINING TIPS

Dr Vida Viliunas OAM
ASA Education Officer
Chair, ASA Education Committee

Dr Kaylee Jordan
Deputy Chair, ASA
Education Committee

Sleep and exercise should be part of your study program

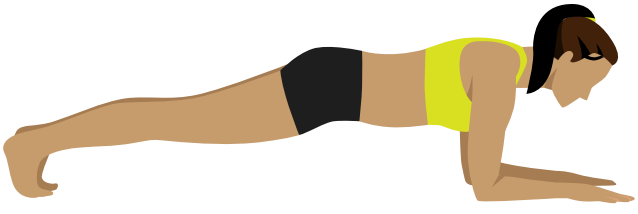
In this new section of Australian Anaesthetist we present tips for exam preparation.

Content and presentation are both required for good performance at exams and in the workplace.

However, a couple of other ingredients are important for good performance. There is a bi-directional relationship between exercise and sleep. Studies show that exercise alleviates sleep-related disorders and good sleep may promote better levels of activity. Better sleep can reduce levels of test and work-related stress and improve cognitive function.

You can combine a content review session listening to podcasts such as "Deep Breaths" (by Drs Kate Steel and Kate McCrossin which covers part 2 topics), Dr Podcast (drpodcast.co.uk) or a selection from "ABCs of Anaesthesia" during a walk or run.

For those who find it hard to find the time for exercise, I recommend "Tabata workouts" as an introduction. There are varied levels of difficulty as well as duration. You can start with a 5-minute session. Google it ~~today~~ now!



TRAINEE EVENT LIST JUNE-SEPT asa.org.au/events

PART 1 Bootcamp

Hosted by NSW ASA committee.

When: Sunday 5 June, 2022
Time: 9.00am – 4.00pm AEDT via Zoom

EPIC Exam Prep.

Hosted by Dr Vida Viliunas and Dr Kaylee Jordan.

When: Saturday July 9, 2022
Time: 9.00am – 4.00pm AEDT via Zoom

SIMG Exam Practice Sessions

Hosted by Dr Vida Viliunas and Dr Kaylee Jordan.

When: July 22, August 26, September 16, October 28
Time: 7:30-8.30pm AEDT via Zoom

Primary Exam Practice Sessions

Hosted by Dr Vida Viliunas and Dr Kaylee Jordan.

When: July 25, August 29, September 26
Time: 7:30-8.30pm AEDT via Zoom

Final Exam Practice Sessions

Hosted by Dr Vida Viliunas and Dr Kaylee Jordan.

When: August 19, October 07
Time: 7:30-8.30pm AEDT via Zoom

PRACTICE VIVA QUESTIONS

Remember that investigations will always come with a context.

A 20-year-old patient with longstanding type 1 diabetes presents to emergency with fever, productive cough, dyspnea and drowsiness.

Interpret this ABG

---

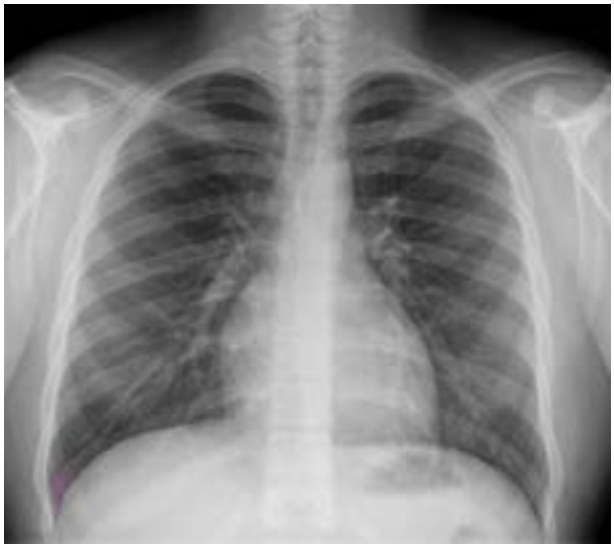
pH	7.0
pO2	100mmHg
pCO2	25mmHg
HCO3-	10mEq/L
Na+	150mmol/L
K+	5.5mmol/L
Cl-	110mmol/L

You should

1. think through the ***likely*** derangement(s) in the context of ***this specific patient*** presented in the scenario and
2. read the ABG systematically (or else the stress of the viva may cause you to omit a vital element such as a comment on the oxygenation). If you are given enough information to calculate the anion gap, make sure you do that.

