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Would you like to contribute to the next issue?

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

All submissions for September 2023 are due July 25

Image and manuscript specifications can be provided upon request.

ANDREW MILLER
PRESIDENT OF THE ASA

FROM THE ASA PRESIDENT

In late 2020, before vaccination had dialled back the severe acute COVID-19 disease for most cohorts, I was booked for an early morning live TV interview - 4am in Perth - on the topic of hotel quarantine.

At around 10pm the evening before, I was in a pitch-dark kid's room when the two-year old unerringly swiped my cornea with her scalpel blade fingernail. At first, the pain was dull, but within half an hour I knew paracetamol was not going to cut it. She had harvested a graft.

Wincing and swearing I headed for the local ED in an Uber at about midnight. By the time I arrived the blepharospasm was such that it was almost impossible to prise open the good eye without intense pain just from the slight sympathetic contralateral lid movement. I would have given the visual analogue scale a brave 7/10, but was really thinking 11.

They regarded the dishevelled middle-aged doctor - weeping from one eye - with a bit of suspicion, until I assured the Triage Nurse that I wanted nothing more than amethocaine.

They lead me down a hallway like a blast victim with eyes covered and laid me on a bed to put the drops in.

It was perhaps ten or fifteen seconds before I was catapulted from the seventh circle of hell into a heavenly paradise of numbness. I promised that nurse my kingdom, or at least whatever quantity of extravagant champagne they cared for.

My brain, unsure what to do with the emptiness now that my afferent thalamic pathways had suddenly fallen silent - like a call cut off - filled with dopamine, gratitude and humour.

We take for granted that which we do on a daily basis. The relief of pain is the bread and butter of our specialty and one of which we should be very proud.

While all of our varied techniques might have drawbacks and issues, our consideration of the risks of their deployment should always be balanced by a clear-eyed understanding of the terrible suffering that many of our patients would otherwise endure.

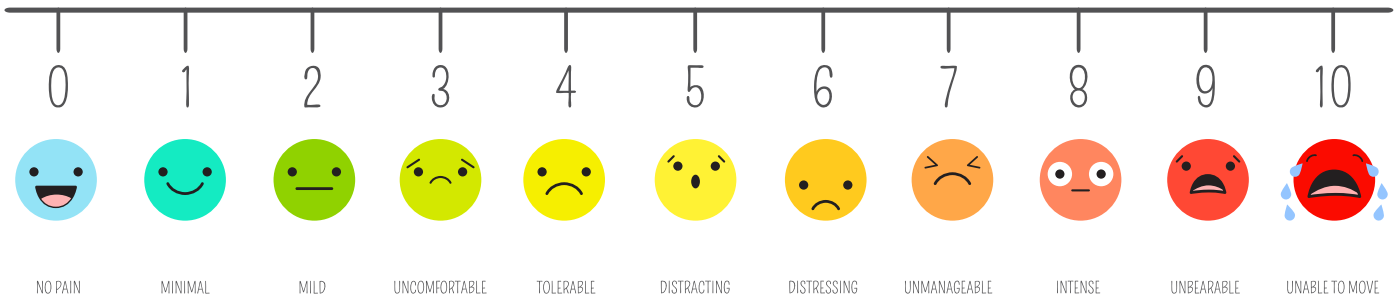
Health insurers and hospitals push the envelope of hospital admission ever shorter, and while most patients benefit from staying in hospital not a minute longer than they have to, I have no doubt that some experience more pain as a result, and that this data is not captured accurately if at all.

It is difficult to imagine that we will be successful in resisting the push for early discharge after surgery, which means we need to send patients home with opiates, or let them suffer.

Apart from the lack of humanity and reduced satisfaction, the range of problems exacerbated by poor control of acute postoperative pain is well documented.

As we send patients into the community with powerful medications, we must also have an eye on the problems associated with inappropriate use, particularly if it is extended.

We must develop systems of community pharmacy, general practice and nursing that properly steward the opiate resource



and ensure that safe and effective analgesia remains available to all of our patients who need it.

If we are to place any restrictions on the prescription of, for example, modified release opiates by specialist anaesthetists for discharge then it should only be in the presence of clear evidence of benefit of such a guideline, and systems that ensure adequate pain relief.

No-one understands our individual practice like we do, and what works in a tertiary centre with an acute pain and domiciliary nursing service may well be different in a regional or private practice setting where one anaesthetist might carry all responsibility for their own patients' pain management.

There are many combinations of drugs and procedures; flexibility in thinking is required to be able to adapt to the circumstances of the patient in front of us and their likely pain journey. Oxycodone is a very different drug to tapentadol or buprenorphine; a UPPP with tongue base reduction surgery is nothing like a total knee replacement or laparotomy in terms of activity induced pain control. Being home with a family member is nothing like being on a ward.

It is very important that we reduce the risk of dependence, diversion and overdose, while preventing acute and chronic pain effectively.

I look forward to learning more - as I always do - from our colleagues who have written about pain in this issue.

After an ED eye exam confirmed the expected injury to my cornea, I went home at 2am trailing fluorescein tears and some contraband local anaesthetic. Each hour I allowed myself two more eye drops, which was enough to get by, even if it was by breaking the rules.

The cameraman turned up at 3.30am and I managed to get my red eye open long enough to do the interview, while looking a bit more emotional than usual in the face of the brutal LED light.

Pain is unmeasurable, almost entirely subjective, and - even from seemingly minor injuries at times - terrible. Eliminating or at least controlling it with excellence must remain our obsessive pursuit.

Dr Andrew Miller

MBBS LLB(Hons) FANZCA
FACLM FAICD FAMA

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

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FROM THE CEO

DR MATTHEW FISHER
CHIEF EXECUTIVE OFFICER, ASA

Our key messages regarding the ASA include that we are the peak body for the profession; we have a major educative role in the specialty and with the public; have 90 years of experience; and are a core part of the health landscape and discourse. Importantly, we have expertise in health care in the hospital setting, and therefore a trusted source of advice to government.

Themes are a great way of focussing a collection of efforts to a single point. I will go off theme as often my role as CEO is to mitigate pain points so we can move forward as an organisation. At the ASA, the Board has adopted a progressive development plan which we term 'Project Exemplar', happening at many structural levels. This includes a cultural review, focus on strategy, operational alignment with strategy, organisational structure and operational efficiency, best practice governance and committee performance, a new IT platform, enhancing our public affairs capability, a change in investment partner, reviewing our flagship A&IC journal, reviewing and setting a segmented membership strategy, defining a communications strategy, improving our engagement with the public sector and ensuring that our education and events fulfil your specialist requirements.

It is a long list with a project and action plan in development for each, including anticipated outcomes and drafted timeframes. Importantly, we want to ensure we complete a 'stop, start, continue' approach to what we do on your behalf – all to achieve 'exemplar' status. I will focus on a few highlights and always happy to engage and discuss with you as you may need.

From a cultural perspective, we used a tool provided by Harvard Business Review (HBR) to make an initial assessment. The first part of the assessment provides a simplified exploration of which two cultural styles the ASA leans towards (out of eight total) and what this means. The second part can help us take stock of how prominent a role culture plays in our organisation and lets us benchmark our answers to those from other HBR readers. It also asks a series of demographic questions to help us learn more about how culture operates within the ASA. According to our ranking of what best describes the ASA's culture, our culture seems to have a greater orientation toward purpose and caring. According to this assessment, organisations with this kind of culture emphasize both contributing to a greater cause and trusting relationships. People tend to give back to their communities and help and support one another.

The apparent advantages of purpose include fostering diversity and inclusivity, and social responsibility. However, the apparent disadvantage of purpose may include an overemphasis on a long-term purpose that can distract from immediate concerns. This is an interesting balance to achieve. The apparent advantages of being a caring organisation include improved teamwork and trust, and increased loyalty. However, an apparent disadvantage of caring may be an overemphasis on consensus-building which can stifle competitiveness. We will repeat this measure over time and see what changes.

As previously communicated, the ASA is embarking on a coordinated public affairs strategy with the Civic Partnership, with the clear objective 'to establish the ASA as a respected partner and adviser to

governments on the issues and needs of our members (and in the public interest). To do this, our strategy must create a framework to both promote the profession, guard it against future challenges (in all sectors) and assert our leadership in healthcare policy. Importantly, this will ensure the public continues to receive high quality care and valued outcomes.

In short, we aim to:

- Advance the ASA's reputation more broadly and publicly so our voice, alongside others can be heard.
- Ensure the ASA is best placed to advocate on future policies or initiatives of interest to the profession and wider health sector.

Challenge any pre-formed views of the profession, with a new narrative.

Our key messages regarding the ASA include that we are the peak body for the profession; we have a major educative role in the specialty and with the public; have 90 years of experience; and are a core part of the health landscape and discourse. Importantly, we have expertise in health care in the hospital setting, and are therefore a trusted source of advice to government. We can help Government with solutions, and this is underpinned by the quality of care by anaesthetists with patient care as the priority. Quality is paramount.

We have embarked on the first phase – 'towards 90', which uses a suite of activities and assets to focus attention while also showcasing the ASA's experience in the Australian healthcare system. We are already experiencing significant interest with politicians and health departments who are interested in engaging with us.

As part of accelerating our learning, I had the privilege of spending two days with the American Society of Anaesthetists, courtesy of an invitation by the long-standing and respected CEO, Paul Pomerantz. Paul opened up the organisation and his people to me and it was a full, productive, and interactive time. My time was spent with Paul, Brian Reilly, Chief Operating Officer, Sarah Braun, Director of Component and Intersociety Relations, Susan Carlson, Chief Learning Officer and Kevin Kirberg, Director of Meetings and Exhibits, Marc Bernstein, Chief Information Officer and AQI Executive Director and Deepa Gudipally, Director of Information Technology, the Anesthesia Quality Institute; Debbie Greif, Corporate Relations and Business Development Executive, Michele Campbell, Director of Governance; Wood Library Museum, Maureen Geoghegan, Chief Membership and Communications Officer, Kim Jansen, Director of Publications, Roseanne Fischoff, Center for Perioperative Medicine Executive Director and Ariel Trocino, Innovation and Implementation Manager, and finally, Manuel Bonilla, Chief Advocacy Officer and Theresa Hill, Director of Public Relations.

Leaving aside the scale of the American Society and structure of our health systems, there are many parallels to our organisations, and we have a commitment to continue our joint and separate journeys. I am deeply appreciative of the opportunity and presented a beautiful aboriginal artwork that portrays the artist's clans and connections which we reflected upon in this exchange. I will now be working with my staff to deepen this connection and exchange.

So back to the start and the theme of pain. First world problem for me … tornadoes and storm disrupted flights and my bag is somewhere else so stuck for two unplanned days. My pain will pass quickly and all ultimately recoverable.

Dr Matthew Fisher

PhD DHlthSt (honoris causa)

Contact

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NAVIGATING THE CHALLENGES OF PAIN MANAGEMENT IN MANAGED CARE

INSIGHTS FROM A PAIN SPECIALIST

Pain management is a complex and often challenging field that requires a comprehensive and individualised approach to care. Speaking with Australian Anaesthesia podcast host, Dr Suzi Nou, pain specialist Dr Samer Narouze, sheds light on the implications and challenges of managed care for both patients and practitioners.

Chronic pain is a complex and challenging condition that affects millions of people worldwide[1]. The management of chronic pain is strongly influenced by healthcare systems and can differ across countries. Given the rising popularity of managed care as a healthcare model worldwide[2], we draw on the experience and insights of Dr Samer Narouze, President of the American Society of Regional Anesthesia and Pain Medicine, pain specialist and anaesthetist in the United States (US), to examine the impact of managed care on pain management and challenges faced by practitioners and patients.

What is managed care

Managed care is a healthcare model that focuses on cost-effectiveness. In managed care, healthcare insurance providers contract with healthcare providers, including hospitals, clinics, and physicians, to provide care to their members. Managed care seeks to manage costs by controlling the use of medical services and promoting preventive care. This model provides a way for healthcare providers to deliver care to patients while controlling costs.

The managed care model has been successful in some areas, but there are concerns about its impact on patient care[3]. The focus on cost-effectiveness has led to the use of measures such as value-based contracting, data collection, incentive payments, and fee-for-performance measures. These measures have been used to control costs and there is much debate on their ability to promote quality care.

What are the implications for pain management

Pain management is a complex and often challenging field that requires a comprehensive and individualised approach to care. Speaking with Australian Anaesthesia podcast host, Dr Suzi Nou, Dr Narouze shed light on the implications and challenges of managed care for both patients and practitioners.

For patients, the limitations of managed care plans can restrict their access to necessary treatments and medications. As Dr Narouze highlighted, managed care plans often have limited options, and it can be difficult to navigate the pros and cons of each plan. Furthermore, the out-of-pocket costs associated with managed care plans can create financial burdens

for patients, even if they have insurance. This can lead to patients receiving suboptimal care, as they may avoid necessary treatments or medications due to cost concerns.

For practitioners, managed care plans can create obstacles in providing quality care. Dr Narouze noted, managed care plans often require pre-authorisation for certain treatments and medications, which can delay care and create administrative burdens. Additionally, the emphasis on cost-containment in managed care plans can lead to pressure on practitioners to limit the treatments they provide. This can create tension between practitioners and their patients, as they may have different opinions on what constitutes necessary care.

What can patients do

To navigate the limitations and challenges of managed care plans, Dr Narouze recommends that patients become informed about their insurance options. He suggests that patients do their homework ahead of time and understand the pros and cons of each plan. This is because managed care plans can differ significantly in terms of coverage, costs, and restrictions. Dr Narouze also emphasised the importance of negotiating ahead, as once a patient has started a plan, they are often stuck with it. By being proactive and informed, patients can better advocate for their own care and make informed decisions about their treatment options.

What can practitioners do

Dr Narouze underscored the significance of healthcare practitioners being cognizant of the restrictions of managed care plans and advocating for their patients' requirements. Practitioners should work to stay informed about different insurance options and be prepared to negotiate with insurance companies on behalf of their patients to ensure they receive necessary treatments and medications. Additionally, practitioners should strive to maintain good communication with their patients and work collaboratively with them to develop individualised treatment plans that are feasible within the limitations of their insurance coverage. By doing so, providers can help ensure that their patients receive optimal care despite the challenges posed by managed care.

Advocating for optimal pain management

Chronic pain management presents unique challenges, particularly with the rise of managed care as a healthcare model. The limitations of managed care plans can create barriers for both patients and practitioners, restricting access to necessary treatments and creating obstacles in providing quality care. In Australia, the added administrative burden and lack of demonstrable outcomes for patients make it difficult to see the benefits of managed care in caring for chronic pain patients. While managed care may have achieved cost containment and delivered profits for private health insurance companies in the US, the focus should remain on ensuring independent, high-quality medical care for patients. For this reason, the Australian Society of Anaesthetists remains vigilant and continues to work with stakeholders to ensure independent, high-quality medical care for patients.

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This article was inspired by Episode 43 of the Australian Anaesthesia podcast Managed care and chronic pain, featuring special guest anaesthetist and pain specialist, Dr Samer Narouze. The Australian Anaesthesia podcast is a regular podcast hosted by Dr Suzi Nou, ASA Immediate Past President, that discusses the latest developments in anaesthesia and the issues impacting anaesthetists. ASA members have access to the complete podcast library, while a series of episodes are publicly available on Apple Podcasts, Spotify, and Google Play. We thank Dr Nou and Dr Narouze for their insightful discussion on the challenges of managed care for both patients and practitioners.

MEET DR GUY BUCHANAN, SPECIALIST PAIN MEDICINE PHYSICIAN

Chronic pain is a common and debilitating condition affecting one in five Australians over the age of 45[1]. Chronic pain can significantly impact quality of life, with those affected being five times as likely to be severely limited in daily activities than those without pain[1]. The number of encounters with GPs for chronic pain has risen by 67% over the last decade[1], reflecting a growing need for management and treatment of chronic pain in Australia. Further, between 2017-18 alone, there were nearly 105,000 hospitalisations involving chronic pain[1], highlighting the significant impact of this condition on our healthcare system. With such a significant impact on Australians, it is important to understand the role of pain physicians in addressing this complex issue. Join us as we dive into the world of pain medicine with specialist anaesthetist and pain medicine physician, Dr Guy Buchanan, gaining insights into treating chronic pain in Australia.

Specialist pain medicine physicians in Australia

Specialist pain medicine physicians are medical practitioners who are trained in the management and treatment of acute pain, cancer pain and chronic non-cancer pain. In Australia a primary medical specialisation is required prior to training to obtain formal recognition as a specialist pain medicine physician. Primary specialisations include anaesthesia, rehabilitation medicine, psychiatry, neurosurgery, and general practice.

Pain is a complex phenomenon arising from a whole person in the context of their environment which is more than nociception, and involves social, psychological, and biological factors. Pain involves many factors associated with the person (not just the brain or just the body) and their interactions with their environment. If there is credible information suggesting the person is in danger or under threat, pain is experienced.

The traditional biomedical approach to treating pain has been very effective in helping many patients but unfortunately there are many painful conditions where cure is not possible. Therefore, it is now common to take a multi-disciplinary approach to the treatment of chronic pain with physical treatments, cognitive treatments, interventional treatments, and pharmacotherapy as well as pain management programmes. Pain medicine physicians typically collaborate with other medical practitioners, and with allied health practitioners such as physiotherapists, psychologists, and occupational therapists to provide patients with a holistic approach to pain treatment.

Pain medicine physicians also play an important role in addressing the opioid epidemic in Australia by providing patients with non-opioid, pain management strategies. This may include the use of interventional pain procedures as well as physical and psychological interventions.

Approaches and techniques

Pain medicine approaches and techniques encompass a range of treatments that aim to alleviate pain and improve patients' quality of life. Pharmacological treatments include analgesics, such as non-steroidal anti-inflammatory drugs (NSAIDs), anti-depressants, anti-convulsants, and opioids[1]. Non-pharmacological treatments include exercise, physiotherapy, and cognitive-behavioural therapy, among others[1]. These treatments may be used alone or in combination, depending on the individual patient's needs and preferences. Pain medicine physicians may also utilise interventional pain procedures, such as injections, radiofrequency treatments and spinal cord stimulation[2], to decrease pain severity in properly selected patients as an adjunct to rehabilitation and self-care. It is important to note however, that every patient's pain is unique, and therefore, treatment plans are tailored to each patient's individual needs and goals.

Q&A with a pain physician

We spoke to Dr Guy Buchanan, a specialist pain medicine physician from Melbourne, Australia, to gain insights into the journey of becoming a pain physician. Dr Buchanan completed specialist anaesthesia training in 2000 and specialist pain medicine training in 2016. He is also a Fellow of Interventional Pain Practice from the World Institute of Pain.

Dr Buchanan is in solo, private practice and is appointed at Epworth and Cabrini Hospitals as well as North Eastern Rehabilitation Centre and Monash House Private Hospital. He works in an interdisciplinary manner with rehabilitation medicine physicians, spine surgeons, and allied health practitioners. He aims to help his patients develop the skills to self-care, especially when curative treatment is not available for the pain diagnosis.

In addition to his practice in pain medicine, Dr Buchanan is a valuable member of the Australian Society of Anaesthetists' (ASA) Economic Advisory Committee (EAC) which provides guidance and recommendations to the Department of Health, private health insurers, and other key stakeholders, including the Australian Medical Association (AMA). The ASA welcomes Dr Buchanan's expertise and contribution to this committee.

