AUSTRALIAN
# Anaesthetist
THE MAGAZINE OF THE AUSTRALIAN SOCIETY OF ANAESTHETISTS • DECEMBER 2022

ANAESTHESIA,
RETRIEVAL AND TRAVEL

DOCTORS IN MONGOLIA
MICRONESIA AND PNG

CSC 2022
NEW ZEALAND
WRAP UP

POSTCARD FROM
NEW ORLEANS


RESEARCH AWARD WINNER:
USING PHARMACOGENOMICS TO
GUIDE PERIOPERATIVE THERAPY

Australian Society of
Anaesthetists®

Australian Society of Anaesthetists®

# RVG 23RD EDITION

## EXCLUSIVE TO ASA MEMBERS

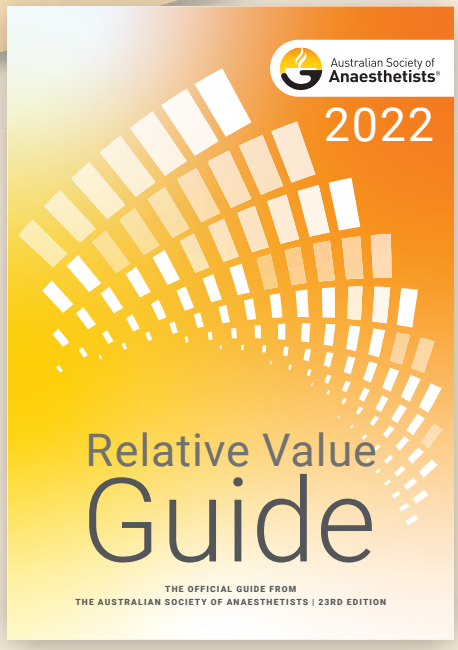

ANDROID APP ON Google play

Download on the App Store

Available for android and iOS.

To download the app search for 'ASA RVG' in your app store and look for the RVG icon. Log in to the app using your standard ASA member log in details.

RVG




## 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 synched favourites, live updates button and push notifications.

New features also include:

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

Australian Society of Anaesthetists®

# Membership fees 2023

Thank you for your ongoing support of the Australian Society of Anaesthetists (ASA). We continue to implement the ASA's vision of supporting, representing and educating members to enable the provision of safe anaesthesia to the community.

Recent changes to the ASA Constitution affecting non-renewals are:

- Declared 'unfinancial' and lose member access on 1st March 2023
- Cancellation of membership on 1st July 2023

You should have received your 2023 membership invoice by mid-December. Any questions, please contact our Membership Services Team at membership@asa.org.au

## *Pay by annual or monthly direct debit*

Please visit **www.asa.org.au/direct** to sign up for annual or monthly direct debit

Complete and submit the relevant online form

## *Pay by BPay*

**www.asa.org.au/payments**

View 'renewal invoice'. Click on the PDF icon at the top to download invoice as PDF

## *Pay online*

**www.asa.org.au/paynow**

***Fees are due by 31 January 2023***

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.

**ADVERTISING ENQUIRIES:**
To advertise in Australian Anaesthetist please contact the Advertising Team on 02 8556 9700 or email advertising@asa.org.au.

**CONTACT US:**

**AUSTRALIAN SOCIETY OF ANAESTHETISTS,**
PO Box 76 St Leonards NSW 1590, Australia
T: 02 8556 9700 E: asa@asa.org.au W: www.asa.org.au



**PRINTED BY:**
Ligare Book Printers Pty Ltd

This book has been printed on paper certified by the Programme for the Endorsement of Forest Certification (PEFC). PEFC is committed to sustainable forest management through third party forest certification of responsibly managed forests. For more info: www.pefc.org.au

## Contents

5 From the ASA President
6 From the CEO
8 Convenors wrap up
10 Compassion
11 Disruptive technology in Anaesthesia
12 Why Mongolia?
14 Doctors In Mongolia
15 East Timor Gratitude
16 Micronesia Anaesthesia Refresher Course
18 Lifebox ANZ
20 Home Away From Home
22 Anaesthesia, Retrieval and Travel
26 Postcard from New Orleans
32 From the SPARC Chair
35 Using pharmacogenomics to guide perioperative therapy
39 Professional Issues Advisory Committee Report
41 Anaesthesia training tips
42 Travel and the CSC
44 Lifebox ANZ - Reflections from the ANZCA trainee representatives
46 Economic Issues Advisory Committee Report
49 webAIRS
50 Policy Matters
52 Letters to the editor
54 Dr Tom Mohler 1965 – 2022
56 New and passing members

Australian Society of Anaesthetists™

A MEMBER SOCIETY OF THE WFSA







## 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

March 2023 issue will feature education: All submissions are due January 25

Image and manuscript specifications can be provided upon request.

Anaesthesia and Intensive Care

## ANAESTHESIA AND INTENSIVE CARE EDITORIAL FELLOW

Dear Colleagues,

Applications are invited from ASA, NZSA, or ANZICS members within their final year of specialty training or within two years of obtaining their specialist qualification for the position of Anaesthesia and Intensive Care Editorial Fellow, 2023.

As with our current editorial positions, the position would be honorary and would be undertaken alongside the applicant's usual employment or training. The term would be for 12 months commencing February 2023.

The successful appointee would be exposed to both the production and editorial aspects of the journal, and would be involved in reviewing submissions, commissioning reviews, contributing to book and media reviews, and undertaking other journal activities, including social media development, all under the supervision of current editorial and/or production staff.

The appointee would be encouraged to attend Editorial Board meetings and the Editors' session at the annual ASA National Scientific Congress. It is anticipated that this activity would be eligible for CPD credits (to be negotiated with the Australian and New Zealand College of Anaesthetists).

Applications will be judged on the basis of applicant's demonstrated interest in research and medical publication. Previous publications experience is desirable but not essential.

Applications should take the form of a one page covering letter indicating the reasons for wishing to undertake this activity, a current CV, and the names of two referees.

Applications should be addressed to the Chief Editor, Anaesthesia and Intensive Care via email aic@asa.org.au by 31 December 2022.

Applicants will be notified of the outcome of their application by mid-January 2023.

Kind regards,

A/Prof John Loadsman

**Chief Editor, Anaesthesia and Intensive Care**

# FROM THE ASA PRESIDENT

ANDREW MILLER
PRESIDENT OF THE ASA

The anaesthetic community can be proud of a long contribution to patient safety and excellence in procedural medicine.

Constant innovation and improvement over the years, built more recently on the work of people like Bill Runciman and Alan Merry last century, has put us well into the category of 'taken for granted' along with clean air and safe air travel.

Experience teaches though that we can take nothing for granted and to stop improving is to start a decline.

The vision for anaesthesia must be to continue to lead the profession in striving to improve quality and patient satisfaction while understanding our role as stewards of the healthcare system that we have and its resources.

By that I mean we cannot simply focus on the best way to block a nerve or model the pharmacokinetics of an infusion.

Good anaesthetists look up around the patient to the entire operating theatre environment. Then they look beyond it to the context of what they are doing to ask how can this whole system run better? We have a responsibility to contribute to that discussion, and to challenge the status quo or the grand new ideas of management when appropriate.

At the recent refreshing face to mask meeting in Wellington, Aotearoa New Zealand, we were challenged to look even further by some excellent speakers covering such topics as equity of access to medicine, compassion and the environment.

If we wish to stake a claim in the wider conversation, about how we work, what work we do, and under what conditions, we need to engage with the bigger issues.

Our conversation must be more sophisticated than 'management and politicians bad', 'doctors good - except that guy - listen to us'.

At the AGM I outlined my optimism about our future organisational capacity to deal in the political public policy space, exploiting the skills of our new CEO Dr Matthew Fisher and his team. For our profession that has traditionally been the domain of only the Federal AMA, with the exception of hot button issues like the Medicare Benefits Schedule review. My vision is that the ASA position itself as a continuously connected advocacy body that is seen as an exemplar society, such that any decision maker who may affect our environment already knows that it is smarter to discuss their ideas with us first.

The recent tabloid claims about Medicare misuse to the tune of $8 billion per annum (out of about $26 billion expenditure) were extraordinary for their professional execution. It was a combined ABC/Fairfax campaign of over 30 articles and television appearances during which the authority of these claims went by and large untested. This has the hallmarks of an organised campaign. We are yet to understand why the people or organisations behind it seem intent on destabilising the universal scheme, but we are preparing to engage in a discussion to defend fee for service medicine and the integrity of our members should it become necessary, which seems quite likely at this stage.

As the eighth wave of covid seems to be gathering steam it is worrying to see some healthcare environments permissive of nosocomial acquisition of the disease, and poor workplace safety in terms of provision of appropriate PPE. Contrast for example the public communications of the Victorian and NSW Chief Health Officers with those of Queensland health, who still focus on hand washing and make no mention of masks.

Anaesthetists should advocate for their own and other staff's safety, because organisations will not always place our well-being before their own rostering and budgetary concerns.

We are currently involved in assisting groups of anaesthetists in public and in private across the country with many aspects of workplace conditions, bundled care arrangements, and Medicare claiming issues.

Please contact the ASA if you feel we can help in any way with any of these issues. We are always stronger together.

**Dr Andrew Miller**

MBBS LLB(Hons) FANZCA
FACLM FAICD FAMA

## Contact

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

# FROM THE CEO

MATTHEW FISHER
CHIEF EXECUTIVE OFFICER, ASA

## Future, Past and Platform

Firstly, I would like to thank the people of the ASA, members and staff, who have engaged with and welcomed me over the past seven months. When I speak to people who ask me about my experience to date, I find it easy to reply - What is not to like about working for an intelligent, empathetic profession who are committed to great outcomes and do so in an unassuming manner. Further, the business has a solid platform to develop, and the staff are engaged with the job they do for the ASA. From a CEO perspective, the board is engaged and provide good support and direction; and the status of the Society and profession provide an identity to take forward.

This can be unpacked further however in short, a great business, profession and people to take forward. The recent CSC2022, business meetings and AGM held in Wellington exemplified this through the observable collegiate interactions, great program and associated events, and a desire to evolve the ASA. The ASA staff who attended – Rhian, Sue, Judy, Natalie, Natasha and Kelly – epitomised the engagement, commitment and professionalism we are anchoring in our work on your behalf, and I greatly appreciate how much they contributed to its success. We aim to reflect the attributes of the profession through our work to ensure a cultural alignment and engender trust and confidence in what we do on your behalf.

Some of the achievements and projects we have in play include:

- Appointing Bernard Rupasinghe as our Policy & Public Affairs Manager to coordinate and drive our efforts in this key area that has been well attended to by Jason and Katya in supporting both PIAC and EAC. Bernard is a lawyer by qualification, has worked in health policy and advocacy for more than 18 years and will be full-time from January.
- Appointing Kelly Chan as our Marketing & Communications Manager to coordinate and focus our strategy and activities in one of the fundamental planks of business and improve what we do. Hayley, Michee and Kate form the basis of her team as we reassess what skills we need into the future. Kelly comes to us from an umbrella body in associations and bring great energy and operations experience to the role.
- Elevating Rhian to our Events and Education Manager and appointing Judy as her key support to improve our capacity and capability in this fundamental member service area.
- Elevating Natalie to be full-time as our Member Engagement Manager and appointing Estelle as her key support to improve our customer service and engagement with you.

Of course, this is supported by Matt and Hannah in finance; Sue, Natasha and Maxine in Executive support and Committee services; and Paul who is directing our IT and cyber-security platforms. Our intent is to make it easier for you to be engaged with the ASA, for you to experience great engagement with us, to trust and have confidence in our professionalism and what we do on your behalf, take the brand of the ASA forward and be an exemplar medical society.

Some of the structural projects we have in play include a public affairs strategy to improve our key messaging to various audiences, taking advice from a health economics group to support our policy team and EAC in submissions, engaging with a member strategist to challenge our thinking in engagement and value, and we have gone to tender on a replacement IT platform to improve our engagement with users and improve the efficiency of how we conduct our business. So, 2023 is already looking interesting.

At the AGM, we made an amendment to the membership business rules given our membership year is 1st January to 31st December and our reporting year is 1st July to 30th June. Members will be asked to renew by 31st January with an effective grace period until the 1st of March when they would be declared unfinancial. I can give you an assurance that we will be engaging with you to ensure you experience value in what we do and do what we can to retain you as members of the ASA through our value proposition and engagement. We, as always, will be taking the approach reflecting your values – which include professionalism and empathy – to ensure if you need assistance or overlook matters, we will be ready to assist. If an unfinancial member resigns or does not re-join by 30th June, they will be removed from the membership database. This will also assist with our compliance and security moving forward.

The ASA continues building relationships for its advocacy platform, meeting with

people and organisations in government and business. What is important is to have our key messages clear and well delivered. These are informed by many of your colleagues who have provided the platform from which we work and refining them for the audience we are meeting with. There are many examples to use, informed by data and brought to life through experience that we use. For example, at a recent breakfast briefing with the Minister of Health and Ageing, the Hon Mark Butler MP, he focused on patient centricity, environment, outcomes, and economics in accordance with the Federal government platform and October budget. All of these are well addressed by the ASA through its submissions to the MBS, our consideration of 'bigger picture' issues but importantly through the work you do. We just need to be provided the greater opportunity to influence not only as the ASA but in concert with other values driven organisations; this will continue to be a priority for us.

I wish you and those important to you, a safe and relaxing festive season.

**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

# COMBINED SCIENTIFIC CONGRESS
# CONVENORS WRAP UP

DR MARK FEATHERSTON

DR CATHERINE CALDWELL

Key note speakers - left to right:
Professor PJ Devereaux, Professor Denny Levett, Professor Kate Leslie, Professor Steve Shafer

The 2022 Combined Scientific Congress (CSC 2022) took a very different shape to its original concept when planning began in 2016. A positive outcome of the Covid-19 pandemic was the hybrid format of the meeting, enabling both face to face and virtual attendance. While disappointing to have to postpone the meeting in 2020, it was well worth the wait to see how excited people were to see each other and the obvious joy in reconnecting with long lost friends.

Wellington Kaumatua (Māori elder), Peter Jackson, set the tone perfectly in his Whakatau (welcome). Recognising that whilst we are enduring tough times in Australasia and across the world,

> "one thing that isn't unsettled, that the average Jo can count on, is the skill that you have, the ability and experience that you bring when we have to undergo a procedure in hospital."

We also recognise the important role these meetings have in allowing us to continue along our learning pathway and in bringing us together. For this CSC there were 760 delegates and 130 exhibitors in person in Te Whanganui-a-Tara, Wellington, and an additional 130 virtual attendees.

Over the four days the scientific programme offered a fantastic breadth of talks, not just scientific in topic but also presentations covering how we deal with people, how we look after the rest of the world, and how important all of these are to us not just as anaesthetists, but also as humans. We received an enormous number of compliments on the high calibre of the speakers and would like to thank the scientific committee for the fantastic job they did here.

Attendees were treated to some highly entertaining talks from experts both local and from abroad. We are grateful to our keynote speakers, Professor PJ Devereaux, Professor Kate Leslie, Professor Denny Levett and Professor Steve Shafer. The debate that concluded the congress on the Monday was both entertaining and thought provoking. As we look towards the future how do we best allocate resources for the greatest outcomes in our field? All four speakers put forward very compelling arguments.

"We received feedback from many delegates, who were grateful for being able to engage with all the speakers and the workshop facilitators over the four days."

Dr Andrew Miller ASA President

Ananesthesia and Intensive Care Journal (AIC) Award winners - left to right:
Dr Jessica Lim, Dr Dilraj Thind, Dr Gregg Best, Dr Patrick Tan, Dr Yasmin Endlich, Dr John Loadsman - (AIC Editor), Dr Kasia Kulmski

CSC2022 Organising Committee

We were very fortunate in that all speakers were able to re-commit to the meeting after the postponement of the 2020 event. It was very generous of them to rearrange their lives, to re-do everything again.

The congress was a heady mix of learning and enjoying each other's company. It is our hope everyone enjoyed it as much as we did, at a professional and academic level, as well as socially. A takeaway for both of us was from the Kester Brown Lecture from Dr Tony Fernando on compassion. It was both entertaining and surprising in that it is something we don't necessarily think about and to understand that it is in-fact something you can think about, learn about, and enhance. That in times when you feel uncompassionate there may be a way to bring yourself back to kindness.

We also greatly valued delving into the research that underpins people's approach to perioperative care, how effective this has been in driving change and the need for more research and multi-centre trials. It has been encouraging to further understand the role artificial intelligence could have in this area to provide the same level of monitoring as we deliver in theatre and to allow timely intervention to maintain patients' recovery in a safe way. It was also reassuring to hear from Professor Steve Shafer that AI and robotics are not going to steal our job!

There are so many individuals to thank in making this event a success. In particular, we would like to mention the organising committee who pulled together so many moving pieces and for overcoming unexpected hurdles along the way. Claire Bark, Brooke Miller, Rachel Cook and the team from Conference Innovators were superb in their organisation and seamlessly overcame so many changes thrown their way since we first engaged with them. They were as much a secret to the success of this congress as the delegates and speakers.

Thanks must go to our two hosting Societies, the Australian Society of Anaesthetists and the New Zealand Society of Anaesthetists. Their important role in providing education to our members and the support of their membership bodies makes meetings and events like this possible.

Whilst it has held many moments of stress and uncertainty this has been an enormously rewarding experience for us both and we hope other anaesthetists attend a meeting like this one and think 'I can do this, and I could do it better'. We believe we all have a professional obligation to get involved in education at whatever level you are comfortable with and encourage others not to run away when the message comes around for the organisation of future events, but to take on the challenge.

Now it is time for us to take some much-needed rest and recovery.

Mā te wā (see you next time).