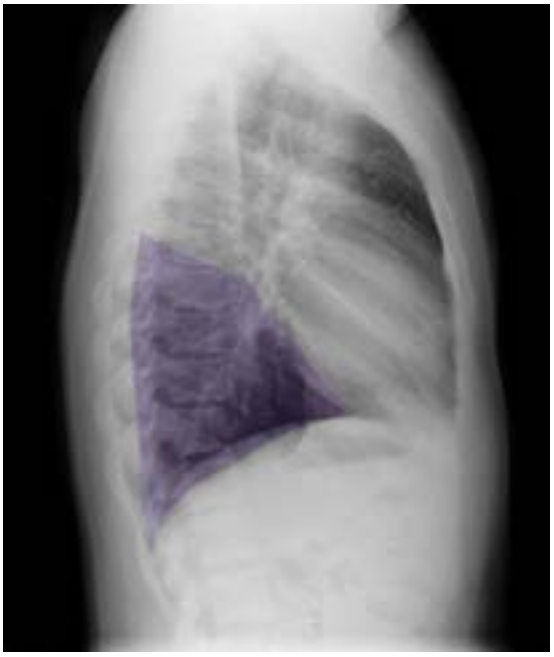
Here the anticipated derangement is a metabolic acidaemia in the context of a diabetic patient with a likely respiratory infection as a precipitant; DKA requires glucose and ketone levels for diagnosis.

The next investigation might be a CXR to interpret.



Given the history of this patient with a productive cough and fever, infection should be excluded. This CXR looks relatively normal – there is certainly no obvious lobar consolidation. The cardiothoracic ratio is normal and there are no signs consistent with failure to explain a cardiac cause for the dyspnoea. Remember to describe not only the x-ray you are given, but what you are looking for in the context of ***this patient.*** Be prepared to give the signs of lobar consolidation on AP and lateral views.

Right lower lobe consolidation on CXR has few features that are obvious on AP or PA projections. The right hemidiaphragm may be obscured and air bronchograms are the most common features. Lateral CXR shows the triangular opacification, the right oblique fissure, obscuration of the dome and posterior aspect of the right hemidiaphragm.



https://radiopaedia.org/articles/right-lower-lobe-consolidation
Dr Phillip Marsh, Radiopaedia.org, rID: 58938

The viva might go on to explore management goals and resuscitation detail. For an in-depth discussion of investigations and a viva based on this scenario, come to the ASA final exam preparation sessions! Register on the website under the trainee events section.

Make sure the edited videos of the ASA viva tutorial sessions on the ASA website are part of your study review.

Drs Vida Viliunas and Kaylee Jordan
ASA Education Committee

WELCOME TO JUNE!

DR ALEX COURTNEY
ASA TMG CHAIR

I hope you have had a fruitful and enjoyable first 6 months of 2022. Like many of you I have spent the majority of my time studying feverishly for exams. Fingers crossed for a good outcome for all of us!

Support

While the pandemic may be entering a new phase with less of an impact on day-to-day living for the public, it's effects are still felt throughout the healthcare industry. Trainees not only in anaesthetics but all other fields of medicine and surgery have felt its impact. Those impacts have been vastly different around the country. Your TMG representatives have heard from your colleagues about issues ranging from ANZCA training concerns with respect to VOP and SSU requirements, to the unfortunately well known exam related concerns. All of these concerns are raised regularly with ANZCA training council representatives in all states as well as nationally.

