AUSTRALIAN Anaesthetist

THE MAGAZINE OF THE AUSTRALIAN SOCIETY OF ANAESTHETISTS • **MARCH 2023**

LIFELONG LEARNING AND EDUCATION

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Alternatives to traditional anaesthetist groups for doctors in private practice

(you don't have to do it all yourself)

Joining a traditional anaesthetist group is not the only option if you want to manage and grow your private practice.

There are alternatives available that involve fewer fees and more freedom.

DIY solo private practice

Handling your own practice management has the significant advantage of being low-cost. The downside, of course, is that you have to spend more time on billing, patient communication, reporting, tax compliance paperwork and finding suitable consulting rooms to borrow from other doctors.

When you are just starting out, it's not easy to learn the intricacies of the Medicare Benefits Scheme (MBS), health fund policies and hospital accreditation requirements.

What's more, as a DIY solo private practice anaesthetist, you are responsible for sourcing your own lists and arranging cover for when you go on holidays, if you need to look after a sick relative, or get sick yourself.

Outsourcing elements of practice management

Some anaesthetists outsource certain aspects of practice management to reduce their administrative workload while keeping costs low. Typical outsourced elements include:

- billing
- information technology solutions
- bookkeeping
- reception services for patient correspondence
- calendar management.

Similar to the downsides of the DIY approach, outsourcing only parts of your practice management means you'll still need to:

- spend a considerable amount of time on administration
- source your own lists
- arrange to have your practice covered while you're on leave.

Fully outsourced practice management

While training as an anaesthetist, very little is taught about private practice and how to run your own practice. It's why outsourcing your practice management to an expert provider such as Zento Group makes running your own practice easy.

Unlike the DIY approach, you save yourself the hassle, time, and potentially costly mistakes.

An expert practice management provider can offer you:

- dedicated consulting rooms on a flexible, as-needed basis
- a dedicated physical reception to provide a point of contact for patients, surgeons and their secretaries
- access to quality lists to help build your practice and professional contacts
- support to cover your lists when you are unable to do so yourself
- the ability to quickly scale up or down the level of practice management support to meet your exact needs
- the latest technology and software to streamline billing and reporting
- competitive fees without any set-up costs or lock-in periods to worry about
- the opportunity to attend regular social events with other medical specialists in private practice.

Ultimately, working with an expert practice management provider gives you all the benefits of a traditional group without the high costs and potential group dynamics.

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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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Australian Society of Anaesthetists®

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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

June 2023 issue will feature education: All submissions are due April 25

Image and manuscript specifications can be provided upon request.


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FROM THE ASA PRESIDENT

ANDREW MILLER
PRESIDENT OF THE ASA

Anaesthetists have had more exposure to the good, the bad, and the ugly of education than most.

By dint of arduous university and College examination processes many of us were left for years with 'late and unprepared for the exam' dreams, which in a sign of my advancing age have been replaced now by the 'can't find any propofol and the patient is waking up' dreams.

Lifelong continuous professional development is no longer a tick the box exercise, but essential in order to keep up with the massive advances in the corpus of medical knowledge, treatment and technology.

We have come to accept that some form of analysis of our own practice is very useful despite the opposition to the introduction of patient feedback as a continuing professional development (CPD) exercise initially.

More recently, the introduction of emergency response modules was criticised by some, but there are few of us who feel less confident in dealing with patients every day as a result of having to complete the occasional cardiac arrest, anaphylaxis, major haemorrhage, or can't intubate, can't oxygenate (CICO) course. Knowing that our colleagues have completed them is of some corporate reassurance to the profession.

What is controversial now, and creating some angst, are new Australian Medical Council (AMC) requirements for CPD homes to have program level requirements for all doctors that "must refer to culturally safe practice, addressing health inequities, professionalism and ethics".

A few already argue this is nothing to do with giving an anaesthetic, or that it is impossible to tailor a course that will be useful, or that it is political correctness gone mad.

There will be some teething discussion no doubt as CPD homes, including the Australian and New Zealand College of Anaesthetists (ANZCA), implement this in a way that is useful, but we should avoid arguing that the requirement itself is unreasonable.

My view is that we must continue to argue that we are central to the appropriate delivery of healthcare, and that we have a role in advocating for resource allocation, and we can only prosecute that with a holistic view of what we as doctors and anaesthetists contribute to society.

We are not just technicians of the airway, reticular activating system, and nerve blockade.

Culturally safe practice means having some education about health inequity, and in the many roles that anaesthetists perform in administration we have ample opportunity to design everything from preoperative assessment clinics, to waitlist reduction initiatives, to postop pain management that take into account different cultural requirements and health inequity.

Over time no doubt this curriculum will expand and contract in response to anaesthetist feedback but we must not restrict our focus to that of the technical tradesperson.

Addressing professionalism and ethics is useful, again requiring attention to specific curricula so that they are meaningful, targeted and not onerous.

We have all had to study things on many occasions that we may struggle to find an everyday clinical application for - starting with the many iterations of the Krebs cycle - so we need to find a balance between our objection to the many meaningless and poorly designed modules and the need to expand our horizons, rather than contract, throughout our career.

The ASA has powerful credentials in both providing relevant education and supporting members in fighting unnecessary bureaucratic interventions.

We will fight for relevant and meaningful CPD requirements while accepting that each of us has much to learn all the time just to keep up with medical science and its most efficient application to the myriad problems of our patients in a somewhat pathological healthcare system and society.

We are eager to hear your views on how the requirements of the AMC and ANZCA - in particular those that are new - are impacting on you and what you would like to see done about it. To this end we plan to survey anaesthetists in the near future about CPD and how you want to do it.

Stay tuned and keep in touch.

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.

Get involved in your ASA ...

EAC is seeking two new members

The Economic Advisory Committee (EAC) is seeking two new members to share their expertise and help shape the future of the committee. If you are a neuroanaesthetist, regional anaesthesia specialist or public sector anaesthetist in NSW interested in joining the committee, please send an email to policy@asa.org.au with your expression of interest.

Passionate about helping the ASA advance its cause?

Find out more about the Society's various committees and groups that work alongside the ASA to help support, represent and educate anaesthetists.

To inquire about how you can contribute and express your interest in being involved, email the Executive Secretary, Sue Donovan at sdonovan@asa.org.au

Economic Advisory Committee

Professional Issues Advisory Committee

Public Practice Advisory Committee

Editorial Board of Anaesthesia & Intensive Care

Overseas Development and Education Committee

ASA Trainee Members Group

General Practitioner Anaesthetists Group

National Scientific Congress Committees

Communications Committee

Retired Anaesthetists Group

History of Anaesthesia Research Unit (HARU)

ASA State Committees

State Committees of Management

Peer support

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FROM THE CEO

The ASA has set its goal to be an exemplar medical society in its actions and effectiveness on behalf of not only our current members but future members, the profession and the Australian public. In 2022, we engaged a public affairs group to interview approximately 15 influencers within the profession to understand their concerns for the profession and how we may act into the future. Some of the key takeaways included:

- There is a perception we only exist for private sector voices
- Nuance is required to convey and promote the profession's value. It's complex, because surgeons generate the work
- Managed care is a big issue, but also a slow burn one, and that's a problem because it could get implemented by stealth, bit by bit
- There is a belief that when anaesthetists advocate on an issue it's because their remuneration is at risk
- We need to ensure we have ways to engage with the patients, because the very nature of our profession limits that
- We don't make use of the opportunities we have to have better government relations
- We need to become the go-to people, ensure that we are consulted, and that we have a door open to key people

So, our intent is to establish the ASA as a respected partner and adviser to governments on the issues and needs of its members, the broader profession and in the public interest. To do this, the strategy must create a framework to clearly describe the role and value of the profession, guard it against future challenges and assert our leadership in healthcare policy on behalf of the profession and the public.

We envisage that we will develop a program to engage with government stakeholders with whom relationships should be enduring (we know that this is a continuous requirement) and raise the awareness of the ASA among identified stakeholders, with whom we have shared goals. Importantly, this is about improving and maintaining ongoing relationships with identified stakeholder groups, members, non-members and the public. The ASA has identified that it needs to challenge any pre-formed views of the profession through a new narrative and effective

DR MATTHEW FISHER
CHIEF EXECUTIVE OFFICER, ASA

engagement. There are three key attributes here – Be realistic in what we are aiming to effect; Be relevant to our stakeholders; and Be relentless in our efforts and commitment.

There are many strengths to take forward. We are approaching '90 years young' with great depth of experience and reach with our members being experts in healthcare and a trusted profession who provide excellence in quality care. Anaesthetists have led quality improvements in patient outcomes and are a sophisticated craft group in medicine. Whilst the role and influence of the ASA both within Australia and internationally is growing, we desire to improve what we do on behalf of you and your patients. These are the givens of who we are and what we are aiming to achieve.

Over the past six months, the ASA has been broadening its efforts and impacts on behalf of its members in the public sector across various states and territories. A case example has been in working with the anaesthetists at the Children's Hospital at Westmead on workforce sustainability with safe and quality care at the centre of the issue. What has been shown in all of this is the amazing commitment of the anaesthetists to continue the great work they do but under very difficult industrial circumstances. As someone who has been integrally involved with this matter since September 2022, it has been highly satisfying to contribute the ASA's expertise and resources to assist. What has been gratifying has been the openness and partnership with the department and the sense that we are making a difference. This was affirmed in a letter received from the Children's Hospital at Westmead which in part says:

> "it is worth recording with clarity that the specialists in our department have been facing a very real workforce crisis that is already challenging our ability to provide the safe and high-quality perioperative care for children that the community rightly expects and on which we pride ourselves. We have been making continuous attempts to work constructively with our Hospital Executive and the Ministry of Health to produce real solutions that will help us recruit and retain the highly specialised staff necessary for our work. It has been an absolute gamechanger to be able to draw on the ASA. This support gives us the confidence to continue. It is hard to capture in words how much this support means to those specialists working away at the clinical frontline even as we have these issues hanging over us. It is real and meaningful. The whole team deserves high praise. There is a perception at times that the ASA may be less interested in matters that impact primarily on those of us in the public sector. Our case study shows exactly how false perceptions can be. The ASA is providing an example of the difference such an organisation can make through real actions that are counting on a daily basis".

We are on our journey and I encourage you to be part of it.

Given this issue has a theme of education, I will conclude with a quote from JFK that I included in my Occasional Address last year to graduates of Health and Social Sciences at Macquarie University.

> "Let us think of education as the means of developing our greatest abilities, because in each of us there is a private hope and dream which, fulfilled, can be translated into benefit for everyone and greater strength of the nation."

The ASA understands that leadership and learning are indispensable to one another and through our role, aim to support you in your professional and life journey.

Dr 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

IS DIGITAL LEARNING A SECOND 'GUTENBERG PRESS MOMENT'?

DR HAYDN PERNDT AM

Andrew Ottaway with Global Outreach Fellow Jennifer Fife and Haydn Perndt have developed a new, online Spinal Anaesthesia eLearning course. The project was funded by the ASA Overseas Development and Education Committee (ODEC).

The invention of the Gutenberg press in the 1400s transformed the way knowledge was shared. Until this time, the scope of learning and the exchange of ideas were limited by the process of hand-copying books. Arguably, the Reformation, the Renaissance and later the Scientific Revolution would not have taken place without this new way of creating and sharing information.

Similarly, the internet has transformed our tools for creating and sharing information and developing new concepts. Knowledge, learning and the exchange of ideas have been liberated from the monopoly of the modern priestly parchment-copying castes of publishers.

Andrew Ottaway with Global Outreach Fellow Jennifer Fife and Haydn Perndt have developed a new, online Spinal Anaesthesia eLearning course. The project was funded by the ASA Overseas Development and Education Committee (ODEC).

This course has great potential for teaching and training would be 'spinalers' in the Developing World of low-income countries (LICs) and low-middle income countries (LMICs) in the Global South. Of course, theoretical online eLearning of spinal anaesthesia should be undertaken in conjunction with practical, hands-on, face-to-face, operating theatre (OT) teaching. No one really learns to give a spinal anaesthetic from a book, let alone a TikTok video or a PowerPoint presentation.

The course was developed against the backdrop of Andrew Ottaway's project in Namibia and his visits and teaching over the past five years, working at the major provincial hospital in the north of the country supporting their 'Physician Anaesthesia Provider' training.

During this time, the two district hospitals in the north of the country, charged with delivering over 5000 babies per year, were unable to provide Caesarean delivery (LSCS) for lack of an anaesthesia provider, despite having a functioning OT, resources and surgeons. Travel to the provincial referral hospital for this service involves travel times of one to three hours with inevitably poor outcomes for mother and baby.

The idea was to specifically create an online course for generalist doctors of the Namibian district hospitals to be used in conjunction with face-to-face, practical teaching, enabling doctors to give spinal anaesthesia for LSCS and other appropriate surgical procedures.

The aim of the eLearning course is to provide the theory and knowledge required for provision of safe spinal anaesthesia for non-specialist physician practitioners. The course includes the anatomy, physiology and pharmacology of spinal anaesthesia as well as practical information on the technical aspects of the conduct of spinals, including indications, contraindications and the management of side effects and complications.

If one of the rate limiting steps in training more anaesthesia providers in the Global South is the lack of teachers, surely part of the solution must be to make appropriate, self-directed, online learning materials more readily available? There is no lack of cases to be done in the Developing World, but the tension between providing service and teaching is unresolvable and ever present. Hence the existence of widespread apprenticeship, on the job (OTJ) training of anaesthetists in countries that the College and the curriculum cannot reach.

But any online learning material needs to be specifically created for its intended learning context. Whilst claims that the internet has everything, there is no need to reinvent the wheel and it's all out there in the ether are true, it's often hard to find what you really need 'out there' despite the Google algorithm. Ask any second part FANZCA candidate about the collation and curation needed to collect useful articles for their exam preparation.

I can imagine a tyro anaesthetist searching for 'developing country difficult intubation' on their phone receiving 1,430,000 results in 0.34 seconds[2].

Self-directed online learning could enrich practical OTJ skill training with the theory and knowledge essential for giving safe anaesthetics and problem solving when the inevitable unexpected situations arise.

The big question of course is whether the digital medium is really that much better than a good text book? I believe it is, but there is much to be done to realise this.

Before getting involved in working on this Spinal Anaesthesia eLearning project, I had expectations that it might be empowering and revolutionary, like the YouTube 'how to fix your lawn mower' tutorials, or the great visual explanations of the Theory of Relativity and the Origins of the Universe. I was a little disappointed. It takes time and money to make videos, commission illustrations and animations to fully utilise the digital medium. There is a lot of mastery (and mystery) involved in producing good material. Ask any Influencer or seven-year-old YouTube toy reviewer[3].