Ngā mihi nui,

Dr Catherine Caldwell &
Dr Mark Featherston
Convenors, CSC 2022

Left to right:
Dr Mark Sinclair - ASA Vice President, Dr Andrew Mulcahy - ASA Past President, Dr Michael Lumsden-Steele ASA EAC Chair, Dr Peter Waterhouse - ASA PIAC Chair

Left to right:
Dr Andrew Klein, Professor Steve Shafer, Professor Kate Leslie, Dr John Loadsman, Dr Linda Weber

# COMPASSION

## DR TONY FERNANDO

In honour of Paediatric Anaesthetist, Dr Kester Brown, the focus of the Kester Brown Lecture is to hear from a local medical specialist outside of anaesthetics, giving insight into their area of medicine. At the Combined Scientific Congress this lecture was delivered by Auckland based psychiatrist and sleep specialist Dr Tony Fernando. Having recently completed his PhD with the University of Auckland studying compassion in medicine he took us deeper into understanding compassion.

During his PhD, Dr Fernando wanted to understand if specific techniques in the east could enhance techniques in the west and to best understand this received temporary ordination as a Buddhist Monk in Myanmar in 2017 at a Monastery that specialises in compassion meditation.

Fernando first warned

> "compassion is not that easy. There are many variables that will prevent us from being compassionate. Compassion is that extra step from empathy. It's being aware a patient is suffering and wanting to alleviate their pain."

But there is hope, you can enhance your compassion and in doing so Fernando shared,

> "when you're in a compassionate state of mind, parts of the brain involved in positive emotions will fire up and you will feel good. It can improve clinical outcomes and patient satisfaction and reduce your risk of burnout."

To begin to unpack how to be more compassionate Fernando demonstrated we need to understand when we are likely to lose compassion. There are many environmental and internal factors that can influence compassion.

> "As doctors our barriers to compassion are increased. We are surrounded in suffering, fatigue, depression from burnout or dealing with a difficult family or patient."

Stress being another inhibitor, Fernando shared an interesting Princeton study by Daniel Batson that demonstrated the impact stress has on your ability to demonstrate compassion through the behaviour of seminarian students under differing levels of pressure when tasked to write a sermon on the Good Samaritan, a parable of unconditional kindness.

> "These are all factors to be conscious of, to be able to enhance your ability to be compassionate. This all requires a lot of skill."

But once we are mindful of what can impact compassion, how can we be compassionate? Fernando offered his recommendations on how to enhance compassion:

- Consider your speech
  "The Buddha in his wisdom listed ten unskilful things humans do that cause suffering and four involve speech. Is what we say true? Is it kind? Is it the right time and place? What's your motivation for saying this? Being aware of this we learn to be more compassionate in our speech."
- Address burnout, depression and anxiety. Our chances of helping if we have little personal resources are slim.
- Mindfulness meditation also known as kindfulness, has been proven to enhance compassion. If we are more open to all of our experiences, positive or negative, compassion will flow.
- Utilise compassion training protocols that are available focussed on enhancing compassion.
- Learn to identify and manage your inner self-critic.
- Remain calm amongst the chaos.
- Ask yourself, how can I be of benefit to others?
- Learn to deal with difficult people.
  "We all have our stories and dramas and I remind myself the reason they're difficult is that they're suffering. Once I can recognise this, I change from wanting to be defensive to wanting to care."
- "One thing that supports me in my desire to be compassionate is compassion satisfaction. The practice of reflection and savouring times we have helped our patients. Personally, when a patient gives me a good comment, I write it down and put it in a compassion satisfaction folder to revisit when I am questioning my worth as a clinician. I use these to remind myself that I have purpose, a boost of self-worth based on compassion towards others."
- As we consider how we can become more compassionate Fernando allows us to consider the technique of Lama Zopa, a Tibetan Buddhist monk known for his countless compassion projects all over the world.
  "To know suffering. If we can see suffering happening all the time not just in me but in everyone else, then compassion flows."

**Rebecca Burton**

COMBINED SCIENTIFIC CONGRESS | FEATURE SPEAKER

# DISRUPTIVE TECHNOLOGY IN ANAESTHESIA

## PROFESSOR STEVEN SHAFER

**Are robots going to replace us? According to Professor Steve Shafer, we have nothing to worry about.**

A Professor of Anesthesiology, Perioperative and Pain Medicine at the Stanford University Medical Centre Professor Steve Shafer set the tone for discovery and empowerment as one of the first keynote speakers at the Combined Scientific Congress, offering reassurance to embrace the opportunities for the future of technology in anaesthetics and care for our patients.

> "We, humans, were born pre-programmed, our brains process information in a fraction of milliseconds. We evolved in response to evolutionary pressures, which is why we can respond quickly to a snake, but cannot solve a maths equation so quickly."

Shafer took us through the evolution of mankind, how we discovered the benefits of co-operation

> "co-operation led to language and language led to cognitive revolution, that lead to civilisation and civilisation led to technology. Today technology has evolved to develop the world we live in."

And to create this technology? We needed maths.

> "We had to discover so much within maths create technology. And we had to invent computing equipment to help us with maths."

IBM, as an example, following their success with Watson on Jeorpardy, turned their focus to healthcare to apply their developments in cognitive computing.

> "IBM Watson healthcare was introduced in 2015, but it failed. Why? At present AI systems don't understand."
>
> "We are constantly learning from day one as humans. Our capacity for learning is pre-programmed. IBM improved Watson with built in learning, machine learning. However, while machine learning sees, interprets, and adjusts based on the data, it does not understand. For example, we fundamentally understand the concept as to why Egypt cannot cross the Golden Gate Bridge. A computer does not."

But in no way is it over for technology in healthcare. Many of our keynote speakers shared opportunities to utilise technology to address current problems in healthcare, and Shafer agrees.

> "Computers can make a huge impact on healthcare. They impact perioperative care because decision support systems built on machine learning do have a role. These systems are in use. They capture vital signs, drug administration, and we get alerts in real time in the operating room for example."

He demonstrated how we could consider technology in the perioperative journey alike how we use Google Maps.

> "Consider that once surgical diagnosis is made, like typing my destination into Google Maps. Upon learning the diagnosis, the data centre will be informed of the need for surgery. The data centre will immediately access medical records, will parse the unstructured data, and will create a procedure plan. Then, the data centre will contact, direct me to the clinics and laboratories in preparation for surgery. It will verify readiness for the procedure. This can all be automated with decision support tools. Even after I reach the hospital the data centre will monitor my vital signs before surgery, after surgery, and into the recovery room. Eventually the data centre monitors me as I return home, and continues to follow my progress during recovery. This is not asking too much from the computing technology."
>
> "However, we cannot stop there. The data centre needs to learn from the process and to share because the goal is to help the next patient who comes in for surgery."

All of this is nothing to fear. Artificial intelligence is not being developed to take our jobs. But is continuing to assist in improving the care we can provide. As Shafer reassured us all,

> "Life has existed for more than two billion years and thrives because biology endlessly renews. No technology can replace us because no technology is self-renewing. It is because we reproduce, we renew generation after generation, that the future belongs to biology."

**Rebecca Burton**

# WHY MONGOLIA?


## Associate Professor DAVID PESCOD AO


A call over 20 years ago from Kester Brown, the Director of Anaesthesia at RCH and also the president of the WFSA. We had met whilst I was a registrar in training at RCH a few years earlier and Kester knew of my early years of drifting around the world delivering anaesthesia. The offer?. Would I like to represent the WFSA at a celebration of 40 years of anaesthesia in Mongolia?. What an offer !, represent the WFSA and travel to Mongolia. Who in their right mind would not leap at the opportunity?. The reality? This was time before surfing the Internet, Mongolia had no tourism, travel was only booked by the travel agents and plane tickets were paper. Kester had approached "everyone" before reaching out to me. Three days of travel to reach Ulaanbataar, minus 40 Celsius, no English, two weeks of only mutton fat and bowls of vodka. But I met an amazing young Mongolian consultant, Ganbold, who had the vision, determination and compassion to raise the standards of anaesthesia in Mongolia.

For decades, anaesthesia training in Mongolia has been neglected. As recently as the 1980s there was limited formal academic training for anaesthetists, with the country's few specialists passing on their imperfect knowledge 'on the job'. Their original training forty years ago (1960) consisted of only several weeks based on 1940s Russian practice. The governing body, the Mongolian Society of Anesthesiologists (MSA), was regarded as disorganised and lacking in education and advocacy. More of a social club for the venerated anaesthetists to share in vodka and snuff.

Ganbold would teach himself English and reach out with a letter requesting a return visit to help him. The next few years were scrappy. I didn't know how to teach and had misconceptions on what to teach but the legendary Dr Amanda Baric OPSM joined me and gradually our Mongolian colleagues learnt English and we learnt what needed to be taught and how to teach.In 2008, the MSA and ASA signed a memorandum of understanding – Anaesthesia Advancement in Mongolia – and drew up a strategic plan to establish the country's own training programs, .


Mongolia had no tourism, travel was only booked by the travel agents and plane tickets were paper. Kester had approached 'everyone' before reaching out to me. Three days of travel to reach Ulaanbataar, minus 40 Celsius, no English, two weeks of only mutton fat and bowls of vodka


Since 2001 over 50 health professionals have joined Amanda and me, raising anaesthesia practice, reducing morbidity/mortality and influencing the development of emergency medicine, surgery and gynaecology in Mongolia. Wherever and whatever we have offered, the MSA has embraced. It has been a joy and a privilege to have collaborated with

our friends over 20 years and we eagerly look forward to further "anaesthesia advancement in Mongolia". The MSA wishes to grow into a true society, the training curriculum is to be redeveloped and extended, draw-over anaesthesia training delivered to the most remote areas and research is in its infancy.

And modern Mongolia? Only a day away, every cuisine is available in the capital city, warm long spring days, beers at the Irish Pub and in the words of Marc Polo " I did not tell half of what I saw, for no one would have believed me". Landlocked between Russia and China, Mongolia is the world's most sparsely populated country, of incredible natural beauty that still preserves the traditional nomadic way of life. Epic landscapes of the foreboding Gobi deserts, jagged peaks and endless steppes, pristine huge Lake Khovsgol in the north, dense forests, and mountain glaciers. And when not engaging in education, our friends will have us riding bactrian camels on the steppe, sharing a bowl of fermented mare's milk and mutton, hearing Mongolian Buddhist prayer chants, scaling huge sand dunes, 'enjoying' throat singing opera, horse riding, seeking dinosaurs and guests at the Naadam festival.

**Associate Professor David Pescod AO**

# DOCTORS IN MONGOLIA

Modern health services in Mongolia began during the 1920s after the country gained independence from China. The Soviet Union joined the Mongolians' battle for independence and maintained a strong influence over the next 70 years. This influence extended to the rapidly expanding Mongolian health service that was based on a model developed by Nikolai Semashko, Commissar of Health in Moscow. But the Semashko model and its focus on developing a large hospital and clinical network had adverse consequences on anaesthesia education and practice. It required the rapid education of vast numbers of health workers, including anaesthetists. The first wave of Mongolian anaesthetists in the 1960s received only four months of training. For decades, anaesthesia training in Mongolia remained neglected. As recently as the 1980s there was limited formal academic training for anaesthetists, with the country's few specialists passing on their imperfect knowledge 'on the job'. By the beginning of the 21st century, the country's anaesthesia practice was under pressure The governing body, the Mongolian Society of Anesthesiologists (MSA), was regarded as disorganised and lacking in education and advocacy. There were only 106 anaesthetists nationwide and an increasing exodus of anaesthetists from the profession. In response, to increase the number of anaesthetists, the Mongolian MOH reduced training time to only four months. Moral decline as morbidity and mortality increased.

Since 2001 ASA members have been collaborating with the MSA. In 2008, the MSA and ASA signed a memorandum of understanding – Anaesthesia Advancement in Mongolia

– and drew up a strategic plan to establish the country's own training programs. It had three major objectives: the advancement of anaesthesia training; improvement in postgraduate training; and support for the academic activities of the MSA. An anaesthesia education centre was established, an Anaesthesia Education Advancement Coordinator appointed, and Australian anaesthetists designed a curriculum and course material.

As of 2017, Mongolia had 200 physician anaesthesia providers or 6.76 per 100,000 population, Currently, 83.6% of Mongolia has achieved the Lancet Commission on Global Surgery goal of access to emergency surgery and anaesthesia within two hours. Surgical mortality decreased from 0.53 per cent in 2000 to 0.2 per cent in 2015 and anaesthetists now safely provide care in more complex procedures, such as open heart and transplant surgery.

Current activities of ASA members include developing a 3 year anaesthesia training curriculum, creating a "GP anaesthesia training program" including draw-over anaesthesia for remote locations, continuing support of the annual MSA scientific meeting, mentoring of research for PhD candidates, and MSA governance.

In 2011 David Pescod was awarded the Medal of Honour by the Mongolian Government and in 2018 the AO. This year Dr Amanda Baric has become the only Australian to be awarded Mongolia's highest honour: The Order of the Polar Star of Mongolia. Previous winners of the Order of the Polar Star include President Barack Obama and Hillary Clinton.

# EAST TIMOR GRATITUDE

Top left: Dr Mingota da Costa Herculano practicing USG. Top right: Vast facilitator training. Above: PSA Conference with Dr Chris Bowden Dr Meg Walmsley and Team

Pada tanggal Kam, 01/09/2022

Dear Hannah,

Good morning

First of all, I want to apologise for the late reply. I've been doing an oncall last night. Secondly, Thank you so much ASA. Thank you for this support. I really appreciate it. ASA has supported us (East Timor Anesthesia) many times in terms of financial support, training and also equipment.

I personally receive immense psychological support every day through Dr. Meg and it helped me a lot. I only can say thank you very much to ASA and to everyone who made it possible.

Warm regards

Dr Maria Pidedade

VIII GOVERNO CONSTITUSIONAL

MINISTERIO DA SAÚDE

HOSPITAL NASIONAL GUIDO VALADARES

Dili, 25/10/2022

My name is Dr Mingota da Costa Herculano, I am an anaesthestist from Timor Leste.

I am grateful for the opportunity from ASA to participate in the Vital Anaesthesia Simulation Training (VAST training) and PSA Conference.

I learned how to became a facilitator in Suva and we applied the practice during the PSA conference.

As part of VAST training, there are a lot of interesting presentations: discussions about the wellbeing of staff, learning from the experiences of other participants during covid time and how they responded to the situation. I was given the opportunity to present an update of anaesthesia in Timor Leste and at the same time share experiences how East Timor Anaesthetists respond to the Covid-19 during the pandemic.

Most interesting was the ultrasound session, where we practiced how to perform block and how to do ECHO and FAST Scans.

Meeting with the experts and listening to the presentations are my big passion.

On behalf of East Timor Anaesthetists and especially from myself I would like to thank ASA for sponsoring me and thanks Dr Chris Bowden, Dr Meg Walmsley and Maxine Wade who made it possible and thanks to all members who support East Timor Anaesthetists directly and indirectly.

Sincerely

Dr Mingota da Costa Herculano


# MICRONESIA ANAESTHESIA REFRESHER COURSE

I have been teaching anaesthesia in Micronesia since 2002. When I speak of my experiences in the region the first question is "Where is Micronesia?"; it is an archipelago of tiny islands (their name comes from the Greek words "small islands") scattered across the North West Pacific.

The archipelago is home to an association of sovereign low-income states, all heavily dependent on overseas aid.

It is a region that is severely under resourced and plagued by a significant burden of untreated surgical disease.

Today, the poorest third of the world's population receive just 6% of the annual global volume of surgery.

This is driven by a lack of qualified personnel, poor equipment, unreliable utilities and a chronic shortage of consumable goods and pharmaceuticals. Many "tertiary" hospitals in low income counties are unable to provide the three bellwether procedures (Caesarian section, laparotomy and open reduction of a long bone fractures) that form the benchmark of safe surgical care.

In 2005, the World Health Organization established a forum to address the global burden of surgical disease and identified the delivery of safe anaesthesia as a key pillar.

Long-term local advocacy by the ASA has been highly instrumental in changing the safety of anaesthesia in Micronesia. The Micronesia Anaesthetic Refresher Course is central to this engagement. It has been running since 1994 and today is the only continuously run continuing medical education (CME) program within the region in any specialty.

The challenges of maintaining a skilled workforce remain very much a stark reality in Micronesia. The limited number of anaesthetists across Micronesia has meant that some of the islands experience an extended absence of medically-delivered anaesthesia.

In Chuuk, an island with a population of 48,000 people, the situation has become chronic where a single nurse anaesthetist has been the sole provider of anaesthesia over the past four years.

The past three decades have witnessed tangible outcomes. The inauguration of the Micronesia Anaesthesiology Society has given agency to the local providers The course has helped bring other specialised courses into the region including Primary Trauma Care, Essential Pain Management and SAFE (Safer Anaesthesia from Education). In 2017 and again in 2020, the program facilitated the distribution of LifeBox pulse oximeters to the region. In 2012 the ASA supported a delegate to attend the World Federation of Societies of Anaesthesiologists (WFSA) meeting in Argentina.

The most rewarding part of this has been the long term partnership and personal connections made with the local anaesthetists, providing agency to a region plagued by significant workforce challenges.

**Dr Arthur Vartis**

Previous page top left: Dr Arthur Vartis presenting the course certificate to Ngoriakl Olmetelel, 'NGO'.
Top right: Dr Stuart Lavender teaching ultrasound.
Top left: Difficult airway workshop.
Upper top right: Palauan meeting in 2017.
Right: Case presentations

# Opportunity to donate

Australian Society of Anaesthetists®

**BENEVOLENT FUND**

**LIFEBOX CHARITY**

**HARRY DALY MUSEUM**

**RICHARD BAILEY LIBRARY**

**Benevolent Fund:**

The purpose of the fund is to assist anaesthetists, their families and dependents or any other person the ASA feels is in dire necessitous circumstances during a time of serious personal hardship.