Of concern however is the number of reports we are hearing of trainee burnout around the country. I'm sure this does not come as a surprise to many of you. We have all been through so much uncertainty and upheaval in the past few years, not to mention stress in work and life. For trainees, the added burden of study and exams adds to this toll. We all manage our stress and anxiety in our own way, but I would reiterate to you all that you are not alone. You are surrounded by friends and colleagues that only want you to achieve your best. If you are struggling with workload or balancing life please talk to your SOT or approach your departmental welfare officer. The ASA has a range of resources available in the welfare section of the website https://asa.org.au/welfare-of-anaesthetists-2/ ANZCA also has resources available in the Health and Wellbeing section https://www.anzca.edu.au/fellowship/doctors-health-and-wellbeing-(1)

To further support our trainees, the ASA will again host a wellbeing course later this year. This course, hosted by an external provider, provides a wealth of information and guidance about various aspects of mental health. It will be a fantastic opportunity to learn new skills and techniques to manage stress and mindfulness. Please keep an eye on your inboxes and our website for sign up opportunities.

Owing to the fantastic success of our two events last year for pre-vocational members, we are planning to host another event this year aimed at junior medical staff who are destined for a career in anaesthesia but have not yet taken the first steps. Participants will have the opportunity to listen and learn from a seasoned interviewer before having direct discussions with trainees who have begun their anaesthetic training. Topics last year revolved around CV building, courses which were worthwhile for junior trainees and tips for success in interviews. There was a lot of discussion around the highlights of the different training networks around the country which proved invaluable for prospective trainees making their applications. Please do encourage your junior colleagues to sign up with the ASA (membership is free for PMETs) and to attend!

Represent

In my role as chair, I attend the ANZCA ATC meetings throughout the year, where I have an opportunity to ensure the voice of ASA trainees is heard by ANZCA representatives clearly. I'm pleased to say that I always find the ANZCA committee members receptive to concerns raised and prompt to provide communication back regarding any findings or outcomes.

At the most recent meeting, a lot of discussion occurred around training concerns and in particular exams! ANZCA wants to ensure everyone is aware of the process of raising

concerns with the training department. If you are concerned about the impact of COVID (or any other issue) on your training, please discuss with your SOT and follow the process via the DPA. This process is not well advertised, but we are assured it is a straightforward and supportive process.

Just a reminder that your local ASA trainee representative is always happy to hear from you, send an email to trainees@asa.org.au with your state and contact information and it will be forwarded to your local representative.

Education

I always mention and rave about them, but now that I'm in the midst of exams I can't commend them enough. The Exam Viva sessions via Zoom hosted by Vida and Kaylee are an invaluable resource for the prospective exam candidate. You'll be quizzed by a range of consultants, several of whom are past examiners. In the lead up to an exam I'm sure you will agree that there could be no better way to prepare. The ASA Education page has a range of resources available, be sure to check them out. (https://asa.org.au/asaeducation/) as well as links to sign up forms.

The ASA Trainee committee is hard at work to update the gargantuan Trainee Handbook. First published in 2020, it is time to update. A lot has changed in the past 2 years (COVID not withstanding) and up-to-date information should be provided. If you have any suggestions of topics not covered please don't hesitate to email trainees@asa.org.au and we will be sure to incorporate your ideas. There will undoubtedly be an announcement email when we publish so be sure to keep your eyes peeled.

I want to highlight the excellent work your state representatives do for your benefit. Part 0 and Part 3 courses are organised and hosted around the country by willing presenters for your benefit. If you have not attended one of these courses, they are always very popular and rapidly filled so be quick to avoid missing out.

In exciting news, now that COVID restrictions are rolling back around the country and the threat of community spread is reducing, social gatherings are on the increase. Your state reps are already planning social events throughout the year, supported by the ASA, so make sure you get your tickets!

For those of you who have sat the first exam sitting this year, I hope by the time this edition reaches your letterboxes, you have already received some good news from your recent exams.

All the best!

