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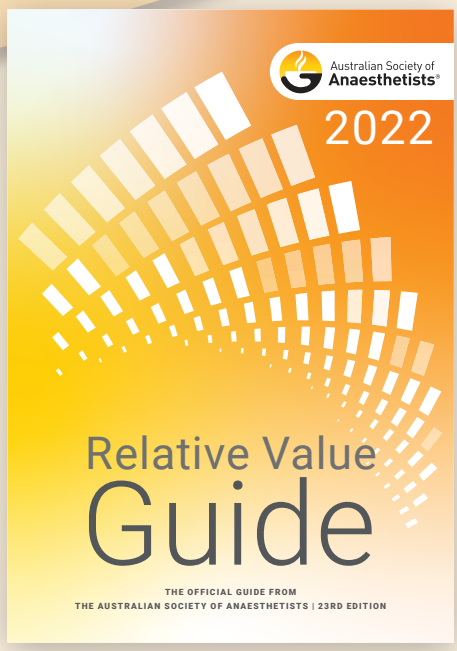

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New improved RVG App now available for iOS

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

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

June issue: submission by April 15.

Image and manuscript specifications can be provided upon request.

Australian Society of Anaesthetists™

A MEMBER SOCIETY OF THE WFSA

FROM THE ASA PRESIDENT

ANDREW MILLER
PRESIDENT OF THE ASA

COVID related resource gathering for ASA Members - Survey results

In the storm of data and opinion generated by a pandemic it can be difficult to find timely anaesthesia specific information about a changing practice environment.

The ASA set out on a mission under the guidance of Dr Suzi Nou in 2020 to make life easier for members by coalescing resources of interest into one location, so that anaesthetists can avoid reinventing the wheel and having to learn for themselves that which our colleagues have already determined.

There are terrific resources already available via the ASA website and we now aim to refresh, adapt and augment the information responding to the results of the survey.

Anaesthetists, as perioperative physicians who often trouble shoot logistics problems throughout healthcare, who interact with every part of the system, and who have critical care and risk management expertise are ideally placed to coordinate solutions to resource allocation and clinical problems, drawing on our usual network of contacts.

In order of the priority assigned by over 800 respondents to the survey, the portal contains the current topics of most interest to members, and the resources that may help from within our current library, government and educational authorities, as well as new sources. Our website, where the further information is held will be updated constantly and expanded as required.

It is likely that we will be affected for some time yet, given the potential for a long tail of BA.2 Omicron, and another variant after that. The equally incessant pressure on the profession in an industrial and workplace sense is foremost also in our minds. We are aware that some will try to take advantage of a crisis and achieve goals that are in conflict with maintaining the central role and effectiveness of medical anaesthesia providers.

The home for the updated version of this table with the live links and a wide range of other information is www.asa.org.au/covid-19-updates-2/

If you are aware of a resource we should add - please let us know.

The ASA remains dedicated to supporting,representing and educating anaesthetists. It is what we do.

Dr Andrew Miller

MBBS LLB(Hons) FANZCA
FACLM FAICD FAMA

Contact

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

ORDER OF THE POLAR STAR OF MONGOLIA

CONGRATULATIONS DR AMANDA BARIC

ODEC member Dr Amanda Baric was recently awarded the Order of the Polar Star by the Ambassador of Mongolia to Australia, D.Davaasuren in recognition of her contribution to teaching and training in the Mongolian Healthcare sector.

The Order of the Polar Star is a state award of Mongolia; it is the highest civilian award Mongolia can present to a foreign citizen, and previous high profile recipients include Barack Obama and Hillary Clinton.

Dr Baric is an Anaesthetist in the Department of Anaesthesia and Perioperative Medicine at Northern Health in Melbourne, and has had an association with Anaesthesia education in Mongolia since 2006.

The ASA signed a Memorandum of Understanding with the Mongolian Government in 2008 to assist with developing anaesthesia training, and with the support of the Mongolia Society of Anaesthetists (MSA) delivered an 18-month training program in 2009.

Dr Baric, along with Dr David Pescod and a large number of Australian anaesthetists were instrumental in developing the curriculum in collaboration with the MSA, and the ASA/MSA partnership continues to build to this day, with a number of active education projects underway.

Dr Baric has also been involved with annual seminars and updates in Mongolia, including the 'Emergencies in Anaesthesia' series over the past 15 years, and whilst directly involved herself, has also facilitated opportunities for medical and nursing colleagues from Emergency Medicine and Obstetrics to build relationships and training opportunities with their Mongolian counterparts.