Final thoughts

Chronic pain is a significant and growing health concern in Australia, with millions of people affected and a rising need for management and treatment. Pain medicine physicians, with their specialised training and multidisciplinary approach to pain management, play a crucial role in addressing this complex issue and improving patients' quality of life. Through the use of evidence-based pharmacological and non-pharmacological therapies, interventional pain procedures, and collaboration with other healthcare professionals, pain specialists strive to provide tailored and holistic care to each patient.

Kelly Chan

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DR GUY BUCHANAN

At what stage did you want to become a pain physician?

About 10 years post-Fellowship. I saw poor outcomes associated with long-term opioid therapy and wondered why this was the case. My curiosity then led to seeking formal training.

How did you manage the training to become a pain physician with your anaesthetic career?

I was kindly offered a non-funded position at Nepean Hospital in Sydney and flexible training was offered. I trained part-time while continuing anaesthesia practice part-time in Canberra. This meant a lot of travelling but allowed me to keep my head above water financially.

How do you balance pain medicine and anaesthesia now?

I have transitioned into full-time work in pain medicine practice and have a mixture of consulting room and hospital practice.

What do you enjoy most about being a pain physician?

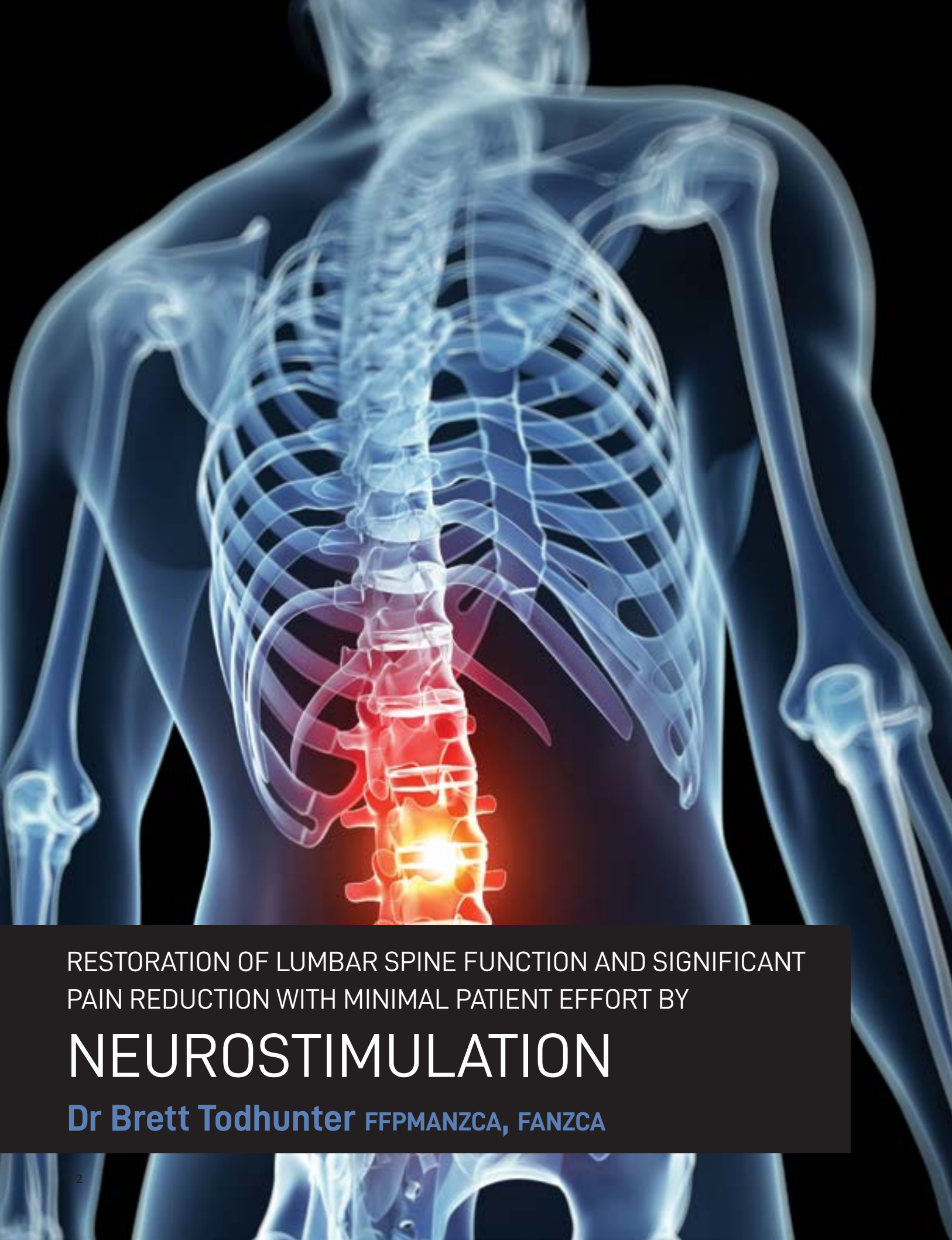
Developing long-term relationships with patients and seeing improvements in their quality of life.

What advice would you give for people considering a dual career in pain medicine and anaesthesia?

Jump in! Anaesthesia is an excellent foundation for pain medicine practice.

You are also part of the Australian Society of Anaesthetist's (ASA's) Economic Advisory Committee. Why do you think it is important for pain physicians to be involved with the ASA?

The ASA provides a means of representing the economic and political interests of pain medicine physicians. The addition of more pain medicine physicians to this effort would undoubtedly strengthen their influence and effectiveness.



RESTORATION OF LUMBAR SPINE FUNCTION AND SIGNIFICANT PAIN REDUCTION WITH MINIMAL PATIENT EFFORT BY

NEUROSTIMULATION

Dr Brett Todhunter FFPMANZCA, FANZCA

Disclosure: Dr Todhunter has not received any direct payments from any neurostimulation company. He has attended workshops paid for by the neurostimulation companies including Mainstay Medical, Abbott, Medtronic and Nevro. All of the opinions in this article are those of Dr Todhunter based on published research as well as personal experience.

Introduction

Management of chronic non-cancer pain remains problematic and there is a great degree of controversy regarding the most appropriate treatment for this common disabling condition. Broadly there are two approaches to treatment and both are consistent with a biopsychosocial paradigm of chronic non-cancer pain. One approach is that of a cognitive behavioral pain management program and this approach addresses the psychosocial aspects of persistent non-cancer pain coupled with therapy to address physical rehabilitation and restoration of function. The other approach involves interventional procedures aimed at reducing the pain itself and then expecting a degree of functional restoration or rehabilitation following because the pain has been reduced. Ideally a combination of both approaches would seem optimal. As an interventional pain physician, I have been involved in various approaches to chronic non-cancer pain both in terms of interventional pain approaches and involvement in cognitive behavioral programs over the last 32 years or so.

Overall, there is a 7.3% global point prevalence for activity limiting low back pain.[2]

Persistent non-cancer low back pain is not a single entity. Pain may arise from structural problems resulting in nociceptive pain. There can be damage to the peripheral or central nervous system resulting in neuropathic pain which tends to be constant unrelenting pain not changing with position, frequently being worse when a person is lying down than standing up. Another concept is nociplastic pain related to central sensitization and wind up where there is a functional change in pain processing in the central nervous system without physical neurological damage.[1]

Overall, there is a 7.3% global point prevalence for activity limiting low back pain.[2]

One of the confounding issues dealing with chronic non-cancer pain is the subjective nature of pain combined with complex psychosocial factors all of which can't be measured directly. Currently we have no way of imaging the dysfunction of the central nervous system when there is no physical damage except for functional MRI brain scans which are nonspecific but objectively show differences in brain function in people with acute and chronic pain compared to people without pain. Some patients present with very definite mechanical pain but other people complain of pain that is still there when sitting or lying but not as bad as when standing up. The pain on standing could be added mechanical pain i.e., nociceptive pain but it could also be nociplastic pain where there is the amplification of afferent signals whereby what should be non-painful stimulation causes pain to be subjectively experienced at a cognitive level. It is impossible to accurately separate these entities. Unfortunately, spinal cord stimulation has minimal effect on nociceptive mechanical spinal pain.

Traditionally interventional pain treatments and indeed spinal surgery for low back pain in the absence of neurocompression were focused on identifying an anatomical structure that was identified as resulting in nociceptive pain. Structures might be degenerative or damaged. A 'pain generator' was sought and if identified led to treatment. From an interventional pain medicine point of view the structures traditionally assessed were the zygapophyseal/facet joints and the intervertebral disc. Diagnostic facet joint blocks where the medial branch nerve supplying the facet joint was infiltrated with local anaesthetic was one approach and if the pain is substantially reduced after the diagnostic blocks for a period of four to eight hours the diagnosis of facet joint pain was made. There are many variables in terms of approaches along these lines but a subsequent facet joint denervation where the medial branch nerves are heated up could result in long term pain reduction of nine months or more but ultimately the nerves do regenerate and the pain returns. The procedure could be repeated. The other diagnostic approach was that of discograms where contrast was injected into the intervertebral disc in an effort to assess whether artificially pressurising the disc resulted in reproduction of pain that was concordant with a person's usual pain experience and so identify the disc as the 'pain generator'. Subsequent spinal fusions and attempts to denervate the disc could be undertaken but with frequently disappointing results. Where a 'pain generator' could not be identified in terms of some anatomical structure the terminology of nonspecific mechanical low back pain is utilised.

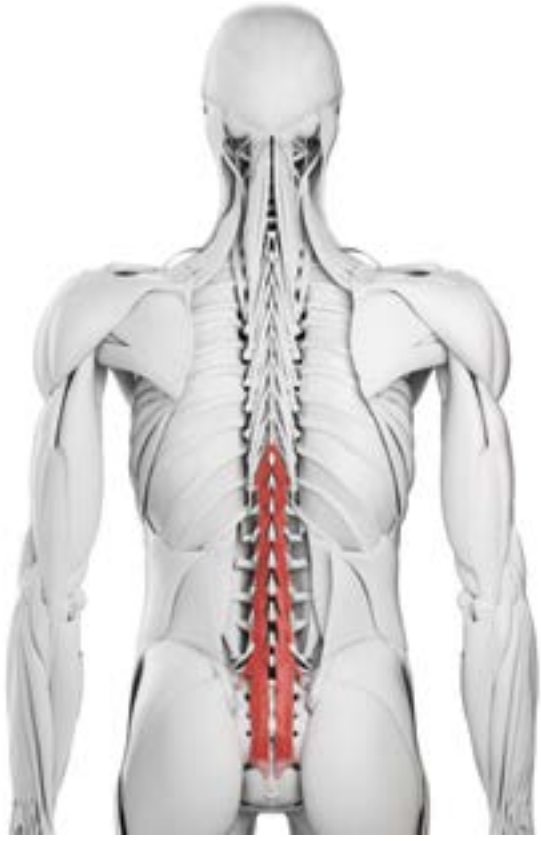
However, research indicates a poor correlation between physical changes identified on medical imaging and a person's subjective pain report.[3]

Recent Developments

For some time, physiotherapists have been involved with the reconditioning of the core muscles notably the transversus abdominis but also the multifidus muscle. Conceptually nociceptive/mechanical pain may arise from a lack of a supporting muscular stabilising system in the lumbar spine and this could be related to muscle degeneration itself or changes in the neurological system controlling the muscles.[4]

In conjunction with the realisation that muscle function is a major factor in spinal stability and lack of that muscular control can result in mechanical back pain is the concept of arthrogenic muscle inhibition. Initially this entity was identified in patients recovering from knee surgery who were unable to activate their quadriceps muscle and this caused major problems with rehabilitation and ongoing pain. The function of the quadriceps muscle was improved with transcutaneous electrical nerve stimulation devices. Electromyographic (EMG) studies have revealed altered recruitments of deep fascicles in the multifidus muscle in people with chronic low back pain.[4]

Evidently the problem of mechanical nociceptive pain which increases with activity prevents many people from actively exercising the effected part of their body. In terms of low back pain, in that exercise to improve the function of the multifidus muscle is difficult and hurts, prevents many people from realistically improving their muscle function which is the goal of rehabilitation. Exercising the core muscles particularly the multifidus muscle is an entirely different entity from exercising the muscles in the leg to mobilise the knee. Also, if there is arthrogenic muscle inhibition where there's neurological inhibition of motor signals getting to the multifidus muscle then clearly the problem is very difficult to overcome despite a person's best efforts.



THE MULTIFIDUS MUSCLE

On the basis that arthrogenic muscle inhibition after painful knee surgery was reduced with the use of transcutaneous electrical neuromuscular stimulation ... pain physicians investigated the concept of neurostimulation to activate the multifidus muscle ...

It was known that the L2 medial branch nerve that crosses the medial aspect of the L3 transverse process was the major motor nerve to the multifidus muscle and activating this nerve during interventional pain procedures involving L3/4 facet joint denervation caused significant multifidus muscle contraction when the test of motor stimulation was undertaken to check a safe position of the electrode.

On the basis that arthrogenic muscle inhibition after painful knee surgery was reduced with the use of transcutaneous electrical neuromuscular stimulation, an international group of interventional pain physicians investigated the concept of neurostimulation to activate the multifidus muscle by placing electrodes over the medial L3 transverse process to stimulate the L2 medial branch nerve.

Following proof of concept, a modified neurostimulator was developed with tines to hold the electrode in the intertransversarius which facilitates the appropriate placement of the lead over the medial branch nerve and holds them stable. There is no trial with this device as on average it takes 2.5 months before there is noticeable improvement which fits in with the concept of muscular rehabilitation improving the functional dynamic of the spine leading to reduced pain. However, there is a group of people referred to as 'rapid responders' who improve within the first four weeks. The likelihood is this rapid pain reduction suggests stimulating the L2 medial branch nerve and thus the L2 nerve root may lead to a reduction in central sensitisation and wind up leading to a further effect of the treatment in terms of pain reduction.

The Reactiv8 neurostimulator comprises the electrodes placed over the L2 medial

branch nerves bilaterally and attached to a pulse generator implanted in the buttock. The system is programmed so that when the patient activates the stimulation there is a pronounced but comfortable contraction of the multifidus muscles bilaterally. The device is programmed to run at 20 hertz with a pulse width of 214 micro seconds for 30 minutes twice a day when they are lying down on their side. The tonic contractions of the multifidus muscle go on for 10 seconds twice a minute.

Outcome

In the published series and the original groups that Mainstay Medical have implanted and followed up for over four years now, there has been a substantial improvement in the majority of those implanted with the system.[5]

The initial trial group was 204 people implanted and 176 were followed up at the 12-month analysis and 156 at the two-year analysis. There is a further follow up at four years but the number of people in that series has fallen to 53 but the long-term outcomes remain stable with significant improvement.

In terms of statistical outcome at two year follow up, the proportion of patients with a 50% reduction in their back pain was 71% and notably 65% reported that their Visual Analog Score (VAS) had decreased to less than 2.5 which is highly significant considering the initial average VAS was 7.3.

The initial Oswestry Disability Index (ODI) mean score was 39.1 (moderate to severe) but after two years in those that were implanted the average ODI score had fallen to 17.6 (normal range) which is a significant functional improvement. As stated above further outcome studies at four years with a much smaller group of only 53 indicated that there was persistent long-term stability in these patients.[5]

Summary

As the leads are placed paravertebrally the risks are low in that while infection clearly will occur, and in the published outcomes from Mainstay Medical who have developed the device there were six cases out of the 204 implanted where the device was removed because of infection, but there is essentially no risk of an intraspinal or epidural infection as the leads are paravertebral.

In many ways this treatment is reducing the dichotomy between a purely interventional based approach to chronic nonspecific mechanical low back pain and that of a cognitive behavioural rehabilitation type of approach in that by implanting these devices there is restoration of functional activity of the multifidus muscle leading to a significant increase in physical activity because the pain has been reduced. As there are no current medical imaging techniques to assess the function of the central nervous system and thus how much of the pain is nociceptive with pain being reduced by improved muscle function and how much of it is a reduction in nociplastic pain is impossible to assess. However, it is most likely a combination of various neurological factors being reduced that lead to such improved physical function.

In that Reactiv8 systems reduce the movement associated/mechanical low back pain, in the absence of neuropitta/radicular leg pain, regardless of the changes found on MRI scans and other medical imaging techniques, I feel the paradigm of interventional pain treatment for back pain should move away from identifying a 'pain generator' in that the treatment of multifidus muscle rehabilitation is effective in reducing pain, seemingly regardless of the changes a person has on their medical imaging findings. This application of technology to help rehabilitate people with disabling pain is a significant step forward in my view.

The Reactiv8 system has been available in Australia for around 12 months and in my limited experience of 14 implants with only one patient realistically not improving, I have found this approach to be unexpectedly good in terms of outcome and it provides the ability to help many people who were previously not able to be assisted with the available interventional pain medicine approaches.

Dr Brett Todhunter

FFPMANZCA, FANZCA

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SAFE ANAESTHESIA AND PERIOPERATIVE CARE ON A GLOBAL SCALE

SAFE Paediatrics Anaesthesia in Tanzania

The World Federation of Societies of Anaesthesiologists

The World Federation of Societies of Anaesthesiologists' (WFSA) strength is its member societies. As the foremost global network of anaesthesiologists, they draw together the expertise and knowledge of hundreds of thousands of anaesthesiologists in their 134 member societies in over 140 countries. Their members' diversity and global reach make the WFSA a unique organisation, leading the way in promoting safe anaesthesia and perioperative care on a global scale. It delivers this change through programmes including education and training and in global advocacy.

Education and training

Though the last three years have been difficult for anaesthesiologists around the world, 2022 has been a turning point with the WFSA regaining momentum lost during the pandemic. In 2022, 601 clinicians were trained on 26 SAFE courses in 15 different countries. The SAFE programme provides anaesthesiologist-led intensive training courses to equip anaesthesia professionals working in low-resource settings with up-to-date knowledge and skills to provide quality anaesthesia and perioperative care. SAFE Obstetric Anaesthesia addresses the core and extended roles of anaesthesia professionals in obstetric emergencies.

SAFE Obstetric Anaesthesia in Mongoli

SAFE Paediatrics Anaesthesia includes sessions on anaesthesia for common elective and emergency conditions in children, pain management, fluid resuscitation, newborn and paediatric life support, and paediatric trauma management. SAFE Paediatric Anaesthesia – Cleft is a two-day course focusing on providing safe anaesthesia to children undergoing cleft lip and palate repair surgery. SAFE Training of Trainers is an integral component of the sustainability of the SAFE training model, the Training of Trainers course seeks to equip local clinicians with the training skills and resources they need to implement their own SAFE training programmes.

Vital Anaesthesia Simulation Training (VAST) teaches essential practices to peri-operative teams by combining online learning with hands-on simulations. The course centres on anaesthesia and resuscitation for obstetrics, paediatrics, and trauma as well as safe general surgery and pre-and post-operative care. The VAST Facilitator Course (VAST FC) is a two-day introduction to simulation education. Graduates of the Facilitator Course are vital in delivering the VAST Courses. Hosted in Rwamagana, Rwanda, the SIMposium event introduced the new VAST Wellbeing Course and refreshed VAST Facilitator skills. The three-day SIMposium brought 42 simulation educators from 12 countries to focus on approaches to reduce clinician burnout and promote professional wellbeing.