Dr Alex Courtney

ASA WELCOMES NEW RECRUITS TO THE TRAINEE MEMBERS GROUP

Congratulations to the ASA's newest recruits to the Trainee Members Group (TMG) appointed earlier this year: Dr Rebecca Wood (WA), Dr Jared Ellsmore (NSW), Dr James Correy (TAS) and Dr Leonie (Noni) Harold (VIC). Dr Jason Kong has also recently joined the Economic and Advisory Committee (EAC).

Formed in 2000 to address the needs of anaesthetic trainees in Australia, the TMG aims to give trainees an official independent voice.

ASA TMG Committee Chair Dr Alex Courtney said the purpose of the TMG is to assist trainees industrially, socially, with health and lifestyle issues, educationally, scientifically, with practice matters and politically.

> "Anaesthesia is a great career, it is broad and adaptable while at times challenging, especially in these uncertain times, and I believe having a voice and representation through the ASA helps to provide some control and certainty over our careers and training," said Alex.

This year the TMG consists of 14 members representing each state as well as two representatives from ANZCA (Dr Carmen Maxwell and Dr Dharan Sukumar) and the NZSA (Dr Mikaela Garland and Dr Aidan Ward).

New recruit for WA, Dr Rebecca Wood is an ANZCA trainee entering her third year on the WA Rotational Anaesthetics Training Program and is currently undertaking her Obstetric and Gynaecology SSU at King Edward Memorial Hospital.

> "I am excited to represent WA trainees on the TMG and have long been a strong advocate for trainee and prevocational trainee issues through local, state and federal avenues including hospital RM Societies, the Postgraduate Medical Council of WA, the AMA (WA) and the AMA Council of Doctors in Training (federal)," Rebecca said.

Dr Jared Ellsmore has joined the TMG this year as the NSW representative along with Dr Luke Anderson and is currently an anaesthetic trainee based at Prince of Wales Hospital in Sydney.

> "I believe we are a talented, driven and hard-working professional group. As such, it can be hard to keep on top of things or know who to go to with problems that might crop up. As a rule, junior doctors are pretty poor at advocating for ourselves, which sometimes means things can get overlooked," said Jared. "I hope to be an easy port of call for our NSW members and help solve any problems they might be having."

Dr James Correy is the ASA's sole representative on the TMG for Tasmania in 2022. James is a provisional fellow (senior registrar) based at the Royal Hobart Hospital.

> "I applied to be on the TMG because I'm grateful to the ASA for some of the educational and social opportunities they've provided during my training and this year I'm hoping to help Tasmanian trainees continue to access the support and extensive resources that the ASA delivers."

Clockwise left to right:
Dr Noni Harold, Dr Jason Kong,
Dr Rebecca Wood, Dr James Correy
and Dr Jared Ellsmore.

Joining Dr Adam Levin in representing Victorian trainees on the TMG this year is Dr Leonie (Noni) Harold. Noni is an anaesthetic trainee normally based on the North-West training scheme in Melbourne, but is currently completing a six-month retrieval placement in Alice Springs with the Royal Flying Doctors Service (RFDS).

> "I really wanted to be a party of the ASA TMG Committee as I'd like to learn more about how the organisation runs and hopefully contribute to education and advocacy relating to trainees in our profession," Noni said.

Dr Jason Kong is the ASA's Economic Advisory Council's (EAC) trainee representative on the TMG this year. Jason is a second-year regional anaesthetic trainee and is part of the government's Integrated Rural Training Plan which enables a specialist trainee to complete at least two thirds of their Fellowship training within a rural region.

Based in Albury, Jason said his main role is to represent and be a "mouthpiece" on the TMG on the EAC.

> "However, whilst I sit on the TMG, as a rural trainee, I will also aim to represent all rural trainees around Australia and help make your training better and easier.
>
> We are widely distributed and all face unique challenges within our training. I want to be able to give you a voice. This year I will also try to add a dedicated rural TMG representative position, or better yet, form a separate rural TMG."