**Lifebox charity:**

The Lifebox project aims to address the need for more robust safety measures by bringing low-cost, good quality pulse oximeters to low-income countries.

**Harry Daly Museum and Richard Bailey library:**

Help preserve our collection for future generations to enjoy

# LIFEBOX ANZ

## DR MICHAEL COOPER


Lifebox is now over ten years old with much having been achieved in that time and even more is planned for the future. In that time over 32,000 oximeters have been distributed to anaesthesia providers, with accompanying oximetry training, in over 116 countries. In low-and middle-income countries (LMICs), much of this training is provided to non-physician anaesthesia providers (NPAPs) who often provide the majority of anaesthetic care.

Over this time, Lifebox has evolved to work across three core pillars of surgical safety:

1. Continuing to invest in safe anaesthesia
2. Reducing surgical site infection with initiatives such as the Clean Cut program
3. Promoting and improving interdisciplinary teamwork in the operating room with workshops such as Checklist Implementation Strategies or Safe OR courses.

This approach allows the implementation of new projects and involves the full multidisciplinary operating theatre team.

## COVID

During COVID-19, Lifebox distributed 8,800 oximeters across 53 countries for COVID-19 care. Alongside this, Lifebox also developed strategies and resources to keep surgical teams and patients safe, including guidance on safe PPE reuse and a COVID-19 Surgical Patient Checklist - developed with Smile Train and the World Federation of Societies of Anaesthesiologists (WFSA).

What has happened with support for very ill COVID patients in our Pacific region?

There have been various requests from our Pacific neighbours through the pandemic, and travel unless with AusMat or NZMat teams, was impossible at various stages. Despite that, 50 oximeters were sent to Fiji and 100 to Papua New Guinea. Distribution to areas of the greatest need in-country was organised by the local anaesthetists. The Society of Anaesthetists of PNG ran several basic ventilator workshops where the anaesthetic scientific officers from provincial hospitals were sent to

Port Moresby, had a two-day course in prolonged ventilation, proning and given several oximeters to take back to their small hospitals. In many of these hospitals, lung ventilation was limited as were oxygen supplies and concentrators. All images are from the Society of Anaesthetists of PNG.

With the virtual cessation of travel for nearly two years, there has been a pivot to online teaching programs which have been very successful and will now be developed into a routine part of teaching and training. Programs aimed at anaesthetic, surgical and nursing topics have been run by the ASA, ANZCA and Interplast. Online Lifebox pulse oximetry training was successfully implemented for Laos in February 2021 and Lifebox has online Train-the-Trainer courses in English, French, and Spanish.

## Appointments

Lifebox co-founder and Global Chief of Operations, Kristine Stave, is the newly appointed CEO of the WFSA which is a wonderful outcome for both organisations. Rob McDougall has been appointed as our regional representative to the Lifebox Global Governance Council and the UK Board of Lifebox. Suzi Nou, Immediate Past President of the ASA is now the ASA representative to Lifebox ANZ.

Our new Lifebox trainee appointment is Catherine Stirzaker, an advanced trainee in Brisbane who joins the NZ trainee Jennifer Fife. These appointments are aimed at trainees being involved with Lifebox ANZ, supporting activities and fundraising and getting an appreciation of how an NGO operates. Lifebox works as a conduit to allow local organisations to deliver programs and build local sustainability.

## The Future

So what is happening in the future? As many have been saying for a long time, there is an enormous need in resource poor settings for low-cost robust and reliable capnography that will work on all patients, including down to neonates. Specifications have been agreed on and tenders called for to try and develop such a capnograph and this will be an important development in the next few years. This work to find a capnography solution is part of the Smile Train-Lifebox Safe Surgery and Anesthesia Initiative. The 'Lifebox Light' - a headlight to provide quality lighting - is in development and being trialled to allow safe surgery in the many places where power outages are the norm.

Lifebox has been closely identified with oximetry for many years but now we need to broaden our horizons with all our OR colleagues to look at overall safe anaesthesia and surgery. As we get back to 'normal' work within ODEC, ANZCA and the NZSA; Lifebox ANZ can support these developments with courses such as Safe OR or VAST and the Clean Cut initiative in the region. Stronger teams mean safer surgery!

Lifebox ANZ will need to continue to fundraise as we have in the past from meetings where speakers waive their fee or gifts in lieu of a donation to Lifebox ANZ. Even simple efforts within an anaesthetic department such as St George Hospital, Sydney, are highly effective. Their recent (and highly competitive) cake bake-off morning raised over $400 for Lifebox ANZ, being won by anaesthetic registrars Madison Reynolds and Lachlan McLennan.

A new MOU between the four organisations is being agreed and signed. Secretariat support is now resting with Interplast. Donations and regular giving programs can be implemented via the Interplast donation site, see https://interplast.org.au/donate/donate-now/ and select Lifebox.

There are many multilingual resources now available at the Lifebox Learning Network, see:

https://www.lifeboxlearningnetwork.com

I would recommend everyone look at the work our colleagues are doing in the Ukraine – it is very sobering.

Providing Patient Care in Ukraine Today: Anesthesia Under Fire

https://www.youtube.com/watch?v=hBE-78SORMw

The Lifebox Foundation annual report for 2021 is available here:

https://www.lifebox.org/2021-lifebox-annual-report/

**Dr Michael Cooper AM**

Chair, Lifebox ANZ
ODEC committee member
HALMA committee member

PAPUA NEW GUNEA

# HOME AWAY FROM HOME

## DR YASMIN ENDLICH


Dr Yasmin Endlich is a consultant anaesthetist working in South Australia and has been the ANZCA Global Development Committee chair since May 2022.

She has been visiting Papua New Guinea (PNG) every year since 2013 (apart from 2021) for teaching and clinical visits.

Her visits initially focused on basic and advanced airway management education in adult and paediatric patients. PNG has one of the world's highest oral cancer rates, and the care of these patients requires advanced surgical and anaesthetic skills.

Over time the teaching has expanded to basic life support for adults and paediatric patients, advanced life support, neonatal resuscitation, ultrasound-guided regional anaesthesia and anything else that is requested from the local community. Since then, the visiting group of educators accompanying her has expanded, including anaesthetic nurses, ultrasound enthusiasts, paramedics, pain specialists, and simulation instructors.

As a member of the Global Development Committee, Yasmin has marked written assignments and supported candidates in their research and audit projects to complete their anaesthetic training in PNG. In addition, in the last years, she has supported the PNG anaesthetic community as one of the external examiners.

Due to the impact of the pandemic in the last few years, the Pacific Online Learning and Education working group has been established. This working group includes representatives from the Pacific, ANZCA, ASA, and NZSA. In addition, a group of young enthusiastic anaesthetic consultants is organising Saturday morning education sessions on topics chosen by the Pacific representatives. Anaesthetic colleagues who would like to contribute to providing online learning sessions via Zoom on a Saturday morning are always welcome!

Papua New Guinea is a fascinating country, home to over 500 different tribes speaking 800 different languages. The local anaesthetic community is excellent and enthusiastic about learning and continuously expanding their skills and knowledge. By regularly visiting the same country and extending the involvement beyond clinical and surgical visits, valuable relationships and friendships have developed over the years until PNG has transformed into a 'home away from home'.


ANZCA | ASA | NZSA
ACE
ANAESTHESIA
CONTINUING
EDUCATION
SAVE THE DATE
ASURA
2023
2–4 MARCH • ADELAIDE
ADELAIDE CONVENTION CENTRE
JOIN US AT ASURA 2023
THE AUSTRALASIAN SYMPOSIUM ON
ULTRASOUND AND REGIONAL ANAESTHESIA
Associate Professor Enrique A Goytizolo
Dr Rosie Hogg
Dr Adam Spencer
Associate Professor Alwin Chuan
• Hear international speakers
• Take part in plenary talks, masterclasses, small group discussions, workshops and hands-on teaching
• Earn CPD points
• Our symposium coincides with the Adelaide Fringe Festival, take advantage of events occuring walking distance of the conference site
WWW.ASURA.ORG.AU

# ANAESTHESIA, RETRIEVAL AND TRAVEL

## DR KATHERINE JEFFREY

**Dr Katherine Jeffrey is a Sydney based Anaesthetist with a strong interest in critical care and high acuity anaesthesia. She currently works part time for CareFlight NT and CareFlight AirAmbulance (CFAA) as a medical retrieval consultant. In her spare time, she is obtaining her private pilot's licence and planning her next great travel adventure. She holds positions in ASA NSW (Vice President and Welfare/Education Officer) and AMA NSW (North West Representative).**

All images courtesy of Katherine Jeffrey



My journey through anaesthesia training to consultant has deeply enhanced my love of travel. Even with years of study and exams, long days, shift work and many weekends and nights walking the theatre corridors, I have taken advantage of the travels you make for your job.

Any opportunity to travel, I have grabbed with vigour. Even on rotations away for training or on those long eagerly awaited (hard fought for) holidays, I have explored my surrounds and beyond. China, Hong Kong, Singapore, Dubai, Switzerland, USA, Canada, Coffs Harbour, Gold Coast, Wagga Wagga, Bathurst and Griffith to name a few.

In recent years, my focus has been on Australia, particularly the Top End of the Northern Territory (NT). This has come about from a fellowship I undertook in 2019-2020 with CareFlight. I had long thought a fellowship out of my east coast comfort zone would expand my skills and my view of Australia. So, after completing a fellowship in Melbourne, I made plans to head to Darwin for a second fellowship.

CareFlight Northern Operations (CareFlight NT) provides aeromedical retrieval services for the population of the Top End (approximately 600,000 square kilometres). More than 3,000 patients are transported by the service and it covers the main hospitals in the Top End (Royal Darwin, Katherine and Gove District Hospitals) and the many remote clinics in the Top End. A majority (90%) of patients transported are of Aboriginal or Torres Strait Islander descent.

My first trip to Darwin in preparation for my fellowship, I travelled by train. On the Ghan, one of the great rail journeys is a two-day trip from Adelaide to Darwin through the heart of Australia. This gave me a ground view of the Northern Territory, which would soon change to an aerial view provided by my future job. One of the key stops is Alice Springs, the home of the Arrernte People. European settlement led to it being the repeater station on the Australian Overland Telegraph Line which linked Adelaide to Darwin and Great Britain. The original cable station is now a museum showcasing the role of the Overland Telegraph Line in the development of Australia. 'Alice' is now a major stop point for those travelling to Uluru and Darwin.

Excitedly I moved to Darwin, lock stock and pets, and settled in my 18th floor apartment on the Esplanade in Darwin City, overlooking Darwin Harbour. Darwin is the capital of the NT and I think is an underrated city. The daily sunsets are never the same and captivate you with the cascade of colour that is seen nowhere else. Darwin is also becoming a foodie town tapping into the amazing food of the multicultural population.

One of my favourite things to do in Darwin is to enjoy the Deck Chair Cinema, located on the harbour. The harbour breeze provides natural air-conditioning throughout the viewing of a variety of local and overseas movies. The highlight for me was watching 'Top End Wedding' one night, listening to the locals commenting on how many times they appeared in the movie.

Previous page: Cruising through Darwin Harbour at Sunset.
From top: The Ghan, Alice Springs, Top End Chapel, Bathurst Island, Dili Airport from the tail, Sunset at Nightcliff, Darwin


During my spare days off I would grab a bag and explore further into the deep heart of Australia.  No visit to Darwin is complete without time spent in Kakadu, Litchfield National Park and a gorge that spells my name correctly (Katherine Gorge now Nitmiluk Gorge).

Kakadu is a three-hour drive from Darwin and is a world heritage listed site; once you've been there you can understand why. Yellow Water is part of the South Alligator River floodplain and is a great introduction to Kakadu. Words cannot express the beauty of Kakadu. It should be on all Australian's bucket lists.

Litchfield is an hour's drive from Darwin and a good introduction to the national parks of the NT.

Nitmiluk Gorge (Katherine Gorge) is breathtaking. I have seen it from the sky and on water and heard of its history from its custodians. A swim at the Katherine hot springs is a must after the drive from Darwin, it refreshes the body and soul.

I revisited Alice Springs and wandered the Todd River, in awe of the extremes it experiences from inundation to drought. I drove through the MacDonald Ranges and walked the land that inspired Albert Namatjira at Hermannsburg. After repeated medical missions to the Tiwi Islands and Groote Eylandt, I became a tourist and explored these precious Islands that have not been commercialised by tourism.

Tiwi Islands are a two-hour ferry ride (or 30-minute flight) from Darwin and consist of Melville and Bathurst Islands and nine other islands. It has become an increasingly popular place to visit after the success of the Australian movie 'Top End Wedding' which came out prior to my movement from the east coast to Darwin. Of course, I did participate in a Top End Wedding tour in Wurrumiyanga on Bathurst Island.

There is strong indigenous art scene led by Tiwi designs, obviously inspired by the Tiwi Islands' beauty. Tiwi Islands are one of the most stunning places to visit on the ground and see from the air. I have vivid memories flying to Bathurst Island for CareFlight NT with a storm chasing us. One of the major weather patterns known in Darwin, 'Hector', originates from the Tiwi Islands and produces some of the most spectacular thunder and lightning storms particularly in the wet season.

All images courtesy of Katherine Jeffrey

Groote Eylandt is approximately a two-hour flight from Darwin. It is the largest island in the Gulf of Carpentaria and the fourth largest island in Australia. Known for its manganese deposit and home to the Anindilyakwa people, it is slowly being recognised as an emerging holiday destination. Groote Eylandt has a variety of habitats: dense stands of monsoon forests rising behind coastal sand dunes, alternating with mangroves and mudflats which add to its stunning beauty. Not yet commercialised, it has a strong art culture and a drive of the indigenous population to generate a future income from cultural tourism.

CareFlight NT also gave the opportunity to travel beyond the NT. I spent time in Broome, Western Australia, to be on call for medical retrieval. Walking onto an oil rig after a two-hour helicopter ride is one thing many will not experience. You must carry your passport as should any issues with the aircraft arise, you will have to go to Indonesia. My touring of Broome was limited due to on call requirements but I was able wander Cable Beach, do some pearl shopping and watch stunning sunsets. CareFlight NT also undertakes international and interstate retrievals. Indonesia, Adelaide and Brisbane were also locations I flew to. Time is limited in these locations but the flight over land and water gives a view I never tire of.

After my fellowship year, I returned home to Sydney with plans to return regularly to Darwin. I progressed from Retrieval Registrar to Medical Retrieval Consultant (MRC) for CareFlight in 2020, however Covid hit and delayed my return due to border closures. I returned to the NT to start my MRC work and further my travels once the borders opened. Every time I walk off the flight from Sydney to Darwin, I am hit with the scent of humidity, dust and avgas, and I know I am back in the Top End. It is such a joyful feeling.

I am planning to return to Groote Eylandt, Tiwi Islands and Gove to explore and finally visit Uluru. Interestingly, I have taken to the sky myself and am obtaining my Private Pilot's Licence to be able to see more of this stunning land. I recently had the privilege to fly with my flight instructor Trent Robinson of Trent Robinson Aviation and Trent Robinson Photography, and allow him to take some stunning shots of the flight from Darwin to the Tiwi Islands. Now that's diversity in one's career.

A close friend recently asked what was the one thing I have learnt from my travels and work in the NT. Simple; by listening to the custodians of these lands including the Larrakia, Anindilyakwa, Arrernte and Tiwi people, I have learnt the meaning of country and connection to the land we all have. There is so much more to explore.

**Dr Katherine Jeffrey**

Previous page left to right: Broome, Sunset over Darwin International Airport, Retrieval registrar, Hot Springs, Katherine Northern Territory.
This page top: Parking at Gove, NT, Flying over MTK airstrip (Trent Robinson Photography). Storms over Tiwi Islands.
Below: Panorama of 'Hector' heading for Darwin.


# POSTCARD FROM NEW ORLEANS

DR NONI HAROLD

**CIG FELLOWSHIP TO THE AMERICAN ANESTHESIOLOGY MEETING IN NEW ORLEANS**

## Travel

Luckily for me, the magazine's theme of travel sums up my 2022 perfectly. In January, I took a detour from anaesthetic training in Melbourne to work as an aeromedical retrieval registrar in Alice Springs (Mparntwe) with the Central Australian Retrieval Service and Royal Flying Doctor Service. While loading a patient into a plane, I received a call telling me I had been awarded the CIG scholarship. While sweating on an airstrip in the Red Central desert, the idea of me travelling to New Orleans for the 2022 American Anesthesiology Meeting felt akin to a trip to the moon. I didn't think I could find a space more dissimilar but I was wrong. My husband and I found ourselves staying at the extraordinary Xixuau Ecolodge in the Amazon Rainforest immediately prior to the conference. If you are looking for an exercise in cultural shock, travel to the United States from a tiny, remote community deep in the world's biggest rainforest.

New Orleans lived up to its reputation for vibrancy and having an eclectic culture. I started by visiting an outstanding immersive museum called Vue Orleans. The views from the 34th floor observation deck show the disorienting layout of the city around the bend of the Mississippi River. I then walked to the artsy Marigny neighbourhood to visit the very cool Jamnola 'experience'. I'm so glad I went to both of these places on day one as they present all aspects of New Orleans history and culture in creative, flamboyant ways. For accommodation, I stayed at an Airbnb in the Gardens District surrounded by opulent 19th century houses which combine European Victorian style with Caribbean influences. To get to know different suburbs, I decided to tour by eating. New Orleans has an array of iconic, Creole dishes which locals describe as 'soul food'. My favourite was a spicy vegetarian jambalaya. I also came across 'frimp' for the first time – deep-fried fake shrimp. Delicious. Of course there is the music. I went to a few decent jazz gigs but the standout musical performance was a Zydeco band in the Warehouse district of town. The washboard and accordion combination somehow summed up New Orleans so well.