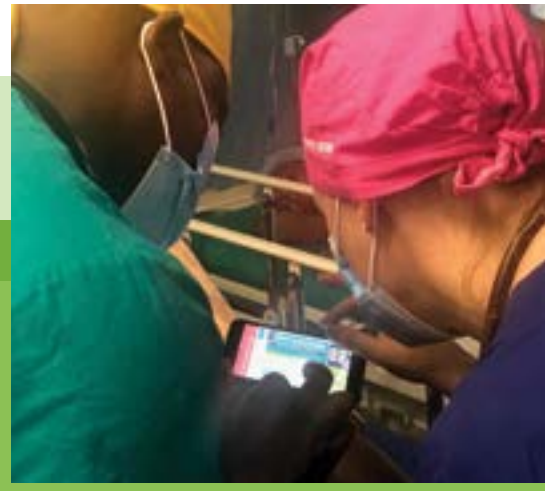
The Spinal Anaesthesia eLearning course took five months to produce through an excellent digital education company, Discover Learning Designs (DLD). The whole DLD process was brilliantly coordinated by Lara Verplak. The final result is however primarily a text-based teaching and learning tool. It is very interactive, but still mostly driven by text content.

What is successful is the clear distillation of the important science and theory with good practical advice on the conduct of spinals, the possible complications and how to manage them. I believe it is mostly relevant to the African context for which it was written. There was much discussion around issues of relevance, aspirational standards and best possible, 'gold standard' practice. For example, should the ALS algorithm include branches for no defibrillator and/or no ECG?

The engagement of the question and answers after each section and the varying way the materials are delivered keep attention and maintain interest. But how effective is it, especially in the cultural educational context of Africa, or anywhere else that does not share the Western educational traditions? An ongoing audit of enrolments and course completions will help determine how well the course works, as will the safe provision of spinal anaesthesia in the two district hospitals.

The eLearning course has received some glowing pre-launch reviews and was very enthusiastically received in Namibia.

Spinal and ketamine anaesthesia are suitable techniques for 21 of the 28 WHO Essential and Emergency Surgical Procedures. Lack of anaesthesia in much of the world can be partially addressed by teaching and promulgating accessible, suitable, online material for learning these techniques. This could significantly improve access to surgery and anaesthesia for the 'bottom billions' and complement efforts to develop



and improve anaesthesia training programs in the LICs and LMICs of the Global South.

There are questions still to be answered: how can eLearning be improved and how can it be best distributed to anaesthesia providers or national societies who might benefit from it? Any thoughts?

Dr Haydn Perndt AM

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LIFELONG LEARNING AND EDUCATION

"Education is the kindling of a flame, not the filling of a vessel." – Socrates

DR KARA ALLEN

The practice of medicine has been inextricably linked with education throughout history, delivered by practitioners to patients, as well as medical students and vocational trainees seeking specialist qualifications. Since inception there has been debate about the best methods for learning, whether this is didactic, by experience, or a combination of the two.

> "To study the phenomena of disease without books is to sail an uncharted sea, while to study books without patients is not to go to sea at all." – William Osler in 'Aequanimitas: with other addresses to medical students, nurses and practitioners of medicine'.

Despite the critical role high-quality education plays in the continuation of the profession, it is often relegated to a side role both clinically and with respect to funding, especially in the prevocational and vocational years. From the aphorism of 'those who can't do teach' to the unpaid time medical educators invest in supporting doctors in training through clinical learning and assessment, it is easy to forget that supporting learning for all healthcare workers remains core business for any training organisation. Clinical practice changes with new evidence, albeit slowly at times. There is evidence for strategies to support lifelong learning, which are variably adopted by workplaces and individuals. Medical education has relied on an apprenticeship model since at least the 19th century, with the significant benefit of providing a socialised, contextual experience of clinical practice but with the risk of inequitable distribution of learning and a hidden curriculum of professional behaviour, both desirable and undesirable. Sustainable, safe, high-quality care of patients is inextricably linked to provision of evidence-based education and opportunities for learning. What does this look like in practice and how can individuals continue to develop competency as medical educators? Education is an influence that leads to behaviour change. This encompasses knowledge, skills and attributes of both individuals and teams. There is an increasing understanding that collective competence[1] and effective communication and team behaviours (previously known as non-technical skills) are trainable and contribute as much as, if not more, to patient outcome, as the knowledge of any individual within the team[2].

As anaesthetists, we work as part of changing teams, evaluating understanding and adapting communication. Discussing care decisions for frail patients with surgical colleagues, supporting nursing colleagues who have variable experience in subspeciality anaesthesia, debriefing a team after a critical incident, teaching a

medical student vascular access skills or advocating for safe discharge of patients from hospital with appropriate medication management all require assessment of knowledge and communication skills. These are the same skills that facilitate learning, in addition to working with learners to establish goals and providing actionable feedback.

Education also encompasses the area of simulation, a huge area of growth and emerging evidence. From a case-based discussion to an immersive scenario designed to provide an opportunity to evaluate communication, the definition of simulation is broader than the mannequin-based platforms that usually come to mind. Simulations can be used to test threats to patient safety, and behaviour change can be powerfully influenced by these experiences. Evidence strongly suggests behaviour change is not linked to the level of technology but the skill of the educators, a theme that is repeated throughout education literature. Selecting appropriate learning goals, evaluating the effectiveness of the session, listening and responding to learner concerns and making changes as appropriate are the key themes that produce change.

Perhaps the most controversial aspect of education is assessment. 'Assessment drives learning' is the truism behind OSCEs for medical students, high stakes exams in vocational training and mandatory, audited CPD for specialists. Scholarship in assessment continues to highlight the challenges of finding assessment tools that are equitable, efficient, inexpensive and reproducible.

Educator skills and competencies

The Australian and New Zealand College of Anaesthetists (ANZCA) released an Educator Competency Framework last year to guide skill development and support Fellows and trainees in implementing education in their practice[3]. This framework was developed around a review of the literature[4] and provides guidance across six domains:

- Teaching and facilitating learning
- Assessment of learning
- Designing and planning learning
- Educational leadership and management
- Educational research and scholarship
- Educational environment, quality and safety

There are a number of competencies that apply to all Fellows of ANZCA, such as recognising the importance of giving and receiving feedback, including feedback on one's own performance, and providing an environment which promotes learning. While this can sound daunting, an accessible entry to this is asking the team at the end of the day "How did today go for you?", or "Is there anything I could do to make your job easier?". This can lead to an interesting discussion, identify learning needs for other team members and promote interprofessional collaboration. Learning is lifelong curiosity, reflection and adaptation promote career longevity and may protect against burnout[5]. These skills are teachable, transferable and rewarding to practice[6].

Further learning and reading

The ANZCA Educators program (AEP) is an excellent, accessible interactive course available in person and on Zoom, helping ANZCA and FPM Fellows and trainees expand skills in education. There are award courses in education at many universities, and several organisations offer support for clinician educators including the Australian and New Zealand College of Emergency Nursing (ANZCEN), the Academy of Clinical educators (ACE) and the Australian and New Zealand Association for Health Professional Educators (ANZAHPE).

For further reading, there are many peer-reviewed journals for scholarship in teaching and learning. These include:

- Journal of Continuing Education in the Health Professions
- Medical Teacher (including the Best Evidence in Medical Education Guides or BEME)
- Medical Education
- Academic Medicine
- Journal of Graduate Medical Education
- Perspectives in Medical Education
- simulation journals including Simulation in Healthcare, Advances in Simulation,
- Podcasts including KeyLIME

There are a huge number of medical educators on social media - follow the hashtags #MedED and #HPE and conference hashtags to see the latest evidence and practice in medical education.

Dr Kara Allen

Dr Kara Allen is an experienced specialist anaesthetist, currently serving as the Supervisor of Training at the Royal Melbourne Hospital. In addition to her role at the hospital, Dr Allen is also the Precinct Liaison for the Gandel Simulation Service, and a Clinical Fellow at The University of Melbourne.

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DROWNING IN THE SEA OF EVIDENCE

STAYING UP TO DATE IN AN AGE OF INFORMATION EXCESS

DR DANIEL JOLLEY

Summiting the Peak.

Achieving your FANZCA involves an arduous ascent to the peak of anaesthesia knowledge. But knowledge decays, and like reaching any peak, descent soon follows.

As this knowledge recedes, experience and wisdom assume the heavy lifting needed to maintain our professional growth. But even then, a niggling fear grows that we may be missing something important, newly emerging from the sea of medical evidence.

The pressure to practice truly patient-focused, evidence-based medicine weighs on every anaesthetist. Yet as the volume of evidence has grown, so has the expectation to always provide the highest quality care.

My own professional fear is not so much that my practice may later be found to be improvable, but that today I may be practising what is already known to be imperfect. The knowledge and evidence are already known but are yet to reach me.

This is a trap of unknown knowns: evidence known in the greater medical-knowledge body but that I am naively ignorant of.

Bastardising William Gibson (1993), we risk that the evidence "…is already here – it's just not very evenly distributed."

The greatest challenge for evidence-based anaesthesia continues to be the translation of research findings into actual practice change. The key to this is the intersection between quality, personal relevance, general significance, and credibility. But how can we achieve this?

The Problem of Overload

At first scratch, the primary problem appears to be simply sheer volume. There is just too much evidence to keep up with!

PubMed has indexed over 35 million citations reaching back to 1966 and adds over 500,000 abstracts every year. Beyond PubMed there are over 28,000 peer-reviewed journals, adding over two million articles, growing 3% annually.

The pandemic saw an unprecedented surge in article publication, much poorly planned, poorly peer-reviewed, and hurriedly released as pre-print. My own medical-evidence website metajournal.com has indexed over 41,000 COVID-related articles since 2020[1] – an indigestible volume of work!

It is not simply enough that research volume is increasing, but that the increase is accelerating and article volume growing exponentially. Staying up to date is like drinking from a firehose.

Anaesthesiology, critical care, and emergency medicine each have around 30 specialty-specific journals, churning out more than 25,000 unique articles annually: almost 70 every day, three every hour, one new publication every 21 minutes.

Even ignoring existing research and following new articles from only the top half-dozen most relevant journals, you would need to browse through more than 150 articles every month, around 2,000 every year – very few of which are either personally relevant or impactful!

But volume is not actually the main problem. Volume is the accelerant for the greater challenge of weighing quality, significance, relevance, and research credibility.

Quality & Persistence

Our understanding of what makes for quality medical research has improved over the past three decades. We understand that research must be ethical, should be reproducible, free of bias and that confounders are managed. We understand that prospective is best, and large, blinded, randomised trials are king.

We can articulate that a study must be appropriately powered to answer our question – but also not over-powered to waste resources and goodwill. Nonetheless many studies, possibly even the majority, do not live up to the standard required.

> "It usually comes as a surprise … to learn that some (perhaps most) published articles belong in the bin, and should certainly not be used to inform practice." – Trisha Greenhalgh (1997).[2]

In 2005 medical meta-researcher, Dr John Ioannidis, concluded that 90% of medical research is fundamentally flawed. In his landmark paper Ioannidis demonstrated that 80% of non-randomised studies were wrong, and among randomised controlled studies 25% were incorrect. Even 10% of large multicentre randomised clinical trials were predictably wrong.

Almost two decades later this quality problem has not improved. In fact, growth in research volume driven by low-quality publications and a publish-or-perish mentality hints that average research quality may have fallen over the last three decades, contributing to the reproducibility crisis affecting much of biomedicine (Catillon 2019).[4]

> "… for most study designs and settings, it is more likely for a research claim to be false than true." – Dr. John Ioannidis (2005)[3]

To explore the extent of the problem, Ioannidis investigated just under 50 of the most highly regarded medical research findings between 1990 and 2003.[5] Of the 45 concluding that interventions were effective, 34 had been retested, of which over 40% were found to be incorrect or exaggerated.

Ioannidis then focused on how clinicians adjust their views when widely cited evidence is later refuted by better quality research. Do we correct our misconceptions when contrary evidence appears?

Ioannidis' team examined persistence in the belief of several big-ticket 1990s errors: vitamin E's supposed cardiovascular benefits, beta carotene's anti-cancer effects, and oestrogen's Alzheimer-protection.[6] Although early observational studies supported these theories, all were subsequently refuted. Surely researchers had adjusted their understanding of the evidence?

Sadly, the disproven observational studies were all still positively cited in 50% or more peer reviewed publications, despite high quality contrary evidence. Even when we have better-quality evidence, established beliefs persist.

The quality of medical evidence is far poorer than we believe, even among studies we consider reliable. When bad evidence is subsequently disproven,

incorrect conclusions continue in practice for decades.

This creates a contradiction: we need to be both more critical and questioning of research conclusions, cautious to incorporate new knowledge into practice – but simultaneously avoid dogmatism, changing our practice when the weight of evidence demands it!

Significance and Relevance

The most important piece of the evidence-based medicine puzzle occurs when we ask: Is this relevant to my patients and my practice?

The quality of a published work relates to what epidemiologists call 'internal validity' – the extent that conclusions are actually warranted given methodology and results. The significance of a piece of evidence to medicine in general, along with its relevance to our own practice, represents the 'external validity'.

External validity describes how well the results and conclusions can be generalised to situations and people beyond just those in the study. It is the most important part of translating research to individual practice.

The challenge is that significance and relevance are imperfectly linked, in fact there is often an inverse relationship: the most personally relevant articles are unlikely to be the most generally significant.

Personally relevant research is the gold that is most likely to translate to practice change and improve the care you provide.

Only you can determine the final relevance of the evidence for your practice and your patients.

Fraud and credibility

The past two decades have revealed extreme examples of perioperative research fraud. Ranging from Boldt and intravenous starch, Reubin and COX-2 inhibitors, to the gargantuan fraud of Fujii in the most boring area of anaesthesia: PONV prophylaxis.[7]

The scale and potential impact of such recent fraud is unlike anything previously faced. Anaesthesia now has the dubious honour of being the number one specialty by fraud volume, even as 90% of retracted publications were from only six researchers![8]

Beyond overt research fraud, a larger threat to credibility is the use of regressive statistical tactics, such as data-dredging and p-value hacking, allowing statistically significant conclusions to be made in absence of any real effect.