More recently, Dr Baric has been involved in work focussed on scholarship, academia and leadership, including support for audit, quality improvement and professionalism.

Her most recent visit to Ulaanbaatar was in 2018 to introduce the SAFE Obstetrics Course; unfortunately COVID has prevented her and many others from visiting in the last two years, but virtual contact has been maintained and plans are in place when the next opportunity arises.

On behalf of the ASA ODEC I would like to warmly congratulate Dr Baric being awarded the Order of the Polar Star of Mongolia.

Dr Chris Bowden
ODEC Chair

Dr Amanda Baric has been awarded the high state honor of Mongolia, Order of the Polar Star, in recognition of her contribution to Mongolia's healthcare sector. Ambassador of Mongolia to Australia D.Davaasuren presented the award on December 3.

FROM THE CEO

MARK CARMICHAEL,
CEO OF THE ASA

Welcome to 2022! Christmas for most of us is probably a distant memory, as is New Year and by the time this article is being read it will almost be Easter! After the disruption of 2020 and 2021 due to the COVID-19 pandemic no doubt we had all hoped for an improvement in 2022. When preparing this article in late January there were signs of case stabilisation in some parts of Australia, while in others it looked like the COVID-19 virus was about to break free.

One thing likely to have occurred is that the landscape of today will most likely be dramatically different to that of late January, hopefully for the better. One can only hope that the very high vaccination levels achieved within the community will, or have been supported by equally high levels of booster shots across the population providing a high level of protection for our society.

Ideally by the time this edition is printed the numbers of hospitalisations and deaths associated with COVID-19 will be declining.

It is no coincidence that this edition of Australian Anaesthetist has as its focus resources and support ideas associated with managing and surviving the COVID world, especially in the workplace. I believe all members will find this material of great benefit.

On a very positive note the Society, as I reported in the last edition, has a new home, located in Naremburn, a lower north shore suburb of Sydney. Staff at present are working using a hybrid model of coming into the office three days per week and continuing to work remotely on the other two. This is staggered on most days so only half the team are in on most days. It is aimed that this gradual return provides staff with the opportunity to re-establish the work relationships so necessary to keeping things going, yet at the same time done in a way that allows staff to be safe.

I do thank the ASA staff who have all been working remotely since July of last year, not to mention the March – December period in 2020! It is not easy trying to do your work, in some cases home school your children, cope with technology challenges and still deliver. I do believe that staff have under very difficult circumstances done a wonderful job in ensuring that members needs and the day-to-day operations of the Society have been met.

Membership is the cornerstone of the Society. All of you will have received your 2021/22 ASA membership renewal notice, and it is pleasing to note that the renewal levels to date are once again very high. Thank you to those who have already renewed, while I encourage those who have not had the opportunity to return their renewal to do so as soon as possible.

In closing, I would like to say a final thank you and good bye as I will after 10 years be finishing as CEO in May. It has been a pleasure working with you all and I hope I have assisted you all in some small way. Wishing you, the Society, and my successor all the best.

Mark Carmichael

Contact:

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

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PUBLIC-IN-PRIVATE SURGERY IN THE AGE OF COVID

DR PETER WATERHOUSE
CHAIR PIAC

Community transmission of COVID-19 is now well established in most Australian states. Public and private hospitals have been impacted not only by the need to treat severe COVID infection, but also by workforce shortages.

Elective surgery throughput has been reduced and there is a growing backlog of work, both public and private.

State governments have responded to the buildup of elective public work by attempting to have some of it carried out in private hospitals. This is a challenging exercise for several reasons:

Clinical risks:

Many aspects of traditional private practice which promote safety are disrupted in PIP. Patient selection and pre-assessment, access to clinical notes and the composition of the peri-operative team are important factors for the safe passage of patients through an episode of care. Contingencies for escalation of care are also likely to differ between public and private patients.

System design:

Earlier PIP schemes resembled traditional private practice, with state governments simply assuming the role of insurer. Recently state governments have favoured a bundled model, transferring administrative responsibility and financial risk to private hospitals. The hospitals in turn must handle payment to participating doctors.

Lack of appeal:

PIP is both clinically and administratively challenging, compared with traditional private practice. Hospitals take on considerable financial risk, and doctors face extra clinical challenges accompanied by reduced control over remuneration. These factors diminish the appeal of PIP surgery. As conditions favour the resumption of business as usual in private hospital practice, it may be difficult to find capacity for PIP.