The WFSA Fellowship Programme provides qualified anaesthesiologists with the opportunity to undergo sub-speciality anaesthesia training or non-clinical training at another medical institution. Since its launch in 1998 over 500 anaesthesiologists have trained through the WFSA Fellowship Programme. 2022 saw the successful post-Covid relaunch with nine fellows receiving training. In 2023 the programme will continue to scale up with over 36 new fellows.

The WFSA Scholarship Programme provides the opportunity for young anaesthesiologists from low-resource countries to attend international congresses, improve their knowledge and form professional contacts. The learning gained and the networks created prove invaluable in cultivating the careers of future anaesthesia leaders. 22 scholars from 13 different countries attended the All-Africa Anaesthesia Congress in 2022. The World Congress of Anaesthesiologists will be the 18th World Congress of Anaesthesiologists and is taking place in Singapore from 3 – 7 March 2024. The WFSA aims to enable 50+ scholars to attend and benefit from this global event. The ASA Overseas Development and Education Committee (ODEC) hopes to support a significant number of our colleagues from the Pacific.

Advocacy

The WFSA engages with key decision-makers to advance the availability, safety and quality of anaesthesia and perioperative services worldwide. It is in official relations with the World Health Organization (WHO) and in consultative status with the United Nations Economic and Social Council (ECOSOC). In 2022, the WFSA participated in seven WHO meetings, presenting nine statements on issues including: workforce strengthening, health emergency preparedness and response, integrated health plans and non-communicable diseases.

In 2019, in partnership with the Laerdal Foundation, the WFSA convened a meeting at Utstein Abbey in Norway to review and develop metrics and reporting criteria for surgery, anaesthesia and obstetrics (SAO), refining the existing indicators down to five: surgical volume, geospatial access, workforce, perioperative mortality, and catastrophic expenditure.

In September 2022, the WFSA convened a follow-up second meeting at Utstein Abbey, Norway, to review the meta data collection manuals, focusing on the basic, intermediate, and full data sets and develop data dictionaries for each metric. In 2023, the tools will be piloted in Ghana and South Africa at the hospital level. The pilot studies will inform the development of a SAO indicator data collection toolkit. Working with stakeholders including WHO, the World Bank and the UN, these toolkits will be employed at national and regional levels to collect data that can be used to inform health system decision-making and resource allocation.

Safe practices and standards are essential for quality patient care. With a focus on safety, WFSA has led on the development of international anaesthesia standards including WHO-WFSA International Standards for a Safe Practice of Anaesthesia, Minimum Capnometer Specifications 2021, and the Consensus Statement on environmentally sustainable anaesthesia.

The ASA and WFSA

Australia and New Zealand have strong representation within the WFSA. Dr Wayne Morriss is the current president and A/Prof David Pescod is on council and the Diversity Equity and Inclusion Committee. Dr Chris Bowden (Education), Dr Justin Burke (Publication), Dr Alicia Dennis (Scientific Affairs), Dr Darren Lowen (Obstetrics), Dr Indur Kapoor (Paediatrics), Dr Chris Orlikowski (Pain) and Drs Robert McDougal, Phoebe Mainland, Mark Fajman (Equipment) all provide support, expertise, and guidance for the WFSA's programmes and activities.

A/Prof David Pescod

AO MB BS FANZCA

Deputy Director, the Northern Hospital Epping, Victoria, Australia

Associate Professor of Anaesthesiology, School of Medicine and Health Sciences, University of Melbourne

ASA SEREIMA BALE PACIFIC FELLOWSHIP SUVA FIJI 2022

I first contacted Dr Justin Burke, the Australian Society of Anaesthetist's (ASA) Pacific Fellowship co-ordinator, in October 2019. While I had provided anaesthetic services on several short trips with Interplast in the Asia Pacific region, I was very keen to participate in a longer program with the potential for a more sustained relationship. I am both an anaesthetist and a pain medicine specialist and I was hopeful that my pain specialty would also be useful on this occasion.

A significant part of the fellowship role is to support and teach the anaesthetic trainees as well as assist with exam preparation.

With the declaration of the Covid-19 pandemic in March 2020, any thoughts of overseas travel were put on hold as Australia and much of the rest of the world went into lockdown. Fast forward to the end of 2021 and plans to resume the fellowship in 2022 were well under way. While I had hoped to make the fellowship a family affair our circumstances had changed in the intervening two years, and it was not going to be possible to travel to Fiji together. Disappointing for my husband who was going to be left at home with our teenage boys! Fortunately, my employer was very supportive and sabbatical leave was approved for the three months. Time to get organised.

A significant part of the fellowship role is to support and teach the anaesthetic trainees as well as assist with exam preparation. I acquired as much teaching material as I could get my hands on before I left and colleagues who had recently sat their final exams generously gave me plenty of material to use for viva practice.

Fiji was significantly impacted by Covid-19 and the international borders were closed until October 2021. Many of the usual government processes had been suspended during this time and as a result sorting out the paperwork required to work and live in Suva for three months was quite challenging! Thankfully, Dr Meg Walmsley, an anaesthetist from Darwin currently working as a Senior Lecturer in the Department of Medical Science at the Fiji National University (FNU), was able to guide me through the process and advocate for timely processing of my documents. With a flurry of emails in the weeks before my departure I was able to travel to Fiji at the beginning of September with most of the required paperwork completed. My medical registration took just over a week to come through after I arrived, so I had time to sort out more permanent accommodation and organise some of the practicalities of living in a new city.

The Colonial War Memorial Hospital in Suva

EPM for medical students in Labasa with Alice Goldsmith nd Emily Fiuakilau

ASA Fellows dining with Dr Serima Bale

I also had time to orientate myself to the workings of the operating theatres at the Colonial War Memorial Hospital (CWMH) and start to get to know the anaesthetic trainees that I would be working with over the next couple of months. The overall set up was not completely unfamiliar given my experience elsewhere in the Pacific but familiarising myself with the idiosyncrasies of the CWMH took some time. Unfortunately, the pain service that had been operating prior to Covid-19 was not operational in any formal capacity when I arrived, so I thought that my experience in setting up and supporting the acute pain service at the Northern Hospital might benefit the department.

I joined two other ASA fellows in Suva, Dr Alice Goldsmith from Sydney, and Dr Joe MacMillan from the UK. We helped with the formal teaching program for the FNU anaesthesia diploma and master's students as well as providing clinical support in theatre. The start of the teaching program had been delayed somewhat due to the pandemic so there was some urgency to get through the required material before the exams at the beginning of December. We also did lots of viva practice, mostly after work but we tried to fit sessions in whenever it suited the trainees. The trainees work incredibly hard, often away from their families for very long periods if they are from elsewhere in the Pacific. The level of supervision in theatre is often limited, mostly due to significant senior staff shortages. The case load and acuity at the CWMH is very high due to a combination of poor health literacy and timely access to medical services, particularly in areas outside the major cities. This creates a very challenging environment in which to work and learn, let alone study for exams.

I primarily helped with the pain medicine lectures and it was clear that despite pain management being a core part of anaesthesia practice, knowledge and appropriate application was sometimes limited. This has been my experience in many settings, both at home and overseas. It is particularly challenging when access to medication and more advanced analgesic techniques is restricted, and the focus is mostly on the intraoperative rather than the perioperative period. As in many parts of the world, the surgeons in Fiji are responsible for postoperative analgesia and convincing people and institutions to change established practices is very difficult.

With a view to getting in on the ground floor we organised a series of Essential Pain Management (EPM) lectures for the final year medical students in Labasa, Lautoka and Suva. This was quite a feat given the multiple locations and the relatively short time frame, but with the support of the FNU staff and the enthusiastic anaesthetists in each city we were able to run some very successful sessions that were well received. Many of the students expressed that they felt ill-equipped to manage pain.

The Pacific Society of Anaesthetists (PSA) is very keen to support the development of acute pain services across Fiji and a huge amount of work is currently underway to make this happen across multiple hospitals. I have been very pleased to help with advice around some of the practical aspects of setting up a service as well as providing policies and procedures that we use at home.

I was also approached to help with an EPM course in Lautoka for health practitioners from a range of disciplines. This was organised by one of the local

anaesthetists who has a special interest in pain. He had managed to get the Cancer Council of Fiji on board, and they had agreed to sponsor the course. The Chief Executive Officer (CEO) was passionate about improving access to appropriate pain management strategies for cancer patients in Fiji. She was concerned that pain management was not seen as a priority and that many people looking after cancer patients felt inadequate to provide effective treatments. The lack of access to appropriate medication is a very significant issue and unlikely to change without ongoing education and advocacy.

EPM for medical students in Lautoka with Emily Fuakilau and Alice Goldsmith and Yogan Deo

I can't recommend the fellowship enough to anyone who is even remotely considering applying. There are so many opportunities to get involved in teaching and training.

Associate Professor David Pescod and Dr Moira Rush

While teaching and clinical supervision took up most of my time during the week, I was very pleased to be peripherally involved with the master's students' projects. The trainees are required to do a research project in their final year. One of the trainees from Timor-Leste was able to show that postoperative pain in the post-acute care unit (PACU) in the main tertiary referral hospital in Dili is very common and often moderate to severe in intensity. This was also the case on the wards where only simple analgesia was provided for pain in most cases. One of the trainees from the Cook Islands has just submitted their project to look at pain after abdominal surgery in the PACU at the CWMH. The results from both projects will likely go a long way to informing the future direction of pain education and pain management strategies in both locations that will be relevant across the Pacific.

My three months in Fiji was very busy but not just about work. I was very grateful to be able to attend the PSA's 31st Annual Refresher Course held on the Coral Coast not long after I arrived in Suva. It was a fantastic meeting and an excellent chance to meet colleagues from all over the Pacific as well as other parts of Australia and New Zealand. I travelled to teach EPM, and I spent quite a few weekends exploring beautiful locations on both Viti and Vanua Levu.

While there is work to be done to improve pain teaching and services across the Pacific, there are some amazing people already working to make this a reality. I am very hopeful that I can be part of this process as a result of the ASA Pacific Fellowship. I can't recommend the fellowship enough to anyone who is even remotely considering applying. There are so many opportunities to get involved in teaching and training. I like to think that I had a positive impact on the wonderful anaesthetic trainees who I now consider friends. Alice, Joe and I received excellent feedback from the diploma students on their end of year feedback! Very humbling indeed. I am certain that I gained more from my time working with them than I gave. I am looking forward to an ongoing relationship with the FNU and contributing to anaesthetic teaching and training in the Pacific.

Dr Moira Rush

Anaesthetist and Pain Medicine Specialist

Department of Anaesthesia and Perioperative Medicine
Northern Health

Looking for a new experience where you can really make a difference?

SEREIMA BALE PACIFIC FELLOWSHIP

The ASA ODEC committee is seeking Australian and New Zealand anaesthetists with a passion for teaching and an interest in working in developing countries.

Three month scholarships are now available. The role involves teaching and clinical support for Pacific trainee anaesthetists based in Suva, Fiji Islands.

The Fellowship is named in honour of Dr Sereima Bale, Senior Lecturer at the Fiji National University and the founder of post-graduate anaesthesia training in the Pacific region.

The ASA provides financial support to the value of AUD$12,500 and an accommodation allowance is provided by Fiji National University.

FANZCAs and experienced Provisional Fellows are encouraged to apply. It is a family friendly environment.

For further information contact Justin Burke Email: j.burke@alfred.org.au

Applications are welcome at any time

ASA RESEARCH GRANTS AND SCHOLARSHIPS 2023

Eligibility: trainee members, and members within 5 years of full membership who have been financial members of the ASA for over 12 months. Applicants are welcome from research teams, but at least one member needs to meet the eligibility requirements.

Requirement to present work in a public forum eg a future NSC, publish in a peer review journal, Australian Anaesthetist or ASA podcast.

The ASA has expanded its Research Priority Program (RPP) with the creation of 4 new small grants of up to $3000 each per year, for original research into the current ASA Research Priority areas:

ENVIRONMENT & ANAESTHESIA
INNOVATION & ANAESTHESIA
SAFETY IN ANAESTHESIA

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

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PRIZE WINNERS

Nerida Dilworth Prize Winner

Preserving the endothelial glycocalyx in patients undergoing cardiopulmonary bypass: A prospective randomised interventional pilot study of doxycycline and lignocaine

Cardiopulmonary bypass is known to have deleterious effects on the lining of blood vessels known as the endothelial glycocalyx (EG). Damage to the EG may contribute to post-cardiac bypass haemodynamic and organ dysfunction. My study investigated the use of doxycycline and lignocaine as EG protective agents. Doxycycline is a matrix metalloprotease inhibitor with known actions to reduce EG shedding; while lignocaine is thought to stabilize the EG.

This was a single-centre, prospective, unblinded, randomised control trial of 60 patients who underwent cardiopulmonary bypass (CABG, valve surgery, or both) between May 2020 to December 2022. Patients were allocated equally to either the control group (treatment as usual), or one of two test groups who received either pre-operative oral doxycycline 200mg, or IV lignocaine 1.5mg/kg bolus then 2mg/kg/hr infusion. The primary outcome was levels of both plasma and coronary sinus Syndecan-1 as an indication of EG shedding, measured at six time points and in pre and post aortic cross-clamping respectively. Secondary outcomes included post-op ICU length of stay, bleeding, arrhythmias, vasopressor requirements, unplanned return to theatres and troponin rise.

Post-operatively, there was no difference between any groups in ICU length of stay, post-op bleeding, arrhythmias, vasopressor requirements or delirium. Plasma Syndecan-1 levels indicated a potential trend to reduced EG shedding in patients receiving either lignocaine or doxycycline compared to control, with a stronger result for lignocaine. To confirm the results of this trial, further investigation on the role of lignocaine for a protective effect on the EG is warranted.

Dr Adrian Pannekoek

Registrar Anaesthesia, Fiona Stanley Hospital

Best Poster Prize at the Tasmanian ACE ASM

The effect of remifentanil infusion on post-anaesthetic care unit discharge and recovery for laparoscopic cholecystectomy – a single centre retrospective study

Remifentanil has a predictable context-sensitive half-time between three to eight minutes as a result of rapid metabolism by nonspecific esterases. However, high dose intraoperative remifentanil infusions has been linked to a higher risk of opioid-induced hyperalgesia and acute opioid tolerance. My study examined the effect of remifentanil on the length of PACU stay, pain scores, and rescue analgesia use in patients after laparoscopic cholecystectomy.

This retrospective audit at Redcliffe hospital included patients from 2020-2021. The length of PACU stay was comparable between the Remifentanil and control groups (69.32 mins in the treatment group vs 69.79 mins in the control group, 95% CI -8.029 – 8.993, p= 0.911). Similarly, Remifentanil infusion did not result in a statistically meaningful difference in the usage of rescue pain protocol medications (mean difference = 0.519, 95% CI -1.034 – -0.004, p= 0.048) despite the fact that patients in the remifentanil group reported higher pain scores (mean difference 0.292 mg of oral morphine Equiv., 95% CI –2.663 – 2.080, p= 0.809).

This audit did not show a clinically significant impact of remifentanil infusion on our outcomes after laparoscopic cholecystectomy. Further multi-centre studies are needed to determine the impact and cost-effectiveness of remifentanil infusion in immediate postoperative recovery.

Dr Kin Man (Kevin) Choi

Anaesthetic resident Redcliffe hospital

Project Supervisor
Dr Jeffrey Mott FANZCA FFPMANZCA
Redcliffe hospital

WEBAIRS

ANZTADC Case Report Writing Group

Wrong Blood in the Tube (WBIT)

This incident was discussed at an Australian Society of Anaesthetists (ASA) Mortality and Morbidity (M&M) meeting and analysed by the authors.

Case reported to webAIRS

Blood was taken from a patient for a routine Group and Hold. The tube was hand labelled, and the pathology request form filled out and witnessed. In the Blood Bank, the blood was tested and found to be different to the blood group previously recorded for a patient with the same three independent identifiers of name, date of birth and hospital record number.

On further investigation, it was found that after drawing the blood the vial was left in the patient's room. The blood tube was labelled and witnessed outside of the room, rather than at the time and site of collection. This resulted in the tube being labelled with another patient's details.

Definition

Wrong Blood in Tube (WBIT) events have typically been described in relation to blood transfusion with validated definitions developed by the International Haemovigilance Network in 2012[1]. WBIT occurs when:

Blood is taken from the wrong patient and labelled with the intended patient's details ('miscollected') or

Blood is taken from the intended patient but labelled with another patient's details ('mislabelled').

These WBIT errors may cause catastrophic outcomes regardless of the blood test but particularly when they result in an incompatible blood transfusion.

Estimated Frequency

The webAIRS database of over 10,000 incident reports was interrogated and there were four cases of suspected wrong blood in tube (WBIT).

The incidence of WBIT has been studied using different methods and consistently found to be between 1 in 1500 to 1 in 3000 samples[2]. WBIT in Emergency Departments has been found to occur 1.7 times higher than inpatient wards and 5.1 times higher than outpatient clinics[3]. Quantifying the incidence of WBIT arising from operating theatres has been difficult. One study found an incidence of WBIT of 1 in 2283 samples, with none of the samples collected in the operating theatre[4].

The incidence of WBIT sampling errors arising from theatres may be low due to the model of care of one patient at a time and the infrequent occurrence of collecting blood samples.

However, the consequences of incompatible blood transfusion may be more severe due to delayed reporting of symptoms or recognition of signs when patients are under sedation or general anaesthesia.

Errors occurring in blood sample collection such as wrong tube type, insufficient sample quantity or quality are estimated at 1 in 2000 samples. Mislabelling of tubes occurs more frequently with an estimated incidence of 1 in 40 samples[5–7] and may include missing or incorrect patient identifiers, without WBIT[6–8].

Bowtie diagram

The Bowtie Diagram Method to analyse incidents in anaesthesia was first described in 2016[9]. It represents a fusion of a Fault Tree and an Event Tree, connected by the Top Event in the middle, thereby creating its distinctive shape.

Hazards

Hazards or risk factors are divided into patient, task, caregiver, and system factors. A WBIT event may affect any patient. No single intervention has been found to reduce the incidence of WBIT to zero or produce a lasting effect on reducing WBIT[2].

Positive patient identification is integral to many aspects of patient safety as well as minimising WBIT. This requires wristband and, where possible, verbal confirmation of the patient's identity and ensuring patient samples are correctly labelled at the bedside[2]. Communication barriers due to cognitive deficits, reduced conscious state and language differences may impair a patients' ability to accurately confirm their identity at the time blood is taken. Patient wristbands that are damaged, changed or removed are a risk factor for WBIT[10] and other events.