Questions of credibility require anaesthetists to read conclusions critically. John Carlisle's (2012) epic analysis revealing the extent of Fujii's fraud serves as an example to us all.[9] We should be suspicious when data looks too neat, when biological plausibility is stretched, and when convenient statistics, such as p-values, are used in place of more meaningful measures, like confidence intervals.

What then?

How are we then to respond in this age of information excess? The needs of our patients demand that we must make an effort to continually improve our care. And while journal reading is only a small part of Continuing Medical Education, it remains important.

Addressing this overload led me to build Metajournal for my own needs: an algorithmic index, weighing and assessing evidence across critical care specialties. But passive reading is not enough. We must consider how our research diet balances issues of quality, significance, relevance, and credibility.

I am reassured, perhaps cynically, to know that very little evidence actually changes practice: Australian anaesthesia is so safe and effective that major changes demand truly major evidence.

When I am moved to change practice, I look for consensus: consensus in articles over time, and consensus among my peers. Is a conclusion plausible? Is the improvement clinically significant?

I try to stay aware that while research deals with populations, almost all our professional work focuses on individual patients who may not map neatly to research groups. Individualised care is about the individual, not about blindly applying a trial conclusion to every patient on a list.

And finally, we must remain comfortable accepting that we will not always know the answers.

Dr Daniel Jolley

Daniel Jolley is a Hobart-based anaesthetist, creator of both metajournal.com and clinicalfox.com. Collected references with summaries can be found at metajournal: https://metajournal.com/collections/158

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INTERNET INFORMATION REVOLUTION AND ANAESTHESIA

The internet has brought about a significant shift in the spread of information and its accessibility. With the introduction of real-time videoconferencing, voice communication, such as podcasts and webinars, has become commonplace. The interactivity offered by the internet allows individuals to make their voices heard, fostering intellectual growth, and enabling new forms of communication, such as polls and self-tests accompanied by discussions.

The development of free access to information has led to the growth of open access journals and sections of journals. However, the increasing immediacy of information availability, brought about by the internet, has resulted in a new way of consuming information, which is on-the-go, and this consequence of the internet's spread is often the least recognised.

On-the-go consumption of information

The increasing immediacy and accessibility of information on the internet has led to a new way of consuming information: on-the-go. This type of access allows individuals to consume information in smaller, more frequent pieces between their daily activities. However, this piecemeal use of information has resulted in a hunger for shorter and more succinct pieces of information that can be easily consumed in a shorter amount of time.

This need for brief and concise information is evident in the success of social media platforms like Twitter, where users are limited to presenting their views in just a few sentences. Infographics, which provide a visual representation of information in a concise and accessible manner, have also become increasingly popular.

Despite the benefits of consuming information in smaller, more frequent pieces, there are also concerns about the potential for information overload and the quality and accuracy of the information being consumed. As such, it is important to balance the convenience of on-the-go access with the need for comprehensive and accurate information.

Established anaesthesia institutions need to adapt

Many traditional institutions are struggling to keep up with the changes brought about by the internet, as they were built for a time before its existence. Some institutions have made upgrades to adapt to the new reality of information consumption. They have introduced podcasts and are posting their articles on various social media platforms. Others have adapted to a larger extent, such as the World Federation of Societies of Anaesthesiologists (WFSA), which has introduced videos and multimedia content to engage with its audience.

However, few institutions have opened discussion forums that remain lively and viable. The ones that do exist tend to be formal and cold, and discussions are typically limited by adherence to prevailing views. This lack of engagement and discussion has led to a gap between traditional institutions and the new ways in which information is consumed, and this gap is likely to widen in the coming years.

The development of the internet and the subsequent changes in information consumption have by no means run their course, and we are certainly bound to witness more prominent shifts in the future. It is up to traditional institutions to adapt and embrace new ways of engaging with their audience, or risk being left behind in a rapidly changing landscape.

Competition from novel online anaesthesia info sources - transient

In today's digital age, it has become easy and low-cost to start a website or a group, and many young academic anaesthetists are venturing into this domain. However, it is possible that some of these groups may disappear with the passing of the initial enthusiasm, as they are often created without proper financial backing or resources.

Despite the challenges faced by these young academic anaesthetists, their efforts to create new, online educational resources should be commended. With the internet providing an unprecedented opportunity to disseminate knowledge, it is important for the medical community to explore new ways of reaching out to

their audiences. While not all these efforts may succeed, they serve as important experiments in developing new ways of learning and teaching in the field of anaesthesia.

New entities

New entities offering education in anaesthesia through the internet have begun to surface with the increase in ease of creating blogs and social media accounts, allowing anaesthetists to share their experiences and discuss their insights into the latest trends and practices. Online platforms like Twitter, LinkedIn, and Facebook have enabled the anaesthesia community to interact and collaborate on a global scale. Moreover, various online courses, webinars, and podcasts offer comprehensive educational content to anaesthesia professionals worldwide, helping them to stay updated with the latest developments in the field.

As the demand for on-the-go education continues to grow, these online entities are likely to play an even more crucial role in the future of anaesthesia education. Independent groups hold a significant advantage in disseminating all available information, unrestricted by any single source, unlike traditional establishments. This makes the information spectrum much more diverse and multi-faceted, and these groups are progressively playing pivotal roles in the dissemination of information and education in the field of anaesthesia.

Dr Ivan Hronek MD

Dr Hronek is a US-based doctor and the creator and moderator of Anesth-Ideas, a free Linked-In group and serious yet fun blog on multimodal anaesthesia, encompassing daily news, reviews, infographics, videos, and open access to major journals. It also features topics such as TIVA, blocks, cardiac, trauma, debates, MCQs, jokes, and jobs, with minimal advertisements.

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SHAPING, STRENGTHENING AND SUPPORTING EDUCATION IN ANAESTHESIA

Peak body, professional associations play a vital role in education. From providing professional development opportunities to setting standards for professions, these organisations exist to support their members and advocate for policies that advance their industry's education system, professional practice and members' careers.

The Australian Society of Anaesthetists (ASA) is no different. Founded in 1934 with the vision to help Australian anaesthetists provide the safest possible anaesthesia for the community, the vision of the association is built on three pillars: representation, support and education for anaesthetists.

The educational theme of this issue of Australian Anaesthetist provides us with an excellent opportunity to reflect upon one of the core pillars of the ASA's mission, education, and how the Society has helped shape, strengthen and support the education of anaesthetists since its inception. Whether it's coordinating a National Scientific Congress to support the continuing professional development or providing aids to help anaesthetists educate their patients, the ASA is proud to continue its history of fostering the development of anaesthetists through ongoing education.

From the get-go...

Educational support starts from the moment an interest in pursuing a career in anaesthesia is sparked. The ASA is dedicated to fostering that spark and providing educational support to those interested in pursuing a career in anaesthesia. A range of opportunities

is available for Prevocational Medical Education and Training, Introductory Trainees, Basic and Advanced Trainees and Provisional Fellow Trainees, registered with the Australian and New Zealand College of Anaesthetists (ANZCA), to gain the knowledge and skills necessary for success in their field. This includes access to workshops, a library of publications, manuals and handbooks, and study support.

The ASA also provides financial assistance for attendance at educational events and offers scholarships for international travel and education, ensuring that Trainees receive a comprehensive and well-rounded education. The education provided is designed to support those at the start of their career, focused on passing their ANZCA exams and ready to immerse themselves in a demanding specialty.

Ongoing Education

The ASA's mission to provide high-quality education supports anaesthetists as they undertake their careers, providing resources for first year and established Fellows as they navigate the healthcare system. For Fellows of the ANZCA (FANZCAs), the ASA offers a range of continuing education initiatives including interactive anaesthetic modules that count as Continuing Professional Development (CPD) points, an automated workflow form for informed financial consent, and access to various awards, prizes, and research grants. Through these offerings, the ASA promotes scientific pursuits and recognises excellence within the field of anaesthesia while encouraging FANZCAs to continually expand their knowledge and skills.

A Broader Reach

In addition to conventional resources provided to Trainee and practicing anaesthetists, the ASA provides a range of tools and networks to support practice managers and patient education.

Practice managers play a crucial role in ensuring the provision of exemplary patient care and the ASA provides practical opportunities for practice managers and anaesthetists working in private practice to access ongoing education.

Through the Registered Practice Managers Network, the ASA provides tailored support and resources to assist practice managers in their professional development. This network offers informative billing support sessions, patient information pamphlets, and regular policy updates. Additionally, the ASA offers assistance with policy submissions, as well as comprehensive and accurate advice on billing, Medicare and private insurance rebates. Outside of these resources, the ASA also provides a range of educational opportunities, including training, events, and conferences, which are designed to help practice managers stay informed, connected with their peers, and able to provide the best possible care to their patients.

As well as the provision of an educational hub for those working to provide access to anaesthesia services, the ASA endeavours to provide an avenue for patients and the general public to obtain up-to-date information in easily digestible formats. There are patient information pamphlets to help doctors educate their patients and resources to explain rebates, billing and informed consent. The provision of precise and complete information enables anaesthetists to support their patients in making informed choices regarding their health and medical care.

Beyond ASA Walls

The ASA also recognises the importance of collaboration and partnerships with other educational institutions to provide the best possible learning experiences. The ASA works closely with organisations such as ANZCA, the New Zealand Society of Anaesthetists (NZSA), Anaesthesia Continuing Education (ACE), and Health Volunteers International, among others, to provide a diverse range of educational opportunities that reach beyond the walls of the ASA. Through these partnerships, the ASA is committed to ensuring anaesthetists have access to the latest knowledge and resources in the field of anaesthesia.

Where to Start

To begin exploring the diverse range of educational offerings provided by the ASA, there are several great places to start. The website is an excellent starting point as it provides access to an extensive collection of digital resources, including informative guidelines, thought-provoking articles, and engaging videos. Print resources, such as the peer-reviewed journal 'Anaesthesia and Intensive Care' and the 'Australian Anaesthetist' magazine, offer a deeper dive into the latest research findings and industry trends. Meanwhile, the 'Australian Anaesthesia' podcast, hosted by Immediate Past President of the ASA, Dr Suzi Nou, offers insightful and engaging perspectives on the field of anaesthesia. And of course, there is the highly anticipated annual National Scientific Congress hosted in Melbourne this year, where attendees have the chance to network with leaders in the industry, attend enlightening workshops, and expand their knowledge.

The ASA's unwavering commitment to advancing professional growth is reflected in its efforts to provide a diverse array of resources, both in-person and online. The ASA strives to provide ongoing educational opportunities for anaesthetists worldwide, providing platforms to sharpen knowledge, enhance skills and enable the delivery of the highest standard of patient care. Whether an anaesthetist is starting their career or seeking to maintain their edge post-retirement, the ASA is dedicated to empowering them to achieve their educational aspirations.

Kelly Chan

Marketing & Communications Manager, ASA

MEDICAL EDUCATION: A RECENT STUDENT'S PERSPECTIVE

DR TOM NEAL-WILLIAMS

To a new student, medical school can be a daunting proposition. From the outside it can appear filled with endless study, intimidating senior doctors, and the unrelenting pressure of trying to succeed in a hypercompetitive environment. While in some ways this is the reality in a demanding area of study, medical education is multifaceted and nuanced, and often some of the most influential lessons are those taught beyond the academic curriculum. In this article I want to reflect on my years as a medical student and share some of the most valuable lessons that I learnt outside a medical textbook. These are obviously personal reflections, as everyone experiences medical school differently, but are the experiences that shaped and influenced my student years, my current practice and the type of consultant I want to be.

The Joys of Table Tennis

An essential element of surviving medical school is friendship. On my first day in the hospital I knew one other person and was nervously sticking to them. We walked into the student common room and saw a table tennis table. My friend suggested we have a game while we waited for some classes to start and little by little people joined us. Before we knew it there was a group of us playing regularly and the table tennis table quickly represented a way to unwind, relax, and debrief about the stresses we were going through.

While for me it was table tennis, there are many ways to find supportive social circles. Looking at universities today there are multitudes of clubs, support societies, and social events. The vehicle isn't important, what is crucial is encouraging and fostering friendships, allowing students to meet likeminded people, and to form long-lasting relationships. Friendship has meant I've been supported through my harder years, gone to events that I wouldn't have normally attended, and found a network that I can rely on when needed. Not many people would call a table tennis table a key part of medical education but for me it was essential.

The Good and the Bad (Feedback)

Giving feedback can be an artform; walking the fine line between providing positive advice and constructive criticism. An area I have sometimes found to be underrepresented is the value of genuine praise. Medical teaching is often focused on perfectionism: yes you have identified ten of the causes of pancreatitis, but what about the eleventh? This means praise is linked with failing, and the failings are often overrepresented.

When I was in my final year of medical school I was allocated an emergency department patient whose case I had to discuss with an ICU consultant. Being relatively inexperienced at making referrals, I was full of trepidation – worried I was going to be asked questions I couldn't answer and be chewed out by a senior ICU clinician. However, the referral went smoothly, and I was later astounded when the ICU consultant specifically sought me out to say he was thoroughly impressed by the referral and that it had captured everything that he wanted. He then said something that stayed with me: "I don't think we praise enough when someone does something right. It's important to acknowledge when someone has done a good job". This experience helped erode my imposter syndrome and gave me reassurance in

my abilities and training. It was one of the first times I didn't feel like a medical student but rather someone who was ready to graduate and be a junior doctor.

Given its impact on me, it's a lesson that I've brought forward to my own teaching. I acknowledge that criticism is important, and giving good, constructive criticism is essential to effective learning. But the value of praise and acknowledgment when someone does a good job is essential in building self-confidence and successfully preparing someone for their future.

Care and Compassion

On my first week in theatre with anaesthetics the theatre emergency buzzer sounded. As a newly minted medical student, I left to watch what was happening. I found a fully-fledged resuscitation happening, with the anaesthetic team, led by a senior anaesthetist, working desperately to try and bring this person back to life. It was the first time I'd seen CPR and the realities of resuscitation, and it was a confronting experience. However, what surprised me the most happened two days later when the senior anaesthetist, who barely knew me, pulled me aside to have a conversation about what had happened. Not about the technicalities of resuscitation, but to check that I was holding up ok after what I had witnessed and to debrief the experience.

Experiences such as these have heavily shaped not only my views towards death, dying, and difficult conversations, but also how to use care and compassion in the workplace. It means I'm conscious of extending my level of care not just to patients but to colleagues and students under my supervision. The fact that a doctor who didn't even know my name sought me out to check I was okay speaks to the level of care that we should provide to each other as medical practitioners, and the importance of this extended care in medical education.