## The Meeting

The grand scale of this conference was something I hadn't previously experienced. I was in the company of 11,000 other delegates in a convention centre spanning almost one kilometre. When I arrived a full marching brass band was energetically performing in the lobby. I met registrants from all corners of the globe. There were two storey high banners in the lobby. People seemed so happy to be with each other. It was infectious pun not intended. I found simply being surrounded by thousands of people - greeting each other, debating, discussing, arguing - in itself a re-energising experience. I probably would have enjoyed myself just sitting amongst the crowds, drinking coffee, people-watching and eavesdropping for a week. Instead, wildly over-estimating my concentration, I enthusiastically jumped into 7-8 hours of daily talks and workshops.

## Diversity, Equity and Inclusion

The highlight of the meeting was the prestigious Emery A. Rovenstine Lecture, a presentation given by Dr Claude Brunson. Dr Brunson is an African-American anaesthesiologist from Mississippi with many impressive accolades to his name. He described his story of being the second ever African American anaesthesiology resident in Mississippi in the late 1980s. For several years he was the only African American anaesthesiologist practicing in the state. He spoke eloquently and carefully but was honest. I thought he was very brave. Anaesthetists are a powerful, influential group of people in our society and we can act as medical leaders to increase

> ... it is not solely up to minority groups to do the work that diversification requires. In Australia, ANZCA and the ASA have a duty to increase diversity in our specialty. As Dr Brunson said, we must "dare to explore and invite new talent qualities" to our tables

diversity in our ranks and leadership. He spoke of recent research describing that financial gains occur with increasing executive leadership diversity. Most importantly however, patients feel safer, have higher rates of satisfaction with their care and will advocate for themselves more when they see doctors similar to themselves. A natural extension of this is an improvement in patient-centred outcomes.

It is not solely up to minority groups to do the work that diversification requires. In Australia, ANZCA and the ASA have a duty to increase diversity in our specialty. As Dr Brunson said, we must "dare to explore and invite new talent qualities" to our tables. By doing this our community will set new precedents while forging new pathways in improving patient-centered anaesthetic care.


## Regional Anaesthesia

The busiest sessions I attended throughout the conference were those on regional anaesthesia. A keen interest in the area was present in the focused crowds. Professor Sanjib Adhikary, a developer of the erector spinae block, told a full room that the mechanism of actions of many fascial plane blocks remain poorly understood.

Multiple tutors spoke of no longer doing transversus abdominal plane blocks (one of the few I feel confident in!) instead shifting almost solely to quadratus lumborum blocks. I was told by a professor in paediatrics that paediatric regional anaesthesia is having a revival and 'renaissance'.

I really enjoyed all of these talks! Despite being interested in the area, I found my knowledge and skill relating to regional anaesthesia is miles behind that of equivalent American residents. I can't ever recall doing or seeing a regional block on a child.

Many residents I spoke to have regional anaesthetic rotations somewhat like a paediatric rotation in Australia. This experience meant their approach to blocks was systematic, somewhat like managing an airway. They talk about plan A, B, C i.e. 'if this approach doesn't work, I'd troubleshoot like this and if that doesn't work I could use this alternate approach to the region'.

Along with the theoretical knowledge I picked up, I hope this approach will be one that I can teach juniors in the future rather than my current plan B which is a general anaesthetic.

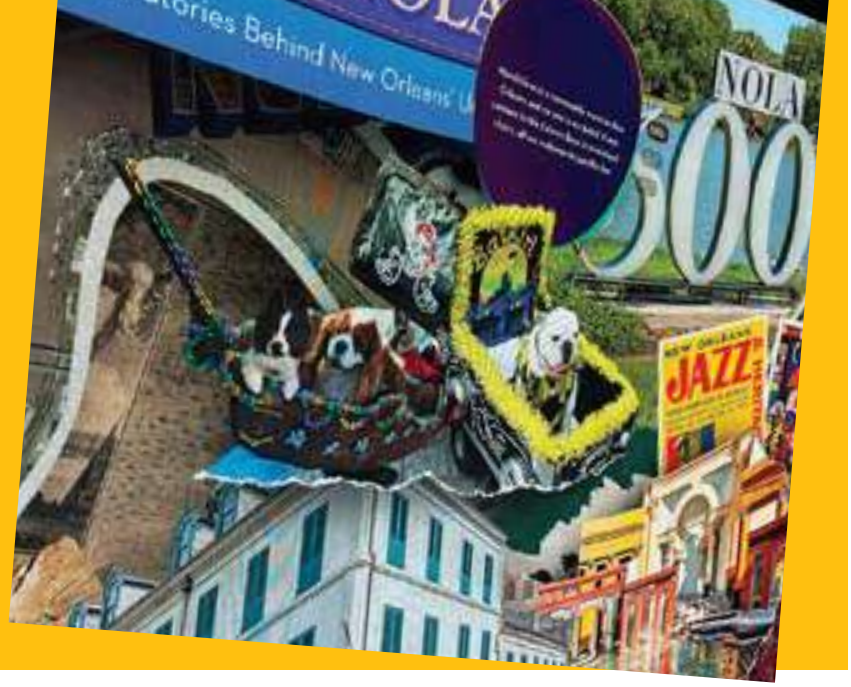
## Sustainability

I had a sleepless night before the first conference day. Similar to the feelings experienced prior to seeing Beyonce live, I was beside myself excited to see world-renowned sustainability experts Professor Jodi Sherman and Associate Professor Harriet Hopf. Both have worked for over ten years to mitigate health care pollution that cuts costs and improves patient outcomes while protecting public health.

Across all the diverse topics of the talks, economics and costs were discussed as integral factors that must be considered in healthcare decision-making. Frustratingly, I didn't hear anything about factors relating to environmental sustainability. It seemed like a glaring admission. Supply-chain resilience and resource stewardship was only mentioned once.

This was disappointing considering many presenters mentioned the shortages that impacted patient care in 2020 and 2021. It is also surprising in context of the increasingly widespread use of disposable items. The large majority of the audience put their hands up to indicate using disposable laryngoscopes. Some departments no longer have established procedures for reprocessing reusable blades. Increased dependency on disposable equipment and increasing risk to supply-chains seems like a recipe for disaster. Both Professor Sherman and Associate Professor Hopf stressed

Across the diverse talks I attended, economics and costs were discussed as integral factors that must be considered in healthcare decision-making. Frustratingly, I didn't hear anything about factors relating to environmental sustainability. It seemed like a glaring admission.




the importance of preparing the global healthcare infrastructure for the climate crisis which will get worse in our lifetimes. They said individual clinicians can do this by contributing to sustainability research and advocating for local measures to mitigate the carbon footprint of healthcare.


## Professional differences

Prior to attending this conference, I only had a vague appreciation of the role and scope of certified registered nurse anaesthetists (CRNAs). I was surprised to hear that CRNAs complete regional anaesthetic blocks and insert invasive lines. In terms of numbers, there are around 59,000 members of the American Association of Nurse Anesthesiology (there are 55,000 members of the American Society of Anesthesiology). CRNAs are the primary anesthesia providers in the United States military. The slogan for the upcoming celebratory week for CRNAs is 'CRNAs: The Original Anesthesia Experts'.

To increase healthcare access during the COVID-19 pandemic many states removed the need for physician supervision for CRNAs. Many of these states have now made these laws permanent. The proponents say that this anesthesia delivery model maximises access to more affordable healthcare.

Interestingly, the American Society of Anesthesiologists (ASA) successfully petitioned the United States government to prevent the Secretary of Veterans Affairs from allowing CRNA-only care to occur in the care of veterans. The 2022 ASA president Dr Randall M. Clark in his opening address to the conference deemed this move would be "lowering the anesthesia standard of care" for veterans. What about all the other patients who are now receiving CRNA-only care?

I imagine that CRNAs will have an evolving and expanding role in Australian-based anaesthesia and I naturally wonder how my role will change over the course of my career in this environment.

## Conclusion

During the conference I met several retired anaesthetists. People who were attending for fun because they still enjoyed hearing about new developments and being amongst a community who shared a common interest. It seems like a great privilege to have a career where a benefit of continual learning is an ability to positively impact other people's lives. It is also a pleasure to have a large, diverse global community of people to engage with. My sincere thanks to the Australian Society of Anaesthetists and its members for supporting me in attending the 2022 ASA Meeting.

**Dr Noni Harold**

Australian Society of Anaesthetists®

# ASA Trainee Members

## Apply for our 2023 international scholarships

**If travel is not possible due to COVID you will be able to defer your scholarship.**

**$4K***

### CANADIAN ANESTHESIOLOGISTS' SOCIETY

Destination

**QUEBEC CITY, CANADA**

Date

**9–12 JUNE 2023**

### ASSOCIATION OF ANAESTHETISTS

Destination

**LEEDS. UK**

Date

**6–7 JULY 2023**

### AMERICAN SOCIETY OF ANESTHESIOLOGISTS

Destination

**SAN FRANCISCO, USA**

Date

**13–17 OCTOBER 2023**

**Attend a conference, network and broaden your experience ...**

Applications open 9 Jan 2023 and close 5pm AEST 31 March 2023. Please log into asa.org.au for more information. Download the application guidelines asa.org.au/trainee-members-group-tmg/

Each participating overseas Society provides one complimentary registration for the Scholarship winner to their meeting.

*Available exclusively to ASA Trainee Members who have been a financial member for 12 months prior to their CIG application. Each scholarship is valued at $4,000 to cover cost of airfares and accommodation.

If COVID prevents overseas travel, scholarship winners may choose to reallocate their win for research or in some way that supports your specialty – with the approval of the ASA.

To become a member of the ASA please contact membership@asa.org.au

# HAPPENINGS AT HALIFAX

In recent years, as we all know, the ASA has had to conduct almost all of its meetings, business and educational, in a virtual format. But in 2022, we were glad to resume face-to-face meetings, with online attendance also available in most cases. So, I was fortunate to be able to travel to Canada in June, along with the ASA Immediate Past President Dr Suzi Nou, to represent the ASA at the meeting of the Common Interest Group (CIG).

The CIG consists of the senior office bearers and CEOs of a group of Anaesthesia Societies and Associations, namely (in alphabetical order):

- American Society of Anesthesiologists
- Association of Anaesthetists (UK and Ireland)
- Australian Society of Anaesthetists
- Canadian Anesthesiologists' Society
- New Zealand Society of Anaesthetists
- South African Society of Anaesthesiologists

The CIG meets annually, rotating from nation to nation, coinciding with the annual scientific conference of the host nation's Society. The executives of the CIG society typically have an extra online meeting each year, as well as attending the face-to-face meetings. In 2022 it was the Canadians' turn, and it was of course the first face-to-face meeting in several years. (Several online meetings were held during the Covid pandemic). The aim of the CIG is to assist in the advancement of anaesthesia practice, patient safety, workforce and industrial issues, and training and development, in each nation.

The meeting was held in Halifax, the capital of the Canadian province of Nova Scotia, on the eastern side of Canada. Which is pretty much the furthest place in the world to travel from Australia! In fact, Google tells me the town closest to the exact opposite point in the world from Halifax (its 'antipodal city', as they term it) is Little Grove, near Albany in WA. Little Grove is about 19,000km from Halifax. My home town of Adelaide is a bit closer, apparently, but it didn't feel like it!

But fortunately, despite the distances involved, my first international trip in some years went largely without a hitch. Seven hours flying overnight in economy across Canada (two flights), after the 15-hour-plus trip from Sydney to Vancouver, was somewhat new to me. But I managed to adjust to the new time zone quite quickly, without much jet lag.

The CIG meeting was held over the subsequent two days. It included a tour of Halifax's Victoria General Hospital, hosted by Prof Orlando Hung (Medical Director of Research, Department of Anesthesiology). We were able to see the Department's 'block room', dedicated to performing local anaesthetic nerve blocks for all patients in the complex who require them (an idea becoming familiar to many of us in Australia) as well as the Department's excellent simulation facility.

Pictured left to right: Orlando Hung, Mike Nathanson (President, Association of Anaesthetists), Beverley Philip (Immediate Past President, ASA USA), Mark Sinclair, Dolores McKeen (President, CAS), Suzi Nou, Lucie Filteau (Vice President, CAS), Michael Champeau, (President-Elect ASA USA). Right: Lego anaesthetic machine.

The rest of the meeting was devoted to updates on current issues in each member nation. Matters which might be of interest to Australian anaesthetists included:

## Certified Registered Nurse Anesthetists (CRNAs) in the USA

As ASA members will be aware, CRNAs have worked alongside medically qualified anesthesiologists in the USA for many years. According to our USA CIG colleagues, the usual model works well. Essentially, this involves CRNAs working semi-independently under the supervision of anesthesiologists. However, there is a strong movement from some within the CRNA profession to move to a fully independent nurse-led model. They have given themselves the title of 'nurse anesthesiologist' (as opposed to 'nurse anesthetist'). Furthermore, we were informed that a one-year part time online course is available to them, resulting in the awarding of a PhD. These CRNA's would then be able to call themselves 'Dr' as well as 'anesthesiologist'. They are energetically lobbying for totally independent practising rights. Needless to say, the American Society of Anesthesiologists is strongly opposing the move, while continuing to support the semi-autonomous CRNA model.

The Canadians do not currently utilise CRNAs. However, there are many Canadian nurses trained as CRNAs, working in the USA. They see Canada as a potentially fertile ground for rolling out a similar model. This was of significant concern to our Canadian CIG colleagues, especially given workforce issues (see below).

Above: Halifax town clock  Below: Halifax, Nova-Scotia

## Managed Care

Our USA (and other) colleagues were very interested in our presentation on the various funding models being proposed by Australian private health insurers. The Americans tell us that we are basically in the same position as they were, a little over two decades ago. When asked what they would have done if able to go back to that point in time, their response was that it would not only involve stronger opposition to such schemes. They would also have done more to prevent 'egregious' billing and other practices by their colleagues, which, while rare, gave insurers and others the opening to step in and 'fix' the 'problem'.

## Workforce Issues

Canada and the USA find themselves facing a relative shortage of anesthesiologists. It was somewhat surprising to our CIG colleagues that things are different in Australia. We have had, in recent times, a relative oversupply in metropolitan areas, although we (and the other CIG members) face shortages in rural and/or remote areas.

There was a concern that an inability to source medically-qualified anesthesiologists may assist "nurse anesthesiologists" in their quest to gain independent status.

The next couple of days were taken up by the CAS Annual Meeting. Both the scientific and CIG meetings were a valuable chance to catch up with familiar faces, and make new contacts, after a couple of years of online-only meetings. While Covid isn't going anywhere yet, the value of face-to-face meetings is clear. At the same time, the new world order will no doubt continue to include virtual components to many such meetings in the future, offering those unable to travel the chance to be involved.

Another advantage of the face-to-face setting was the discovery that CAS Vice President (now President) Dr Lucie Filteau is a Lego expert! Lucie and her husband have designed a number of world-class models, which they display at various Lego conventions, but the highlight to me was the Lego anaesthetic machine (pictured previous page). A portion of the funds raised by sales of this model go to the CAS International Education Foundation (CASIEF). Visit https://casief.ca/ for more information!

Unfortunately, I wasn't able to take enough leave to more fully explore Nova Scotia, apart from a couple of self-guided walking tours around Halifax. Suffice to say that it is a beautiful part of the world. The architecture is colourful and cheerful. As are the people, especially when the summertime temperature gets above 15°C and the outdoor bar and restaurant areas are all open. The flight time from New York is less than two hours. Well worth consideration!

**Dr Mark Sinclair**

# FROM THE SPARC CHAIR

ASSOCIATE PROFESSOR ALWIN CHUAN

I am pleased to have taken the role of Chair of the Science, Prizes, Awards and Research Committee (SPARC) in June 2022. I wish to thank the preceding, and inaugural, SPARC chair Associate Professor Stephanie Phillips who oversaw significant changes: the introduction of the Trainee Audit and Survey Prize at the National Scientific Congress, the introduction of the Small Grants initiative, rewriting of by-laws pertaining to grants and prizes, all with the backdrop of large changes wrought by Covid-19.

We have since implemented changes to the metrics used by reviewers and prize adjudicators, aligning them with National Health and Medical Research Council standards to improve consistency of scoring. An overriding goal of the ASA is to educate – thus, reviewers' formative feedback is provided to all grant applicants (and to reviewers as well) to assist in improving the academic rigour of our specialty.

We have held our first face-to-face meeting since Covid-19, with the successful conclusion of the Combined Scientific Congress (CSC) in Wellington in October 2022. I wish to congratulate the winners of the prizes awarded during the CSC, as well as the Annual Research Grant and inaugural Small Grant winners so far in 2022. At the time of writing, we have received multiple applications for the October round of the Small Grants, with successful applicants to be informed by Christmas.

The ASA has over $120,000 in grants and prizes awarded annually, and I encourage members to apply. We support both trainee and consultant members in their research in anaesthesia, pain medicine, intensive care, and perioperative medicine.

For information on all the available grants and prizes, log in as an ASA member and point your browser to

https://asa.org.au/asa-awards-prizes-and-research-grants/

Here you'll find guidance on eligibility, application forms, review templates and scoring metrics.

**Associate Professor Alwin Chuan**

## Grants available in 2023

The ASA Small Grants are designed to provide rapid application and approval for seed funding of small projects. These provide 'kickstart' funding for exciting research that could develop into larger trials. Up to four Small Grants may be awarded annually, with deadlines in March and October every year.