Task factors are often presented as hospital protocols, such as having two staff members witnessing patient identification and labelling the samples at the point of sampling. The introduction of handwritten request forms and not permitting the use of

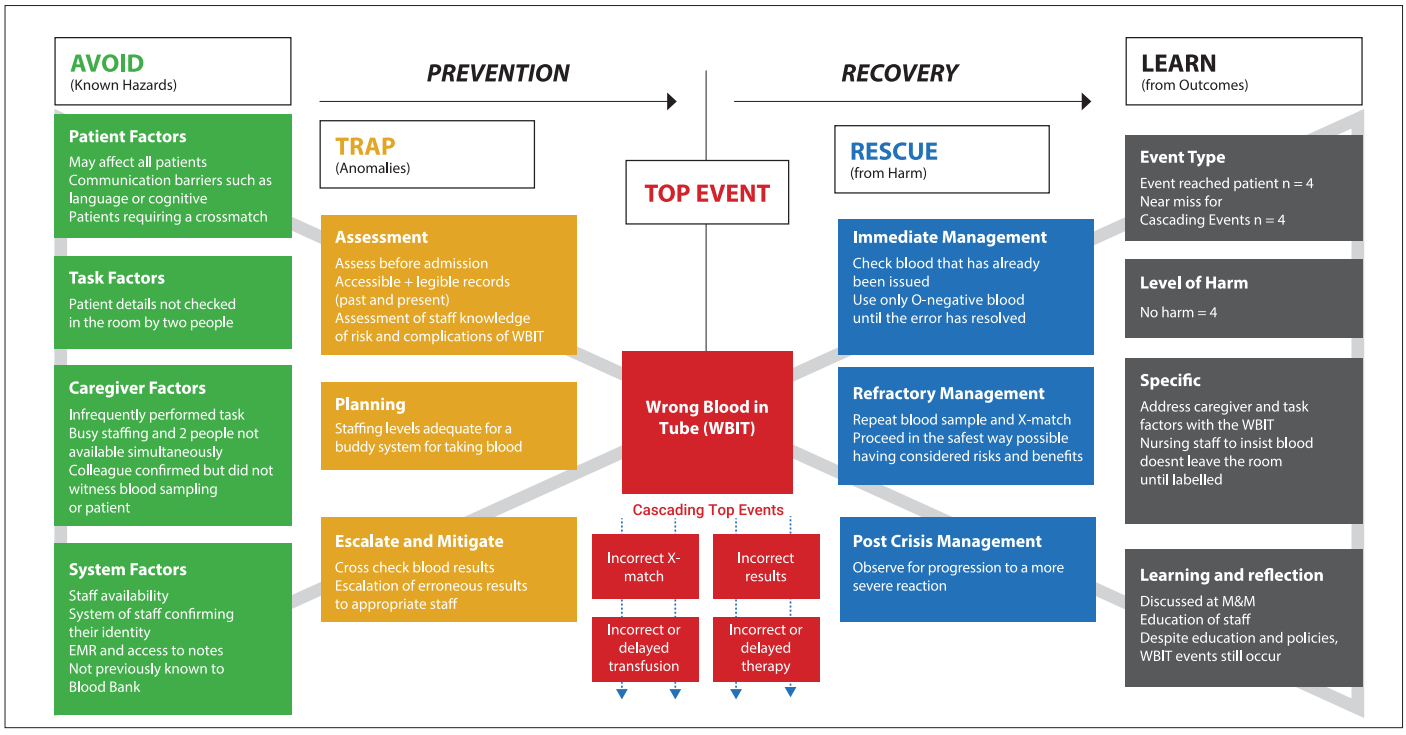

Figure 1 A Bowtie Diagram summarising the analysis of WBIT.

addressograph labels is thought to encourage caregivers to focus on positive patient identification[2] however, for anaesthetists caring for patients undergoing anaesthesia, this may result in task distraction and other adverse consequences.

In terms of caregiver factors, having a multitude of staff undertaking the sampling of blood across a health facility increases the risk of WBIT, as opposed to a limited number of staff who have undertaken specific education and competency training. A UK audit found that doctors were the cohort most likely to make errors and phlebotomists the least likely[11]. This may be due to system factors, such as being more likely to perform blood sampling after hours, or not having bedside access to clinical computer systems. Medical staff may not have been taught the importance of positive patient identification. Reductions in the incidence of WBIT have been reported following education interventions and by utilising specifically trained phlebotomists[2,12].

Breaches to hospital protocols on positive patient identification and labelling samples before leaving the patient are more likely to occur in areas with rapid patient turnover, busy workloads or inadequate staffing[10].

In terms of system factors, standardised processes of unique positive patient identification reduce the incidence of WBIT. Lack of access to the charts and notes in the patient's room or having an electronic medical record (EMR) open on another patient also pose a risk. Barcode technology is an evolving technology[2], however this too may result in workarounds and human error contributing to WBIT. Conducting continual audit and providing regular feedback has been shown to reduce the incidence of WBIT. This is seen as critical for engaging with clinical teams to support changes in practice[2].

Trap

The second column in the Bowtie diagram depicts examples of processes which might 'Trap' the progression of hazards to prevent them from progressing to the 'Top Event'. Traps to prevent incidents might be further broken into the categories of assessment, planning and escalation and mitigation.

The WBIT in this case was detected due to the patient's blood type having been previously assessed prior to this admission. Pretransfusion sampling, prior to patient admission, and bedside confirmation of blood group reduces the incidence of WBIT and incompatible blood transfusion. This needs to be accompanied with accessible and legible records. The sharing of historical controls between institutions or having a centralised transfusion service database may further trap WBIT errors[2,10].

Staffing levels and staff training and competency should be regularly assessed to determine if there is sufficient to ensure that two staff members are available to witness blood being taken. Alternatively, having a limited number of trained and competent staff to take blood samples has been shown to reduce WBIT incidents.

In terms of mitigation, in this case the Blood Bank was able to cross check this sample with previous samples and notify the delivery suite. End-to-end electronic blood transfusion management systems have been shown to have a significant impact on patient safety. These systems not only address WBIT errors but other aspects of the transfusion process[2,13].

However, they cannot eliminate human error and need to be simple to use to reduce the risk of error.

In terms of escalation, in this case the Blood Bank was able to notify the delivery suite, so that a repeat sample could be taken from the correct patient. Having a system of identifying outlier, or aberrant results, and contacting a nurse or doctor who can investigate further has been recommended in other settings and would be beneficial in mitigating a WBIT incident. Identifying the patient from whom the blood has been mislabelled remains a challenge and is of concern particularly if the blood test showed a significantly aberrant result and the patient may have been discharged home, for example from the Emergency Department.

Top Event

WBIT is the Top Event. The purpose for which the blood was drawn would impact the cascading top events. In this case, the blood was taken for cross match. Had the WBIT incident not been detected, this could have ultimately resulted in an ABO incompatible blood transfusion and an acute haemolytic transfusion reaction to the patient who had their label incorrectly placed on the blood tube. The patient from which the blood was taken, or "miscollected" would also not have a current group and hold which may result in delayed blood transfusion. Likewise, if the blood was taken for other investigations, then this could contribute to misdiagnosis and incorrect or delayed treatment.

Rescue

The third column of the Bowtie Diagram addresses immediate, definitive, and post-crisis management. The immediate management of a WBIT event that could result in an incompatible blood transfusion would include checking for any blood that has already been issued and only use O-negative blood until the error has been resolved. Definitive management would be to re-sample the patient with positive patient identification and a two-person buddy system and repeat the cross match. The post-event management would be to address the latent factors listed in the first 'Avoid Hazards' column.

Learn

In the final column, 'Learn from Outcomes' the analysis of the first 8000 reports revealed three other cases of WBIT making four in total. None of the cases resulted in harm and were classified as near miss WBIT events by the reporter as the error was detected before the blood was cross-matched. However, for the WBIT event, they could be viewed as Incidents with No Harm rather than Near Misses. As shown in the diagram, WBIT could then lead to several cascading Top Events including an Incorrect Cross Match if not detected and therefore these cascading potential events were all Near Misses.

WBIT incidents keep occurring and although ABO incompatible blood transfusions are rare, with approximately 20 people dying yearly in the US[14], the most common cause of ABO incompatibility is administrative error. Sampling and mislabelling of blood resulting in WBIT is one of procedural steps that contribute to this potentially fatal event.

Transfusion is a multistep, multidisciplinary process, and the literature indicates that the human error rate has remained unchanged despite educational and other interventions. Strategies to reduce WBIT need to address multiple hazards and traps and be sustained if the incidence is to remain low.

Dr Suzi Nou and the ANZTADC Case Report Writing Group ■

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ECONOMIC ISSUES ADVISORY COMMITTEE REPORT

DR MICHAEL LUMSDEN-STEEL
EAC CHAIR

Regional catheter application update

The ASA recently met with Department of Health to continue the progression of the introduction of a new MBS number, for a regional nerve block catheter inserted in association with anaesthesia, for post-operative analgesia. Increasingly, regional nerve block catheters are being incorporated in to Enhanced Recovery After Surgery (ERAS) pathways, as well as for the management of trauma related injuries which, whilst managed non-operatively (for example ribs fractures), a regional nerve block catheter is inserted at the time of surgery and is in association with anaesthesia. The ASA has argued that the insertion of a regional nerve block catheter, proximal to the elbow and knee, for post-op pain management of trauma injuries, should be permitted by this new regional catheter item (for example an Erector Spinae Plane or Serratus Anterior Plane for rib fracture management). Where a regional nerve block catheter is inserted as a specific procedure to manage pain, and not in association with anaesthesia, then the correct MBS item numbers to bill are the same as for a single shot nerve block performed not in association with surgery (for example a femoral nerve block performed for a patient with a Neck of Femur Fracture for pain management prior to surgery), located within the MBS at Category 3, Group T7, Regional or nerve Field Blocks. The ASA will keep members informed of any developments with the regional nerve block catheter MBS application.

Preanaesthesia consultations

Anaesthetists have an integral role in the perioperative care of patients undergoing procedures, particularly with respect to perioperative pain management and the discharge analgesia requirements. Prior to undertaking surgery, at the pre-anaesthetic consultation, the anaesthesia plan is formulated, discussed with the patient, including the analgesia plan, consent is obtained, and the perioperative plan is documented. The anaesthetist formulates and individualises the plan based on patient factors (past medical history, current active medical conditions, relevant previous anaesthetic history and response to analgesia, history of complex, chronic or difficult pain management), the Surgical 'X' factor (surgical technique, use of LIA, etc.), and the hospital institutional factors. The anaesthetist may also provide the patient with written information, such as brochures downloadable from the ASA website.

Perioperative medication management of medication is often necessary, and can include antiplatelet and anticoagulant medication to facilitate the anaesthesia technique, perioperative analgesia medication management, and a clearly communicated and documented plan for post-operative pain management. Members should note that anaesthetists who always are billing MBS items 17615 or 17620 for pre-anaesthetic consultations may be flagged by Medicare and insurers to confirm that that the pre-anaesthetic assessments are compliant for both the time and

complexity requirements of those items. Anaesthetists should be aware of the specific requirements for each of the more complex pre-anaesthesia consult items (such as 17615) and also the general requirements for all pre-anaesthesia consults in the MBS:

MBS note TN 10.7: The Health Insurance Act 1973 provides that where anaesthesia is administered to a patient, the premedication of the patient in preparation for anaesthesia is deemed to form part of the administration of anaesthesia. The administration of anaesthesia also includes the pre-anaesthesia consultation with the patient in preparation for that administration, except where such consultation entails a separate attendance carried out at a place other than an operating theatre or an anaesthesia induction room. The pre-anaesthesia consultation for a patient should be performed in association with a clinically relevant service.....

Inpatient pain management consultations

Many public hospitals, and some larger private hospitals, will have a dedicated clinician lead Acute Pain Service (APS). Patients who require advanced analgaesic techniques including Intravenous opioids and patient-controlled analgesia devices (PCAs) or have a regional anaesthesia continuous infusion are often referred to the APS for ongoing management. This service may also receive referrals for pain consults to assist with other pain management procedures. These services for public Medicare eligible patients are funded from hospital Activity Based Funding (ABF) as determined by the National Health Reform Agreement (NHRA). Non-eligible patients are usually billed as compensable patients (privately insured patients, overseas visitors on travel insurance, workers compensation etc.) using MBS and/or AMA numbers depending on the circumstances, where an appropriate service has been provided by a specialist. Many public hospital

salaried anaesthetists participate in the billing of private patients through a private patient scheme under local hospital or network arrangements, whilst visiting medical officer anaesthetists may be in a private patient scheme or bill compensable patients directly. Anaesthetists need to be aware of what is being billed under their provider number, and ensure the correct numbers are being billed.

In private hospitals, post-operative pain management is largely managed by the anaesthetist (+/- in conjunction with the surgeon). Where an appropriate post-operative pain management consultation occurs and is documented, MBS consultation numbers may be used. Where the attendance involves the review and management of adjustable regional infusions delivered by a programable pump (and not a simple fixed flow rate elastomeric infusion device), specific consultation numbers exist. Fellows of Faculty of Pain Medicine can bill specific pain consultation numbers.

ASA classifications

Where the ASA physical status modifier is utilised (MBS items 25000, 25005, 25010) there must be evidence for assigning the appropriate ASA physical status. Assigning all patients an ASA 3 is likely to draw attention by Medicare and health funds. Patients with a past history of chronic pain, now stable, functional at work and socially and on intermittent PRN opioids with is unlikely to be ASA 3 (A patient with severe systemic disease, substantive functional limitations, one or more moderate to severe diseases), whereas a patient debilitated with poorly controlled chronic pain, on extensive multimodal analgesia, with substantive function limitations would qualify for an ASA 3.

Regional techniques for post operative pain management

Post-operative analgesia may include the use of neuraxial techniques at the time of anaesthesia such as a spinal, epidural, a single shot regional block and/or the insertion of a regional nerve block catheter performed by the anaesthetist at the time of surgery. The information may be provided to the patient at the initial pre-anaesthetic consultation, or at the time of admission for the procedure. Where the post analgesia plan includes the anaesthetist performing a single block, for example a Transverse Abdominal Plan (TAP Block) or rectus sheath plane block, the ASA recommends that the anaesthetist only claims one MBS Item for these plane blocks (e.g. TAP block)

they require a bilateral injection to be effective. Where there are two specific nerves and or nerve plexus blocked for post-operative analgesia (e.g. femoral and sciatic nerves), the anaesthetist is able to claim for both (i.e. 22041 x 2).

The ASA from time to time receives enquiries from ASA members, health insurers, workers compensation and work cover organisations seeking clarification about correct MBS numbers for patient pre-anaesthesia consultations and specialist attendances, ASA physical status classification, and initiation of anaesthesia numbers for specific pain procedures. Insurers and third-party bodies are increasingly analyzing specialist billing activity, and reviewing charts and notes where they believe a pre-anaesthetic item or ASA physical status classification is not justified, and seeking to dispute the pre-anaesthetic assessment MBS item (for example always claiming a 17615) and / or ASA physical status classification assigned (for example always claiming a 25000).

Initiation of anaesthesia for percutaneous pain management procedures

Initiation of anaesthesia for pain procedures also has received recent scrutiny from insurers and Work Cover Organisations. Where anaesthesia is provided for percutaneous spine pain management procedures (as opposed to open surgical spine/spinal cord procedures) 20690, 'initiation of management of anaesthesia' for percutaneous spinal procedures, not being a service to which another item in this subgroup applies, is the recommended MBS item to use, regardless of the level (and number of levels) of the percutaneous procedure.

21945 is appropriate for 'initiation of management of anaesthesia' for lumbar puncture, cisternal puncture, or epidural injection, and is also appropriate for the insertion of lumbar epidurals for pain management. MBS numbers 20600, 20620, 20630, and MBS 20670 are generally not appropriate for percutaneous interventional pain management procedures.

Noting the ongoing inadequate indexation to the MBS patient rebate and private health insurance rebates, members should be aware that the ASA RVG unit value is now $96.00 (as of 25 March 2023). ASA RVG item codes are identified within the ASA RVG Book, the ASA RVG App, and ASA members can contact the ASA for assistance.

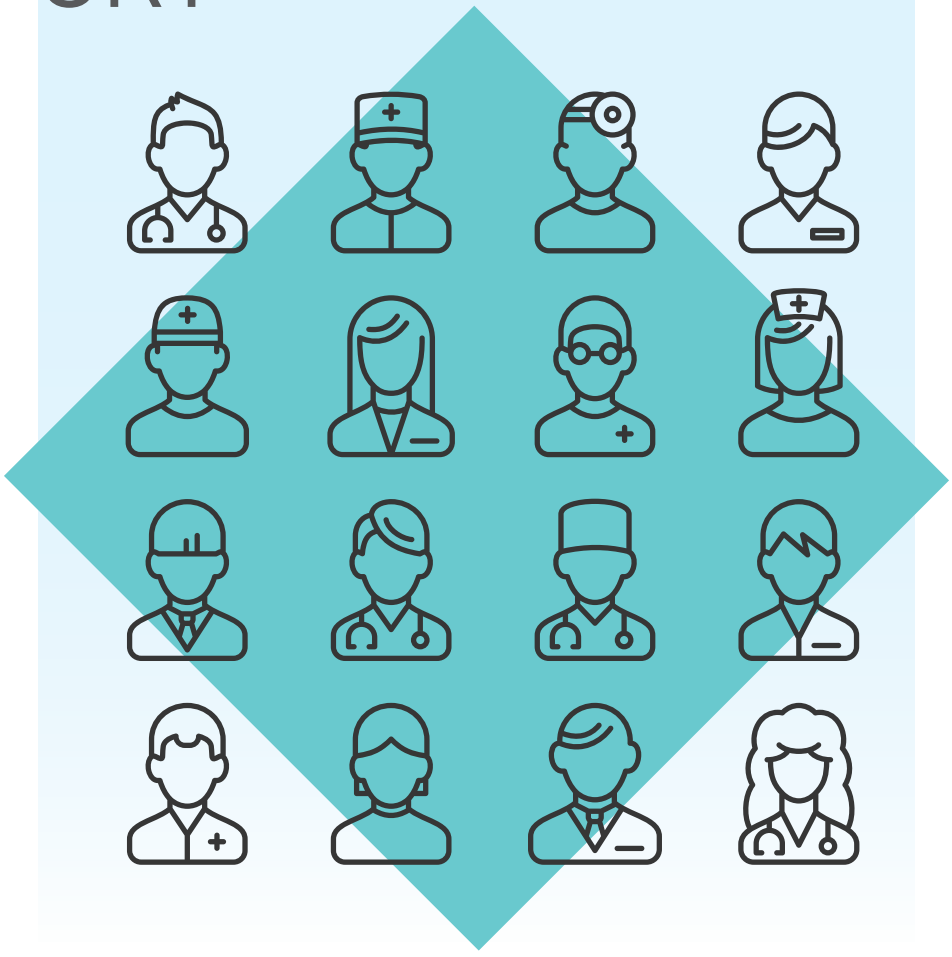
Dr Michael Lumsden-Steel

EAC Chair

Example of Activity	MBS Item	Note
Pre-anaesthetic consultation	17610-17625	Time and complexity requirements
Pre-anaesthetic consultation - video	92701	Telehealth, by video, 17615 time and complexity requirements
Regional block performed at in association with anaesthesia for post op pain relief	22041	Block proximal to elbow and knee
Regional nerve catheter inserted in association with anaesthesia for post op pain relief	No specific MBS number: use 22041	For regional catheters inserted proximal to elbow and knee
Neuroaxial (spinal and/or epidural) in association with anaesthesia for post op pain relief	22031	
Labour epidural	18216/18219/ 18226/281127	See appendix D: Obstetric RVG Quick Guide
Consultation for pain management	MBS 17640-17645	Example review of intravenous PCA, specific review of oral opioid analgesia medication (non-routine), complex pain management
Consultation for review and or top up epidural or regional analgesia infusion	18222 < 15min, 18225 > 15min	
Regional block, and or regional catheter inserted, for pain management, not in association with initiation of anaesthesia	MBS 18213, 18234-18288 ASA CV 052, CV200-CV330,	MBS Item at category 3, Group T7, regional or nerve field blocks.