The Surge Workforce

I would be remiss to ignore the significant impact COVID-19 had on medical education. In one fell swoop, in-person teaching became unfeasible and we switched to online learning. Students were essentially barred from hospitals. This obviously has major ramifications, however while it presented significant challenges, in many ways it also delivered benefits. It forced a complete rethink in the design and delivery of the course, identifying areas that have been lacking and offering opportunities to develop better alternatives to replace them.

An example of this is the surge workforce. I was one of the many students that worked in the fever clinics, helped in COVID-19 testing, and screened people at hospital entrances. This experience, while challenging for obvious reasons, gave me a taste of being in the health system, not as a student but as a worker. It significantly developed my clinical and procedural skills, meant I interacted with patients on a professional level, and developed skills in conflict resolution and communication. On top of this it also impacted my life in a very important way: financial. Medical students are expected to undertake essentially a full-time job and study with minimal income for many years. Becoming part of the workforce in a way that also supplements learning can be a lifeline to students struggling to balance competing study and financial demands.

In many ways this has been recognised and implemented, with positions such as clinical assistants being created to seize this opportunity. This symbiotic relationship may represent a significant shift in how medical education is delivered in the future, and present different ways that universities can provide teaching.

Conclusion

When writing this piece, I was struck by how most of my reflections were around the importance of positivity, support, and care for each other. There were no 'core experiences' on the importance of lecture structure, exams, or OSCE teaching. To me this highlights the difficult role of a medical educator, as it incorporates teaching content, supporting students, and leading by example. The experiences these educators give us should be recognised in medical teaching and emphasised, as ultimately these are the areas that students will remember most and take forward into their own teaching and medical practices.

Dr Tom Neal-Williams

Dr Tom Neal-Williams is an HMO3 at Monash Health, who completed his medical school and junior doctor years through Northern Health. He has a strong interest in anaesthesia and critical care and has held various research and teaching positions in this field.

A SHORT HISTORY OF ASAED

BY DR VIDA VILIUNAS OAM

In January of 2020 there were rumours and a few cases of the coronavirus, but nothing was firm for the southern hemisphere…yet. After cruise ships docked in February, the prime minister activated the Health Sector Emergency Response. By March, we had run out of toilet paper. When Tom Hanks made the headlines after being hospitalised with the virus in Queensland, we knew we were in trouble.

An unprecedented problem

The COVID-19 pandemic dramatically changed the way anaesthetists work and receive education. With physical distancing measures in place and a focus on reducing the spread of the virus, in-person continuing professional development events for anaesthetists were cancelled or postponed, leaving many practitioners with limited opportunities to learn and stay up to date.

… and how the ASA adapted to provide an innovative solution

The ASA nimbly pivoted to create an online education platform for anaesthetists: ASAEd. The platform aimed to provide recorded lectures, articles, and live webinars, as well as interactive sessions, exam preparation tutorials, discussion forums and case studies. This allowed anaesthetists to continue learning and developing their skills while we navigated the ever-changing landscape of the pandemic. In addition, the ASA Board and Council immediately focussed on the job of advocacy for its members and the provision of safe working conditions for all healthcare workers.

All we had to do was implement

The newly appointed ASA-Education and Events Manager, Rhian Foster, conferred with the then education officer to work out a plan for the delivery of continuing education for members and exam preparation for trainee members in the era of lockdowns and quarantine as the new normal. The ASA's Information Technology Manager and 'enabler', Paul Singh, made it happen. A tsunami of educational zoom events was about to begin.

DR VIDA VILIUNAS

DR KAYLEE JORDAN

DR SUZI NOU

PAUL SINGH

RHIAN FOSTER

ASAEd was launched

It was created to be 'a place where the ASA's Anaesthetic Fellows and Trainees can find professional resources for all facets of anaesthetic learning… wherever and whenever' members required them.

In collaboration with the ASA Education Committee's deputy chair, Dr Kaylee Jordan, key topics and areas of focus were identified. These included updates on the latest COVID-19 treatment protocols, anaesthetist well-being seminars and strategies for maintaining patient safety and comfort during the pandemic.

One of our first moves was to test the running of real-time on-line exam preparation and archiving edited videos of those sessions. For the Primary and Final exam sessions we aimed to provide high fidelity written and viva questions, using advice from consultants with an interest in exam preparation, recently successful candidates as well as current and ex-examiners.

Those sessions were supplemented with in-depth analyses of written and viva questions and strategies to improve performance.

ASAEd aimed to be user-friendly, easy to navigate and optimised for mobile devices, so anaesthetists could access it on-the-go. It was made to be interactive where applicable, through livestreaming, video conferencing and webinars with the integration of discussion forums, quizzes and case studies.

ASAEd has grown

Since those early days, ASAEd has grown to include regular wellness sessions, Director of Department content, a library of recordings, resources for trainees and New Fellows, podcasts by Dr Suzi Nou and ASA publications. ASAEd is a core member benefit for Australian anaesthetists and a significant 'go to' part of the ASA website for continuing professional education.

The ASA Education Team is committed to building our accessible education resources to ensure members have access to the most up-to-date learning resources and information.

ASA SPECIALIST INTERNATIONAL MEDICAL GRADUATE SESSIONS

My exam journey was a long and bumpy one and going through a revalidation process here as a Specialist International Medical Graduate (SIMG), can be quite challenging, especially if you have English as a second language. Fortunately, after COVID-19 hit us in 2020, the support provided by the ASA regarding exam preparation escalated enormously thanks to the continuous efforts of the amazing education team led by Dr Vida Viliunas, Dr Kaylee Jordan and Events and Education Manager, Rhian Foster. It was for me, personally, a great opportunity to see how local trainees and other SIMG candidates perform and deliver their answers.

My top three takeaway messages for the ones considering attending are:

- They have scheduled session dates that are released way in advance, making easier to make any work arrangements to change your roster
- The sessions have a well-established pattern of delivery which allows up to three candidates to have their go on each viva (usually two per session) plus a comprehensive discussion afterwards about the relevant topics related to each viva
- It is a great opportunity to speak to consultants that have worked with exam preparation for many years as well as to be tested and assessed by the former Chair of the ANZCA final exam

Many thanks also to Dr Margaret Buckham and Dr Andrew Puddy (former final exam examiners) for their ongoing support during sessions either delivering vivas or providing feedback on candidates' performances.

I would definitely recommend the ASA sessions (both Final Exam and SIMG sessions) for everyone siting the final exam as well as the EPIC course, run annually by Dr Vida Viliunas for ASA members. So, join the ASA and enjoy the amazing support offered by the amazing education team!

Thanks Vida, Kaylee and Rhian for organising everything!

Dr Fernando Arduini
FANZCA, TEA/SBA, MD (Hons)

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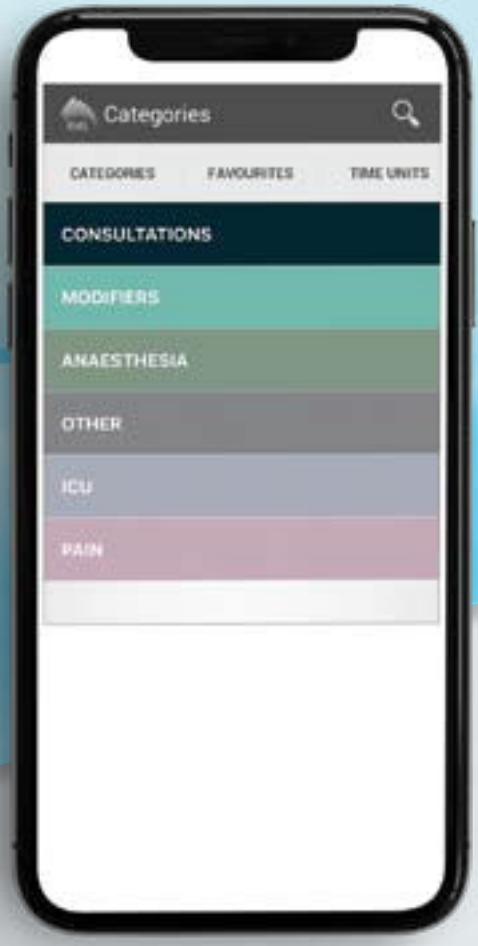

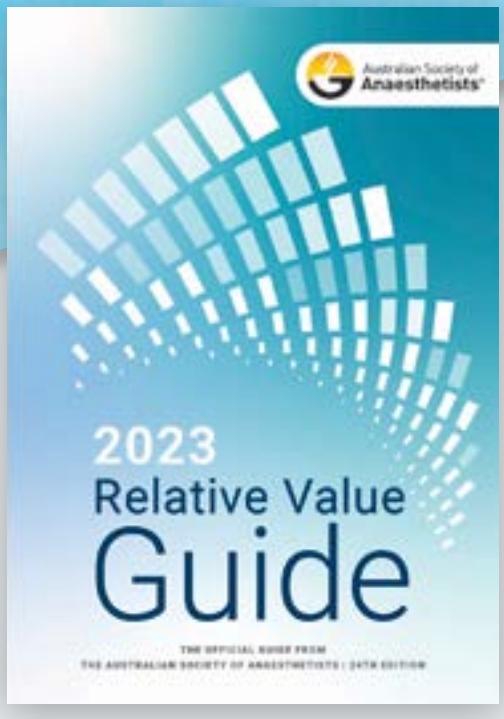

HARD COPY OUT NOW

New improved RVG app now available

Download the new improved version of the ASA RVG app via App Store or Google Marketplace for all the latest updates to the Relative Value Guide, including current item numbers and new features such as synced favourites, live updates button and push notifications.

New features also include:

- Favourites synced across installations
- Favourites stored under relevant categories
- Dark mode support
- Push notifications; and
- Dynamic type support – customised font sizes.

TMG: EXAM PREPARATION

AND OTHER EDUCATION OPPORTUNITIES

Hello 2023! The theme of this edition of Australian Anaesthetist is education. It is such an important topic for the anaesthetic trainee and unfortunately also gargantuan. I will endeavour to break down what I did for my exam preparation, the resources I found and used and then what other educational opportunities there are out there.

Things to consider for yourself before you embark on exam study.

Digital vs handwritten notes

Advocates for handwritten notes/ cards say you recall better because the connection between pen and brain is stronger than keyboard and brain. I made the decision that easy, portable access to my notes on my phone 24 hours a day was more important. I used OneNote.

Study group/Solo

This one is individualised; I went solo for the Primary and study group for the Final exam. Benefits both ways in my eyes. It all boils down to how you study.

Time course

The College recommends 1000 hours of study. Consultants will tell you they did it in 500 to 1000. I didn't actually record it, but it was a lot. Consistency is key. Also, forgiveness, you will have off days or weeks. Focussing negatively on not studying well for a week or so won't help in the slightest. My advice, give yourself some programmed breaks to look forward to as you go.

Primary Exam

I enrolled in the University of Sydney's Master of Medicine (Critical Care) degree with the plan to do the four science subjects, anatomy, physiology, pathology and pharmacology. While they were individually interesting and helped me remember how to study for assessments and exams, I didn't find the anatomy or pathology subjects particularly helpful for exam preparation. The anatomy component of our exam is very specific and is one small part of the university subject. Pharmacology and physiology however were definitely very useful, I would recommend those. I did a one subject per semester approach, with plans to break in the year. Some colleagues hit it a bit harder with two subjects at a time, but the workload can be intense at times!

I used Mak95 (https://www.mak95.com/) to guide my exam study and I cannot recommend it enough. It is a very, very, very worthwhile return on your small investment. The program breaks the syllabus down into sections (e.g. anatomy, physiology) and lists past multiple choice questions (MCQs) and short answer questions (SAQs) within each secion, as well as a viva section. Most SAQs link to various websites, named after various anaesthetic drugs, which have example answers for each question. My approach early on was to read the question, look at the example answers and then consult textbooks about things I didn't understand or know. I would finally write my own, far from perfect answer. As time went on, I realised that many topics and themes would repeat through the questions, and I would consult the textbooks less and less. This gave me some reassurance that I was learning something.

Textbook-wise, I only used:

- Miller's Anesthesia by Gropper et al
- West's Respiratory Physiology by West and Luks
- Cardiovascular Physiology by Pappano
- Stoelting's Pharmacology and Physiology by Rathmell
- Pharmacology and Physiology for Anesthesia by Hemmings
- Principles of Physiology for the Anaesthetist by Kim and Power

These books are all available from the ANZCA library (https://libguides.anzca.edu.au/primary).

In the last three or four months, I started handwriting my SAQ answers rather than typing to practice how to write as much as possible as neatly and succinctly as I could in eight minutes (with a two-minute

buffer). Luckily, my department provides the most amazing teaching program. We have weekly sessions with consultants on topics, marked SAQs, practice exam sessions, you name it. I know many of you won't have this sort of structured program, which is where a study group and a consultant mentor would be helpful.

After the written exam, vivas were all about revising my notes and getting painfully grilled by consultants and colleagues, over and over again. Remember, the viva is just a conversation about a topic you know lots about. My style is very conversational, so it's a bit of back and forth. I will admit, I probably don't cover the entire viva as I speak at a reasonably moderate tempo, but I feel comfortable doing it and don't feel rushed. Even so, the examiners would not always catch everything I said, so I would need to repeat!

Timeline wise, I started studying one to two hours per weeknight and four to six hours per day on weekends from about April 2019, with the odd weekend off. I sat the exam in March 2020 and the extra delayed viva in November 2020 (Thanks COVID-19!).

Final Exam

A far more nebulous affair, despite the existence of a curriculum. As an example, I split my notes into a few areas:

- Anaesthesia for xxx (procedure/ surgical specialty)
- Presenting condition (medical conditions)
- Emergency response (e.g. anaphylaxis, CICO, LAST)
- How I manage (e.g. gas induction, MDMA toxicity, drowning)
- Equipment/Monitoring
- Professional documents
- Welfare documents
- Guidelines (just the big ones like NAP)
- Anatomy/Procedures (e.g. CVC, blocks)

Again, I was lucky to be in a department with an excellent teaching program. We covered the controversial, difficult and previously challenging topics in our weekly tutorials. Resources-wise, there is no Mak95 unfortunately, so it is a 'choose your own adventure' affair. There are many study guides people have constructed out there – I tried to follow them but failed dismally at the one I picked. I built my notes over time via reference to the BJA Education/CCEAP/ WFSA tutorial of the week documents which are all freely available. Textbook-wise, Miller's again, Stoelting's Anesthesia and Coexisting Disease and Yao and Artusio's Anesthesiology

I spent a lot of time looking at the past SAQs and exam reports to get an idea of what the examiners were after. Not necessarily to frame my study, but to frame my approach to my notes. Lots of pre/intra/post op questions about procedural things or assessment/risk stratification/optimisation about medical things. This seemed to help me structure my answers in retrospect.
Practice, practice, practice. There is so much information to get out of your head and onto the page in such a short time. Practicing answering helps you identify where you might waffle, or waste precious seconds spelling things out unnecessarily. Asking your colleagues and consultants to review what you have written is painfully helpful at times, but worthwhile.