The TMG meets at least four times a year, including an annual face-to-face meeting prior to the ASA National Scientific Convention and an update on its activities is published in Australian Anaesthetist on a quarterly basis.

The TMG Chair also represents trainees at ASA Council meetings and is an invited guest at meetings for the ANZCA Trainee Committee and AMA Council of Doctors in Training. The TMG also has representatives on a number of other committees including EAC, the Communications Committee and the Public Practice Advisory Committee.

The ASA has a number of resources available to members on the website including the recently updated trainee handbook.

> "The TMG is an incredibly driven and energetic group and has shown itself to be a powerful representative voice for trainees in Australia. I would encourage all trainees to join the ASA!" said Dr Alex Courtney, Chair, ASA TMG Committee.

For more information about the benefits of trainee membership, visit our Trainee Membership Page www.asa.org.au/trainee-membership and all trainees are encouraged to contact us with any issues or concerns at trainees@asa.org.au

Richelle Pellegrini

THE MUSEUM TAKES SHAPE

Moving our head office to Chandos Street saw the floor and display space of the museum and library double. This means more of your historic collection will be accessible in person and allow us greater capacity to host tours, member events and public programs in the future.

It also means the exhibition accompanying the objects was ripe for an expansion and so, with the help of the HALMA committee, the museum is shifting away from a strict linear timeline presentation towards a thematic narrative, allowing visitors to 'walk through' the stages of anaesthesia.

For example, Dr Reg Cammack, has assisted with organising the drug collection into several subgroups (analgesic, sedatives, inhalational gases, intravenous agents and paralytics), which will greatly enhance our ability to educate non-ASA visitors about the types of anaesthetic drugs given to patients, as well as dive into the reasons various drugs were developed over the course of the past century.

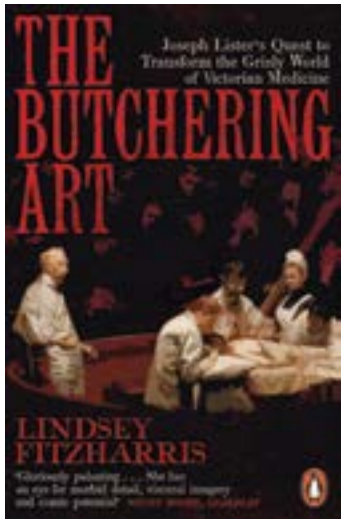
There will also be exhibition space reserved for smaller, temporary 'exhiblets' and we hope to invite member's feedback and co-curation in the development of these future stories.

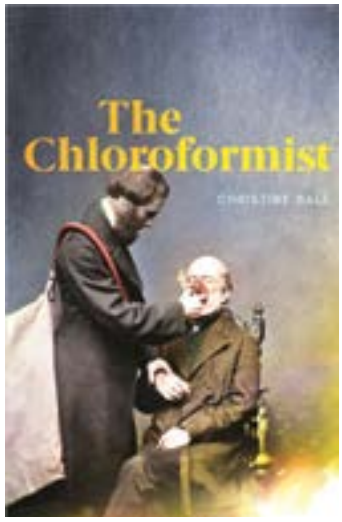
Visitors

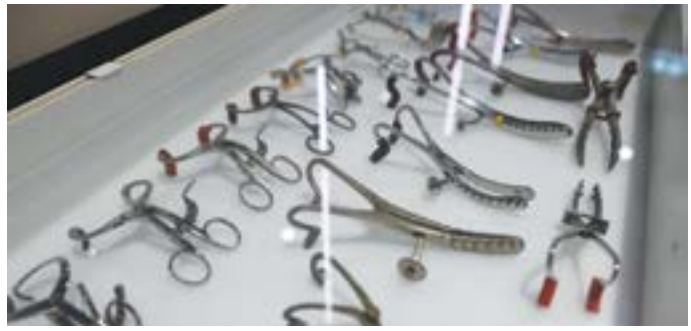
In March the North Sydney Historical Society visited the museum and library, and were given a true behind-the-scenes tour of the collection. The Society visits up to five museums and collecting institutions per year, and the Harry Daly Museum had been on their to do list for several years. Their enthusiasm was evident in their questions, and they were particularly keen to learn how anaesthetics progressed from doctor's having to supply their own drugs through the modern computerised machines, as well as how the collection came to be. They hope to revisit the museum once the new exhibition is completed.