PROFESSIONAL ISSUES ADVISORY COMMITTEE (PIAC) REPORT

DR PETER WATERHOUSE
PIAC CHAIR



Anaesthetic workforce

Recruiting and retaining medical specialists in regional areas has always been challenging. Many well-understood factors contribute to the ongoing maldistribution of Australia's medical workforce. Metropolitan areas have enjoyed better access to medical services, and recruitment of doctors to our major cities has required little effort. In 2016, the Australian Department of Health determined that the anaesthetic workforce was in balance, with the potential to shift into oversupply[1]. Contemporary anecdotal evidence supported this conclusion, with reports of underemployment amongst city-based anaesthetists, especially in Melbourne and Sydney. In an apparent reversal of this trend, evidence is emerging of nation-wide difficulty recruiting anaesthetists. Rising locum pay after a decade of stagnation supports widespread anecdotal evidence of this apparent shortage. Less clear is the cause for this abrupt change in workforce dynamics. Elective surgery is returning to pre-pandemic levels, but how has the workforce changed in three short years? Did anaesthetists bring forward their retirement? Is there a changing attitude to long working hours? These and other questions are difficult to answer objectively without data.

Workforce data

Several bodies have collected medical workforce data over recent years. The Medical Board of Australia incentivises responses by linking participation to ongoing registration. This information is presented as part of the National Health Workforce Data Set (NHWDS)[2]. Other organisations need to rely on voluntary participation. This group includes the University of Melbourne, whose Medicine in Australia: Balancing Employment and Life (MABEL) survey is into its second decade[3].

The ASA member survey

Australia's anaesthetic workforce was assessed in four ASA member surveys between 2014 and 2021. These surveys provided detailed analysis of workforce characteristics and their evolution over time. The ASA is indebted to Dr James Bradley, past president and long-serving PIAC chair for establishing and maintaining the survey. Jim's hard work

allows us to rely on data instead of anecdote when interpreting workforce changes and advising governments and other bodies tasked with the creation of medical workforce policy. This year the ASA member survey will benefit from the assistance of HealthConsult, a firm with experience in workforce modelling for various medical specialty groups.

Contacted care and public in private

Efforts by health insurers to enter into contracts with doctors continue. Recent activity appears centred around outpatient endoscopy services. Members are being approached to sign contracts for no-gap endoscopies, even if their patients are not paying out-of-pocket. This round of contracts is presented in the usual way: With little notice and as a fait-accompli, often with intrusive conditions attached. In the current environment of apparent workforce shortage, it is unclear why any doctor would need to consider the insertion of a contracted payer into their relationship with patients. Public in private surgery continues, similarly hampered by lack of interest and capacity. More successful programmes are offering relative value guide (RVG) billing at rates around $55 per unit. Concerns regarding patient selection and escalation of care require careful local planning.

ASA professional documents

ASA position statement 26 (PS26) on deep sedation

ANZCA PG09 on sedation is in pilot stage. Deep sedation has been omitted from PG09 because it is outside the realm of most non-anaesthetic sedation providers. An unintended consequence of this omission is the conclusion by some that PG09 gives implicit encouragement for non-anaesthetic providers to make up their own rules for deep sedation. Endorsement of unsafe practice is certainly not the intention of PG09.

The ASA has published a statement to this effect, endorsing the spirit of PG09 and reinforcing the message that deep sedation is indistinguishable from general anaesthesia4.

ASA position statement 25 (PS25) on rest facilities in hospitals

Some hospitals require anaesthetists, often registrars, to stay on-site overnight in case their skills are required at short notice. Common sense suggests that when these doctors are not busy providing urgent treatment they should rest. The ASA has received reports of hospitals declining to facilitate this rest, creating unnecessary fatigue and the consequent risk of clinical error and road accidents. PS25 briefly sets out the case for provision of simple rest facilities to be used when there are no patients requiring the urgent attention of an anaesthetist[5].

Slow-Release opioids

In recent years the broader medical profession has been devoted to reduction of opioid-related harm. Community-level systems such as real-time prescription monitoring have been introduced in all states (albeit slightly differently in each jurisdiction). Our own specialty has joined in this re-evaluation of opioid use. Anaesthetists have a unique appreciation of opioids. Most of us prescribe and administers these agents on a daily basis. This familiarity brings both expertise and responsibility.

Guidelines versus individual care

Slow-release (SR) opioids, including atypical agents like tapentadol, have found a place in the management of acute and peri-operative pain. Evidence that overuse of these agents was placing patients at risk prompted advice from the Therapeutic Goods Administration (TGA) and changes to the Pharmaceutical Benefits Scheme (PBS) with effect on 1 June 2020[6]. What does this mean for anaesthetists and our patients? Is it acceptable to use SR agents in the face of advice to be cautious with them? Fundamentally, most medical practice including anaesthesia is very individual in nature: An individual doctor treats patients one at a time, with the best interests of each patient at the centre of medical decision-making. The prescription of any drug is an individual decision. Thoughtful medical practice is more than algorithms and protocols. Doctors must be aware of evolving evidence but remain flexible in their thinking. Guidelines need to acknowledge this subtle point. Advice 'never' to use any drug oversteps the mark, presuming that a guideline is better for patient safety than the considered opinion of a well-informed senior clinician. Few would argue against the minimisation of opioids in medical practice. The many problems associated with SR opioids are most easily avoided by simply not prescribing them. However, this is not to say that some doctors might reasonably choose to use them some of the time. 'Never' guidelines create unnecessary medico-legal risk for these doctors while limiting therapeutic options for their patients.

Dr Peter Waterhouse

Chair, PIAC

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DEALING WITH THE PAIN OF PREPARING FOR FINAL EXAMS

DR VIDA VILIUNAS AND DR KAYLEE JORDAN - ASA EDUCATION COMMITTEE

The exam reports are written to help candidates and their teachers prepare for the exams. They are now a comprehensive guide to exam content, elements the examination panel thinks are important and performance tips for all sections of the exam.

Candidates should not only read but analyse the statistics in the exam reports. Questions that perform poorly should be reviewed. Questions that cover curriculum aspects that are important, clinically relevant and have low pass rate deserve particular attention.

Specialist International Medical Graduates who only sit the viva components of the final exam should not ignore the valuable information regarding content and presentation for the MCQ and SAQ sections.

Test yourself!

The latest exam report noted a number of 'recurring themes in candidates who performed suboptimally' in the vivas. The following viva questions in bold reflect the content that was of particular concern. Surprisingly, none of the material relates to rare or complex pathology.

Use formal language and a structure every time someone asks you a question in theatre.

STEM

70 year old with an obstructed inguinal hernia for emergency surgery. He has a known heart murmur.

Medications:
Irbesartan, Empagliflozin, Aspirin

How will you assess this patient for surgery?

In answering this question – focus on what you would do differently **for this patient** given his medical conditions (that you can infer from his medications) and his relatively urgent surgery using history, examination and investigations.

Make sure to mention in particular history/examination and investigation elements that will reveal

- Consequences of obstruction
- Implications of a murmur, its nature and correlates of severity
- Target organs of diabetes and hypertension (since there is not much that can be done about poor control given the timeline)
- Management options to mitigate the above.

VITAL SIGNS

HR	***135bpm***
BP	***100/80 mmHg***
RR	***20***

What does this tell you?

Signal to the examiner that this is what you were expecting (or not). That reassures the examiner that you are not just reacting to a series of surprises, but thinking about whether or not results and observations are consistent with the circumstances.

Given the history, a degree of dehydration should be expected and can be inferred from these observations. Urine output should be monitored, electrolyte derangements anticipated and corrected where possible and baseline renal function established and monitored. A management plan should be outlined.

Whenever you perform a significant action, state its details, mode of administration and endpoints.

What causes of hypotension are you considering?

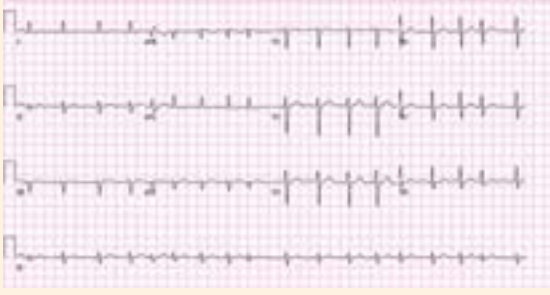
Hypo and hypertension are both very common in the

Remember that hypotension has cardiac and non-cardiac causes. Ensure that you have a systematic approach. Use a structure: whether it is preload, afterload, contractility, rate, rhythm or the classifications of hypovolaemic, distributive, cardiogenic or obstructive.

The court noted that distinguishing different causes of shock was an issue for candidates who performed poorly. Hypotension is very common in the exam. Make sure that you have an approach to diagnosis and management that keeps the patient safe and captures the likely causes of hypotension in the context of the patient described to you.

Interpret this ECG.

How does it affect what you will do?



Interpretation must occur in the context of this particular patient. Tell the examiner that it is consistent (or not) with what you expected for this patient in this context.

If you decide to consult with another specialist, make sure to make the aim of the consultation clear: advice on rate or rhythm control (or both), valve assessment, clot, severity etc.

All types of arrythmias occur clinically. Arrythmias and various types of heart block are very common in the exam. Make sure that you have a systematic approach to diagnosis, cause, management options and understanding of their impact on anaesthesia.

Examination reveals a systolic murmur. How will you diagnose its aetiology?

It is not enough to ask for a TOE. By all means say that this is the gold standard for diagnosis. This question is interrogating your knowledge of the different characteristics of systolic murmurs. This is an opportunity to signal your knowledge relating to history, examination and correlates of severity of significant systolic murmurs – as well as the detail that you seek in investigations.

The patient has aortic stenosis. What are the clinical correlates of severity?

This is a question about the history and examination (CLINICAL) features of aortic stenosis. Describe how the severity is stratified with symptoms (syncope etc) and where these fit in with the natural history of the disease. It is probably irresistible to mention valve area… but that has not been asked!

The surgery is deemed urgent.

How will you manage the empagliflozin?

The court noted that poorly performing candidates had difficulties managing perioperative SGLT-2 inhibitors. These are emerging as a group of drugs commonly used to treat diabetes as well as heart failure. Candidates should be very familiar with the surveillance for and the management of euglycaemic ketoacidosis.

The surgery is deemed urgent.

How will you anaesthetise the patient?

This is one of the final common pathways for an anaesthesia viva question.

Instead of jumping in with drugs and doses, signal to the examiner that you have a number of issues to consider for this patient. Nominate and rank those.

That stratification will help to communicate how you will monitor and mitigate the risks to the patient during induction and maintenance and emergence.

Improving performance in the vivas comes from rehearsal. Every time someone asks you a question in operating theatres, reply with a structured answer using formal language. During the course of a day in the operating theatre, we answer dozens of questions - make sure you make the most of those opportunities!

"The harder you work, the luckier you get."

FROM THE TRAINEE MEMBERS GROUP CHAIR

DR JASON KONG
TMG CHAIR

> Pain is an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage.

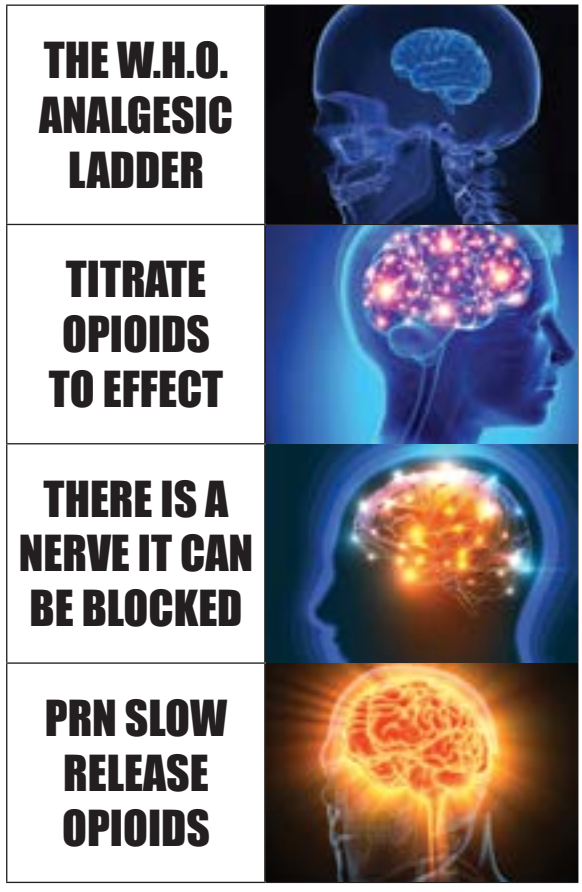
So, it turns out that it is traditional for the Chair of the TMG to write something in each edition of AA. This is usually done really well, and the articles are really informative. But, being in this new role, I put all of my proverbial eggs in one basket i.e. trainee updates into the TMG newsletter. Now with nothing more to say, rather than repeat myself, I'm going to try to lighten the mood and explain how I fumbled my way into an interest in pain medicine. Some of what I'm going to say is a joke. All of it is entirely unscientific. But hopefully, it can entice you to think about your practice, and consider being more involved in the fascinating world of pain medicine.

As I think back through my time as a trainee, I recall how my understanding of pain has evolved. I remember as a medical student being asked to define pain. I may have mumbled something about a sensation occurring with injury. Pain medicine was simple then. Start at Panadol, and work your way up until something works, and the patient is no longer in pain. The WHO analgesic ladder – beautiful, simple, useless.

So, what a good thing it is then that 'pain' is examined in the Part 1 exam. We've all seen this definition from the International Association for the Study of Pain (IASP) (which I note has recently been updated).

> 'Pain is an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage.'

I'm sure this definition rings a bell to most trainees. I still haven't quite worked out what 'described in terms of such damage' means, but it seems to refer to the subjective nature of pain. We all recall the patient that shows no signs of nociception under anaesthesia, yet emerge in significant pain. I learned that the patient's subjective interpretation or 'description' of their nociceptive signals is what differentiates nociception from pain. I decided then that I would titrate intraoperative analgesia to physiological signs of nociception – heart rate, blood pressure, resp rate and plethysmography changes, and modify my post-operative analgesia orders for patients I thought were more likely to 'describe' being in more pain post-operatively, and chart up higher doses of analgesics to those patients.



Then for Part 2, I learnt about nerve blocks. This was attractive to me as I was always looking for ways to minimise opioid use, after all, I had learnt that opioids caused all sorts of badness like itching, nausea and respiratory depression. I spent most of my fourth year of training running around sticking needles into various bits and pieces and numbing them up. Like the orthopaedic registrar fixated on a fracture, my mantra was "There is a nerve. I must block it." When I did it well, I thought the outcomes were fantastic. I could reduce both opioid use and run a lighter plane of anaesthesia. There was tram-track anaesthesia. Turnover was faster. In recovery, patients were pain-free, had less nausea, were more alert and spent less time in post-anaesthesia care unit (PACU).

I was confident that I had it figured out. I believed that my approach was solid. Except it wasn't. All good blocks wear off. And when I thought about it, in-patients that would have emerged with only mild pain, I probably didn't need to do a block, and subject them to the risk of nerve damage without any meaningful gain. And, for the patients who would have emerged with severe pain, I lost the ability to identify them in recovery, where systemic analgesia could be more easily titrated, and simply moved that problem to the overnight ward staff. I needed a way to identify patients that were likely to be in significant pain post-operatively and figure out a better way to do things. Blocks were clearly a great tool, but there were still significant problems. Recently I've moved back to doing mostly rescue blocks in recovery, or pre-operatively for specific elective operations in well counselled patients.

Then there was still the issue of subjectivity. We all recall the patient who at the end of the bed, shows no physical expression of pain. They can walk, breathe, cough and go out for a smoke, yet still report high pain scores. And at the opposite end of the spectrum – the patient that uses no PRN opioid, and reports no pain, and high levels of satisfaction, but they lie completely still and don't breathe. My understanding of pain as something that could be accurately quantified was being challenged, and that made things even more difficult. After all, all the pain literature measures the efficacy of treatments through pain scores. If pain scores didn't paint the whole picture, if they weren't the most important thing, what was? What about function? Don't all types of pain inhibit function?

I strongly encourage those of you who are looking for a challenge to consider pain medicine as an additional fellowship. We need more of you in this country!

I did some reflecting on the evolutionary basis of pain. They say that the purpose of acute pain is to speed up healing, and prevent further injury. This makes sense – a cut heals faster if the edges don't move. Sensible on an evolutionary basis back when sutures, cement and metalware didn't exist. But when we have ways of keeping things still and secured, surely then we don't have to take extraordinary measures to keep injuries immobilised (of course there are specific instances where this is not the case). Surely then, pain as a sensation is really there to be noticed, then ignored, within reason. Now when I see a patient in a pre-admission clinic, I spend quite a lot of time going through post-operative pain, and helping patients understand what pain to push through, and what pain to be concerned about.

Then I started thinking about a controversial topic – slow-release opioids. I used to use them all the time. They worked great … Sometimes. Other times, they were bad. There were great concerns about their safety. Looking into the literature, these concerns were based on studies that compared regular slow-release opioids and PRN immediate-release opioids. But two key control groups were missing - regular immediate-release opioids (which I suspect are even more unsafe than regular slow-release at the same dose due to higher peak concentrations), and PRN slow-release which may be safer due to lower peak concentrations. The number of times I've heard patients say – I slept well, until about 3am when the pain relief wore off, nursing staff didn't give me pain relief until 4am, and couldn't fall back asleep until 5am when the next lot kicked in. PRN slow-release opioids (or modified-release as the case might technically be the case with Targin) would be a great option in this situation. I wonder if we'll ever look at this in pain research.

Clearly, there is a lot more for me to understand about pain. It is a fascinating, nuanced and challenging field, and if I had a more patient temperament I would strongly consider further training. Pain pharmacology is fascinating and so is chronic and psychosomatic pain. Many times, I've read that chronic pain serves the organism no purpose. I have a theory that it actually does serve a social function, analogous to the use of the 'bongcloud' opening in chess. And, as I sit here in my hypothetical bongcloud, spitting out more unsupported theories than facts, I strongly encourage those of you who are looking for a challenge to consider pain medicine as an additional fellowship. We need more of you in this country!

Dr Jason Kong

TMG Chair

THE SCOPE OF ANAESTHESIA

DOES THE SCOPE OF ANAESTHESIA STILL INCLUDE THE TRADITIONAL ROLE OF ANAESTHETISTS IN MANAGING NON-ACUTE PAIN AND SHOULD IT?

Recently, the ASA was asked by a long-standing member whether the association would consider developing a definition of the full scope of anaesthesia that included the traditional role of anaesthetists in managing pain, as well as other areas outside the operating room and pre-anaesthesia/post anaesthesia activities.