Vivas swung more towards Yao and Artusio's Anesthesiology as its structure seems to work quite well for our vivas. Although it is written for the American audience it is very applicable. Naturally, viva study lends itself to practicing vivas. I didn't count how many I practiced but know a few colleagues who practiced well over 100 times in the leadup. The ASA Education team's 'Exam Prep Vivas' are an exceptional resource available to ASA trainee members, signups are regularly sent via email and a range of other resources is available on the website (https://asa.org.au/asaeducation/).
I feel my style of speaking in a viva was helpful for this exam, past examiners and candidates describe their viva as a conversation with a colleague. I suggest you practice this type of approach with consultants regularly. Rehearsing a spiel for investigations for the medical viva in its current form would also be very beneficial!

Timeline-wise, I started studying in Feb 2021, Sat in March 2022 and May 2022. There were a few periods of a week or two off in that time. It was exhausting, but thankfully it's over now!

Other stuff!

I mentioned the Crit Care masters at the University of Sydney however there are others in perioperative medicine, teaching, research and many more. In my role here I have seen a number of resumes with a huge list of courses and other education people have done. I will say, it is obvious which candidate has done courses to build their resume and which one has chosen courses based on their interests or career plans. These things all cost money and while you can claim the costs on tax or salary packaging, you will still need to pay for them upfront and out of pocket. I would encourage you to find courses via the ASA or other organisations which are of interest for your personal career development.

Don't forget to consider educational opportunities outside anaesthesia to broaden your horizons. Aeromedical retrieval, education, simulation, leadership and research are just a few of the possibilities.

All the best!

Dr Alex Courtney

Dr Alex Courtney is an experienced anaesthetist currently working as an Anaesthetic Provisional Fellow at Fiona Stanley Hospital. He has worked as an Anaesthetic Registrar at Monash Health and has experience working in Orthopaedics, Emergency and General Medicine. He holds a Doctor of Medicine from the University of Melbourne.

Applications are welcome at any time

ASA RESEARCH GRANTS AND SCHOLARSHIPS 2023

The ASA has expanded its Research Priority Program (RPP) with the creation of four new small grants of up to $3000 each per year, for original research into the current ASA Research Priority areas:

ENVIRONMENT & ANAESTHESIA
INNOVATION & ANAESTHESIA
SAFETY IN ANAESTHESIA

Eligibility: trainee members, and members within five years of full membership who have been financial members of the ASA for over 12 months. Applicants are welcome from research teams, but at least one member needs to meet the eligibility requirements.
Requirement to present work in a public forum eg a future NSC, publish in a peer review journal, Australian Anaesthetist or ASA podcast.

The research grant may be used to purchase or lease equipment, facilities or material or to fund administrative or scientific support.

FOR FURTHER INFORMATION APPLICATION & FORMS LOG IN TO

asa.org.au/asa-awards-prizes-and-research-grants/
or contact sdonovan@asa.org.au

FROM THE SPARC CHAIR

ASSOCIATE PROFESSOR
ALWIN CHUAN

In this issue of Australian Anaesthetist, I am pleased to announce the three winners of the September 2022 round of the ASA Small Grants. This round included strong and competitive submissions, and these three winners exemplify core mission objectives of the ASA Science and Research: Environment, Innovation, and Safety. The ASA also encourages early career researchers to apply to our available grants; it is pleasing to see our specialty's emerging future leaders and post-doctoral researchers are represented in this round.

There are exciting opportunities in the next 6 months. Applications are open for the next round of the ASA Small Grants (deadline – March 31), Melbourne National Scientific Congress oral presentation prizes (deadline – June 16), and the ASA major grants (Annual Research Grant with scholarship, Jackson-Rees Research Grant, Kevin McCaul Prize, and Jeanne Collison Prize (deadline – June 30).

Further information is available at the ASA website https://asa.org.au/asa-awards-prizes-and-research-grants/ and the Melbourne NSC abstracts submission portal https://asansc.com.au/abstracts/

Associate Professor Alwin Chuan
PhD, MBBS (Hons), PGCertCU, FANZCA

SMALL GRANTS RESEARCH WINNERS

Dr Jess Davies

Dr Jess Davies is an anaesthetist at Austin Health and leads a group of enthusiastic trainee researchers at TRA2SH (Trainee-led Research and Audit in Anaesthesia for Sustainable Healthcare). For the last three years TRA2SH has held an annual implementation event focussing on sustainable healthcare engagement called Operation Clean Up (OCU), which aims to educate and engage staff in operating theatres in improving their environmental impact. The successful ASA funding will facilitate OCU survey research into the feasibility, acceptability and repeatability of OCU in a variety of hospital settings as perceived by OCU participants. It will help TRA2SH understand participant demographics, activities undertaken as part of OCU as well as the barriers to environmental sustainability for the volunteer participants. The ASA funding will contribute to the ongoing costs of delivering OCU via website hosting, resource storage and distribution. Healthcare contributes 7% of Australia's carbon footprint and finding ways to implement improved environmental sustainability through education and behaviour change are important steps in addressing individual clinician actions and their impact on climate change and health.

Dr Mathew Miller

Dr Matthew Miller is a Staff Specialist with NSW Aeromedical Operations and VMO anaesthetist at St George Hospital, Sydney. His research team includes, Dr Frances Page, Head of Department at Gosford Hospital and organiser of the Gosford Awake Fibre Optic Intubation Course and Dr Clare Hayes-Bradley, Airway lead and Staff Specialist with NSW Aeromedical Operations and Blacktown Hospitals, Sydney. The team is investigating the use of local anaesthetic before performing awake fibreoptic intubation in clinical practice, using a variety of techniques. The study will involve healthy volunteer physicians who will apply the anaesthetic to their own airways and will compare the effectiveness of a 4% lignocaine preparation diluted to 2%, versus alkalinised 2% lignocaine. The study will measure plasma lignocaine levels and the amount of lignocaine needed for endoscopy. This is the first study to measure lignocaine levels after topicalisation with alkalinised lignocaine. The ASA Grant will cover the cost of shipping and processing blood samples to a lab in Queensland for lignocaine measurement.

Dr Yayoi Ohashi

Dr Ohashi is a consultant anaesthetist at Fiona Stanley Hospital in WA, has a passion to improve obstetric anaesthesia care and is leading this project. Co-investigator, Dr Mullington is a consultant anaesthetist at St Mary's Hospital in London UK, and is an expert in human thermoregulation. The team consists of anaesthetists, obstetricians, a research nurse, a statistician, and a clinical engineer.

Hypothermia can occur in up to 50% of patients undergoing elective Caesarean section (CS) under subarachnoid block if active warming is not used. By contrast, hyperthermia is a side effect of labour epidural analgesia, which occurs in 20% of cases and is associated with adverse maternal and neonatal outcomes. Therefore, it is important not to iatrogenically exacerbate hyperthermia during an emergency CS by instituting active warming inappropriately. Shivering is a common side effect of neuraxial blockade during CS. It is an unpleasant experience which hinders monitoring of mother's vital signs and prevents early mother-baby bonding. Their study aims to compare temperature changes during elective and emergency CS, differentiate shivering, monitor temperature, and develop personalised temperature regulation strategies. The ASA funding will support purchasing equipment for the study.

THE MEDICAL BOARD OF AUSTRALIA AND AHPRA

BERNARD RUPASINGHE
POLICY & PUBLIC AFFAIRS MANAGER

Can a notification be made, and a disciplinary process initiated, in relation to behaviour which occurs when a practitioner is no longer registered?

The December 2022 issue of the Australian Anaesthetist Magazine included a letter to the Editor highlighting the powers of AHPRA to regulate the activities of unregistered medical practitioners and stating the following:

"I wish to highlight a little known law that will amaze you. The moment you cease your AHPRA registration you are not allowed to use your medical knowledge in any way. I was at a senior active doctor's conference recently where this issue was raised and confirmed by AHPRA and the Medical Board. AHPRA have a very broad definition of "practice" so they can prosecute the small number of deregistered doctors. The problem being this also captures those who have retired. Numerous examples were given to the panel and each time the AHPRA representative and Medical Board chair confirmed that you could be prosecuted for practicing without registration. Examples included were; teaching medical students, sitting on a committee or board, writing a chapter in a textbook, or even administering advanced life support."

This statement raises several issues which this article will attempt to provide further clarity on.

First, even if a health practitioner is retired and no longer registered, **a relevant Board (such as the Medical Board of Australia)** may still have jurisdiction to:

- Assess and investigate a notification (or a complaint) about that person;
- Establish a panel to conduct a hearing about their health, performance or conduct
- Refer a matter about that person to a relevant tribunal.

The AHPRA regulatory guide, which was last updated in October 2022 and is available on its website, states as follows:

AHPRA is established by Part 4 of the National Law. Its primary function is to provide administrative assistance and support to the Boards, and the Boards' committees, in exercising their functions.

The Boards are established by Part 5 of the National Law and Part 2 of the National Law Regulation. The functions of the Boards are set out in section 35 of the National Law. Relevant to this guide, and the operation of Part 8 of the National Law, the functions of the Boards include:

- to oversee the receipt, assessment and investigation of notifications about people who:
  - ✓ are ***or were*** registered as health practitioners in the health profession under this Law or a corresponding prior Act; or
  - ✓ are students in the health profession;
- to establish panels to conduct hearings about —
  - ✓ health and performance and professional standards matters about people who are ***or were*** registered in the health profession under this Law or a corresponding prior Act; and
  - ✓ health matters about students registered by the Board;
- to refer matters about health practitioners who are ***or were*** registered under this Law or a corresponding prior Act to responsible tribunals for participating jurisdictions; and
- to oversee the management of health practitioners and students registered in the health profession, including monitoring conditions, undertaking and suspensions imposed on the registration of the practitioners or students.

Under section 138 of the National Law, the health, performance and conduct provisions of the National Law apply even if a person was, but is no longer, registered in a health profession. A notification may be made, and a disciplinary process may be initiated, about the person's behaviour **while registered** as if the person were still registered by the relevant Board. Section 138 would, for example, capture a practitioner who surrendered their registration to avoid a potential disciplinary process.

A relevant point to note however is that in many cases there is often little or no utility in pursuing a matter against an unregistered practitioner if they are no longer practicing. The Boards and AHPRA adopt a risk-based approach to the regulation of health practitioners, as opposed to a sanctions-based approach which punishes someone for doing the wrong thing.

When performing their duties, the Boards (and their committees) and AHPRA identify the risks posed by the health, conduct or performance of health practitioners, consider the possible consequences of those risks (to the public) and respond accordingly. Therefore, if a practitioner is unregistered and no longer practicing, there is a commonly held belief that there is likely to be little or no ongoing risk to the public. It would be different of course where an unregistered practitioner continued to practice even though they were not appropriately registered.

Interestingly, amendments to the National Law enacted late last year have inserted a new paramount principle making protection of the public **and public confidence in the safety of services provided by registered health practitioners and students paramount considerations**. This places an explicit legislative obligation on entities performing functions under the National Law (such as the Medical Board of Australia) to place protection of the public and public confidence foremost in all decisions and actions. It is probably too early to determine if this will change, in any way, the behaviour of the National Boards and AHPRA when investigating complaints about practitioners.

However, recent adverse media reporting such as the recent ABC Four Corners investigation into the health complaints handling process (which found hundreds of practitioners have been sanctioned by tribunals for sexual misconduct involving patients since 2010, and many of them are still registered to work) may force the National Boards and AHPRA to change their behaviour when investigating complaints about practitioners, whether they want to or not.

The second issue is whether the powers of National Boards extend to behaviour that occurs when a person is no longer registered. Can a notification be made, and a disciplinary process initiated, in relation to behaviour which occurs when someone is no longer registered? The answer is maybe.

In March 2012, the Medical Board of Australia published a statement of advice titled, 'Medical Registration – What does it mean? Who should be registered?' to help individuals with medical qualifications decide whether or not they should be registered.

Before restating some of the advice from this statement (which

is available on the Medical Board of Australia's website) it is worth noting that the definition of 'practice' is quite broad and extends beyond direct clinical care. Many National Boards, including the Medical Board of Australia, define "practice" as follows:

> Practice means any role, whether remunerated or not, in which the individual uses their skills and knowledge as a health practitioner in their profession. **For the purposes of this registration standard, practice is not restricted to the provision of direct clinical care.** It also includes using professional knowledge in a direct non-clinical relationship with clients, working in management, administration, education, research, advisory, regulatory or policy development roles, and any other roles that impact on safe, effective delivery of services in the profession.

The following information is restated directly from the Medical Board of Australia's March 2012 advice referred to above.

Many qualified health practitioners who use their skills and knowledge in a range of activities outside direct patient care **may not need to be registered.**

Other than a few notable exceptions (that apply to restricted dental acts, prescription of optical appliances and manipulation of the cervical spine) the National Law does not define the activities that require registration as a particular health practitioner. That is, it is not a breach of the National Law for a medical practitioner to use their knowledge and skills relating to the medical profession **without being registered**, if the individual does not breach the sections of the National Law related to the protection of title or to the specific practice protections.

As the primary purpose of registration is to protect the public, **medical practitioners should be registered if they have any direct clinical contact with patients or provide treatment or opinion about individuals**. As well, other State and Commonwealth legislation provides that registration is required to enable prescribing and in order for a patient to be eligible for a Medicare benefit for a medical service.

For roles beyond direct patient care, the Medical Board of Australia **advises practitioners to be registered when**:

- their work impacts on safe, effective delivery of health care to individuals and/or
- they are directing or supervising or advising other health practitioners about the health care of an individual(s) and/or
- their employer and/or their employer's professional indemnity insurer requires a person in that role to be registered and/or
- professional peers and the community would expect a person in that role to comply with the Board's registration standards for professional indemnity insurance, continuing professional development and recency of practice and/or
- they are required to be registered under any law to undertake any specific activity.