In 2023, all four major grants are available: the Annual Research Grant (which may also support a PhD or other higher degree research program), the Jackson-Rees Research Grant, the Kevin McCaul Prize, and the Jeanne Collison Prize.

Due dates for these major grants is June 30.

## Prizes available in 2023

All applicants will submit an abstract and verbally present their projects to compete in the Gilbert Troup, ASA Best Poster, ASA Trainee Best Poster, ASA Trainee Audit/Survey, and Rupert Hornabrook Prizes at the 2023 National Scientific Congress.

Eligibility, call for abstracts, due dates, and applications will become available on the Melbourne NSC 2023 registration website. This will aslo be available on the asa website: www.asa.com.au

## Dr David Lam
## Winner: 2022 Gilbert Troup Prize

Dr David Lam is a VMO working at Eastern Health (Victoria) and in private practice. His special interests include the pharmacokinetics of TIVA and mathematical models used in TCI.

David's winning Gilbert Troup presentation was on the feasibility of a lidocaine-remifentanil mixture (10mg/ml and 40mcg/ml) in a single syringe. The chemical stability of this mixture was examined using ultra-high-performance liquid chromatography. No significant degradation of either drug was detected.

In a mathematical model, the total amount of lidocaine delivered over six hours using a bolus infusion (1.5mg/kg bolus followed by 2mg/kg/hr) was similar to using TCI (lidocaine-remifentanil mixture, Minto model at a constant effect site target 4ng/ml) after a three-hour infusion. As this was a computer simulation, further research will be required before clinical use.

## Dr Christine Wood
## Runner up: Combined ASA/NZSA Best Poster Prize

Dr Christine Wood is an Advanced Trainee at Christchurch Hospital, New Zealand. She has a strong interest in wellbeing and trainee welfare, obstetric anaesthesia and perioperative medicine.

Christine's Best Poster presentation was a six-month retrospective audit of maternal outcomes and staff perspectives after a change in labour epidural analgesia pre-mix from ropivacaine 0.2% with fentanyl to bupivacaine 0.0625% with fentanyl.

There was no significant difference in modes of delivery between the groups. While most women received excellent analgesia from their epidurals, there was a statistically significant increase in the number of women who received no analgesia using the low-concentration bupivacaine pre-mix. Obstetric anaesthetists preferred using the previous ropivacaine pre-mix, reporting the low-concentration bupivacaine pre-mix increased their workload. Based on results of the audit, the Anaesthesia Department changed their protocols to reinstate the ropivacaine mixture.

## Dr Xianglin Yeaw
## Winner: Combined ASA/NZSA Best Poster Prize

Dr Xianglin Yeaw undertook subspeciality fellowship training at the Royal Victorian Eye and Ear and the Royal Women's Hospital Melbourne, where she still continues to work as well as at Eastern Health (Victoria). She has academic interests in perioperative medicine and quality improvement.

Xianglin's winning presentation was about a project to standardise regional anaesthesia trolleys across multiple campuses to reduce medication errors when performing blocks, and to improve efficiency amongst staff. Based on electronic surveys, and anchored using ANZCA PG51 (A) Medication Safety guidelines, 93% of anaesthetists reported being satisfied with the newly arranged block trolleys. 72% agreed that standardisation improved their work efficiency. Opinions were mixed on whether their interventions had reduced their error at work.

## Dr Matilda Tang
## Winner: Combined ASA/NZSA Trainee Member Group Best Poster Prize

Dr Matilda Tang currently works at Western Health (Victoria) after a varied career in regional Australia including a previous life as an economist. Her hope is to one day become a clinician-scientist and amalgamate medicine, health economics and data science.

Matilda's winning TMG Best Poster presentation focused on minimising pharmaceutical waste and improving environmental sustainability in theatres. In particular, propofol is an environmental hazard requiring incineration to be destroyed. A cross-campus study was conducted and found 23% of propofol discarded, 60% of which was disposed in general waste bins, accounting for an extrapolated cost of A$3,393 per year. Reductions in propofol wastage can be achieved through audits with feedback to clinicians using smaller ampoules, minimising pre-emptive drawing up, introduction of pharmaceutical bins to reduce environmental contamination risks, and accurately. predicting case duration.

## Dr Robyn Scott
## Winner: Combined ASA/NZSA Trainee Member Audit/Survey Prize

Dr Robyn Scott is a second year anaesthesia trainee at Te Whatu Ora-Waitaha Canterbury, New Zealand. In her previous life, Dr Scott was a respiratory physiologist working on a combined golf/academic scholarship in the USA.

Robyn's winning Audit/Survey Prize presentation focused on her interests in well-being, with the Physician Well-Being Index screening tool revealing that almost 20% of Canterbury Waitaha senior medical officers and 25% of anaesthesia trainees reached the threshold for distress. When weighted to increase the sensitivity for suicidal ideation, 60% of trainees reached the threshold for distress. Personal well-being was constrained by many organisational factors, but the importance of collegiality was affirmed. These results are important to inform initiatives to improve well-being in her department.

## Dr Alexandrea Frankpitt
## Commendation: Combined ASA/NZSA Trainee Member Audit/Survey Prize

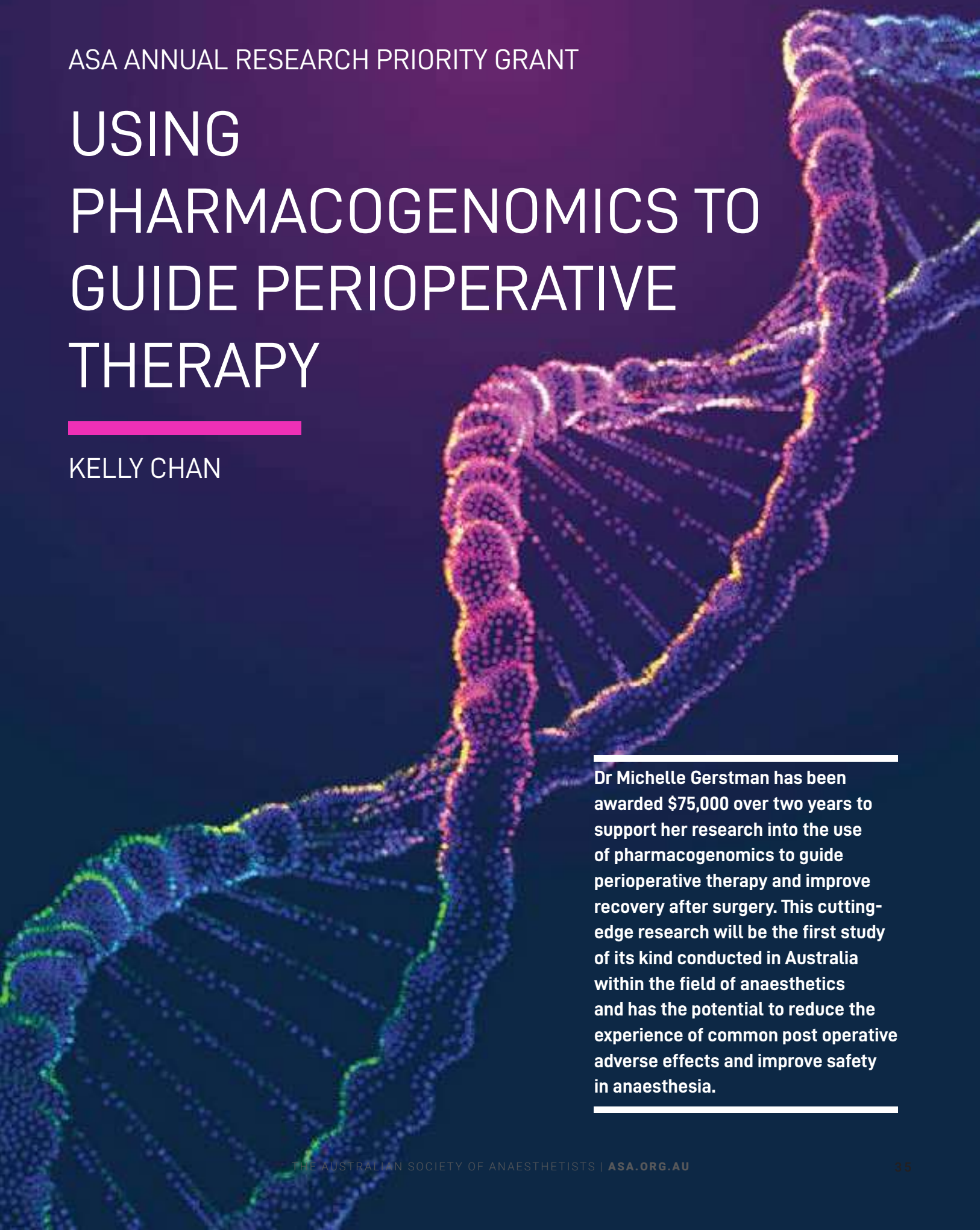
Dr Alexandrea Frankpitt undertook her survey project whilst working as a trainee at Te Whatu Ora-Waitaha, Canterbury, New Zealand. Alex's clinical interests include vascular and hepatobiliary anaesthesia. Her non-clinical interests include medical education and quality improvement in the perioperative journey.

Her commended presentation was an audit of postoperative blood pressure management following carotid endarterectomy (CEA) at Christchurch Hospital. Uncontrolled hypertension or hypotension is common following CEA, and increases the risk of complications, but local practice was variable, and no local guidelines for PACU management existed. Her project found quality gaps in her institution's care with respect to documentation of postoperative BP targets, and escalation and management of postoperative hypertension and hypotension. The audit has since informed a quality improvement initiative including a practice guideline and education package.

ASA ANNUAL RESEARCH PRIORITY GRANT

# USING PHARMACOGENOMICS TO GUIDE PERIOPERATIVE THERAPY

KELLY CHAN



**Dr Michelle Gerstman has been awarded $75,000 over two years to support her research into the use of pharmacogenomics to guide perioperative therapy and improve recovery after surgery. This cutting-edge research will be the first study of its kind conducted in Australia within the field of anaesthetics and has the potential to reduce the experience of common post operative adverse effects and improve safety in anaesthesia.**

Of the 2.6 million patients undergoing surgery each year across Australia, more than one-third experience significant postoperative complications. These common side-effects have a substantial impact on patients' lives and lead to morbidity, increased hospital stays, delayed return to work and increased societal economic burden.

Patients undergoing surgery receive many different medications during anaesthesia and the immediate period after surgery to induce amnesia, provide analgesia and reduce the body's physiologic stress to surgery. Analgesic medications such as morphine however, are not always effective and leave close to 30% [1] of patients suffering from inadequate pain relief and intolerable side effects. Nearly 90% [2] of anaesthetic mortality is attributed to anaesthetic overdose or adverse drug effects. Despite ongoing research and treatment advances, these adverse patient experiences continue to challenge anaesthetists and surgeons.

Dr Michelle Gerstman, specialist anaesthetist at the Peter MacCallum Cancer Centre and Alfred Hospital and a Clinical Lecturer at the University of Melbourne Medical School's Department of Critical Care, has proposed undertaking research that has the potential to improve the care of patients requiring surgery.

"The research is looking at how genes affect a person's response to anaesthetics. The aim is to personalise a person's anaesthetic medications to ensure the best outcome," which is "reducing the risk of adverse side effects and improving comfort," Dr Gerstman said.

Whilst this has been done clinically for chemotherapy and psychiatry medications, it has not been done in the field of anaesthetics. Dr Gerstman's study will be the first of its kind conducted in Australia.

> Pharmacogenomics, the field of research that studies how genetic variations affect individual patient drug response, is used to guide targeted drug therapy and reduce medication related side effects.

Pharmacogenomics, the field of research that studies how genetic variations affect individual patient drug response, is used to guide targeted drug therapy and reduce medication-related side effects. This emerging field examines how genetic variations can play a role in determining how medicines enter the body, are transported, their receptor site affinity and transduction pathways, and the activity of their metabolic elimination pathways.

The potential of pharmacogenomics to personalise medicine and provide improved patient safety, recovery and comfort after surgery has been supported by a recent study published in the American Journal of Surgery. The study used pharmacogenomic-guided postoperative analgesia following major abdominal surgery and reported a 50% reduction in opioid consumption and reduced incidences of analgesic-related side-effects. With over 20% of patients undergoing surgery likely to have a clinically important pharmacogenomic variant, the field has great potential to assist with the administration of medications during anaesthesia.

In her research, Dr Gerstman will be conducting one large trial over two years with 200 patients.

> "We've recruited 50 so far and the funds from this grant will go a long way to help pay for the team necessary to ensure the successful conduct and completion of this ground-breaking trial," she said.

Applying the principles of pharmacogenomics Dr Gerstman hopes to "take the trial and error out of prescribing so that medications are tailored to the individual."

An established research unit at Peter MacCallum Cancer Centre with extensive experience in conducting local investigator-initiated and international multi-centre trials in perioperative and surgical settings will conduct the study. The unit has received over $10 million in research funding over the last five years which has resulted in an output of over 50 publications which included publications that were awarded 'best paper of the year', a 'top ten most cited paper' in two international journals and numerous awards including the State Health Minister award for quality improvement initiatives.

This single-centre study will also help determine the feasibility of performing a future, larger perioperative pharmacogenomic randomised controlled trial, by testing the efficacy of pharmacogenomic testing to improve patient safety and quality of recovery from anaesthesia and surgery. This study will return data on patient acceptability (patients willing to undergo pharmacogenomic testing), accessibility (timely return of test results)

and actionability (adequate number of pharmacogenomic variants in patients to guide perioperative drug changes).

Further, the study will provide pilot data to assess if pharmacogenomic-guided therapy will improve postoperative quality of recovery, reduce postoperative nausea, and improve postoperative pain control. Finally, the study will improve our understanding of the impact of genetic variations on how the body processes commonly used anaesthetic agents and pain medicines to grow the limited body of research for pharmacogenomic-guided recommendations for drugs in surgical settings.

Working with scientists to help guide a widespread introduction of pharmacogenomic guided prescribing into clinical practice, this innovative research will also contribute to the scientific evidence which can enable the personalisation of additional medications, such as propofol, fentanyl and oxycodone, which currently lack evidence for guidelines.

Dr Gerstman's research will examine patients scheduled for elective intermediate to major surgery, with an expected anaesthesia duration of two or more hours and an anticipated hospital admission of at least one night. Two hundred patients who meet the eligibility criteria will be randomised into a pharmacogenomic group (patients who have their pharmacogenomic results provided to the treating anaesthetist and anaesthetic plan modified as per personalised medication plan) and a control group (perioperative care managed according to current institutional 'standard care'). Outcome measures include postoperative pain, oral morphine equivalent dose and quality of recovery as measured by a validated, patient centric, multi-dimensional tool, the PostopQRS™.

Mentored by world leaders in their respective fields, Dr Gerstman expressed her gratitude to her PhD supervisors, Professor Bernard Riedel, Director of Anaesthesia and Pain Medicine at the Peter MacCallum Cancer Centre, Professor Andrew Somogyi, Pharmacologist at the University of Adelaide and Professor Carl Kirkpatrick, Pharmacologist at Monash University, as well as the team at the Peter MacCallum Cancer Centre who have enabled this research to occur.

She also expressed her gratitude to the ASA, stating the Society's support

> "is a significant contribution to my research, and I am really excited to have the opportunity to do this research because it has huge potential for application in all sorts of areas of clinical medicine"

With the decreasing cost of pharmacogenomic testing it is likely that the personalisation of medications will become the standard of care in the future. Dr Gerstman and her team are at the forefront of this innovative research, working to improve patient safety with research that has direct clinical applicability and the potential for future scalability.

**Kelly Chan**

Reference


1. Cherny N, Ripamonti C, Pereira J, Davis C, Fallon M, McQuay H, et al. Strategies to manage the adverse effects of oral morphine: an evidence-based report. J Clin Oncol. 2001;19(9):2542-54.
2. Ross JR, Rutter D, Welsh K, Joel SP, Goller K, Wells AU, et al. Clinical response to morphine in cancer patients and genetic variation in candidate genes. Pharmacogenomics J. 2005;5(5):324-36.

In partnership with psychiatrists at Hand-n-Hand, the Australian Society of Anaesthetists proudly present

Australian Society of Anaesthetists®

*members for members*

# Peer Support Programme

Simply put, peer support is a way of providing emotional and wellbeing assistance where both the facilitator and participant are equals. Through this, people can connect through shared experience. It's not mentorship or career guidance - your facilitators are peers you can relate to.

When you sign up, you're linked in with a facilitator from the same profession and similar level of training. Our facilitators are trained and experienced in providing peer support.

**Benefits of peer support**

- 1-on-1 or group support available.
- Meet as often or as little as you like, at times that suit your schedule.
- Withdraw at any time, for any reason.
- Involves no clinical psychiatric treatment.
- Supported by evidence as a pre-clinical mental health intervention.

## Are you looking for peer support?

## Are you a peer support facilitator, or interested in becoming a trained facilitator?

By volunteering as a peer support facilitator, you can help others in your position navigate the ups and downs of the health profession.

**Our triage method is guided by Hand-n-Hand to best suit you**
**Contact the ASA Wellbeing Advocates SubCommittee**

**ASApeersupport@asa.org.au**

# PROFESSIONAL ISSUES ADVISORY COMMITTEE REPORT

**2022 has been a year of great change. The global economic and geopolitical environment has undergone a seismic shift since January. In Australia, a new government faces up to these challenges, while representative bodies such as the ASA attempt to meet the new faces in Canberra.**

DR PETER WATERHOUSE
PIAC CHAIR

## Independent Medicine under fire

Professional societies are not the only groups keen to make an impression on the new government and its advisors.