How to donate

The Harry Daly Museum seeks and accepts donations of artefacts and objects relating to the history of anaesthesia, its practice and development in Australia and the history of the Society and our members, in accordance with the Collection Development Policy. Donations are accessed for the object's provenance, originality and/or rarity, research value, interpretation value and condition (including the museum's ability to display, store and conserve the item). Pharmaceutical items have additional assessment criteria to consider before a donation can move forward. To find out more contact the curator via curator@asa.org.au.







New to the library

The Butchering Art: Joseph Lister's Quest to Transform the Grisly World of Victorian Medicine by Lindsey Fitzharris, Penguin Random House, 2017

Lindsey Fitzharris traces the story of Joseph Lister and his quest to improve the brutal surgical practices of the Victorian period. She takes you inside the operating theatres, at a time when up to half of all patients who underwent the knife would not live to tell their tale, and when hospitals were both excessively overcrowded and squalid, incubators of infections impacting those already sick within their walls. Enter the young Quaker surgeon, Joseph Lister, who claimed the source of these infections could be treated with antiseptics.

Fitzharris holds a PhD in the History of Science, Medicine and technology from the University of Oxford and was a post-doctoral research fellow at the Welcome Institute. She is the creator of the popular website *The Chirurgeon's Apprentice* and has written for the Lancet.

The Chloroformist by Christine Ball, Melbourne University Press, 2021

Dr Christine Ball transports the reader to 1840s England, and follows the life and training of Joseph Clover who learnt the surgeon's trade at a time before modern anesthesia was common. When doctors were faced with terrified patients, screams and minuscule amounts of time to perform complex operations. But with an unconscious patient, surgeons could conduct slower surgeries, leading to more precise and delicate treatments.

This thoroughly researched work explores the complex and interdependent relationship between the surgeon and the anaesthetist.

Ball is an anaesthetist at the Alfred Hospital in Melbourne, co-manages a Master of Medicine (Perioperative) at Monash University, and is the 2020–2024 Wood Library-Museum Laureate of the History of Anesthesiology. She has been an honorary curator at the Geoffrey Kaye Museum of Anaesthetic History for thirty years and is the author of many works in this field.

Upcoming Events

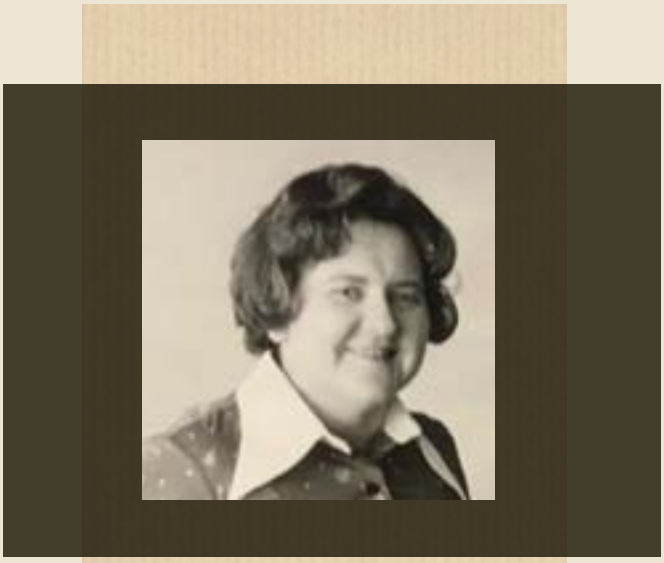
History Week 2022: 'Hands On History' As part of NSW History Week, the museum and library will be hosting an open day and seminars/talks/speakers on Sunday, 11 September. The theme will explore 'Hands on History' in the medical history context. Stay tuned for more information.