On the other hand, the Medical Board of Australia advises that practitioners engaging in the following activities **do not necessarily require any registration** or may choose to hold non-practising registration:

- An examiner or assessor of medical students or medical graduates, when the student or graduate is not treating patients as part of the assessment, provided that the organisation on whose behalf they are acting believes that current practising registration is not necessary for the scope of activity
- A tutor or teacher working in settings that involve simulated patients or settings in which there are no patients present, provided that the organisation on whose behalf they are acting believes that current practising registration is not necessary for the scope of activity
- A researcher whose work does not include any human subjects and whose research facility does not require them to be registered
- A person who speaks publicly about a health or medical related topic and who will not be giving any individual patient advice

- A person serving on a board or committee or accreditation body, when their appointment is not dependent on their status as a "registered medical practitioner"
- A person who may be using skills and knowledge gained from an approved qualification but is not using a protected title, nor claiming or holding themselves out to be registered, such as a person in an advisory or policy role
- A medical practitioner who is registered overseas and is visiting for any role not involved in providing treatment or opinion about the physical or mental health of any individuals.

Does this mean the Medical Board of Australia can investigate a complaint made about your voluntary work on the Board of the ASA or an ASA committee for example, if you are no longer registered? Not unless you're using your professional knowledge in a direct non-clinical relationship with clients or patients, which is highly unlikely, or your role directly impacts on the safe, effective delivery of services in the medical profession, also unlikely.

Finally, there are other examples where AHPRA or a National Board (such as the Medical Board of Australia) have jurisdiction over the conduct of an individual who is not a registered health practitioner. For example, section 116 of the Health Practitioner Regulation National Law Act 2009 deals with claims by persons as to registration as a health practitioner. 116(1)(c) says "a person who is not a registered health practitioner must not knowingly or recklessly claim to be registered under this Law or hold himself or herself out as being registered under this Law." Quite clearly, this provision would apply to a qualified medical practitioner who was no longer registered. The maximum penalty in the case of an individual is $60,000 or three years imprisonment or both.

Similarly, the advertising provisions in the National Law (section 133) impose financial penalties for a breach of those provisions on individuals, whether they are a registered health practitioner or not. The maximum penalty per offence is $5,000.

The idea that a notification can be made and a disciplinary process initiated against you, in relation to behaviour which occurs when you are no longer registered may seem startling at first. However, as hopefully shown above, its highly unlikely to happen to the vast majority of medical and health practitioners. In those rare cases when it does occur, it will be because a person's behaviour may be placing the public at risk.

Bernard Rupasinghe

Policy & Public Affairs Manager

WEBAIRS

ANZTADC Case Report Writing Group

Intraoperative Hypotension

The web based anaesthetic incident reporting system (WebAIRS) reached over 10,000 incident reports by the end of November 2022. 1,796 reports were coded by the reporters as involving the cardiovascular system and nearly 400 of these reports were reported as involving hypotension. As there is no available widely accepted definition of intraoperative hypotension or safe limits for the duration of the event, the Australian and New Zealand Tripartite Anaesthetic Data Committee (ANZTADC) did not include a definition of hypotension in the WebAIRS reporting system. If a reporter is sufficiently concerned regarding a low blood pressure, they are encouraged to report the incident for review. .

CARDIOVASCULAR INCIDENTS	NO.	%	> 15%
Blood loss	160	7.97%	
Bradycardia	207	10.31%	*
Cardiac Arrest	388	19.32%	*
Cardiac Failure	50	2.49%	
CVS trauma (unintentional surgical)	18	0.90%	
Disseminated Intravascular Coagulation	4	0.20%	
Dysrhythmia (other)	32	1.59%	
Electrolyte/Metabolic disturbance	5	0.25%	
Embolism	65	3.24%	
Hypertension	57	2.84%	
Hypotension	399	19.87%	*
Myocardial Infarction	64	3.19%	
Myocardial Ischaemia	86	4.28%	
Tachycardia	191	9.51%	
Other	282	14.04%	
Total events from 1796 reports	**2008**		

Table 1. Cardiovascular incidents reported to WebAIRS – Nov 2022

Table 1 shows that 1,796 cardiovascular incidents had been reported to WebAIRS by the end of November 2022. As it is possible to code more than one incident per report, there were slightly more incidents (2,008) than reports (1,796). Also, when the subgroups are analysed, it is expected that slightly more events will be found during a narrative search. For instance, some of these hypotensive events might be due to anaphylaxis and then progress to a cardiac arrest but it is possible that only hypotension is coded by the original reporter. Anaphylaxis events are currently being analysed separately from the other cardiovascular incidents as anaphylaxis might have been reported as involving the respiratory system, angioneurotic oedema or rash instead of the cardiovascular system. Also, many of the anaphylaxis reports have simply been reported as a medication incident and the narrative sections describe the details of the event.

PRELOAD	MYOCARDIAL FUNCTION	AFTERLOAD
(Venous return)	(Heart rate, rhythm & contractility)	(Systemic vascular resistance)
Hypovolaemia: Blood loss, fluid loss, capillary leak, or dehydration.	Ischaemic heart disease, myocardial ischaemia, or acute myocardial infarction	Anaesthetic drugs including induction drugs, volatile agents muscle relaxants and narcotics.
Obstructed venous return	Drugs (including anaesthetic drugs)	Vasodilators
Pneumoperitoneum	Cardiomyopathy	Regional blockade
Elevated intrathoracic pressure	Myocarditis	Anaphylaxis
Tamponade	Arrhythmia	Sepsis
Embolism: Air, venous, amniotic fluid, fat, bone cement, tumour and other.	Valvular heart disease	Post cardiopulmonary bypass
	Sudden increased afterload	Neuropathy
	Vasovagal	Tourniquet / clamp release
Patient position or position changes under anaesthesia	Reduced sympathetic drive: (General or regional techniques)	Addison's disease
Pregnancy (IVC compression)		Thyroid disease
	Hypothermia Electrolyte abnormalities	Bone cement
Common causes		
Anaesthetic agents, narcotics, regional blockade, hypovolaemia, vasovagal, IVC compression, and elevated intrathoracic pressure.		
Measurement error Equipment error including transducer height, arterial trace damping, incorrect blood pressure cuff size, incorrect detection secondary to patient arrhythmias		

Table 2. Adapted from: The anaesthetic Crisis Manual - David C. Borshoff- First published 2011.

The differential diagnosis of hypotension includes factors affecting preload, myocardial function and afterload,[1,2] as shown in Table 2, and commonly occurs as a side effect of the drugs used in general anaesthesia. At different stages of the perioperative journey, some causes are more common than others. During induction, hypotension secondary to anaesthetic drugs is common and might be exacerbated by combinations of age, comorbidities or hypovolemia, secondary to blood loss, fluid loss or dehydration. The effects of narcotics, volatile agents or regional blockade on peripheral vascular resistance might contribute to the fall in blood pressure. Medications that have been used should be checked for errors of wrong drug or wrong dose. Also, during this phase anaphylaxis might occur, as antibiotics, muscle relaxants and on rare occasions even propofol might be responsible. During maintenance and emergence, surgical causes should be considered. These predominantly affect preload but on occasions might involve myocardial function or afterload as shown in Table 1. Other causes of hypotension from the list above might not be related to any particular stage of the perioperative care.

As pressure is a reflection of the balance between myocardial contractility and vascular resistance, intraoperative hypotension is not necessarily an indication of reduced flow. However, tissue ischaemic injuries due to inadequate organ perfusion may occur if perfusion is compromised. A detailed analysis of the hypotensive events reported to WebAIRS is about to be commenced and ANZTADC welcomes any feedback or suggestions related to this topic.

References

1. Morris, R., et al., Crisis management during anaesthesia: hypotension. Qual Saf Health Care, 2005. 14(3): p. e11.
2. Borshoff D. The Anaesthetic Crisis Manual. Leeuwin Press. First published 2011. ISBN 978-0-646-90652-2.

ANZTADC Case Report Writing Group

MEDICARE COMPLIANCE EDUCATION

DR MICHAEL LUMSDEN-STEEL
EAC CHAIR

KATYA SADETSKAYA
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ECONOMIC AFFAIRS

The Economic Advisory Committee (EAC) has jumped into action at the start of 2023, determined to provide insightful analysis and support to ASA members and the wider anaesthesia community. With a focus on interpreting and complying with the Medicare Benefits Schedule (MBS), the committee is delivering updates and strategies for navigating the ever-changing landscape, covering everything from industry trends to policy updates.

Business and Billing for Anaesthetists

The ASA is enhancing support for billing and compliance by bringing together Relative Value Guide (RVG) resources and creating training videos and an FAQ section. On 11 February this year, the first session of 'Business and Billing Essentials' was launched featuring a panel discussion on current issues, RVG billing basics and compliance. Held in Sydney at the ASA head office, the event also featured the opportunity for anaesthetists to network with peers and visit the ASA Harry Daly Museum. Dates for other states will be announced and registration will be open soon.

Medicare Benefits Schedule Compliance – common issues

As Australian anaesthetists in both the public and private sectors, it is our responsibility to comply with the ongoing obligation of the Medicare Benefits Schedule (MBS). The use of correct RVG item numbers is crucial to maintain MBS integrity. In order to bill patients, it is our responsibility to ensure that the correct item numbers are used for eligible services, which are clinically relevant professional services that are listed in the MBS schedule and defined as attracting an anaesthetic fee. However, there is a common exception when services are performed by a dentist or surgeon claiming dental numbers and there is no MBS number claimed.

To ensure compliance with the MBS, it is recommended to use the RVG App, which has the most up-to-date billing codes and fees. This app is recognized in the MBS and is denoted in the Category 3, Group T10 of the MBS. However, it's important to note that co-claiming of items outside of Group 10 has been prohibited since July 2022. Lastly, it's important to remember that nerve blocks in Category 3, Group T7 must be performed as separate procedures, not in association with anaesthesia, in order to maintain compliance with the MBS.

Another important aspect of MBS compliance is the provision of accurate and complete records. Anaesthetists are required to keep detailed records of the services provided, including the type of anaesthetic used, the duration of the procedure, and any complications that may have arisen. These records have proven to be of great value during auditing processes or where anaesthetists have been questioned by Health Funds. In particular, documentation of specific details in the anaesthesia record, such as challenging IV access necessitating ultrasound, premedication needs, increased time for patient positioning and preparation, and prolonged recovery

or pain management requiring the anaesthetist's presence until transfer to the post-anaesthesia care unit, have proven valuable in resolving disputes with Private Health Insurers regarding anaesthesia time.

Finally, anaesthetists must be aware of the MBS Note TN.10.5 (minimum requirement for claiming benefits under items in the RVG) and must also comply with the guidelines set out by the ASA, the Australian and New Zealand College of Anaesthetists (ANZCA) and the Australian Medical Association (AMA). These guidelines cover issues such as the use of appropriate anaesthetic techniques, the administration of anaesthesia, and the management of complications. Hospitals will also have their own hospital credentialing requirements. Please ensure you understand those requirements and how they apply to you.

In the recent years, MBS compliance activity has significantly increased in Australia. There have been three areas of increase related to anaesthetists:

- Claiming MBS anaesthesia services without an associated diagnostic and/or therapeutic service in the same patient episode
- Claiming services with potentially improbable working hours (time units and pre-anaesthesia consultation item numbers)
- Claiming an anaesthesia item and procedure in the same patient episode

The Department of Health (DOH) identified that around 6% of anaesthesia services have been claimed without an associated diagnostic and/or therapeutic procedure. As the result 20 providers have been audited. The key reasons why some services were claimed not in association with diagnostic or therapeutic services included:

- Surgeons not claiming the associated service within 90 days
- Hospital claiming practices were more complex than anticipated
- There was a misunderstanding in the correct use of items 20170, 22900 and 22905

Please discuss with your surgeon or your hospital if there is a significant delay in submitting the claims, as this can result in your claim being rejected.

The second biggest issue that became subject to compliance over the last year was providers claiming services with an accumulated number of hours exceeding 12 hours a day on more than 20 days in a 12-month period. In Oct 2021, the DOH decided to adopt a new audit threshold of claiming over 12 hours, exceeding 20 days per year, after consulting with both the ASA and ANZCA. The ASA had previously noted that the high number of long hours was due to various reasons such as limited theatre capacity, complex surgeries, emergency cases, backlogged waitlists, and a shortage of specialists, both before and during the pandemic.

The DOH however found that largely exceeding the 12-hour threshold over 20 days was due to the misunderstanding of attendance requirements, use of unsupervised registrars while anaesthetists attended to other patients, admin errors, and unclear item requirements.

Anaesthetists should be aware that working more than 12 hours, for 20 or more days, may trigger an request by the DOH to undertake a self-review or self-audit, and confirmation that the items claimed are correct. Claims where errors are identified must be repaid to Medicare and where applicable to Health Funds. A new claim must be re-submitted with the correct claiming amount. Patient acknowledgement for the new claim must be also obtained. The ASA strongly advises that members contact the ASA and speak to their Medical Defence Organisation (MDO), prior to agreeing or proposing any settlements with Medicare.

The third compliance issue over the last year has been claiming an anaesthesia item and procedure in the same patient episode. The DOH referred to, and has now enforced, Section 16(1) of the Health Insurance Act 1973, Medicare benefits are not payable for the anaesthetic services. With effect from 1 July 22, note TN.10.8 was amended, with the removal of the paragraph "where an anaesthetist provides an additional (clinically relevant) service during anaesthesia that is not one listed in Subgroup 19 (excluding intravenous infusion or electrocardiographic monitoring) the relevant non-RVG item should be claimed." The ASA submission to the DOH, resulted in Medical Services Advisory Committee (MSAC) endorsing ASA's request to have 55135, 13703 and 40018 replicated in the RVG. The approval for replication of 55135, 13703 and 40018 is now subject to the budget approval process, and the ASA will keep you updated once this is actioned.

MBS compliance process

Please note that the DOH's usual process to incorrect billing and non-compliance is done via the Audit and Targeted letter programme. If you believe you made a billing error, please acknowledge it voluntarily. There is no penalty for voluntary acknowledging incorrect claims. Please see the timeline of compliance process last year.