The lay press has recently devoted countless columns to the subject of Medicare fraud. In addition to accusations of widespread over-claiming by doctors, the AMA has endured unfavourable comparisons to protection racketeers in a typically moderate national newspaper.

To what end is this negative coverage directed? Undermining the integrity of the medical profession neither improves patient care, nor punishes the few practitioners guilty of improper claiming.

As Medicare devotes less resources to patient rebates, and more to compliance activity, doctors could be forgiven for simply charging a fee and letting the patient run the gauntlet with Medicare.

A breakdown in the Medicare rebate system would play to the crisis narrative promoted by Australia's listed health insurers, who already loudly undermine the hospital sector with dubious claims of the unavailability of independent private medicine. Their solution is to enter into contracted care arrangements and take control of healthcare funding.

While the health funds are only slowly making inroads into hospital medicine, an invitation into primary care funding would profoundly increase the power of insurers to create preferred-provider networks. Patients would be directed to insurer-run primary care clinics, where contracted practitioners would make 'in-network' referrals to preferred specialists. Specialist care would then take place in preferred hospitals, according to insurer guidelines with respect to length of stay, rehabilitation and an increasing number of other parameters.

Viewed in this context, this year's negative press is at best unfortunate. At worst it could represent part of a deliberate campaign to discredit our profession and weaken the ideal of independent medicine as underwritten by Medicare. We need to be prepared for further attacks on our system.

## The year ahead

As part of a wider effort to improve the ASA's website and member resources, PIAC will review the society's professional documents in 2023. Patient information brochures will be made publicly available, as will professional documents outlining the ASA's public position on professional issues.

The biennial ASA member survey will be conducted in 2023. The survey has provided valuable in sights into the anaesthesia workforce since 2014. Each new survey adds depth to our data, painting a detailed picture of our specialty over time.

Liaising with ANZCA is a core business for the PIAC. With PS09 (sedation) almost complete, the focus is shifting to perioperative medicine. The definition and funding model for this emerging discipline are still in their infancies.

Individual advocacy continues in the background. Members have been assisted with challenges ranging from impairment in a colleague, to industrial and rostering difficulties. Remember that support is only a phone call away.

## Join us!

Do you have an interest in the professional issues facing anaesthetists? PIAC is always looking for new members, ready to play a part in maintaining the high standards of practice enjoyed by our members and their patients.

## Happy Holidays!

Whether you are heading away for some overdue travel, or relaxing at home, I wish you a peaceful break with your loved ones.

See you in 2023.

**Peter Waterhouse**


ANZCA
FPM
Be connected
ANZCA ASM 2023 5-9 May, Sydney
Save the date and visit the website to find out more.
asm.anzca.edu.au | #ASM23SYD
Australian and New Zealand College of Anaesthetists & Faculty of Pain Medicine

# ANAESTHESIA TRAINING TIPS

Dr Vida Viliunas OAM
ASA Education Officer
and EPIC convenor

Dr Kaylee Jordan
Deputy Chair,
ASA Education Committee

**The ASA Mission is to support, represent and educate its members. It has been a big year for the ASAEd education platform. There have been dozens of trainee and exam preparation events with over 700 registered participants this year.**

## EDUCATION

A major focus of ASAEd is both primary and final exam preparation for our trainee members for all sections of both exams, not just the vivas. During our regular live exam practice sessions over Zoom, we focus primarily on short answer question preparation in the run-up to the written exams, with a focus on knowledge content and answer structure, approach and technique.

For short answer questions, performance can be improved considerably by using a structure and ranking that signals an understanding of the material beyond just the facts. During live sessions candidates think more deeply about what a really good answer will look like and how improvements to answers can be achieved in the timeframe allowed.

Between the written and viva examinations, this focus shifts towards the anaesthetic and medical vivas, where the entire sessions are dedicated to live viva practice. Some of the content covered in these sessions is made available to be watched on demand. In addition to the primary and final exam preparation sessions, we also offer final examination sessions specifically for specialist international medical graduates.

The bootcamp-style 'Exam Performance Improvement Clinic' (EPIC) was once again delivered virtually this year. Here's hoping that 2023 will see the return of a face-to-face encounter.

## SUPPORT

The exam preparation sessions for trainees have several aims, only one of which is education.

Since the start of the Covid-19 pandemic, the uncertainty surrounding exams has been stressful for candidates. The ASA Education Committee recognised this, along with the challenges that this presented in gaining sufficient exposure to face-to-face viva practice. To support registrars, we commenced regular online viva practice, which has then expanded to include written content and performance improvement coaching.

For those that have participated in the Zoom sessions, the rules are well-known. Cameras on with subjects centred in optimal 'look good on Zoom' position is not just about controlling the audience. The opportunities to improve performance and to connect with other candidates is an important part of getting together.

Over what has now been a substantial period, we have developed a community of trainees that have found collegiality in the thumb-nail world of Zoom. The opportunity for isolated trainees to recognise their colleagues at the actual exams has been valuable and not to be underestimated. Zoom has offered a way for candidates to maintain their exam readiness even if it has been practising to a camera and not another person.

Having to maintain 'exam-face' on screen is good practise: what you do in training, you will do on the day (whether face to face or via Zoom).

The ASAEd team and Education subcommittee are looking forward to working on new and better ways to support trainees in 2023, and we welcome suggestions as to how we may do this better. We look forward to seeing you at our exam preparation sessions!




# TRAVEL AND THE CSC

DR ALEX COURTNEY
ASA TMG CHAIR

Well, another year is drawing to a close as you read this. I do hope that 2022 has been a rewarding year for all of you.

As you prepare for the end of the calendar year and the medical year shortly after that, many of you may be travelling in this time, which is a convenient segue into the theme of this edition of Australian Anaesthetist, Travel.

The theme provides me an opportunity to remind you of some of the wonderful opportunities that are available to ASA Trainee members.

Firstly, we provide three trainees per year a substantial scholarship to attend one of our sister associations' conferences. These scholarships are for travel, accomodation and other costs to the value of $4000 each. In 2023 the scholarships will be awarded for the following conferences:

- Canadian Anesthesiologists' Society in Quebec City
- Association of Anaesthetists in the UK
- American Society of Anesthesiologists in San Francisco

The successful applicant will be required to write a report following their visit, reporting on the benefits of attending such conferences for trainees.

Further details will be sent out via email to all trainee members.

The Overseas Development and Education Committee (ODEC) is a wonderful ASA committee who oversees all aid outside of Australia and New Zealand. This committee has spearheaded projects related to education and skills, material and financial aid, and has a particular focus on the Pacific nations and South East Asia.

ODEC has played a significant role in the Lifebox and Interplast programs. ODEC offers fellowship programs in Fiji and East Timor and recruits volunteers to a database of anaesthetists to provide assistance and humanitarian medical work.

Our recently updated Trainee Members Handbook contains information about some overseas fellowship opportunities and information about how to apply, including the governmental requirements. The COVID pandemic certainly reduced the number of people I knew who went overseas to undertake fellowship positions, but that has finally abated and I have colleagues who have gone to Africa, UK and the USA in recent months. As we move forward, I would remind you that there are limitless opportunities available overseas as both a trainee and a consultant. In some cases, specialist qualification does make obtaining a 'fellowship' position overseas a bit easier, but there are certainly a number of supported trainee positions around the world. I have heard many positive things from colleagues who spent time overseas, even if it was only for six months. Benefits have included the exposure to different practises and different patient populations, and the opportunity to develop new perspectives on your own practice. You can access the Trainee Members Handbook on the trainees section of the website (https://asa.org.au/trainee-membership-benefits-2/)

Finally, I was able to attend the NZSA and ASA Combined Scientific Congress in Wellington, NZ earlier this year (October). It was the first time I had travelled outside of Victoria since the pandemic was

declared back in 2020. Coincidentally, the last time I'd been anywhere was to Christchurch for a Primary exam course (also very good!).

I learnt a number of things at the CSC, some highlights

- robots aren't likely to take over my job any time soon
- there are lots of opportunities to improve care in the pre-admission space
- transexammic acid is good
- Crystalloid is good and bad
- deep anaesthesia is (probably) not good for the brain
- $PaO_2$ on Mount Everest can drop below 20mmHg!!!

I also attended the trainee poster session and I was incredibly impressed to see so many interns and HMO/RMO's presenting at this scientific congress. I thought the topics presented were well designed studies with thought provoking results and discussion. One in particular by Robyn Scott demonstrated that there is a lot of work to do on wellbeing in anaesthetists.

The trainee session provided some excellent advice for preparing for the fellowship exam, leadership and research and was well attended.

I realise it is difficult for some trainees to attend these conferences when not in their home city. I would like to remind you one of the benefits of trainee membership as an AT/PFT is one complimentary registration at an NSC or CSC. Please do not forget about this great benefit!

I would encourage all of you to try to attend a national or international conference in person as a trainee if you can. It provides an excellent opportunity to network with colleagues from around the world and hear from them about regional projects, practice differences and also the great many opportunities in our field.

I would like to remind you all of the support available to all of you. Whether you are feeling the pressure from work or study, personal or global crisis, please do not suffer in silence. Locally, your department will have appointed welfare officers, your hospital will have EAP systems. More broadly, the ASA[1] and ANZCA[2] have support resources available on their respective websites. Most importantly, your friends and family as well as your GP (we should all have one!) will also be a source of strength and support when you need them.

Finally, I will be stepping down as the National Chair of the TMG. Expressions of interest should have hit your inboxes by the time you are reading this article. The Chair position offers a significant opportunity to have input into many issues within the ASA as well as ANZCA and provides many contacts throughout our speciality. I would encourage any TMG member to apply.

I hope you all have a safe and happy festive season and new year.

All the best!

**Dr Alex Courtney**

References


1 https://asa.org.au/welfare-of-anaesthetists-2/

2 https://www.anzca.edu.au/fellowship/doctors-health-and-wellbeing-(1)

# LIFEBOX ANZ - REFLECTIONS FROM THE ANZCA TRAINEE REPRESENTATIVES

DR CATHERINE STIRZAKER AND DR JENNIFER FIFE

We'd like to introduce ourselves as the ANZCA trainee representatives for Lifebox Australia and New Zealand (Lifebox ANZ) and reflect on our experiences so far on the Lifebox committee.

## Catherine:

I joined the Lifebox ANZ committee as the Australian trainee representative in June this year. I was excited to apply for this opportunity to contribute to global anaesthesia safety with Lifebox. The application process for the role included writing an expression of interest and interviewing with the Lifebox ANZ chair, ASA Immediate Past President, and CEO of Interplast. Meeting these inspiring anaesthetists and leaders with a long history of working in global anaesthesia and surgery in the Asia-Pacific region was an amazing introduction to the Lifebox team.

I have been interested in global health since my undergraduate medical degree and two years ago completed a Master of International Public Health (now Global Health) at the University of Sydney. It was during my study that I first learnt about Lifebox and how they contribute to making anaesthesia safer globally. With international borders closed due to the Covid-19 pandemic and as a new mum to two small children, I hadn't had the opportunity after my Masters to undertake any overseas experience. The ANZCA trainee representative role with Lifebox ANZ sounded like a perfect opportunity to continue to gain some understanding and experience in the global health space with such an inspiring organisation, while completing my anaesthetic fellowship year.

## Jennifer:

I joined the Lifebox ANZ committee as the New Zealand trainee representative in 2021, and have continued in the role during my anaesthetic fellowship in global outreach and development at Royal Hobart Hospital this year. During my fellowship I have contributed to an e-learning package for obstetric anaesthesia, and will be continuing this project when I travel to Namibia with Health Volunteers International in November.

I aim to continue working in the global development sphere during my anaesthetic career, so developing networks and mentorship with Lifebox is invaluable. Lifebox's mission appeals as it builds local sustainability through strengthening local organisations and focuses on multidisciplinary teamwork and education. I am also fascinated by the adaption of medical technology to low resource settings and the impacts of these innovations on surgical safety.

## Lifebox: Saving lives through safer surgery

Lifebox is a not-for-profit organisation working towards improving safety and quality in anaesthesia and surgery in low resource settings. Lifebox was founded in 2011 by Professor Atul Gawande (creator of the WHO Surgical Safety Checklist) in partnership with the World Federation of Societies of Anaesthesiologists, the Association of Anaesthetists, and the Harvard School of Public Health. In the Asia-Pacific region, Lifebox ANZ is a joint regional partnership between the ASA, ANZCA, NZSA, Interplast and the parent Lifebox organisation.

Lifebox's core areas of work are in anaesthesia safety, surgical teamwork, and reducing surgical infections. Lifebox has developed the world's foremost low-cost high-quality pulse oximeter which can be supplied along with a training package to low resource settings globally. In the Covid-19 response of 2021, Lifebox delivered 7,400 pulse oximeters worldwide. The Lifebox ANZ Covid-19 response has included rapidly sourcing pulse oximeters for our Asia-Pacific neighbours including Laos, Timor-Leste, Papua New Guinea, the Solomon Islands, Samoa and Fiji as they faced outbreaks and has been made possible due to the donations from many Australian and New Zealand anaesthetists.

Sitting on the Lifebox committee is an exciting opportunity to learn from experts in the global development field while gaining experience in committee work, strategic planning, and understanding the governance and structure of a global

non-profit organisation. We are learning about the operational processes and financial systems required for the successful implementation of anaesthetic and surgical safety initiatives, and about measuring improvement and assessing the impact of the interventions and programs. As trainee representatives we hope to be able to bring fresh perspectives and ideas to the committee, and use our trainee network connections to increase the visibility of Lifebox and its work.

We have learnt about how Lifebox ANZ fits into the global structure of the Lifebox Foundation, engages with local beneficiaries, and adapts global goals and programs to specific needs in the Asia-Pacific region. We have participated in strategic planning sessions about the future direction of Lifebox ANZ beyond pulse oximetry. Upcoming initiatives include setting up a scholarship for Pacific anaesthesia training, and restarting education and training programs as travel becomes possible again. We have explored the potential for increasing the reach of Lifebox through collaboration with surgical and nursing colleagues, and involving medical colleges and universities in the regions where we are working.

We are creating a Lifebox ANZ 'fundraising pack' that can be provided to ANZCA trainees or consultants organising an event where there is an opportunity to fundraise for Lifebox, for example through a raffle or donations. The pack makes it an easy process for event organisers, and includes marketing materials, information about Lifebox, fundraising equipment, and rules and regulations for Australian states or New Zealand.

If you are organising an event for anaesthetists in Australia or New Zealand and would like to include fundraising for Lifebox please reach out to us so we can provide you with our fundraising information pack. Tax deductible donations can also be made at any time to Lifebox ANZ projects through Interplast https://interplast.org.au/learn-more/our-work/lifebox-australia-new-zealand/

**Dr Catherine Stirzaker**
**Dr Jennifer Fife**


## Conversations to inform, challenge and inspire

**Past President Dr Suzi Nou discusses all things relevant to Australian (and beyond) anaesthesia. Join us in conversations that serve to keep you performing at your best and safest throughout your career.**

**In the 'Talking Money' series, we do more than talk money. We discuss the professional, economic and business aspects of running an anaesthetic practice so that you can focus on the important task of caring for you patients. Full episodes are only available on the ASA website.**

## ... and for trainees

**There are plenty of podcasts on navigating the training program as well as our newest series with Drs Vida Viliunas and Kaylee Jordan on practice vivas. These are also great refreshers for non-trainees. Don't forget to claim your Continuing Professional Development (CPD) points.**

**Australian Anaesthesia can be found on all the major podcast platforms and YouTube. ASA members can access full length versions of all the episodes on the ASA website.**

## Log in to www.asa.org.au and search podcasts

# ECONOMIC ISSUES ADVISORY COMMITTEE REPORT

DR MICHAEL LUMSDEN-STEEL
EAC CHAIR

With the year coming to a close and the festive season fast approaching, we hope it will be accompanied for all by the opportunity to spend time with family and friends after enduring the grips of the COVID-19 pandemic. The resurgence of face-to-face gatherings throughout the year has been strong and anaesthetists have relished occasions to share knowledge, wisdom and pertinent advances across the field of anaesthesia, most recently at the 2022 Australian Society of Anaesthetists Combined Scientific Conference (ASA CSC) held in Wellington, New Zealand.

It has been a demanding year for anaesthetists across Australia. Anaesthetists provide services 24/7 across both the public and private sectors. Anaesthetists make a significant contribution to Australia's healthcare system through perioperative medicine, high quality analgesia and improved post-surgery and post-procedure patient outcomes. According to the ATO data for 2019—2020 which analysed earnings of approximately 63% of anaesthetists (3509 anaesthetists), anaesthetists are the second highest earning profession in Australia with an average earning of $388,814 per annum. The Australian Society of Anaesthetist (ASA) workforce surveys show that anaesthetists are working hard and as a profession are contributing significant taxes to help fund the Australian Government's spending on healthcare, welfare, defence, public service, infrastructure spending and the NDIS.

In October 2022, the integrity of the medical profession's Medicare billing came under media scrutiny with sensationalist headlines reporting an $8 billion Medicare rort, a figure that represents almost one third of total Medicare billing. The Australian Medical Association (AMA) and other medical bodies vigorously defended doctors, finding there was no evidence to justify the widely sited claim. Sensational as it may be, the claim has also unveiled the opportunity to review and respond to the complexity of the Medicare Benefits Scheme (MBS), the challenges of updating the MBS to reflect current anaesthesia services and dispel myths perpetuated by the media.

Coinciding with this review, Dr Andrew Mulcahy provided an update at the 2022 ASA CSC, including key data on anaesthesia billing. During the Financial Year (FY) 21/22 there were 2,470,838 patients receiving anaesthesia services (excluding consultations). This also excludes public hospital activity based funded care, as well as public outsourced work. This represents less than 0.5% of all Medicare services.