Background

Over a long career, this member has practiced the full scope of anaesthesia, but has always had a strong interest in regional anaesthesia and aspects of pain medicine. When attending international meetings prior to COVID-19, he mixed with a variety of anaesthetists and both pain and musculoskeletal specialists, all with overlapping interests and practices. He has, on occasion, been an invited international speaker at pain and musculoskeletal meetings. His training, before the Faculty of Pain Medicine existed, included work in chronic pain and some pain interventions, neurolytic blocks etc.

While his practice is now transitioning more to pain with ultrasound guided injections and procedures, he feels ANZCA is transitioning away from pain as a part of the Specialty of Anaesthesia, except for acute pain. While this is perhaps understandable now that the Faculty of Pain Medicine exists, he feels this development no longer supports the concept of an anaesthetist with an interest in pain medicine.

This was brought home to him when he recently received his re-accreditation

with a private hospital which was for anaesthesia (age above 2) acute pain management, point of care ultrasound, sedation and peri-operative medicine. While these areas are all well and good, he believes they are much more specific than before and he suspects the specialty is being defined with a more restricted scope, which leaves some of his pain practice in somewhat of a grey area.

When the member asked his private hospital about this, they asked him to submit documentation from the Faculty of Pain Medicine. His FANZCA, it seems, was no longer deemed good enough to permit him to admit non acute pain patients.

Discussion

This matter was addressed by the ASA's Professional Issues Advisory Committee (PIAC) at its meeting in mid-April, with some members of the committee noting this member's reputation in regional anaesthesia and that anaesthetic trainees generally speak highly of him.

PIAC agreed the ASA should generally support him, if only because who else would treat his patients if he cannot? Furthermore, it would appear he has been practicing safely at this hospital for many, many years. Committee members wondered why he was now required to have a fellowship from the Faculty of Pain Medicine in order to admit a patient for chronic pain.

After some discussion, PIAC agreed this member should be advised to escalate the matter to his hospital Medical Advisory Committee (MAC), and that the ASA could provide him with a letter of support if needed.

Subsequently, during a discussion with PIAC Chair, Dr Pete Waterhouse, the member indicated that he was receptive to the idea of escalating his issue to his hospital MAC to see if there really was an appetite to stop his long-standing practice of admitting patients for pain therapy. He said he was more confident now that this would likely resolve the current situation.

However, he also wondered if the ASA would go further and issue a more general statement acknowledging the legitimacy of those anaesthetists in his type of practice?

The essence of such a statement would be:

1. As medicine continues to evolve, pain and intensive care medicine are now independent areas of specialisation with discrete training pathways, funding models etc.
2. However, both of these areas arose from anaesthesia and many anaesthetists continue to contribute to these fields, as they have for decades.
3. There is therefore still a place for these all-round anaesthetists with interests and skills beyond the strictly peri-operative realm.

Dr Waterhouse says he has sympathy for this sentiment. "It is well accepted within the profession that many anaesthetists have broad interests, and our enthusiasm for the emerging area of 'peri-operative medicine', including by ANZCA, confirms this" he said.

"In fact, this embrace of peri-operative medicine seemingly swims against the current of recent years as the profession has increasingly let go of pain and ICU medicine with little or no apparent regret."

Dr Waterhouse says he is relatively confident that the member in question will be able to continue with his current, broad practice, following a discussion with his hospital MAC. However, Dr Waterhouse was less confident about the long-term future of all-rounder anaesthetists. For better or worse, the specialty has allowed its scope to become narrower and more strictly defined.

CHRONIC PAIN IN AUSTRALIA

1.6 million (1 in 5) Australians aged 45 and over had chronic pain in 2016

People with chronic pain are 5 times as likely as those without pain to be 'limited a lot' in daily activities

GPs are seeing more people for chronic pain – patient encounters have risen by 67% over 10 years

People with chronic pain are almost 3 times as likely to be dispensed opioids and other analgesics and migraine medication as those without pain

In 2017-2018 there were nearly 105,000 hospitalisations involving chronic pain

Reference: https://www.aihw.gov.au/reports/chronic-disease/chronic-pain-in-Australia/summary

TAKING THE PAIN OUT OF HEALTHCARE WITH DIGITAL HEALTH

As more individuals and healthcare organisations embrace digital health, clinicians need to be aware of digital health developments, understand how these tools may alleviate some of the pain points encountered in healthcare and ensure the tools are not additional sources of pain by protecting the security of the information held in these systems.

Digital health is transforming the way in which healthcare is provided in Australia, enabling clinicians to safely share critical patient information to support informed clinical decision-making and healthcare management as well as empowering people to participate in their own health care. As more individuals and healthcare organisations embrace digital health, clinicians need to be aware of digital health developments, understand how these tools may alleviate some of the pain points encountered in healthcare and ensure the tools are not additional sources of pain by protecting the security of the information held in these systems.

Pain point 1
Paper records

Many hospitals and specialists are going digital; however, paper records and charts may still be present in some departments. Sifting through paper charts and records is a common exercise when searching for past medical history. This can be time consuming, especially if they are archived or held off-site. Often critical patient health information remains locked in siloed clinical information systems and cannot be shared easily across the health system and care settings. Even where information sharing is possible it is not always happening as often as it should be.

My Health Record has been developed to help address this issue, enabling information to be shared between different clinical information systems and care settings. My Health Record is a secure, online system where clinicians involved in a patient's care can access key health information from a range of other sources. Information available may include a patient's medical history, medicines information, allergies, adverse drug reactions, hospital discharge summaries, specialist letters as well as pathology and diagnostic imaging reports and more. An increasing number of public and private hospitals have implemented My Health Record. Check with your hospital clinical information manager to find out how to access My Health Record through the hospital information system. It's often just a click of a button away.

> "There is such a wealth of information. I would certainly use it every day that I'm working in the emergency department...It's become pretty much a reflex from our emergency department medical staff to go into My Health Record if they have any sort of questions." – Dr Amanda Stafford, Consultant, Royal Perth Hospital Emergency Department

To learn more, join one of the Australian Digital Health Agency's free webinars as listed here: https://www.digitalhealth.gov.au/healthcare-providers/webinars. For information about implementing My Health Record in your private practice visit: https://www.digitalhealth.gov.au/healthcare-providers/initiatives-and-programs/my-health-record/implementing-my-health-record-in-your-healthcare-organisation

Pain point 2
Bags of medications

Patients on multiple medications can present to a pre-anaesthetic assessment clinic without a clear record of their current prescriptions or medication

history. A common occurrence is a plastic bag full of unlabelled, loose medications.

Now it is easier for patients to keep track of their health information, including their medicines information, and share it with their healthcare providers, using the new my health app. The app gives patients secure, convenient access to their My Health Record information on their mobile device. Key health information you and other healthcare providers have added to a patient's My Health Record can be accessed via my health, ensuring patients have this information readily available whenever it is needed. This can be particularly useful if your hospital or practice is not yet using My Health Record. my health, is an Australian Digital Health Agency owned and managed app, and is the latest digital tool developed by the Agency to help consumers and their carers engage with and be proactive in managing their health. For more information visit www.digitalhealth.gov.au/myhealth or watch this short video.

Pain point 3
Faxed and scanned referrals and forms

Commonly, when a new patient is referred to your practice, referral letters and other documents will be faxed or scanned. New patient details then need to be manually entered into the local clinical information system, a time-consuming process for administration staff. Other records or results that need to be sent or received, may also need to be requested, then faxed or scanned. This can also take considerable time and effort.

Secure message delivery can help to alleviate this administrative burden. Referrals and other forms can now be filled automatically at the general practice or referrer-end, based on the patient and provider information stored within the GPs clinical software. When sent by secure messaging, these referrals can then be securely delivered directly into your practice's local software system. If you have a compatible system, the referral can be matched to either an existing patient, or in the case where one does not exist, a new patient record can be created from the details in the referral usually with a single click.

Simplifying data and digital interfaces, for example making sharing of key information a by-product of clinical workflow, reduces time spent on administration and removes the risk of crucial information being missed or unavailable when required. This enables you to spend time on what matters most — delivering safe, high-quality care.

Check with your software vendor or secure messaging provider to find out more.

Pain point 4
Cyber-attacks

While digital health tools bring many benefits, cyber-attacks can be a major source of pain within the healthcare system. Cyber-attacks can lead to loss or theft of sensitive health information, reputational damage, disruption to service delivery and financial loss. However, ensuring you and your team take cyber-security seriously and understanding how you can protect your practice can make you less vulnerable encountering this pain point.

A few key cyber-security tips include educating and training staff about the importance of data protection and how to recognise the signs of a data breach, regularly updating your clinical software, keeping frequent back-ups of all critical information, and ensuring these are stored securely off site. The Australian Cyber Security Centre has a range of useful resources for individuals and businesses.

The Australian Digital Health Agency has a free eLearning Digital Health Security Awareness course for healthcare providers. The course has been developed by the Agency's cyber security team, in consultation with representatives from a range of healthcare settings and disciplines. The course can be accessed by visiting: https://training.digitalhealth.gov.au/

Dr Kathy Rainbird

Manager, Education,
Australian Digital Health Agency

ASURA 2023 REPORT

After two postponements and four years of evanescent planning, the eighth Australasian Symposium on Ultrasound and Regional Anaesthesia (ASURA) finally took place over three days in early March 2023

DR DAVID MCLEOD

Over 252 delegates from Australia and New Zealand registered for the conference. Three international luminaries plus one Australian as invited speakers, along with 95 Australasian faculty delivered the content of the meeting.

Dr Rosie Hogg from the Belfast Health and Social Care Trust, Northern Ireland, Associate Professor Enrique A. Goytizolo from the Hospital for Special Surgery, New York, USA, Dr Adam Spencer from the Alberta Children's Hospital, Calgary, Canada, and Associate Professor Alwin Chuan from Liverpool Hospital, Sydney, Australia anchored the meeting with their expertise in teaching, research and administration of regional anaesthesia and acute pain management.

Day one ran at two concurrent venues. Whilst advanced cadaver workshops were run morning and afternoon in the Medical School by Dr Alistair Browne and involved all four invited speakers for the entire day, across at the main venue Dr Chris Mitchell ran his masterclass All Around the Block, a guide for beginners and teachers. At the same time the Australian and New Zealand College of Anaesthetists (ANZCA) PD Emergency Response Workshops (ASBD, CICO, Major Haemorrhage and Anaphylaxis) were held. Thanks to the staff of Flinders Medical Centre Anaesthetic Department who ran them. At the conclusion of day one a welcome reception was held in the stunning upstairs foyer of the Convention Centre looking north over the River Torrens precinct and Adelaide Oval.

Days two and three ran along similar formats with plenary sessions in the morning followed by hands on ultrasound scanning workshops, masterclasses and small group discussions in the afternoon.

The first plenary session commenced with a welcome to country from Mickey Kumatpi O'Brien, followed by the Darcy Price Memorial Lecture delivered by the 2020 Australian of the Year Dr James Meucke. His talk focussed on the current obesity epidemic, type 2 diabetes and its dire ophthalmological, cardiovascular and renal consequences, and the failings of contemporary western diets. Although his lecture had little to do with regional anaesthesia per se, Dr Meucke delivered a poignant message that all doctors as societal leaders should be aware of. Lectures were then delivered by Dr Goytizolo on joint arthroplasty, Dr Hogg on transforming healthcare with regional anaesthesia, Dr Katrina Webster on breast surgery, Dr Brigid Brown on PENG blocks and Dr Hogg on enhanced recovery. The afternoon sessions were a combination of small group discussions and hands on scanning ultrasound regional anaesthesia workshops.

Concurrent to this, and as an alternative to the scanning workshops were two masterclasses, paediatric regional anaesthesia with presentations from our four paediatric regional anaesthesia specialists, Dr Adam Spencer, Dr Cheryl Chooi, Dr Phillip Cheung and Dr Nathan Hewitt, and 'All About the Trunk' featuring Dr Peter Hebbard and Dr Katrina Webster.

Following day two a dinner for the faculty who delivered the teaching was held at Press Food and Wine in Adelaide. It was a fine evening with excellent food and wine, and a great deal of conversation. Impromptu speeches were given, thanking me and the organising committee, followed by my announced retirement from the Chair and Executive Committee of the Regional Anaesthesia Special Interest Group, and Dr Katrina Webster taking on both the role of Chair and Convenor of the next ASURA in Hobart in 2025.

The third and last day commenced with morning plenaries by Dr James Murtagh on ESP Blocks, Dr Alwin Chuan on virtual reality and regional anaesthesia, Dr Enrique Goytizolo on refining new approaches on upper and lower limb regional anaesthesia. For the second session we had for the first time a plenary session devoted to paediatric regional anaesthesia with talks from Dr Adam Spencer on the Alberta experience,

Dr Cheryl Chooi on the Boston, USA experience and Dr Philip Cheung and Dr Nathan Hewitt on the Westmead Approach to regional anaesthesia.

The final afternoon session was again a combination of scanning ultrasound workshops and small group discussion. Two further masterclasses, modernising care pathways using regional anaesthesia, featuring Dr Rosie Hogg and Dr Adam Spencer, and continuous catheters with Dr Pedro Diaz and Dr Andrew Lansdown were held.

All of the masterclass sessions were held in the Gilbert room, a fabulous glassed-in room that jutted out towards the River Torrens with panoramic green views, and seating for 100 delegates.

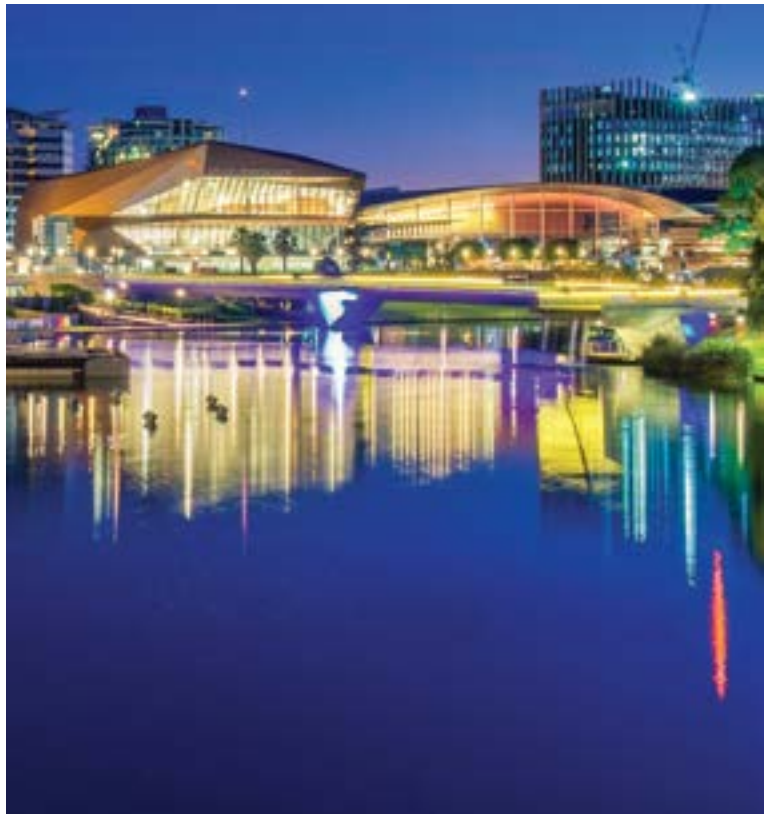
The final social event was the symposium dinner at Adelaide Oval, providing another fine opportunity to socialise, network, and converse with our four invited speakers, and watch the interior of Adelaide Oval being set up for the Ed Sheeran concert.

Thanks to our sponsors General Electric, BBraun, Fujifilm Sonosite, Priority Life, LTR Medical, Clarius Mobile Health, AFT Pharmaceuticals, Device Technologies, Fisher and Paykel, and Surimex. Special applause for the organising committee David McLeod, Craig Morrison, Nik Fraser, Alastair Browne, Peter Hebbard, Rhian Foster and Judy Ung.

Look forward to meeting with the regional anaesthesia crowd at Hobart ASURA 2025, convened by Dr Katrina Webster.

Dr David McLeod

Convenor Adelaide ASURA 2023



ASURA KEYNOTES SHARE THEIR INSIGHTS ON REGIONAL ANAESTHESIA

Q&A

We sat down with Keynote speaker, Dr Rosie Hogg, at the 2023 Adelaide ASURA, where she shared her expertise and insights on the latest advancements in regional anaesthesia. A specialist in the field, Dr Hogg's extensive experience and contributions to regional anaesthesia have made her a leading figure in the industry.

Dr Rosie Hogg

Dr Rosie Hogg is a consultant anaesthetist, researcher, and advocate for flexible working, with a special focus on regional anaesthesia and patient-centred outcomes. She has clinical interests in point-of-care ultrasound, colorectal surgery recovery, and medical education via social media. Additionally, she's a member of the Northern Ireland Society of Regional Anaesthesia and trustee of the Belfast arthroplasty research trust.

Could you tell us a little bit about your background and expertise?

I am an anaesthetist who works in Belfast, Northern Ireland. I did all my anaesthesia training and three years of research into patient-centred outcomes in Northern Ireland. I also spent a year working at the University of Pennsylvania in Philadelphia. My special interests are regional anaesthesia and point-of-care ultrasound.

What key insights do you aim to convey to ASURA delegates in your sessions?

For me it's all about incorporating regional anaesthesia into our daily practice for patient-centred outcomes. When we do a lot of research, we tend to be looking for outcomes that are important to anaesthetists, but they're not always the same outcomes that are important to patients. I hope to get across to the delegates that it's about thinking slightly differently about how you incorporate regional anaesthesia into your practice.

What do you think are the most pressing issues facing the field of anaesthesia?

The biggest one is patients getting access to regional anaesthesia. When you're an expert in the area you can think that everybody does the same practice as you but, regional anaesthesia is not anywhere near as widely used as it could be. There are a lot of barriers to that, the main one is probably education, and anaesthetists feeling confident about delivering nerve blocks. We need to encourage more doctors to do nerve blocks and be more confident in their abilities.

How do you see healthcare evolving over the next few years, and what opportunities and challenges do you anticipate?

One of the most significant opportunities is shorter stays for patients. Post-pandemic the culture has changed, and we want to get patients out of hospital as soon as possible. A significant challenge is patients having more comorbidities. We will need to address and develop our practice to keep improving patient outcomes.

In your opinion, what are some of the most exciting innovations that are shaping the field of anaesthesia?

Having access to very good educational videos online and apps – before you had to go look in a book and it didn't make sense, but now we have access to tactile learning, and being able to learn in your own time. You can train at a regional hospital, you don't have to go to a specialty centre, learning has become more accessible. AI is going to transform how we learn, how we teach, it's going to be interesting to see what anaesthesia looks like. Ultrasound is also the future and incorporating it into everything we do will become a natural extension of anaesthesia practice.

What advice would you give to young professionals who are just starting out in the field?

My advice to young professionals is to start with plan A blocks, the easier ones, and try to master them. Ultrasound may seem overwhelming at first, but with practice, it becomes second nature. Incorporate it into everything you do, and it will become a natural extension of your practice.

What were the highlights of your experience at ASURA?

I was just looking forward to coming back to Australia – I haven't been here since the 2000 Olympics. Really nice as well to get back to face-to-face meetings, for me this has been one of the most friendly conferences I've ever, ever attended. All the delegates have been so engaged, the faculty has been so friendly. I come to conferences because I learn as much as the delegates do, it's been great talking to people and learning about their challenges. Even as an expert you come away having learnt so much more.