The DOH has outlined the guidance for providing compliant services. When billing an MBS item for the service provided, the provider should:

- Be confident that the service is clinically relevant and that the provider has fulfilled the service requirement as specified in the item descriptor
- If one service was rendered, one item is billed
- If more than one service was rendered in one patient episode, appropriate items for each service may be billed provided each service fully meets the item descriptor
- If a combination of procedures commonly performed together and an MBS item specifically describes the combination of procedures, only that one item may be billed
- It is important to understand the full requirements of each medical service, and the complete medical service principle prior to billing an MBS item

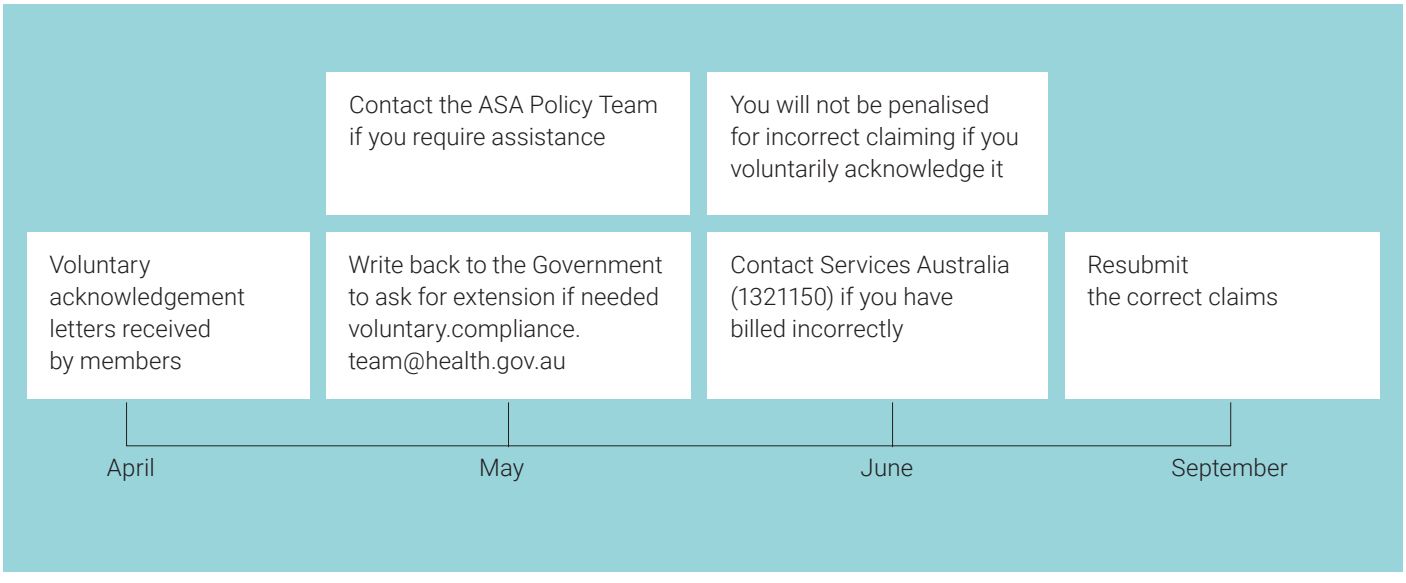
Record keeping is another important aspect of compliant billing. When providing, or initiating, a service where a medical or pharmaceutical benefit is payable, it is important to keep adequate and up-to-date records. Records should:

- Clearly identify the name of the patient
- Have a separate entry for each patient attendance or service
- Include the date the service was initiated or provided
- Contain enough information to explain the type of service provided
- Be clear enough so another health professional, relying on the record, could effectively undertake the patient's care
- Be up to date by creating the record during or as soon after the treatment or service occurred
- Be either in a paper or electronic form.

Scan the QR code to access the quick guide for record keeping

SCAN ME

Dr Michael Lumsden-Steel and Katya Sadetskaya PhD



PROFESSIONAL ISSUE ADVISARY COMMITTEE REPORT

DR PETER WATERHOUSE
PIAC CHAIR

The focus on education in this edition of Australian Anaesthetist has afforded me an opportunity to reflect upon what I have learned about professional issues over the past few years. The professional challenges facing individual anaesthetists or small groups are not often publicised, although there is much to be learned from these cases.

Members come to the ASA for assistance with a diverse range of challenging situations. The spectrum ranges from management of impairment in a colleague, to harassment by opportunistic personal injury lawyers. However, two themes account for the majority of requests for help: clinical accreditation and after-hours rosters. The relationship between doctors and hospital managers is fundamental to both of these themes.

After-hours rostering

Few would argue that hospitals and doctors share a responsibility to provide after-hours and emergency care to patients. The devil, it appears, is in the detail. Perhaps the main reason that rostering disputes occur so frequently is that there is no universal solution to the provision of after-hours care. There are simply too many variables for any single solution to be widely applicable.

Healthcare facilities vary greatly with respect to the volume, acuity and specialty of their out-of-hours work. Geographical factors including traffic and travel times have a major influence too. While some major cities provide after-hours cover on a group practice basis, others have a separate roster for each hospital or group of hospitals. Regional centres often have a unified roster for the entire town to ease the burden on individual doctors. Obstetric rosters are especially challenging, and several successful models have evolved to suit the requirements of individual units and communities.

Participation in some rosters becomes optional after the age of fifty-five. Others reduce commitment through more subtle mechanisms. Similarly, physical frailty, pregnancy and social factors are all dealt with on their own merits when considering roster participation. The myriad variables inherent in after-hours care pose a challenge for hospital administrators. Fortunately, in most cases, collaboration between doctors and managers ensures that patients are cared for at all hours.

Accreditation

Accreditation by healthcare facilities is fundamental to the practice of anaesthesia. From an administrative point of view, accreditation represents the intersection of individual medical practice with hospital management. Its purpose is to clarify the responsibilities of both parties in the collaborative provision of patient care.

Essentially, accreditation seeks to ensure adequate standards of:

- Qualifications and indemnity cover
- Scope of practice including areas of specialty
- Continuing professional development and ongoing practice evaluation
- Fitness to practice and good character
- After-hours cover

High emotions

It is important to acknowledge that accreditation produces strong emotional responses in both doctors and hospital administrators. There is much at stake for both parties. Most obviously, without accreditation a doctor cannot work. Consequently, any threat to accreditation is likely to induce strong negative emotions, including fear and anger.

From the viewpoint of hospital administrators, accreditation can be seen as a tool to assist in achieving management goals. Where frustration exists in the context of difficult negotiations, it is tempting to link compliance to accreditation, but this strategy risks losing good will between management and accredited practitioners.

Who loses accreditation?

Statistics regarding the withdrawal of clinical privileges are not available. One would expect loss of accreditation to result from evidence of poor clinical skills or judgement, but this is not so in many cases. The behaviour and reactions of doctors in challenging situations appear to be fundamentally important with respect to ongoing accreditation.

Fairness

The observation above suggests that accreditation processes are not necessarily fair. How can a competent doctor lose accreditation when patient safety has not been jeopardised? The processes followed in accreditation disputes can be opaque and appeals for procedural fairness are rarely effective in changing the outcome. Ultimately accreditation at a healthcare facility is a privilege granted by the facility in its absolute discretion. From the hospital's point of view, breakdown of its relationship with an accredited doctor might constitute grounds for withdrawal of privileges, irrespective of other considerations.

What works in difficult discussions?

Doctors and hospital managers are on the same team, partners in patient care. This is easy to overlook when relationships are strained. In the day-to-day operation of a hospital, the immediate objectives of doctors and managers are not always perfectly aligned. Conservation of a good working relationship will facilitate a path through these inevitable differences of opinion.

Communication

Irrespective of the merits of any case, open and respectful communication is essential to obtaining a mutually acceptable outcome. This is especially important when it seems there is no case to answer. A vexatious report or trivial problem should not threaten a doctor's accreditation and ability to practice. It is natural to feel angry under these circumstances. However, an emotional response can lead to rapid escalation of the problem. It is more important to preserve dignity and accreditation than to be proven right.

Positivity

Once the major issues are identified, a collaborative and open-minded search for solutions can begin. Problems will be solved when all parties genuinely want a solution.

What doesn't work

Threats

Threats are at once inflammatory and ineffective. The threat to revoke a doctor's credentials in a roster dispute is a case in point. Hospital managers struggling to fill a roster may be tempted to withdraw the accreditation of those who do not comply with their directives. Logic dictates that this can only worsen the roster crisis by reducing the pool of people able to participate. A better course may be to acknowledge and address any obstacles to success. If there were no major problems with the previous roster it wouldn't have failed. Once problems have been acknowledged a collaborative solution may be found. Unilaterally imposed 'solutions' tend not to be very durable.

To my knowledge, threats to deny accreditation to groups of doctors over a roster dispute have not been acted upon. The consequences of such a course of action would be harmful to patients, doctors, the reputation of the facility and perhaps the career prospects of the administrator responsible.

Public statements

Issuing public statements in the midst of a dispute heightens antipathy between opposing parties. Resolution is unlikely to be facilitated by this approach.

Direct external intervention

If a problem could not be resolved by a decree from management, then a decree from an external body (such as the ASA) is unlikely to be any more successful. In difficult negotiations, compromise is likely to be required. This is facilitated by ongoing respectful communication.

The role of professional societies

While direct intervention is likely to be both unwelcome and unsuccessful, there is an important place for bodies like the ASA in accreditation and rostering disputes.

The effect of scrutiny

The Hawthorne effect describes changes in a person's behaviour in response to the knowledge that he or she is being observed. This is a powerful effect, often ensuring good and reasonable behaviour during tense negotiations.

Validation

When lost in a difficult negotiation it is easy to fall prey to doubt and demoralisation. Involvement of a professional body provides a dispassionate sounding board, even if no easy solutions are forthcoming. In addition, the involvement of a professional organisation demonstrates to hospital managers that those involved in the dispute are probably not an isolated cohort of difficult people. Rather they are likely to be representative of a larger group with a similar outlook.

Moral support

The presence of professional bodies during tough meetings is a source of solidarity and strength.

Material support

Simple administrative resources can be most useful. The ASA can host virtual meetings, administer surveys and facilitate communication. Each of these have been very helpful in recent disputes.

Prevention is best

Thankfully, accreditation and roster disputes only affect a small proportion the workforce at any one time. How does the majority stay out of trouble? Personalities certainly play a part, on both sides of the doctor-hospital relationship. There will always be challenging people and situations. Steps can be taken to mitigate the risk of serious disputes and ensure that any problems which do arise do not lead to undue stress or even unemployment.

Be involved in hospital administration

Good relationships in hospitals do not cultivate themselves. Working relationships with managers are easily developed in the low-stress context of committee work. When a difficult situation arises, it is helpful if the people involved are not strangers to each other.

Participate in your craft group

A robust anaesthetic department or craft group will detect unfavourable developments as they arise and will be of great assistance in promoting a culture of doctor-led medical care. Mentoring and clinical support are also facilitated by the existence of a close group of accredited specialists in any hospital. Furthermore, nursing staff will feel supported by a unified medical group, who can assist in negotiations with hospital management regarding clinical matters.

Always be respectful

Like lawsuits, accreditation problems appear to be less likely for doctors who are well liked. Of course, just being nice might not make a person a good doctor, but it might reduce the chances of a stressful confrontation.

Dr Peter Waterhouse

THE HARRY DALY MUSEUM RE-OPENS FOR BUSINESS

The historical trio

Education is one of life's empowerments, not only for the individual but for society in general. It is a dynamic definitely worthy of nurturing.

The process of education comprises a set of personal challenges. It consists of stimulating events and encounters, which are driven by one's own thirst for knowledge and experience. It consists not only of listening to someone else's vocal emanations or pictorial projections during a formal lecture, but it also entails self-directed study and research by the individual – be it in the field, a laboratory, a library (or equivalent such as the internet) or in a museum. Acquiring a knowledge of history, in this particular case the history of anaesthesia, enables one to have a deeper appreciation of a career choice and profession as well as the development of the systems, apparatuses and drugs that we, as anaesthetists, use every day. Such acquisition can help build confidence in our present practices and device usage.

As well, a more detailed examination of historical events and objects can give us inspirational insights and ideas for future developments. To know where we have been, can help us know what we want to avoid and just where we want and need to go.

To this end, ASA members have the privilege of marvellous and free resources available to them at the eponymously named 'Historical Trio' of the Harry Daly Museum, the Richard Bailey Library and the Gwen Wilson Archives. The Society's History of Anaesthesia Library, Museum and Archives (HALMA) committee has the responsibility for the care of that trio. All of these facilities are now housed in the new ASA headquarters at 86 Chandos Street, Naremburn, conveniently located a five-minute walk from St Leonards train station and serviced by many two hour timed parking spots in the street right at the door of the building.

The museum is named after one of the seven founders of the ASA, a man who also served as the Society's third President from 1946-1947, Dr Harry Daly. He donated his entire collection of

objects, which included many that had come from the Melbourne-based Dr Geoffrey Kaye, to the New South Wales Section of the Society in the 1950s. This formed the basis of the now much-expanded facility we have today. Over the years, we have received donations of objects from individual anaesthetists and their families as well as several hospitals when they were undertaking equipment upgrades. We now have well over 2,000 objects in the collection. These objects are displayed in cabinets, in drawers and on open shelves. They are, of course, numbered and listed in readily available printed catalogues and iPads where descriptors and information on relevance, donors and side-stories exist.

The museum facility is also enhanced by providing the following internet pathways from its page on the ASA website:

- History of Harry Daly Museum
- The Collection – explore our online collection on eHive
- Online exhibitions – Recollections: Working in Sydney's Operating Theatres
- History of Anaesthesia Timeline – an historiographic listing of nearly 1,200 snippets of the history of anaesthesia gleaned from numerous peer-reviewed journal articles and books to help stir interest and possibly produce a spark for further research

Harry Daly Museum Events

HALMA is particularly proud that our collection includes objects devised by Australians or people working in Australia. Their names include Drs Duncan Campbell, David Komesaroff, Mark Lidwill, "Dick" Stephens, John Stocks and Kevin Yee and also Engineer Hubert Clements. They have all, by their ingenuity, helped advance the science and art of anaesthetic practice. It is an education in itself to find out how they achieved this and so you are more than welcome to do so by visiting your museum.

The library, which is a collection of over 3,000 books, comprising both historical and more modern (i.e. future historical) books, is named after its greatest contributor and previous honorary librarian and museum curator, Dr Richard Bailey. In the past, Dr Bailey not only contributed his collection of approximately 300 historical books on mesmerism, including the first translation of Anton Mesmer's 1779 'Memoire sur la decouverte du Magnetisme Animal' but also many other extremely valuable volumes, including two more just before Christmas gone. One of these latter ones is titled 'A Treatise on The Inhalation of the Vapour of Ether for the Prevention of Pain in Surgical Operations' – A first edition (1847) of the first textbook of ether anaesthesia by the first person to deliver an ether anaesthetic in the United Kingdom (on December 19, 1846), Dr James Robinson, a London dentist. Because of the significance of the library's contents, it is not a 'lending' library as such, but visitors are more than welcome to access and make use of its books during a visit to the facility. Much research can be done at the library's beautiful oak table!