Despite a growth in anaesthesia services, it is important to note that, that growth is below that of all Medicare growth (8% growth vs 28% growth respectively), with nerve blocks (excluding eye blocks; the relevant items were expanded to cover a broader clinical range of blocks in 2019), being the largest growth in anaesthesia services.

| Service | 2017 vol | 2022 vol | 5 yr growth |
|---|---|---|---|
| art lines | 117,975 | 135,904 | |
| CVC's | 22,911 | 21,265 | |
| press. monitoring | 153,889 | 171,798 | |
| epidural/spinal* | 91,106 | 98,667 | |
| nerve blocks (exc. eyes)** | 59,926 | 92,544 | |
| Therapeutic & Diagnostic | 558,796 | 707,695 | |
| | | | |
| | 2,943,767 | 3,178,533 | |
| | 399,485,575 | 511,520,053 | |

*This refers to intraoperative procedures and not obstetric other non-intraoperative blocks
** This includes a broader clinical range of blocks

Figure 1: Anaesthesia services 5 year growth between FY 2017 and 2022

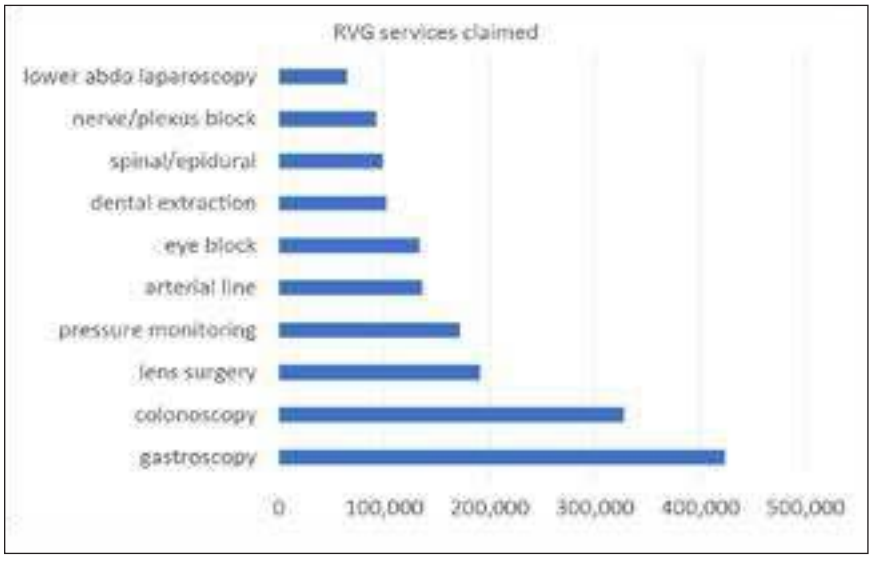



Figure 2: Gap fees per service for private health insured patients by specialty
*Anaesthesia is an estimate of complete anaesthetic episode

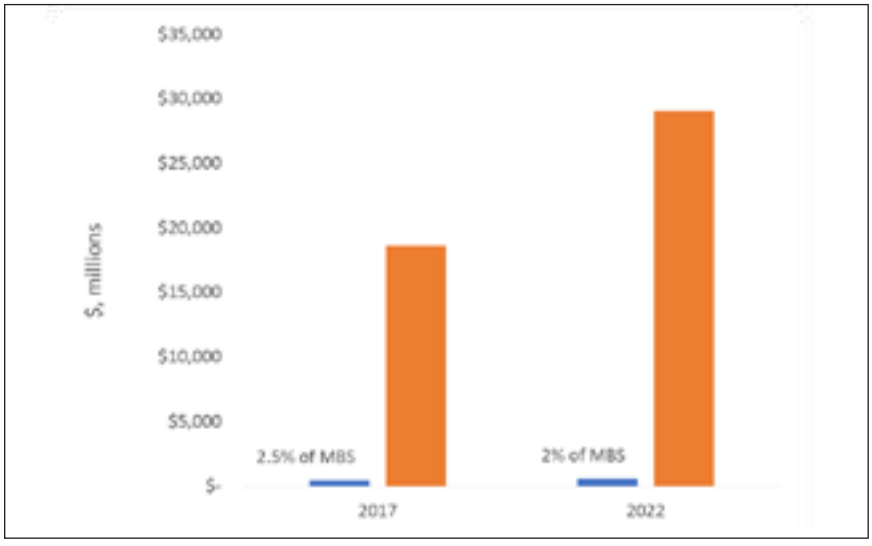



Figure 3: Medicare expenditure on anaesthesia - RVG+consults expenditure vs total MBS expenditure


Figure 4: Private health insurance fees - percentage of no gap, known gap and combined anaesthetic fees over time, FY 2007-2022

Figure 2 shows in FY 2021/22 there was a total of 3,178,533 (including diagnostic and therapeutic procedures) items claimed, the most common service being anaesthesia for gastroscopy.

Figure 3 shows Anaesthesia claims, as a proportion of the MBS expenditure has declined, comprising only 2% of the total MBS expenditure.

Figure 4 shows percentage of all anaesthesia services (covered by private health insurers) billed at no-gap and known-gap. It is clear that the trend for known-gap billing is on an increasing trajectory.

Where a gap is charged, the out-of-pocket expense (gap) per service varies considerably for different specialties. For anaesthesia the gap per service (where a gap is charged) is $136. Allowing for the fact that there are on average approximately 3.1 'services' per anaesthetic episode of care, the average anaesthetic gap per patient is estimated at $423. See Figure 5.

On 1 November 2022 the AMA Relative Value Guide (RVG) increased to $94.00, however the government indexed Medicare rebates based on the Wage Cost Index (WCI5). Whilst there was previously a strong correlation between Consumer Price Index (CPI) and WCI, evident in the 1990s, there has been a significant divergence between the two indices. Medicare has continued its indexation using the WCI5 index and in November 1996, froze all fees at the levels of 1 November 1995. There was a further freeze in MBS rebates from 2012 to 2017.

Figure 6 represents divergence between the two indices. There is a case to be made about Medicare insufficiently indexing the MBS rebate.

It is worth noting that private health insurers are required to pay the 25% top up to the MBS schedule fee for inpatient episodes of care. Private health funds pay a loading above the MBS fee to encourage specialists to provide no gap or maximum known gap, to give out of pocket certainty to patients. It is likely private health funds want to ensure the certainty of profits paid to their shareholders or return benefits to members to make their

offering more attractive. There are several private health funds who have not indexed their RVG such as HCF and HBF (WA) and some have increased their RVG by less than the Medicare indexation. This means that the health funds are likely making savings by not passing on the full indexation.

If the MBS rebates had been indexed, instead of frozen between 2012 and 2019, the MBS RVG unit value would be approximately $22.70 (given very moderate annual growth of 1.8% per annum) as opposed to the current MBS rate of $20.95.

Figure 7 below shows the effects of the lack of indexation to the RVG by the MBS and health funds compared to the AMA RVG indexation. The gap is increasing and the net effect is that the wage growth has been behind inflation for many years. In addition, many anaesthetists can only charge a maximum of $500 out of pocket fee (the private health insurer known gap limit). This known gap limit has changed from being applied to each service (i.e., each MBS number) to the entire episode of care and has not been indexed since inception.

Anaesthetists who elect to accept the maximum known gap limit cannot charge out of pocket fees greater than $500 which means that both complex and simple procedures are subject to the same fee. Anaesthetists must then reduce their fee to ensure the fee does not breach the known gap limit. As we do not want to penalise patients, anaesthetists are ultimately forced to charge lower fees for complex procedures.

Data shows that 95% of anaesthesia episodes are covered by no gap or known gap fees. This suggests that anaesthetists are capping their fees which negatively impacts anaesthetists' net disposable income.

**Dr Michael Lumsden-Steel**

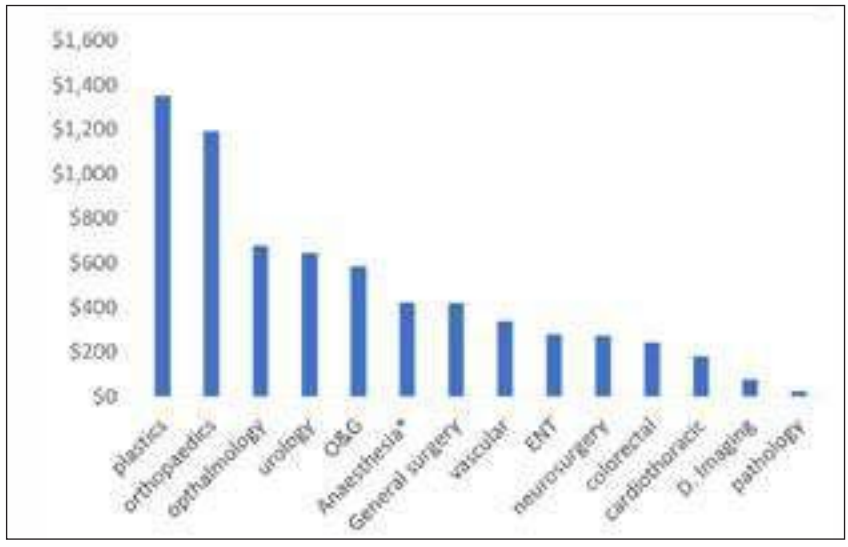



Figure 5: *No gap fees for private health insurance funded*

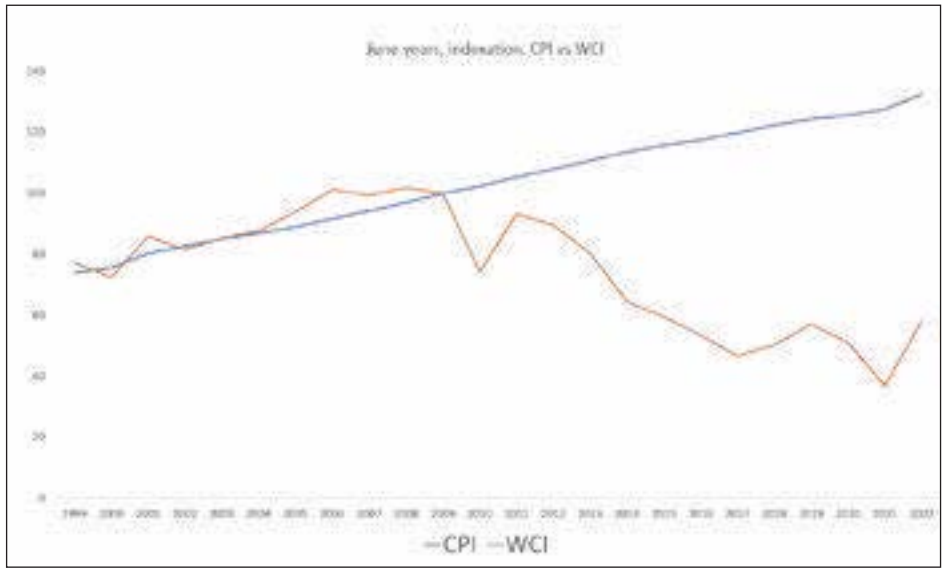



Figure 6: June years indexation. CPI versus WCI

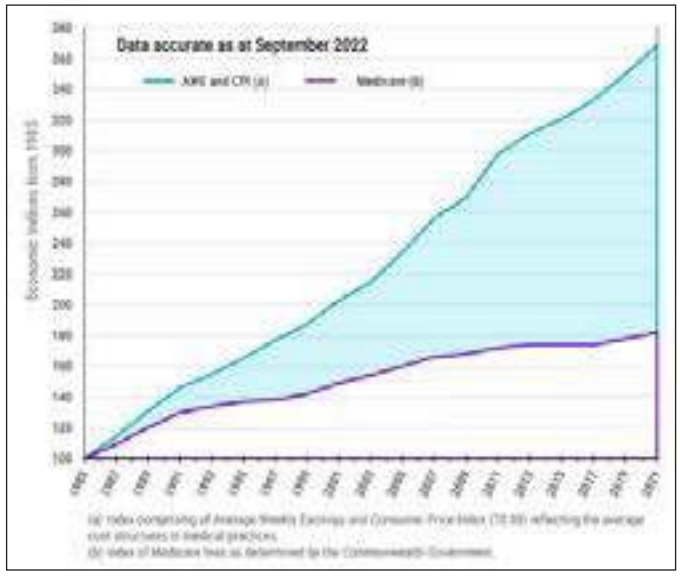



Figure 7: AMA Fees Gap update. Economic indices from 1985 demonstrate the gap between average weekly earnings and CPI vs Medicare indexation

# WEBAIRS

ANZTADC Case Report Writing Group

## Retained throat packs reported to webAIRS

WebAIRS has received numerous reports of anaesthetic incidents involving throat packs which are commonly used in Australia during dental, maxillofacial, nasal, or upper airway surgery to reduce the risk of airway complications. They are made of woven gauze or similar soft fabric such as polyurethane foam and used under general anaesthesia to:

- absorb blood and other bodily fluids/ material created by surgery, and prevent ingress via the back of the throat to the oesophagus or airway;
- prevent amalgam and similar foreign material from lodging near the glottic entrance or oesophagus;
- seal the area around the endotracheal tube to prevent leaks;
- stabilise endotracheal tubes or supraglottic airway devices [1]

A recognised complication of the use of throat packs is unintended retention. Despite taking precautions, throat packs may be inadvertently left in situ after the procedure, with the risk of obstructing the airway [1]. Whilst the packs might be inserted either by anaesthetists or surgeons, they are commonly inserted by the anaesthetist and removed by the surgeon. This shared role might contribute to the risk of inadvertent retention especially if the pack is not included in the swab count. The question of legal responsibility or shared responsibility might not be obvious, but usually remains with the person who performs a procedure, unless a formal handover of the responsibility for ongoing care takes place. However, the anaesthetist is responsible for airway management during emergence from anaesthesia and that includes ensuring that the airway is clear of any foreign material, which might include, for instance, fluids, blood or in this case a throat pack.

A recent evidence-based consensus statement by the Difficult Airway Society (DAS), the British Association of Oral and Maxillofacial Surgery (BAOMS) and the British Association of Otorhinolaryngology, Head and Neck Surgery (ENT-UK) stated that they no longer recommend the routine insertion of throat packs by anaesthetists[2]. If a throat pack is regarded as clinically necessary, suggested prevention strategies to reduce risk of inadvertent retention include both documented evidence and visual cues[1]:

Documented evidence

- The reasons a throat pack is clinically indicated and justified.
- Record the two-persons check of both the insertion and the removal of the pack.
- Add the pack to the swab count.

Visual cues

- Place a label or mark on the patient, for example, a sticker on the patient's forehead.
- Attach a label to the airway device or part of the anaesthetic circuit where it will be seen during removal of the airway device.
- Attach the pack to the airway device.
- Leave a portion of the pack protruding from the patient's mouth.

In addition to the previous strategies:

- Insist those responsible for the insertion are responsible for the removal of the pack.
- Announce loudly in the OR that a throat pack has been inserted and follow this with the announcement that the pack has been removed.
- All airway suction is to be performed under vision, particularly at the end of the operation.

The throat pack should have a radio-opaque strip so that if the above strategies fail the location of a retained throat pack can be determined by X-ray.

ANZTADC is currently systematically analysing the webAIRS reports that involve throat packs with a view to publication in Anaesthesia and Intensive Care.

**ANZTADC Case Report Writing Group**

**Dr Chris Acott, AM**

**Dr Peter Roessler, ANZCA**

Director of Professional Affairs (Professional documents)

References

1. Curran J, Ward M, Knepil GJ. Reducing the risk of retained throat packs after surgery 2009. Available from: https://www.medis-medical.com/content-files/NPSA-Report-Reducing-Risk-Retained-Throat-Packs-Surgery.pdf.
2. Athanassoglou V, Patel A, McGuire B, Higgs A, Dover MS, Brennan PA, et al. Systematic review of benefits or harms of routine anaesthetist-inserted throat packs in adults: practice recommendations for inserting and counting throat packs. Anaesthesia. 2018;73(5):612-8.

# POLICY MATTERS

Jason Alam
Policy Manager
Professional Affairs

Katya Sadetskaya
Policy Manager
Economic Affairs

Bernard Rupasinghe
Policy and Public
Affairs Manager

## Introduction

Over the past quarter, the major issues the policy team have been dealing with included telehealth, submissions for the new item numbers, elective surgery and public in private in New South Wales and more provider-controlled schemes which impact anaesthetic fees. We also continue strengthening our advocacy and engagement by forming stronger alliances with our counterparts, affiliated societies, and industry organisations.

## Advocacy

In this quarter, the ASA, through subsequent PIAC meetings have continued to deliberate strategic avenues on how to combat this threat. Discussions are being held around specialised meetings with associated societies, including not for profit health funds.

What is becoming increasingly apparent is the level of threat that higher rate/no gap strategies are having, specifically on younger and emerging Anaesthetists who will largely consider the 'rate' above average, and for existing Anaesthetists – a pay rise.

What we continue to demonstrate is that by entertaining or engaging in these 'plans', Anaesthetists are essentially waving goodbye to their ownership over their billing practices and leads directly into a managed care operating platform. In short, we need to stand together in unison to rebuff these continuous bundled care challenges.

## Engagement

During this Quarter, the ASA Policy Team has had a very strong focus on supporting our strategic objectives in brand awareness, brand recognition, and being keenly informed in other areas on our industry that we may have not have had as much oversight on historically. In order to do this, the Policy Team has been working to strengthen our relationships and brand awareness through building new relationships with our counterpart and industry organisations

We met with ***Reconciliation Australia*** this month to discuss understanding, implementation and collaboration on First Nation support and objectives. This meeting was fruitful as we gained a positive relationship with a strong organisation focused on supporting Indigenous Australians while also understanding and providing context for the health needs and opportunities in rural and regional Australia.