Kate Pentecost
ASA curator, librarian and archivist

DR HELENE MARY KING

MBBS, FFARACS, FANZCA

1934 - 2022



Helene was born in Melbourne on the 5th of October 1934, the only child of Frank and Mabel Wood. She grew up in Hampton and went to the Star of the Sea School in Brighton from Prep through to Matric. At the age of ten she had a slipped upper femoral epiphysis which was missed initially and she spent several months in hospital in a plaster cast and had two years off school. She was left with a limp and increasing pain as she aged, but it didn't slow her down much in her work.

Dining out was one of her passions and she was renowned for being late, having driven around and around till she found the closest parking spot.

Helene went to the University of Melbourne Medical School, graduating in 1958. Being a woman at medical school was being in a minority - they sat as a separate group from the men. Although the women made up only about 10 – 15% of the class, they performed well above average and regularly took the prizes.

She spent two years at St Vincent's Hospital as a junior medical officer (JMO) in the days when the JMOs resided in the Hospital.

Her anaesthetic training was at St Vincent's, the Royal Women's Hospital and the Royal Children's Hospital. She also spent a year as a surgical registrar. She gained her FFARACS in 1965 and spent 1966 as a full-time assistant anaesthetist at St Vincent's.

At one stage she spent several months sleeping in the room next to a sick patient with a tracheostomy, only leaving the hospital for brief periods to visit her family - dedication.

In 1967, Helene moved back to the Royal Children's as a full time anaesthetist. She worked closely with John Stocks who was the Deputy Director, Basil Hutchinson and Mary Donovan (Dwyer) and other registrars.

The next eight years were the most demanding and fulfilling time of her anaesthetic career. The work begun by Ian McDonald - managing babies and children with respiratory failure with nasal intubation and prolonged ventilation was continued and expanded.

The skill of the medical and nursing staff was critical. Part of the Recovery Room was used for the first few years, before a dedicated Paediatric ICU was built . This was pioneering work and as Helene recalled later, they had to "invent intensive care". She was also very busy as an anaesthetist, including cardiac anaesthesia, teaching and some research.

She co-authored a paper on "Haemangioma of the Larynx in children" with Dr HE Williams.

In 1970 she became Deputy Director of Anaesthesia and in 1974, Acting Director, after John Stocks' untimely death.

She was well liked and very well respected by her anaesthetic colleagues, surgeons and nurses.

In 1975, Helene married Allen King, some twelve years her senior. An abrupt change in her life. They moved to French's Forest until their son Jono was born, and then to Allen's birthplace, the NSW Central Coast, where they remained.

Helene always missed Melbourne and would return at the least excuse. Her colleagues at RCH became friends for life and she joined the Alumni of RCH, attending meetings several times a year.

Allen soon retired and Helene worked part time to supplement the

household income and for intellectual stimulation. She took on regular lists when Jono started school. Her lists were structured around Jono's school timetable.

She loved to chat to the nursing staff and had a dry sense of humour which always made her lists entertaining. Not only were her patients now mostly elderly, one day she commented that the combined age of the surgeon, assistant and the anaesthetist exceeded 200 years!

Tragedy struck in 1991 when Allen suffered a significant cerebrovascular accident (CVA), changing his personality and limiting his physical ability. Jono was only fifteen.

Helene's career came to an abrupt end in 1996 when she was diagnosed with breast cancer, necessitating mastectomy and chemotherapy. She had continuing health problems but always remained positive and had an active social life supported by her Church community.

She passionately followed the development of her grandchildren of whom she was immensely proud.

Helene passed away peacefully on the 13th of February, aged 87, in her favourite recliner chair, where she spent much of her time seeking relief from her various aches and pains.

Our sympathy goes to Jono and Lana and their children Annabelle, Lachlan and Samuel.

We appreciate the help of Jono and Helene's life-long friend Mary Donovan in writing this brief biography.