The archives contain documents relating to the running of the business of the Society. Apart from the legally required financial records, there exist minutes of meetings held by committees across the organisation since its inception. Many of these Society records, together with records held by the College, contributed greatly to the now deceased Dr Gwenifer Wilson's research behind her dual volume publication, 'One Grand Chain', which records the history of anaesthesia in Australia from 1846 to 1962. The archives have since been named in Dr Wilson's honour.

Now that HALMA's charges are once again operational, following about two years of closures for both relocation to a new ASA headquarters' building and the introductory curse of Covid-19, we will again be organising formal seminars on anaesthesia-history-related topics throughout the year. The first of these will definitely be a 'first'! It will



Harry Daly Museum re-opening December 2022

be an onsite museum workshop, held in conjunction with ANZCA's Annual Scientific Meeting organisers in May this year, when we will be presenting an event titled 'Staying Connected'. This will include presentations by the Curators of the Harry Daly Museum (Sydney) and the Geoffrey Kaye Museum (Melbourne), Kate Pentecost and Monica Cronin respectively, along with other history-minded speakers, such as Dr Michael Cooper AM, the Editor of the History Supplement of Anaesthesia & Intensive Care journal, Dr Andrew Walpole, the Chairman of the History of Anaesthesia Special Interest Group and Dr Christine Ball AM, the Honorary Curator of the Geoffrey Kaye Museum in Melbourne. A special hands-on guided tour of the three facilities will be an integral part of the event. Future seminars will be open to both ASA members as well as members of the general public.

Not only will members be welcomed at these planned seminars, but they are especially welcome to visit individually at any time throughout the year. Currently, our Harry Daly Museum Curator, Kate, is available from Monday to Wednesday each week, so a visit would be optimal on those days.

I urge all ASA members to invoke their curiosity, and hence possibly help others to settle their own curiosity, by using the 'Historical Trio' to extend the research goals of an holistic education in anaesthesia by including the profession's history in that itinerary.

Dr Reg Cammack

Chairman, HALMA

Date: Friday 5 May

Time: 3:30pm – 5:00pm

Register:

https://asm.anzca.edu.au/2023-registration

Cost: $35 (paid as part of ANZCA ASM registration)

Further information: contact Kate Pentecost curator@asa.org.au

ANZCA ASM Event at the ASA Museum and Library History of Anaesthesia Special Interest Group: Staying connected!

Discover the rich history of anaesthesia at the History of Anaesthesia SIG workshop. Explore the new site of the Richard Bailey Library and Harry Daly Museum, learn about research grants and prizes, and participate in group discussions on preserving departmental history. Gain insight into how anaesthetic equipment developments have reduced complications and improved patient outcomes, all in a historical context.

2014 CPD: Knowledge and skills
Short format learning at one credit per hour

2023 CPD: Knowledge and skills
Short format learning – 1.5 hours

Key facilitator/s:

Dr Michael Cooper, Dr Andrew Walpole, Dr Christine Ball, Dr Reg Cammack, Monica Cronin and Kate Pentecost

AROUND AUSTRALIA

New South Wales

Dr Simon Martel

Chair of the New South Wales Committee of Management
NSWchair@asa.org.au

Firstly, I'd like to personally thank Dr Lan-Hoa Lê on behalf of the NSW Committee and all NSW anaesthetists, for three years of excellent service as the NSW Chair. It's been a turbulent time, which has kept our committee busy, and Dr Lê has shown tireless and exceptional leadership. I look forward to leading the NSW Committee, hoping it will be somewhat less eventful than the last three years, though aware that the actions of government, hospitals and health funds will likely keep our committee busy.

Workforce

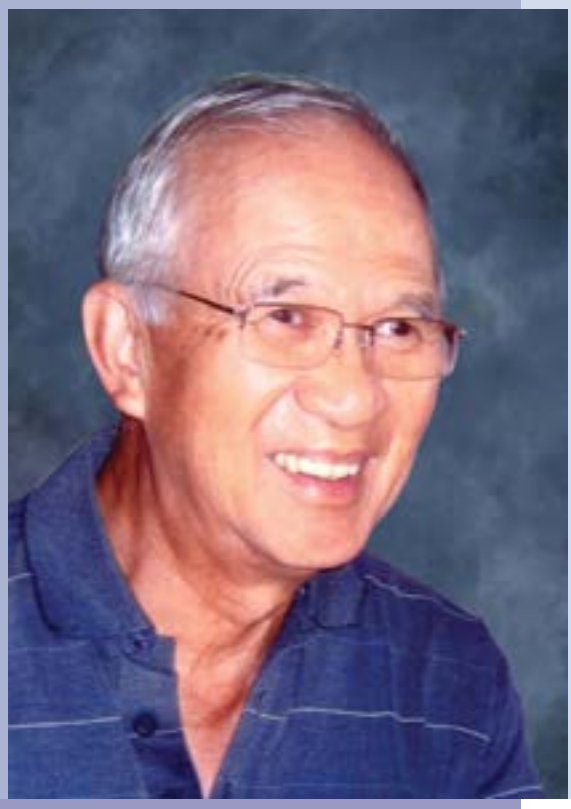
The public elective surgery waitlist continues to increase. This has been exacerbated by workforce shortages, with the cancellation of lists due to anaesthetist shortages at multiple hospitals. Workforce shortages are leaking over into the private, where once popular paid on-call shifts are impossible to give away, with people offering bounties of several hundred dollars. In response, many private hospitals have significantly increased their public in private rates. The ASA has supported groups of anaesthetists in applying for an ACCC exemption to collectively bargain. If you feel you would benefit from this, please contact the ASA policy team at policy@asa.org.au.

Staff Specialist Members

The ASA has been supporting public hospital staff specialist anaesthetists, where an outdated, poorly structured and uncompetitive award comparative to other states, has resulted in difficulty recruiting specialist anaesthetists. This is particularly so in subspecialty areas such as paediatrics, where the ASA has provided significant support to anaesthetists at the Children's Hospital Westmead. Staff specialist anaesthetists at other hospitals have also been in touch with our committee, and we are keen to explore ways in which we can better represent these members. We would welcome interest from staff specialists with an interest in industrial representation, to join our committee. Please contact me at NSWChair@asa.org.au.

State Insurance Regulatory Authority (SIRA)

The NSW government has recently passed legislation that provides SIRA with powers in relation to its workers compensation scheme. This includes directing medical practitioners to provide claim-related data, take specified action or provide relevant services in a specified way, to not provide some or all relevant services to an injured person, and the ability to publish a public register of practitioners who do not comply with directions issued by SIRA. We are monitoring the issue and would like to hear from anaesthetists who believe SIRA is using these new powers inappropriately, at policy@asa.org.au.



EDMUND (EDDIE) LOONG OAM 1940 – 2023

Eddie was the last of the great founding fathers of anaesthesia at the Prince of Wales, Prince Henry, Eastern Suburbs Hospital in the early 70s. Those who shared that title with Eddie who have gone before include George Davidson, Graham Fisk, Jim Loughman, Keith Lethean, John Von Willer, Judy Williams, Nick Coroneos, John Lawrence and Colin Friendship. He was part of that big team of people who gave their time and their lives to ensure that anaesthesia and intensive care came out of the backwaters and onto the high ground in the late 60s and 70s, establishing anaesthesia as a valued and important part of the practice of medicine and not just in surgery. He was one of the giants on whose shoulders we were able to see the future.

Eddie was educated at Marist Brothers College in Parramatta and at the University of Sydney, going to Tasmania for resident training at Launceston and returning to Sydney in 1966–1970 to the Prince of Wales, Prince Henry Group, becoming a Member of the Faculty in 1970. In 1970 he was a staff specialist at Sutherland Hospital and was the Resuscitation Officer, becoming Director of Anaesthesia in 1974 until 1987 when he moved to Lismore.

Eddie was a most energetic, very neat, quiet person, who always seemed to be on the go, getting things done better. He established an epidural service at Sutherland, whilst rushing down between cases to cope with the artificial rupture of membranes and planned deliveries the floor below. And, on Wednesdays, Eddie went to St Vincent's Hospital intensive care unit to consult with Bob Wright and Professor Harrison, with whom he had a very close relationship, taking his registrar along. At that time, he lived in a nunnery and was married to a charming woman, Margaret, with a tribe of kids, doing it all as a staff specialist.

Eddie was an innovator and an organisational genius, a skilled teacher and analyser of new methods and new methodologies, a promoter of high-quality practice, a man of enormous personal integrity and forthright often to the point of bluntness. But behind all of that was a compassion and wisdom that showed in his judgement and practice, and the way in which he organised the hospital at Sutherland and personally cared for patients. He was also a great attender of meetings, right to the very end, and a great picker of brains. It was not uncommon to hear Eddie ask the pertinent question.

Eddie has made many major contributions. He was Director of Anaesthetics at Sutherland Hospital where he established the approved Registrar Training Program. He became a renowned clinical tutor, especially in regional anaesthesia, for the fellowship course at the University of Sydney and kept that position until he left Sydney in 1987. From 1975 he was a member of the Resuscitation Council of NSW and Medical Advisory Panel of the Life Saving Association, and a lecturer in the program brought to Australia by Professor

Stewart from Los Angeles for Paramedic training for NSW Ambulance Officers. In 1979 he was a member of the Technical Advisory Committee on Operating Theatres, helping design both the quality and standards in our public hospital system. That year he also gave his time to go to Indonesia to work in Malang and Bandung with the gynaecological team sponsored by the Australian Department of Foreign Affairs.

Other major contributions include serving as the Medical Advisor on NSW Government Stores for the NSW Health Department in 1981, taking the role of Visiting Clinical Professor for the Department of Anaesthetics at the University Hospital in Edmonton, Canada in 1982, serving on the Australian Resuscitation Council as the Appointee of Faculty of Anaesthetists and Royal Australian College of Surgeons and the Australian and New Zealand Intensive Care Society in 1983, serving on the Medical Advisory Committee of the Ambulance Service, particularly in the area of paramedics from 1981 to 86, and representing the Department of Health in 1986 on the Committee of Standards of Association of Australia. Throughout these commitments, he was an advisor to the Red Cross in Transfusion Medicine.

For all of this and more he was awarded the Order of Australia Medal in 2002 for services to community, resuscitation and to anaesthesia, particularly regional anaesthesia.

In 1987 Eddie made a tree change and moved to Lismore, which was undergoing a rebuilding after the loss of several department members. The Northern Rivers was fortunate to have a person who, prior to his arrival from Sydney, was recognised by the Society of Anaesthetists, the Society of Intensive Care, the College of Surgeons and the Health Department as a person whose opinions and research skills were of the highest order. Eddie rebuilt the anaesthesia and intensive care departments in Lismore until handing over the reins in 1993, although he continued to provide excellent service until his retirement in 2000. He was a man prepared to share his knowledge and skills to ensure rural patients received the same standards of care as those in metropolitan Sydney.

Unsurprisingly, after retirement, Eddie and Margaret threw themselves very much into reorganising the church and religious life, Alstonville, U3A, tennis, and a lot of other community service.

Eddie was a successful clinician, a beloved father, friend and most certainly anaesthetist with a collection of friends at the highest level internationally, especially in the field of regional anaesthesia.

Condolences to Eddie's family on their loss.

Dr Brian Pezzutti

LETTERS TO THE EDITOR

Dear Ed.,

The articles by Drs Mark Sinclair and Peter Waterhouse in the December 2022 Australian Anaesthetist contain timely warnings about how medicine in Australia should progress.

The North American example of health care places patient needs secondary to company profits, has sections of the population left out and medical care directed by commercial interests. Perhaps this has improved under 'Obamacare'? The British NHS appears to be a more equitable, inclusive model, which provides an acceptable level of care and training. Our Medicare has performed quite well too, though rebates have not kept up with practice costs and State governments have often underfunded training institutions.

However there is another threat and that is loss of control of medicine. Medicine is best directed by medically qualified medical clinicians.

One loss was reported by Dr Sinclair. The ASA and our College have been adamant that anaesthesia should be a medical procedure, as has occurred in other countries. They have lobbied hard on our behalf. In America, and other countries, anaesthesia has been farmed out as a nursing procedure and they have developed a training scheme. This has culminated in a ludicrous, shameful proposal to award a Doctorate of Philosophy in anaesthesia after a one year, online, part-time course! This is the complete antithesis of the academic excellence and original research implied in a PhD. Medically qualified anaesthetists will be indistinguishable from nurse anaesthetists and the topic (sic) of anaesthesia will have been dumbed-down.

Both Dr Sinclair and Dr Waterhouse describe a model which causes medical practice to be directed by financial factors and commercial profits. When a third party intrudes between a patient and doctor, it alters the relationship and care the patient receives.

If Australia adopts the American model of health care, Australians will come to know what they have lost. The early signs are there with reports of decreasing numbers of medical graduates opting for general practice. One certainty exists: charging excessive amounts for procedures, prostheses, medications and hospital stays will force an alliance between patients and insurers.

Let's not lose control!

Dave Fenwick
(Retired anaesthetist, South Australia)

Join now and connect with your community

Australian Society of Anaesthetists®

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.

www.asa.org.au | 1800 806 654 | membership@asa.org.au

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

ASANSC2023

4–8 October Melbourne

Choice Challenge Change

International Keynote Speakers

A/Professor Gunisha Kaur

Professor Jennifer Weller

Dr Vanessa Beavis

International 'Virtual' Keynote Speakers

Professor Robert Hahn

Professor Elizabeth Malinzak

Professor Ramani Moonesinghe

Next Generation Keynote Speakers

A/Professor Jai Darvall

A/Professor Lachlan Miles

A/Professor Julia Dubowitz

The Australian Society of Anaesthetists annual National Scientific Congress will be held in Melbourne in October 2023. This in person Congress will include a fantastic scientific program featuring distinguished international keynote speakers. Non-Scientific program includes Welcome party on 4 Oct, Gala dinner on 6 Oct, laneway tours and more. It is the perfect opportunity to meet research and prize winners and collect Practice Evaluation CPD points that will meet the new CPD program, all while networking and socialising with colleagues. International speakers in addition to Keynote Speakers include Prof. Elizabeth Malinzak, Prof. Ramani Moonesinghe and Prof. Robert Hanh.

Tune in to Australian Anaesthesia podcast with Dr Suzi Nou to hear more from our international speakers

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