Words of Wisdom from our keynotes:

In addition to Dr Hogg, we had the opportunity to sit down with ASURA's keynote speakers, who offered their perspectives on the latest developments and trends in regional anaesthesia, and advice to anaesthetists looking to make their mark in this exciting field.

Associate Professor Enrique A. Goytizolo

Associate Professor Enrique A. Goytizolo is a board-certified anaesthesiologist with a passion for regional anaesthesia and postoperative pain management. He spent six years developing Lenox Hill Hospital's regional anaesthesia program and is now the Assistant Clinical Director of Anaesthesiology at the Hospital for Special Surgery. Dr Goytizolo's primary interest is the impact of anaesthesia on orthopaedic surgery rehabilitation, focusing on peripheral nerve catheters. He's a valued member of the Department of Anesthesiology, Critical Care and Pain Management's Education Committee and oversees their Academic Observership Program.

What are the key takeaways from your ASURA sessions?

Regional anaesthesia is a specialty that has excellent outcomes on patients undergoing orthopaedic surgery, especially total joint arthroplasty. The specialty continues to evolve with new peripheral nerve blocks, that allow patients to perform rehabilitation more efficiently, discharge earlier from hospital, endure less side effects and improve their satisfaction.

What advice would you give to young anaesthetists, starting out in the field?

I encourage them to be involved in research and innovation to bring our specialty forward and have even better outcomes for our patients.

Associate Professor Alwin Chuan

Associate Professor Alwin Chuan is a senior specialist at Liverpool Hospital in Sydney, Australia. His clinical practice includes orthopaedics, trauma, and major surgery, while his research spans regional anaesthesia, pain medicine, and medical education. Alwin's research is widely published, having received funding from grants like NHMRC Postgraduate Fellowship and ASA Jackson-Rees Prize. He's a sought-after speaker, played an integral role in professional organizations, and directs the provisional fellowship in regional anaesthesia at Liverpool Hospital.

What are the key takeaways from your ASURA sessions?

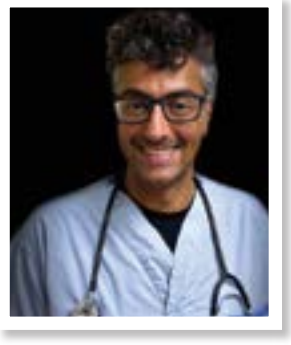
Technology is a key driver of innovation in the field of regional anaesthesia. The only other subspecialty that has seen similar transformative change from new technology is airway management. In regional anaesthesia AI will drive computer-assisted identification of nerves, muscles, blood vessels and fascial planes. There will be a direct impact on training, as these AI systems will help novice regional anaesthetists in recognising important anatomical structures necessary for safe and successful nerve blocks. These first-generation AI systems are commercially available and will change the way nerve blocks are taught and performed.

Similarly, virtual reality (VR) is another form of technology with the promise of transformative change. When used as a type of simulation, VR can be harnessed as an education tool to allow novices to quickly learn cognitive motor skills such as needling with ultrasound guidance.

VR could replace the deliberate practice part of training with a VR environment that can make learning fun and interactive.

What advice would you give to young anaesthetists, starting out in the field?

Over a 30-plus year career, you will experience changes in medical technology, drugs, devices, policies, health systems, and even the emergence of new diseases like what we experienced from 2020 onwards. As such, having a mindset that accepts such changes is inevitable, and enjoying the process of learning, being challenged, interacting with colleagues, trying new things, and taking risks – and reflecting on those that worked and those that didn't – is a powerful tool to help you adapt and develop as a physician. I encourage all to get involved in some form of research, as that is the ultimate in being challenged and intimately involved in continuous cycles of learning.



Dr Adam Spencer

Dr Adam Spencer is a paediatric anaesthesiologist based in Calgary, Alberta, Canada. With a Montpellier fellowship in ultrasound-guided regional anaesthesia, he's a leading expert in his field and a passionate advocate for improving paediatric patient care. He spearheaded perioperative guidelines for various procedures, conducts research, and shares his knowledge through regional anaesthesia and POCUS workshops. Dr Spencer developed an innovative program that allows children to recover at home after surgery.

Key takeaways from your ASURA sessions:

Modern equipment including ultrasound allows kids of all sizes to also benefit from the addition of nerve blocks and catheters even though they are getting a general anaesthetic.

There is mounting evidence that peripheral nerve blocks and catheters provide excellent analgesia and should be chosen over neuraxial techniques whenever possible.

We highlighted novel techniques such as the suprazygomatic maxillary nerve block for cleft surgeries and lumbar plexus block for hip surgeries. These have been found to be very effective for kids of all ages when included in a clinical care pathway.

What advice would you give to young anaesthetists, starting out in the field?

For regional anaesthesia enthusiasts keen to hear about advancements and learn new techniques, look to conference like the ASURA, which offers a mix of hands-on workshops, plenaries and masterclasses from colleagues around the world. These provide excellent networking opportunities and a forum to share a variety of ideas that can be used in your day-to-day practice.

When contemplating an anaesthesia fellowship to further sub-specialise into a field like regional or paediatric anaesthesia, I recommend thinking outside the box and exploring international training opportunities as this experience will challenge how you think, the way you do things and ultimately lead to the development of new skills and knowledge.

Kelly Chan

BLSS, BMus, MBA/LLM Candidate
Marketing Communications Manager,
Australian Society of Anaesthetists

BACK TO WORK SUPPORT FOR ASA MEMBERS

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.

A big thanks to you and all of the CRASH team for devoting your time to this.

I found the course immensely helpful with my return to work process - I used the templates given for a return to work plan, used topics from the round table to negotiate with my department (e.g. expressing breaks), and, very importantly felt much more confident and comfortable that I could manage tricky clinical situations after our day of sims and lectures. I would strongly recommend the course to anyone returning to clinical anaesthesia after a break, regardless of the circumstances of the time off. It's a safe and supportive environment to re-skill/remember the basics of ALS, airway management, massive haemorrhage control ... and many other topics.

I was grateful to be able to attend, especially for the scholarship, which ameliorated some of the costs of travel.

Warm Regards,
Dr Tessa Finney-Brown

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.

20 CRASH scholarships available per year

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

CONGRATULATIONS DR ERIC HEWETT

ON 50 YEARS OF ASA MEMBERSHIP

Congratulations to Dr Eric Hewett for 50 years of ASA Membership. Presentation of Certificate and PIN.

On March 27, 2023, Dr Graham Mapp, ASA Queensland State Chair, presented Dr Eric Hewett with a commemorative ASA Membership Certificate and Lapel Pin to celebrate a momentous 50 years of membership. Eric spent his childhood on a small dairy farm, but his parents had ambitious plans for him and sent him to Brisbane Grammar School (1960-63) as a boarder. He pursued his interest in medicine at the University of Queensland, where he earned his MBBS degree in 1969. After completing his residency at the Mater Hospital in Brisbane, he moved to London in 1970. At St Bartholomew's Hospital (St Bart's) between 1971 and 1972, Eric worked as an SHO in anaesthesia. At that time, six out of eight locum positions were in anaesthesia, and St Bart's had a strong tradition in this field. In 1972, Eric passed the English Primary Exam and was promoted to Registrar. The following year, Eric returned to Royal Children's Hospital (RCH) in Melbourne, where he had previously worked, thanks to great references from consultants at St Bart's.

Eric accomplished a significant milestone in 1973 when he passed the Australian Faculty of Anaesthetists exam, earning him the prestigious FFARACS award. He credits his success to the guidance and tutelage he received from Dr Kester Brown and Dr John Stocks, as well as the staff of RCH. It was also in 1973 when Eric joined the ASA. The following year, he became a junior consultant at the Royal Women's Hospital (RWH) Melbourne, where he worked closely with Dr Kevin McCaul to refine his expertise in epidural and spinal procedures.

In 1975, Eric relocated to Brisbane and joined the Royal Brisbane Hospital (RBH) as a consultant. The following year, he took a leave of absence from RBH to assume the role of Chief Resident at Virginia Mason Hospital in Seattle, USA. The hospital's Department had a global reputation for teaching regional anaesthesia and was associated with the University of Washington's pain clinic, which was established by Dr John Bonica and had a multidisciplinary approach.

In 1977, Eric returned to Brisbane as the Director of the RBH Department of Anaesthesia. The following year, private practice finally called and in 1978 he joined the Narcosia Anaesthesia Group, remaining in private practice until his retirement in 2015.

During the intervening years, Eric achieved several professional accomplishments. He was elected to the Queensland Faculty of Anaesthetists regional committee in 1980, became a supervisor of training in 1982, and was appointed as a second-part examiner in 1984. In 1986, Eric was elected as the chair of the Queensland regional committee. Alongside Joan Lawrence, Eric also played an instrumental role in the establishment of the Doctors Health Advisory Service (DHAS), where he served as the treasurer on the DHAS committee until 2014.

Eric retired in 2015 and now devotes his time to his passions, which include fitness, chess, travel, model boat building, and enjoying life with his wonderful wife. Congratulations Eric on a stellar career and 50 years of ASA membership!

FAREWELL ASA

As Tracey Grimshaw from A Current Affair said on her last day: 'I am not too old, I am just a bit tired'. After eight years at the Australian Society of Anaesthetists (ASA) and well past my retirement age, this is how I feel right now. So, after I recover from knee surgery, I am planning a city fringe change, tree change or even a state change – who knows where I will end up.

My eight years with the ASA have certainly been interesting, challenging, mind-expanding, a vertical learning curve – at times frustrating due to so many staff changes, but basically an overall enjoyable experience to end my working life.

My Chairs and Executive Committee members have kept me on my toes. Some days, I wore one hat, other days all seven, with some challenges turning your whole day on its head. Certainly not a regular nine-to-five role, and that kept it interesting!

The ASA is undergoing a new direction, and there will certainly be interesting times ahead for you all to enjoy and grow with – I wish you the best of luck!

I'd now like to thank the Academy – oops – sorry, wrong speech …** ha ha.

Thanks for all your help, friendship and fun. Sue for her support and allowing me to bend her ear and add to her chocolate and wine intake, Matt and Hannah for their patience with reallocation of funds and budget, Paul for my soda water deliveries and patiently supporting this self-recognised IT nerdette, Michee for the plant cuttings - they are growing well, Natalie for her singing and providing music while we work, Hayley for making Informz look interesting – and the rest of you who have been great work colleagues over the last eight years.

It wouldn't be fair if I didn't leave you with this tongue-in-cheek quote from Google Books – Public Works 1953: 'A committee is a group of people who individually can do nothing, but as a group can decide that nothing can be done.' See ya!!

Maxine Wade has been a staff member and committees assistant at the ASA for the past eight years. She is now retiring, and we would like to thank her for her hard work, many conversations, and insights. We wish her time to recover and explore new opportunities, and all the best for the future

STAFF UPDATE

In early May the ASA appointed Beth Firipis to the role of Senior Policy and Regulatory Affairs Officer. Beth will help lead and manage the development and implementation of projects to advance the interests of the ASA and its members. Her role will focus on economics in healthcare, and she will work closely with Dr Michael Lumsden-Steel and the Economics Advisory Committee (EAC).

Beth recently graduated with a Master of Health Economics from Deakin University supplementing her earlier Bachelor of Science double majoring in chemistry and cell biology, also from Deakin University. She is currently enrolled in the Biostatistics Collaboration of Australia's (BCA) Graduate Diploma program through the University of Adelaide.

Beth's background is as a professional data analyst with domain specific experience in health economics, epidemiology, and logistics. She spent six years in logistics within construction and manufacturing industries, three years of those in management and leadership roles. Seeing the value in data-driven, business decision-making to advise logistical process design, Beth picked up skills in data analysis, financial modelling and statistics. Harnessing data from various ERP and CRM packages, along with empirically determined model parameters to create business cases and data visualisation to advise stakeholders.

Excited by the complexity of the modelling and biostatistics involved in the health economics industry, Beth chose to complement her industrial experience with a Master of Health Economics. Gaining a strong understanding of Australian healthcare policy, epidemiology, health technology analysis, and the health economics techniques utilized by the Australian public and private sector.

Beth comes to the ASA after finishing a previous role with the Australian Digital Health Agency (ADHA), performing health economic cost-benefit analyses of My Health Records and various other digital health interventions. While at the ADHA she also assisted in the design and development of a socioeconomic benefits dashboard, along with several cost-benefit models and project management tools used to model, forecast and monitor the measurable outcomes of various digital health interventions.

Bernard Rupasinghe ■

Policy and Public Affairs Manager

AROUND AUSTRALIA

Queensland

Dr Graham Mapp

Chair of the Queensland Committee of Management

Congratulations to Dr Eric Hewitt for 50 years of ASA Membership

I recently presented Dr Eric Hewitt with a certificate and pin to celebrate his 50 years of ASA Membership. Eric had a 34-year history in both public and private anaesthesia. He was elected to the Queensland Faculty of Anaesthetists Regional Committee in 1980, became a supervisor of training in 1982, and was appointed as a second part examiner in 1984. Eric became the chair of the Queensland Regional Committee in 1986.

With the help of Joan Lawrence, Eric helped to establish the Doctors Health Advisory Service (DHAS) and remained on the DHAS committee as treasurer until 2014.

Meeting with Assistant Minister for Health and Regional Health Infrastructure

Members of the Queensland Committee of Management met with the Assistant Minister for Health and Regional Health Infrastructure, Mrs Julieanne Gilbert in early May to discuss three issues currently affecting members in Queensland. QScript, Surgery Connect and the workforce shortage crisis in regional Queensland.

Update on QScript

The QScript check became a mandatory process from October 2021 under the Medicines and Poisons Act 2019. Relevant practitioners (medical practitioners, pharmacists, intern pharmacists, nurse practitioners, endorsed midwives, dentists, podiatric surgeons and endorsed podiatrists) are required to check QScript for patient records before:

- prescribing a monitored medicine for a patient
- dispensing a monitored medicine for a patient
- giving a treatment dose of a monitored medicine for a patient.

This applies to relevant health practitioners who are authorised to prescribe or dispense a monitored medicine, including those in private and public hospitals, aged care facilities, prisons, and other health services.

Nevertheless, a post implementation survey in August 2022 revealed only 67% of eligible medical practitioners had registered for QScript.

Following a large amount of negative feedback, Queensland Health released a consultation paper on mandatory checking of QScript in January and asked for comment regarding monitored medicines standard compliance requirements and QScript look-up requirements.

A submission by the ASA acknowledged the benefits of real time monitoring of medicines but called for a number of regulatory changes including:

- an exemption to the QScript check for in-hospital episodes of care including discharge medications (where the hospital pharmacy dispenses the medications)
- an improved method of accessing the QScript check (one that doesn't require downgrading of device security, multiple layers of login checks, and provides a reliable connection to the QScript system)

We also believe that the system should be a truly national system allowing for checking of interstate prescriptions.

There were several thousand submissions to the consultation and Queensland Health hopes to have a response by November 2023. In the meantime, letters of compliance are being received by members for not performing the check. We will seek an exemption to the check until the review is completed.

Out-patient / private scripts for monitored medicines will always require a QScript check, even after the review process.

Surgery Connect

I met with Kaleigh Leggett, Assistant Director, Surgery Connect, Queensland Health in January to discuss issues with Surgery Connect and request ASA representation on the Surgery Connect Advisory Committee.

Prior to 2017, Queensland Health ran the surgery connect program and facilities provided the services. Anaesthetists were paid at 68% of AMA rate (as were surgeons) and were indemnified by the state.

After 2017, Surgery Connect became the facility-based scheme that it is today. The consequences of this change have led to issues with appropriate patient selection, access to documentation and patient information, variable remuneration, variable adherence to RVG principles, and personal indemnity cover for public patients in private.

The current rates of remuneration range from DVA $34.65/unit to $55/unit for surgical procedures. Unfortunately,

we still see some facilities using a rate slightly above the MBS fee. Rates for gastroenterology and ophthalmology are generally at DVA rates. Inflationary pressures are mounting, and the cost of treating Surgery Connect patients is certainly rising across all areas.

I have subsequently been reassured by Ms Leggett that all providers will be accountable for ensuring all documentation is available to all key personal. Patient selection and suitability will be reviewed with up-to-date assessments by health service prior to being sent to the program. Ms Leggett will be speaking at the State-wide Surgery Coordinators forum on 15th May and presenting these issues.

The ASA will survey Queensland members that participate in Surgery Connect and ask for feedback about any concerns they have. We especially want to hear about poor patient selection, inappropriate referrals, lack of documentation and issues with payments and remuneration.

Queensland Health is reluctant to set guidelines for facilities regarding remuneration, preferring to let facilities negotiate with providers. I encourage you all to work with anaesthetic representatives on medical advisory committees (MAC) and anaesthetic committees to negotiate as contacts come up for renewal.

Workforce Shortages

We were approached to assist with efforts to change Area of Need and District of Workforce Shortage (DWS) restrictions in regional centres. These long-term restrictions on the number of provider numbers in a given location have meant that overseas trained and bonded specialists cannot obtain a provider number to practice as specialists in restricted area unless they are granted a 19AB exemption by the Government. Provider number dilution due to FIFO workers or IMG's that have subsequently moved away from the area has contributed to the problem.

Local communities rely on anaesthetic services for supporting medical, surgical and procedural support and having sufficient anaesthetists ensures efficient service delivery and supports the welfare of the anaesthetists and high on call rotations. Regional centres that are particularly affected are Bundaberg, Gladstone, Rockhampton and Mackay.

Discussions with local ASA and non-ASA members in these areas have highlighted a serious crisis in these regions and we are very concerned for the welfare of our colleagues and their patients. In our meeting with the Assistant Minister, we discussed our concerns for the anaesthetist's welfare, requested a change to the funding model used in these centres (from inner regional to outer regional funding such as for Cairns and Townsville).

Finally, we also encouraged a whole of community approach to each regional centre anaesthetic services such that state and federal governments resolve to remove DWS restrictions on IMG's employed by the public and encourage VMO or appropriate SMO contracts for private specialists to boost public hospital workforces in those regions.

2023 Queensland ACE Meeting

The 2023 Queensland ACE Meeting 'Everyday topics from the tropics', will be held at the Shangri-La The Marina in Cairns, Queensland on 15-16 July, 2023. Registrations are now open and I look forward to the meeting.

The AGM of the Queensland Committee of Management will take place on Saturday 15th July.

Credentialling at Private Facilities

Over recent years the requirements for credentialling in private facilities has become an increasingly challenging process. The Australian Commission on Safety and Quality in Healthcare provides guidelines to Health Service organisations and as a consequence, these organisations must implement credentialling process that complies with the guidelines for governance. Lately we have seen requests for identity checks, immunisation evidence and mandatory training requirements over and above the usual requests for scope of practice, CPD, indemnity and references.

It is usually the head offices of the organisations that determine the credentialling requirements for the local facilities. When concerns are raised by members we ask for justification for the process and reinforce requirements for confidentiality and identity security.

Stay up to date

Keep an eye out for latest news and emails regarding workshops and events for both trainees and specialists. I am always happy to hear from members and would encourage all non-members to join the ASA. As you can see there is a lot happening in Queensland. Look out for the Surgery Connect survey, and get in touch if you want to raise any issue with the ASA.