Alastair Watt
Di and John Walton

NEW AND PASSING MEMBERS

The ASA would like to welcome all new members from March 2022 to May 2022.

Ordinary Member	
Dr Siju Joseph Abraham	VIC
Dr Stewart Anderson	SA
Dr Furqan Arshad	NSW
Dr Jennifer Bird	SA
Dr Derrick Malcolm Brown	QLD
Dr Mark Caporn	QLD
Dr Ali Jilani Coowar	SA
Dr Linden Anton de Ridder	VIC
Dr Sabry Eissa	NSW
Dr Tomy George	SA
Dr Alice Gynther	VIC
Dr James Hafner	SA
Dr Melissa Haque	WA
Dr Maria Masha Jukes	QLD
Dr Andrew Lamb	WA
Dr David Loo	VIC
Dr Andrew Maccioni	NSW
Dr Ramesh Menon	VIC
Dr Jeremy Ian Milne	WA
Dr Tobias Nientiedt	WA
Dr Kate O'Hare	WA
Dr Mark David Sharples	WA
Dr Michael Howard Toon	QLD
Dr Nandy Varatharajan	NSW
Dr Jeremy KD Wong	VIC
Introductory/Basic Trainee	
Dr Meghan Kate Bowtell	VIC
Dr Jessica Byrnes	QLD
Dr Kevin Chun Kit Chan	QLD
Dr Olivia Meredith Coleman	VIC
Dr Thomas Curtis	NSW
Dr Mitchell Campbell Deck	NSW
Dr Tim Patrick Donohoe	QLD
Dr Hailey Frances Drinkwater	NSW
Dr Natasha A.S Fry	NSW
Dr Timothy Gilmour	QLD
Dr Linley Hayes	VIC
Dr Claire Ishak	VIC
Dr Joshua Lin	NSW
Dr William Lindores	QLD
Dr Han Lu	WA
Dr Andrew Lin Luo	NSW
Dr Thomas Donald Martin	VIC
Dr Evan Oliver Matthews	QLD
Dr Teo Mocioaca	SA
Dr Aleksandra Trajkovska	ACT
Advanced/Provisional Fellow Trainee	
Dr Hayden de Mouncey	TAS
Dr Laura Fisher	SA
Dr Kirsten Sarah Long	VIC
Dr Sarvpreet Pala	NSW
Dr Ganesh Ramanathan	NSW
Dr Lukasz Zdanowicz	ACT
Associate	
Dr Nnadozie Awujo	SA
Dr Chris Brown	VIC
Dr Matthew Faulkner	VIC
Associate International Medical Graduate	
Dr Jalil Makarem	VIC
PMET	
Dr David Edric Barlow	VIC
Dr Siobhan Kathleen Dillon	QLD
Dr Harry LeMass	VIC
Dr Zhong Ren Ong	SA
Dr Hannah Soon	VIC
Dr Piers Turner	VIC
Dr Matthew Vella	VIC
Dr Sean Jeremiah Walsh	VIC
Dr Alexandria White	QLD

IN MEMORIUM

The ASA regrets to announce the passing of ASA members

Dr John Lockwood Holmes	NSW
Dr Helene Mary Wood	NSW

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

Dr Michael Fong raising a toast to "Absent Friends".

RAG Qld Lunch - 20 April 2022, held at La Belle Vie Bistro and Wine Bar, Bardon, Qld

Join now and connect with your community

Australian Society of Anaesthetists®

You received a poster with this issue. Please display at work and support ASA membership!

Dr Lan-Hoa Lê
ASA Member since 2016

EDUCATION

ADVOCACY

SCHOLARSHIPS AND GRANTS*

EVENTS

PUBLICATIONS

RESOURCES

FORUMS

The ASA represents and advises Anaesthetists and is a peak body organisation that is respected and consulted by government, hospital management, local health districts and health insurers.

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*Applicants require a minimum of 12 months ASA membership to be eligible.

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