The Policy Team also met with the ***Australian Patient Association***. One of the reasons for doing this has been the need to have insights from a patient advocacy group. Promotion and awareness against managed care from both perspectives is always on the front of mind, so engaging with a peak body for patients whose mission is to protect and champion patients' rights while protecting the Dr patient relationship is a positive step for the ASA.

Lastly, we met with the ***Climate and Health Alliance*** whose mission is to unite health care organisations in an effort towards climate action and sustainable healthcare. CAHA has a member base of over 100 organisations such as ours that together have a respectable and trusted voice in the community. We spoke at length about building brand awareness, the opportunity to network with other societies and organisations, and of course leading and supporting climate initiatives from a health perspective.

We will continue to strengthen our relationships, gaining or building bridges in the interest of advocacy, collaborative healthcare and strengthening our existing priorities and objectives to assist our members. On this topic, then President Barack Obama in 2009 narrated on health care stating "*identifying what works is not about dictating what kind of care should be provided. It's about providing patients and doctors with the information they need to make the best medical decision*", and with this in mind, the ASA will strive on your behalf to achieve it.

## Affiliation

ASA Policy Team again has secured a partnership with Australian Digital Health Agency in a contract that will run to June 2023. This partnership is to continue our work in support of promoting and engaging Anaesthetists to participate in the uptake of My Health Record and E-Health related products.

## Relative Value Guide

Australian Medical Association (AMA) will be issuing an update of the AMA Fees List on the 1st of November 2022. Relative Value Guide (RVG) will be updated accordingly shortly after. We have also been working on updating relevant to the RVG resources including ASA billing sheet which contains key information on how anaesthetic billing works and can be used for consultation with your patients.

## Telehealth consultations

Anaesthesia Telehealth consultations have ramped up during the COVID-19 Pandemic, however the MBS telehealth numbers only covered video conference and the Temporary COVID-19 pre-anaesthesia assessment numbers (phone and video pre-anaesthetic assessments that meet 17615 requirements – time, surgical and or patient complexity requirements). The only current number for anaesthetists for Telehealth consultations is the video conference number 92701.

The ASA has worked with the AMA to have new Telehealth phone pre-anaesthesia consultation numbers added to the AMA schedule.

CA021 for < 15 mins;

CA022 for > 15 - 30 mins;

CA023 for > 30 - 45 mins; and

CA024 for > 45 mins.

The ASA has been discussing with the Department of Health (DoH) the requirement for Pre-anaesthesia Telehealth Phone numbers, progress has stalled and DoH have advised that any approval for a new phone telehealth number will not be considered until May 2023 budget.

## Submissions to the Department of Health

The ASA has been actively engaging with the Department of Health on the range of submissions for item numbers that are currently being co-claimed by anaesthetists but sit outside the Relative Value Guide section of MBS. Please note any services that sit outside T10 section (RVG) of the MBS must not be co-claimed in association with anaesthesia. If in doubt please get in touch with policy@asa.org.au.

ASA and regional Special Interest Group nominated experts have also been working on the continuous nerve blockade using the catheter technique submission. We are requesting for the new item number and additional funding for this service. The initial application was submitted on the 18th of November.

## Medicare compliance

The recent media reports concerning inappropriate Medicare rebates have been unsettling. The ASA policy team has been engaging with DoH Compliance Division in regards to a number of queries as the result of the increased Medicare activity. The ASA Policy team has been taking a proactive approach to address some of the compliance concerns and queries. The ASA has been working with both Compliance Education team and private insurance stakeholders to educate our members in regards to Medicare requirements, and educate insurance providers on how the anaesthetic billing works to minimize rejections and mistakes when claims are being processed.

## Federal Budget 2022

Our work in the next quarter will be shaped by recent government budget announcements. The new federal budget for healthcare is a mixed bag. On the one hand people will benefit from cheaper medicines ($787.1 million over the next 4 years). People living in rural and regional Australia will be benefiting from the Government's $185.3 million Rural Workforce package (attract more doctors and allied health professionals to those communities). The Government is investing $750m in the strengthening Medicare Fund, with the Strengthening Medicare Taskforce determining how to best spend to improve access and care for patients. And another $235 million to roll out Urgent care clinics to reduce pressure on public hospitals. However, there is no additional funding for public hospitals and still no certainty over how the government will address Medicare funding. The ASA policy team will be increasing our advocacy efforts to engage with the government on the budget initiatives that impact on anaesthetists.

## Changes to the Policy Team

In October 2022, we also welcomed a new Policy and Public Affairs Manager, Bernard Rupasinghe. Bernard has a Bachelor of Arts (Political Science) Bachelor of Laws from the Australian National University and a Master of Labour Law & Relations from the University of Sydney. He has almost two decades experience working in senior policy roles for not-for-profit member associations representing registered health practitioners in Australia. Prior to this he worked as an Employment Relations Advisor to Catholic School Employers in NSW and the ACT. Bernard was also an appointed community member of the Nursing and Midwifery Council of NSW from 2015 to 2018.

He is currently working on a review of veterinary schools in Australia and New Zealand and will work part-time for the ASA until the end of December and be full-time from January, 2023. Please welcome Bernard to the ASA team and reach out to if you require assistance. Our friendly team is here to help.

# LETTERS TO THE EDITOR

## AHPRA

To my fellow colleagues, 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 doctors 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.

The conference also discussed how during the pandemic some recently retired doctors wanted to help (vaccinate, contract trace, etc) but the barriers placed by AHPRA were too insurmountable.

Please visit the Australian Senior Active Doctors Association website for more information. https://asada.asn.au/

$N_2O$ allows the reduction of the amount of volatile agents used, as well as reducing cardiac events and other complications by allowing a reduced amount of narcotics to be used during anaesthesia.

This is a serious issue and will affect all of us at some point.

Dr Jeff James MBBS FANZCA

*Editor's note*
*Doctors are advised to check directly with AHPRA regarding any limitations to practice as advice may vary between individuals and jurisdictions.*

## Plastic Wrap

I thoroughly enjoyed the latest issue of *Australian Anaesthetist* which alerted our profession to the challenge of waste management and climate change. Thank you.

I have been an ASA member since the 1970s and also a member of the AAGBI, whose journal *Anaesthesia* has been delivered by post in a compostable plastic envelope for over a year now. To date it is the only journal to which I subscribe to have made the decision not to use the usual plastic envelopes.

So, I write to suggest that the ASA considers using compostable plastic for mailing the hard copies of Australian Anaesthetist and Anaesthesia & Intensive Care.

With best wishes,

Yours sincerely,
Dr John Crowhurst

*Editor's note*
*The ASA is currently investigating the feasability of changing to compostable wrap.*

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

**The ASA has 20 CRASH scholarships a year available for members**

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

### What is CRASH?

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

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

CRASH virtual is accredited for one emergency response.

### What is the ASA CRASH Scholarship?

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

### Who can apply for an ASA CRASH Course Scholarship?

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

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

### How do I apply?

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

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

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

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

For course information, dates and scholarship application please log in to the members website and go to

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

# DR TOM MOHLER 1965 – 2022

Across a professional career it is rare to meet an individual who consistently sustains their knowledge, skills and professionalism at the very highest level. Who can always be relied upon for considered advice and help delivered quietly yet generously. Tom was such a person. It was an absolute privilege to have him as both a colleague and friend.

Dr Thomas Mohler was born in Murten, Switzerland in1965. His parents moved to Nigeria in 1970 where Tom did several early years of schooling, returned to Switzerland for two years, then decided to emigrate to Australia in 1975, settling in northern Tasmania near Launceston.

Following secondary schooling at Riversdale High School and Launceston Community College Tom gained entrance into medicine at the University of Tasmania, commencing a six year degree in 1984. He received numerous academic awards through his undergraduate years, finishing at the top of his year and graduating in 1989 with honours and an additional Bachelor of Medical Science. It was during clinical training in Launceston that Tom met his future wife Paula.

Tom was initially intrigued by the possibilities of general practice in regional Australia – both the professional challenges on offer and the opportunity to explore with Paula.

After two years as intern then RMO at the Royal Hobart Hospital, Tom and Paula departed for the top end. Two years at Royal Darwin Hospital included time in general practice, a rotation to Katherine and a Diploma of Obstetrics.

Darwin was followed by a GP trainee appointment in Naracoorte in the south-east of South Australia. Keen to gain anaesthetic expertise as part of rural GP training, Tom decided to take an anaesthetics senior house officer (SHO) job in the United Kingdom. It is easy to imagine how Tom must have delighted in the particular professional challenges offered by clinical anaesthesia – the daily application of basic science, the focus required for situational awareness, technical and procedural skills and overarching this the compassion required to guide patients often in their most vulnerable state. Tom excelled in all these areas and had found his vocation. So a great loss to rural general practice but an obvious gain to anaesthesia. Tom and Paula returned to Naracoorte to complete his trainee contract there and their first daughter, Georgia was born in 1995.

Commencing anaesthetic training back in Tasmania at the Royal Hobart Hospital (RHH) in early 1996, Tom completed two years of training there separated by one year at the Launceston General Hospital. In that era, Tasmanian trainees could choose to spend a year in Melbourne consisting of four month rotations to The Royal Children's Hospital, the Royal Women's Hospital and the Western General Hospital. Seeing this as an excellent opportunity, Tom, Paula and Georgia decamped to Melbourne in 1999. In that year, their second daughter, Sophie was born. While on rotation to the Royal Children's Hospital, Tom's considerable anaesthetic talents were noticed by then department director Kester Brown and he was offered a fellowship position for the following year. This he accepted and at the end of that year was offered a further position as Fellow/Junior Consultant which he also accepted.

By the end of 2001, Tom and Paula had been in Melbourne for three years. A career in tertiary paediatric anaesthesia at the Royal Children's Hospital (RHH) beckoned. However, to the enormous benefit of the Tasmanian community, they made the decision to return home and Tom commenced practice as a consultant at the Royal Hobart Hospital in early 2002, where he remained.

It is difficult to communicate the breadth of Tom's contribution to anaesthesia in Tasmania and more widely. Paediatric anaesthesia was of course a passion but also education, global outreach and sustainability. He had returned to a rapidly changing anaesthetic department in a state of evolution but without a clear structure to the paediatric anaesthetic service. Quietly and without necessarily

having been assigned the role, Tom very rapidly became seen as the leader of paediatric anaesthesia in Hobart. His was always the opinion sought and incrementally what is now a highly functioning service was built around him.

Opportunity arose in 2006 for a team to visit Laos and look at providing assistance with specialty anaesthesia training in that country. Initially led by Andrew Ottaway and Tom, this first visit led to a sustained program of basic science teaching and curriculum formation for Laos anaesthesia training. Continuing under Tom's leadership, by 2019 there had been 12 visits to Laos involving numerous members of the RHH anaesthetic department. I was very fortunate to be a part of many of these. A repeating three year cycle of registrar teaching was established as were Essential Pain Medicine and Primary Trauma Care courses. In Laos, Tom's natural reserved style would be abandoned as he enthusiastically drew in ever more examples in an effort to overcome language barriers and communicate the more complex principles. His obvious sincerity, commitment, warmth and wisdom endeared him to the Laos registrars and anaesthetists. He was viewed as a genuine friend by the anaesthetic leaders in Laos, especially Dr Traichit Chantasiri with whom he was always in regular contact.

Tom was a valued member of the Overseas Development and Education Committee (ODEC) of the Australian Society of Anaesthetists (ASA). Having joined the ASA in 2000, he was quick to recognise the value of the work done by members of ODEC and the importance of the knowledge they offered and the financial support so important for the success of overseas projects. Consequently, ODEC has provided ongoing support for much of the work done in Laos.

Tom was also clinical lead for the Global Outreach Program at the RHH, coordinated overseas visiting anaesthetists to the RHH (including funding from the Rotary Club of Glenorchy) and managed the introduction of Lifebox into Laos.

In our current era of subspecialisation, Tom maintained a truly extraordinary scope of practice. He recognised the value of point of care ultrasound early, gaining a postgraduate certificate in clinical ultrasound from the University of Melbourne in 2010. He went on to be one of two anaesthetists in our department providing an anaesthetic-led transthoracic echo service to the pre-assessment clinic. He was an accredited provider of cell salvage. At various times and in both the public and private sector, he provided advice or guidelines in the areas of paediatrics, bariatrics, acute pain management, sustainability and recycling. This is not an exhaustive list. Tom was an ANZCA final part examiner from 2009 to 2021. He had ongoing involvement as an assessor of examiners.

His 22 year consultant career encompassed major contributions to both the public and private sector, having also been an associate of the Hobart Anaesthetic Group for 11 years. A wise head who could be relied upon for considered advice, his interactions with both patients and colleagues were always delivered with care and compassion.

Never loud, never brash, never angry, he had the universal respect of anaesthetists, nursing staff and surgeons alike.

For me, what will remain outstanding about Tom is this care and compassion and how it pervaded all aspects of his life. He was at heart a family man. Our very great professional loss is eclipsed by that suffered by his family. I will treasure memories of quiet evening conversations in Laos, talking about families and friends. As humble as he was, the immense pride Tom held in his daughters and his devotion to his beloved wife Paula would shine through.

Dr Tom Mohler passed away after a very sudden, acute medical illness on Saturday 1st October 2022. He is survived by his wife Paula, daughters Georgia and Sophie and his sister and mother.

His loss will be keenly felt for a very long time but his teaching and wisdom lives on in the Tasmanian anaesthetic community and beyond.

**Dr Simon Morphett**

# NEW AND PASSING MEMBERS

The ASA would like to welcome all new members from 26 July 2022 to 31 October 2022.

| Prevocational Medical Education and Training | |
|---|---|
| Dr Amy Benness | NSW |
| Dr Stephanie Gassner | WA |
| Dr Matthew Kuo | NSW |
| Dr Bosco GodwinRaj Lawrence | VIC |
| Dr Jakob Sean Malouf | VIC |
| Dr Clark Mei | WA |
| Dr Callum Khang Nguyen | VIC |
| Dr Liem Tran | SA |
| **Advanced/Provisional Fellow Trainee** | |
| Dr Ahmed Abdelwahab | VIC |
| Dr Claire Attwood | VIC |
| Dr Suzanne Barbour | SA |
| Dr Jessica Barry | NSW |
| Dr Shreyas Boppana | QLD |
| Dr Christina Cheng | NSW |
| Dr Arghya Gupta | NSW |
| Dr Michael Remilton | VIC |
| Dr Shorsha Ross | VIC |
| Dr Victoria Sadick | NSW |
| Dr James Leigh Sgroi | VIC |
| Dr Peter Stark | NSW |
| **Introductory/Basic Trainee** | |
| Dr Peter Stark | WA |
| Dr Peter Stark | VIC |
| Dr Tayla Coles | ACT |
| Dr Elinor Jeanne Cripps | NSW |
| Dr Tahlia Gentle | QLD |
| Dr Joel Greaney | VIC |
| Dr Joel Mugambi Kiburi | QLD |
| Dr Vibhushan Manchanda | WA |
| Dr Daniel Patti | NT |
| Dr Jack Perkins | WA |
| Dr Skye Propsting Perkins | NSW |
| Dr Salm Ramzani | QLD |
| Dr Jesse Renouf | NSW |
| Dr Krishan Subhaharan | NSW |
| Dr Claudia Toro | WA |
| Dr Clare White | NSW |
| Dr Jessica Zheng | WA |

| Ordinary Member | |
|---|---|
| Dr Keith Addy | QLD |
| Dr Maysana Allaf | VIC |
| Dr Benjamin David Allnutt | VIC |
| Dr Fiona Avril Barron | QLD |
| Dr Matthew Jonathan Bolland | VIC |
| Dr Antony William Brown | NSW |
| Dr Rebecca Caragata | VIC |
| Dr Mark Timothy Downing | QLD |
| Dr Anna Englin | VIC |
| Dr Tanya Rochelle Farrell | WA |
| Dr Anthony Fisher | SA |
| Dr Greta Gormley | VIC |
| Dr Oliver Thomas Gouldthorpe | VIC |
| Dr Jatinder Paul Grewal | QLD |
| Dr Namrata Jhummon-Mahadnac | NT |
| Dr Angela Maree Marsiglio | VIC |
| Dr Stella Fiona McLaughlin | QLD |
| Dr William John O'Regan | NSW |
| Dr Carling Simmons | QLD |
| Dr Christopher Slattery | QLD |
| Dr Thomas Peter Sullivan | VIC |
| Dr Ya-Chu May Tsai | VIC |
| Dr Samuel Walker | TAS |
| Dr Courtney Louise Williams | SA |

## IN MEMORIUM

The ASA regrets to announce the passing of the following members

| | |
|---|---|
| Dr Thomas Mohler | TAS |
| Dr Kenneth John Hales | QLD |
| Dr Heather Lopert | ACT |
| Dr Arthur Julian Penberthy | VIC |
| Dr William James Power | QLD |

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

# Join now and connect with your community

Australian Society of Anaesthetists®

Dr Ammar Ali Beck
ASA Member since 2009

EDUCATION

ADVOCACY

SCHOLARSHIPS AND GRANTS*

EVENTS

PUBLICATIONS

RESOURCES

FORUMS

**ASA is like a family home, always welcoming and supportive, inclusive and caring. Since its inception in the 1930s, ASA continues to communicate the value of anaesthetists to the public, policy makers and healthcare providers.**

**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

## 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 educational and social program featuring distinguished international keynote speakers. The opportunity to meet research and prize winners and collect valuable CPD points that will meet the new CPD program, all while networking and socialising with colleagues. You will also have the option to attend virtually with access to every scientific session.

**Melbourne Convention and Exhibition Centre**

**www.asansc.com.au**

Australian Society of Anaesthetists®