South Australia

Dr Tim Donaldson

Chair of the South Australian Committee of Management

REPRESENT

We continue to work alongside the national committee to push for safe and fiscally responsible anaesthetic care. Locally our team is working closely with AMA and Return to Work SA to ensure that Workcover rates are in line with the rest of the country. We will keep you informed of progress

SUPPORT

Our annual bright young things wellbeing/networking event organised by Dr Bec Madigan and Dr Cheryl Chooi is set to continue on Saturday 21st of October. Save the date.

I encourage all new graduates to attend to unite and support each other as you begin to build your careers.

EDUCATE

Excellent Part Zero and Part Three courses were run by our trainee reps Julia Rouse and Bec Madigan, with great attendance and feedback.

The state committee is here to support you and your practice, please don't hesitate to reach out to myself or any of the committee members.

Western Australia

Dr David Kingsbury

Chair of the Western Australian Committee of Management

The ASA was proud to be able to support 'The Volatiles,' a band formed by five of our anaesthetists who competed in, and went on to win, the charity Corporate Battle of the Bands competition here Perth. Congratulations to Dr Alex Wycherley, Dr Gary Devine, Dr Andy Lamb, Dr Robbie Brogan and Dr Mike Nash for representing the diverse talents of our anaesthetic community.

Over the last few months we have been actively involved in facilitating fair outcomes for our anaesthetic colleagues in on call discussions with private hospitals, reviewing the impact of managed care systems, and welcoming new members to the WA Management Committee.

A number of private hospitals in Perth have been reviewing the structure of their emergency and after hours on call systems, including the obligations placed on anaesthetists as part of their accreditation at the hospitals. The ASA WA Committee has been active in facilitating discussions between hospitals and accredited specialists, to ensure fair outcomes for anaesthetists involved.

Managed care like systems have started to raise their head in WA over the last 12 months. We have seen the introduction of a number of new proposals from insurers and funders into the market recently. The ASA's professional and economics advisory committees have been very active in reviewing these proposals, and assisting members with understanding where they might impact upon their practice.

We have seen an expansion in the number of members of the WA Management Committee in the last 12 months, with the addition of some fantastic advocates into the group.

We experienced very high levels of turnout for our educational and social events at the end of last year and into the beginning of this year, with a fantastic breath of representation at these events from trainees, to fellows and retired colleagues.

THE VOLATILES

Australian Capital Territory

Dr Vida Viliunas

Chair of the ACT Committee of Management

The Economic Issues Advisory Committee has been actively involved both locally and nationally to maintain strong advocacy for the indexation of DVA payments, as well as promoting the importance of public and private work and fair remuneration for staff specialists. It is evident that a significant amount of public work is currently being undertaken in the private sector, aiming to alleviate the strain on waiting lists caused by the aftermath of COVID-19 and the unfortunate fire incident at Calvary Hospital.

Amidst the initial challenges and distractions encountered during the introductory phases, the Department of Health and Rehabilitation (DHR) has established itself as a permanent presence. As time progresses, the overall experience within the system is gradually improving, despite occasional interruptions to patient care.

Drs. Girish Palnitkar and Adam Eslick have effectively represented anaesthetists' interests at the Voluntary Assisted Dying discussions, ensuring voices are heard and considered.

The AMA (Australian Medical Association) hospital report card has recently revealed suboptimal ratings for ACT's public hospitals, indicating there are areas in need of improvement. This report serves as a valuable resource for identifying key areas of concern and potential areas for progress to be made.

In the past month of May, ASA CEO Matt Fisher visited Canberra for important meetings with health bureaucrats from both the territory and national levels.

HISTORY OF ANAESTHESIA SIG WORKSHOP: ANZCA ASM

On Friday fifth May, the History of Anaesthesia, Library Museum and Archives (HALMA) welcomed visitors from the Australian and New Zealand College of Anaesthetists (ANZCA) Annual Scientific Meeting (ASM) to an offsite workshop, hosted at the ASA headquarters. 'History of Anaesthesia SIG: Staying connected!' is the first workshop and seminar held at the new location for the Harry Daly Museum and Richard Bailey Library. Participants toured the museum and viewed rare books from the library.

The four short presentations covered a range of topics, including:

- Recording department histories by Dr Michael Cooper AM. Highlighting the fact that many major anaesthetic departments around Australia and New Zealand are now 60 – 70 years old and are ripe for recording the history of the department, including notable past staff and significant milestones. Dr Cooper mentioned publishing formal and/or informal histories of your department, conducting oral history projects and organising your department's cupboard or similar of vintage and/or one-off machines, equipment and textbooks gathered over the years.
- What is the purpose of your collection? By Monica Cronin, Curator at the Geoffrey Kaye Museum. A comprehensive introduction to outlining your collection policy (why, what and how are you collecting items) and touching on basic principles of object handling and preservation.
- Cataloguing, digitisation and archives by Kate Pentecost, ASA Museum Curator and Librarian. A quick overview with a technical slant on how to record your collection: how to number items, whether to use a database or spreadsheet to track your collection, taxonomies, photography of items and what to keep in an archive (no sticky tape, no staples, no paperclips, no scrapbooks).
- How to do oral history by Dr Christine Ball AM. Dr Ball has been doing oral histories for the Geoffrey Kaye Museum for over 20 years and offered some sage advice on interview techniques, recording basics and copyright concerns.

We hope visitors are eager to record the histories of their workplaces, either in written or oral history forms, and also that participants gained skills to approach the discovery and preservation of the history of anaesthesia.

Also in attendance was Dr Graham Grant, inventor of the Grant Humidifier – which the Harry Daly Museum has two of in its collection.

Dr Grant originally trained as a mechanical engineer before moving into medicine and specialising in anaesthesia. Dr Grant is a spritely 94-year-old and talked with visitors about two of his inventions:

A prototype for a neonatal/paediatric ventilator, designed and built by him in 1972. The mechanisms and valves still work, and this rare item garnered much interest from the visitors, who spoke with Graham at length.

The Grant Humidifier – another original prototype, designed with a unique electrically heated hose system and reliable temperature sensors to save the doctor/technician time and reduce the need too constantly adjust the temperature controls.

His presence on the day underscored the unique items worthy of preserving, symbolising the history of anaesthesia in Australia, and representative of how often Australian and New Zealand anaesthetists have contributed to improving patient care and outcomes.

Mark your diary: NSW History Week 1 - 9 September 2023 'Voices from the past'

History Week is the annual, state-wide celebration of History organised by the History Council of New South Wales.

Initiated by the HCNSW in 1997, History Week is a fantastic opportunity for member organisations, large and small, throughout NSW to engage and educate the community about the vitality, diversity and meaning of History and its practice.

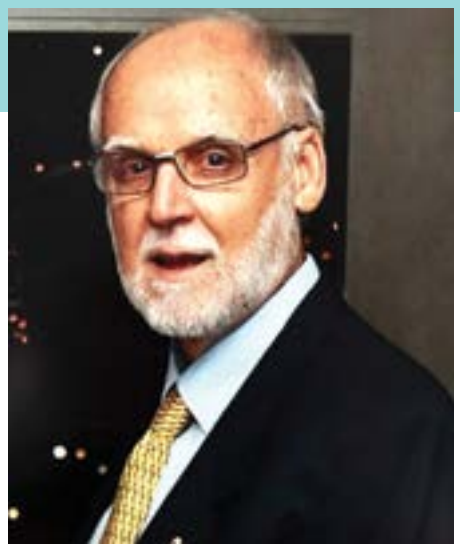
Kate Pentecost

ASA Curator

ASSOCIATE PROFESSOR VICTOR IAN CALLANAN

AM MBBS FANZCA FCICM FFPMANZCA FACTM DIPDHM

1942-2023



Vic Callanan passed away in Townsville on the fourth of Feb 2023. It was perhaps fitting that around the time of his death, Townsville, his home for most of his professional life, was lashed by a spectacular tropical storm.

An accomplished and extraordinarily respected clinician, organiser and teacher, Vic made huge contributions to medicine in the fields of anaesthetics, intensive care, hyperbaric medicine, pain medicine and resuscitation, and to the North Queensland community more broadly.

Vic was born in Lismore on 22nd May 1942, his mother having been moved from Brisbane at the height of the threat of Japanese invasion. They returned to Queensland two years later, and Vic essentially remained a proud Queenslander for the rest of his life.

After attending the Brisbane Grammar School for his secondary education, Vic studied medicine at the University of Queensland, graduating in 1965. He worked as an intern at the Royal Brisbane hospital before becoming the medical superintendent of Home Hill hospital for four years, which was a requirement to repay his scholarship to the Queensland Government.

Vic moved back to Brisbane in 1971, spending two years as an anaesthetic registrar at the Mater hospital before moving to Sydney for another two years at the St Vincent's hospital undertaking further training in anaesthesia and intensive care.

Vic returned to the north in 1975, invited to take up the position as Director of Anaesthetics and establish the anaesthetic department at Townsville Hospital. He essentially built the intensive care unit from scratch, and over the next few years founded the pain service and the hyperbaric medicine unit. He remained Director of Anaesthesia until 2011. His aptitude for and love of hands-on clinical work and clinical mentoring were clear until he retired in 2016.

Vic was a driving force in every aspect of improving medical services in North Queensland. He was central to the expansion of the Townsville General Hospital, constantly pushing for improvements and establishment of tertiary services, cardiac surgery and oncology being standout examples. He was a passionate advocate of the relocation of the Townsville Hospital to the Douglas campus, and spent countless hours helping to make it happen. He was also part of the steering committee to establish a medical school at James Cook University.

Vic's professional interests were varied and far reaching. He was an expert in the management of marine stings, and many of the preventive and treatment strategies seen in the north are in large part due to Vic.

He was president of the Australian Resuscitation Council and a member of the International Liaison Committee on Resuscitation, constantly advancing the role of CPR in the community.

He was heavily involved in College affairs including as an examiner, regional committee member and the initial perioperative medicine committee. He was medical advisor to Surf Lifesaving Queensland, Queensland Ambulance, and the Anton Breinl Centre of James Cook University.

Vic received many accolades throughout his life, including the Renton prize for the primary examination, the Australian Resuscitation Council Roll of Honour, the ARC Medal, the ANZCA Citation and in 2005 the Member of the Order of Australia.

All of his achievements he accomplished were done with the steadfast support of his devoted wife, Doreen.

While undertaking his many professional achievements Vic maintained a love of music, especially Italian opera, and was a skilled wood craftsman. His deteriorating health in later life limited his ability to pursue these interests, a situation that he bore with remarkably good grace.

For many of us, Vic's greatest legacy is the profound influence he had on

generations of doctors of every level due to the wonderful example he set.

He had an amazing combination of being incredibly bright, fantastically knowledgeable, had great practical common sense and unparalleled technical skill. He was also incredibly cool under pressure and was empathic and compassionate to staff, patients and their relatives.

Vic was very approachable, ready to offer advice and support colleagues which encouraged even the most junior staff to ask for help. Many did and still remember those conversations to this day. Even after retirement he enjoyed interacting with colleagues and still many insights were gained over a coffee with Vic.

Vic is survived by his wife Doreen, his loving extended family, and a legacy of clinical and personal excellence.

He helped guide the professional careers of countless anaesthetists and intensivists throughout Australia. We have truly stood on the shoulders of a giant and are forever in his debt.

Vale Vic

Chris Butler
MBBS, Dip DHM, FANZCA, MPH&TM, Cert DHM, PGDipEcho

Senior staff specialist
Department of Anaesthesia
Townsville University Hospital

Michael Corkeron
CSC MBBS (Hons) FANZCA FCICM Grad Cert Health Management

Senior staff specialist
Departments of Anaesthesia and Intensive Care
Townsville University Hospital

Brett Segal BSc (Hons), MBBS (Hons), FANZCA

Senior visiting specialist
Department of Anaesthesia
Townsville University Hospital

ASA members-for-members

Are you interested in becoming a trained peer support facilitator? *Or looking for peer support?*

ELIGIBLE FOR CPD KNOWLEDGE & SKILLS HOURS

The time taken for peer support continuing professional development is eligible as a Knowledge and Skills activity.

Peer support is a way of providing emotional and wellbeing assistance where both the facilitator and participant are equals.

Our peer support facilitators are Anaesthetists ASA members trained by expert psychiatrists from hand-n-hand (handnhand.org.au) and they are ready to connect and share similar experiences among colleagues!

Benefits:

- One to one or group support available
- Meet as often or as little as you like, at times that suit your schedule
- Opt-in and opt-out anytime
- Involves no clinical psychiatric treatment
- Supported by evidence as a pre-clinical mental health intervention.

We welcome you to contact us.

Dr Lan-Hoa Lê,
ASA Wellbeing Committee Chair

We welcome you to contact us

ASApeersupport@asa.org.au

DR BRIAN JAMES POLLARD 1925-2023

Brian Pollard, who died on 23 March 2023, was an outstanding anaesthetist who made significant and long-standing contributions to anaesthesia in Australia, as well as being one of the pioneers of Palliative Care.

Brian Pollard, who died on 23 March 2023, was an outstanding anaesthetist who made significant and long-standing contributions to anaesthesia in Australia, as well as being one of the pioneers of Palliative Care. He will be remembered by those he taught and worked with, as well by his family and many friends as a gentleman who was quietly spoken, courteous to all, with however a devilish wit and dry sense of humour. Whilst he may be regarded as one of the giants of our profession, he was only 5'4" (160cm) tall and known to all his colleagues as 'Polly'.

Brian was born in Sydney and grew up in Willoughby. He was an only child, learning to be self-sufficient with his books as his best companions. Fortunately, his grandfather worked for the railways in various country towns allowing his holidays to be spent with cats, dogs, horses, and cows, with the ultimate fun for a city kid, having steam trains roaring past with their whistles sounding for him! His schooling was unorthodox, in not starting school until seven years of age. Once started, he progressed rapidly to the Marist Brothers at Mosman, then Darlinghurst before onto the Christian Brothers Lewisham. He finally achieved, after three attempts, excellent results to everyone's astonishment (except Brian himself), enabling him to embark on his medical career.

At the University of Sydney, he was spurred on by discovering that he could do well if he tried – and do well he did! He was third in first year; an anatomy prosector in second year, graduating in 1950 with Honours Class II. He had relaxed somewhat in the clinical years, playing tennis and meeting in his final year a young lady, Carmel O'Sullivan, a student at the Conservatorium of Music-Opera, who became his wife a year later. Brian was also an amateur comic, with those who knew him later in life, most surprised to learn of his alter ego Dr Schnivelpus, who with hat, black moustache, spectacles, and a funny accent, won a number of amateur hours, as well as going on to perform at various clubs.

After graduation and a year as an intern at Sydney Hospital, he transferred to Royal Newcastle Hospital (RNH), intending to become a GP. A further year as a Medical Registrar helped his decision to become an anaesthetist, as Resident Medical Officers gave most of the anaesthetics both routine and urgent. The switch was aided by the Director of Anaesthesia Ivan Schalit. Brian then commenced at St Vincent's Hospital (SVH) in October 1953, the hospital's second ever Registrar. However, before his leaving RNH, that same Director of Anaesthesia suffered acute appendicitis requiring urgent surgery. And so it came to pass that Brian, ably assisted by Warren Gunner (soon to appear on the SVH scene) managed a rather stressful situation described by Brian in his words, "anaesthesia by committee". About 18 months after he started at SVH another Brian appeared, Brian Dwyer, as the Department's

Whilst in California, he discovered a method of fee-setting for private patients … This was the beginning of the Relative Value Guide (RVG), though it would be another 30 years before the Australian government accepted its validity.

first Director after his training with Sir Robert Macintosh at Oxford. Intriguingly, a photograph of Mosman Marist 'Intermediate 1939' shows the two Brians, each to become a future President of the ASA, Dwyer in 1965-66 and Pollard in 1974-76.

On obtaining his Fellowship in 1956, Brian his asked to join a large group of anaesthetists in private practice at Elizabeth Bay. As many of this group at some stage of their careers held office in either the Society or the Faculty of Anaesthetists both at State and Federal levels, it was not surprising to find this new member as the next State Secretary, becoming Chairman in 1968 prior to his Federal Presidency as noted above. Building his practice was not easy in the late 1950s and 1960s but Brian succeeded, based on his expertise and his personality. He worked with some of the leading surgeons in Sydney, especially in major cancer, ear, nose, and throat (ENT), and neurosurgery.

In the latter instance, his successful techniques in anaesthetising patients with tic doloureux having cranial nerve division in the sitting position, with incremental thiopentone and a Guedal airway, would seem incredible today. Another of his surgeons (ENT) became involved in the early microsurgery of the larynx, particularly involving tumours. As standard endotracheal tubes (ETT) in use at the time could prove troublesome, he devised his special double-diametered 'Pollard Tube' which became standard use for microlaryngoscopy of the larynx, particularly involving tumours. He also gave anaesthetics for ECTs at Mount St. Margarets in Ryde, though this provided little financial reward, it came to the fore in Brian and Carmel's later life, after raising a loving and caring family of three boys and three girls.

In 1964, he had his first overseas trip, more work than holiday, visiting anaesthesia departments in both the USA and UK. Whilst in California, he discovered a method of fee-setting for private patients, where both duration and complexity of the anaesthetic was taken into account. This was the beginning of the Relative Value Guide (RVG), though it would be another 30 years before the Australian government accepted its validity. Brian spent countless hours fine-tuning this project as did many other ASA Presidents and committee members.

Another major contribution Brian made was at an ASA meeting in Sydney, 'A Chair of Anaesthesia'. This caused much concern as an agenda item, all forgiven when it was realised that it was not an individual but an object. A comfortable chair in the operating theatre, with wheels, a back and a footrest instead of the usual 3-legged stool. Brian pointed out that its only problem was that it was so frequently stolen by a surgeon!

In 1972 Brian's career took a major new path when he became the new Director at Concord Repat Hospital after the retirement of his good friend Kevin Byers. Under his guidance over the next decade, the Department expanded until it became one of the most sought-after places in Sydney for registrar training. Although having to give up private practice, he was still involved in clinical work at Concord. It was during this period that, along with Frank Junius, they made a discovery that was to save many lives worldwide, in recognising and publishing that oesophageal intubation could mimic breath sounds and chest expansion as per normal intubation.

On a visit to the UK in 1980, Brian visited St Christopher's Hospice in London. He was so impressed with their attitude to the dying patient, that on his return to Concord, after discussion with his colleagues both anaesthetic and other disciplines plus with DVA approval, he initiated a Palliative care Unit, the first in NSW. Little did he know of the tragedy that lay ahead, when two years later his youngest child was diagnosed with a bone cancer which would cause her death nine months later. Brian used his newly acquired skills to care for Lisa at home with Carmel and family and friends. In Brian's words:

"I had been led to a new career which I had not sought, that prepared me to do what was needed for her, better than anybody I knew."

He was awarded a Papal Knighthood in 1990 and a Commonwealth Government Centenary Medal in 2003. Brian and Carmel continued to travel overseas in retirement before moving to a retirement village in the former Mount Saint Margaret's Hospital that Brian knew so well. He cared for Carmel during the deterioration of her health until she died. He continued to live there until his own demise. Our thoughts and prayers go to his family.

Vale Brennum, requiescat in pace!

Dr Joe McGuinness
OAM RFD
Dr Richard J Bailey

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