Remuneration:

There are two broad categories for remuneration of anaesthetists carrying out PIP surgery. A sessional model based on public hospital Visiting Medical Officer arrangements is appropriate for complicated surgery with slow turnover, and extended anaesthetic roles such as intensive care. Fee-for-service billing based on the Relative Value Guide would be suitable for efficient elective work. The unit value should acknowledge the complexity of the work undertaken. While the Department of Veteran's Affairs rate may suffice for high-turnover endoscopy, this may not be the case for other surgical disciplines. Remember that this work cannot be done without anaesthetists!

Collective negotiation: It is permissible for anaesthetists to negotiate all conditions, including pay, collectively with hospitals and state health departments. The Australian Competition and Consumer Commission requires notification of the intended negotiation by means of a simple application form.

Please refer to the ASA website for documents guiding members dealing with PIP work.

ASA Vic: Guidance regarding list of documents relating to public in private patients to be made available pre-operatively in receiving hospital and to clinicians (anaesthetist/surgeon)

ADMISSIONS

- Previous anaesthetic records (ALL available anaesthetic records, not just the most recent)
- Previous drug charts
- Operative notes
- Discharge summaries inc ICU if applicable

CLINICS

- Pre admission clinic notes inc surgical clinic, anaesthetic clinic, pre admission clinic
- Correspondence from Specialist clinics inc for example endocrinology, oncology, cardiology, neurology where available

ED

- ED notes if relevant: especially initial assessment & discharge note
- Obs chart if recent (within 2 weeks)

INVESTIGATIONS / CARDIOLOGY

- Cardiology investigations esp ECHO, stress tests, ECG
- Pathology: most recent bloods (inc coags, HbA1c, blood gas where available)
- Sleep studies
- Respiratory function tests
- XR/USS relating to the relevant system
- CT/MRI reports
- Pacemaker/AICD documentation if applicable

OTHER

- Advanced Care Directive/Goals of Patient Care if documented
- *the listed documents should be included where available recognising that less complex patients will not have records available from all the above categories
- *Admission questionnaire should be completed on admission according to usual processes for elective cases in each institution

Dr Peter Waterhouse

Congratulations to the following anaesthetists who were awarded honours in the Australia Day Awards

Member of the Order of Australia
Professor Peter Thomas Morley Victoria

Medal of the Order of Australia
Emeritus Professor Laurence Edward Mather – NSW

Medal of the Order of Australia
Dr Deborah Simmons – SA

COVID-19 AND WELLBEING RESOURCES

Proactive wellbeing is a strategic priority of the Society. The ASA COVID-19 Working Group from the beginning ensured that resources target for members wellbeing preparation during the pandemic phases.

ASA has anaesthetists who are also trained counsellors willing to chat with members. Please contact ASA CEO to be put in touch and to discuss subsidies for their services. Easy links to external supports are also located under wellbeing resources, go to www.asa.org.au/welfare-of-anaesthetists-2

Dr. Suzi Nou, past chair of the 'long-lives and healthy workplaces' initiative, faced the onset of the pandemic during her ASA Presidency term. Her clear guidance on 'command, control and communicate' during the crisis still resonates today.

As we transit to an endemic, ASA President, Immediate Past President, State/Territories Chairs and Committee Members continue advocacy for PPE, fit-testing and vaccination. We collate and provide up-to-date COVID-19 resources including timing of elective surgery after COVID-19 infection based on latest living evidence and guidelines. Representing for workplace safety protects clinicians. A safe doctor is a safe patient.

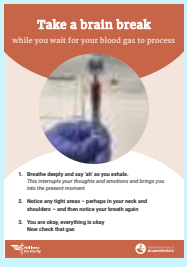
Further support on individual and system factors affecting performance (human factors and wellbeing) forum was well-received at the combined NSC and QLD ACE 2021.

ASA Wellbeing Advocates are committed to host multiple education and networking wellbeing events. We have been facilitating interactive webinars and workshops during COVID-19 for trainees preparing exams and fellow members seeking for an advocate, interested in becoming a wellbeing advocate or requiring support as a wellbeing advocate.

The ASAEd library holds webinar recordings and 'Wellness-on-the-fly' posters for you to share with your hospital(s) educators and wellbeing representatives. To download go to www.asa.org.au/asaeducation/wellness-resources.

Please distribute them and join us to champion wellbeing and workplace safety!

Dr Lan-Hoa Lê
Australian Society of Anaesthetists
Wellbeing Advocates SubCommittee Chair



COVID-RELATED ANAESTHETIC INCIDENTS REPORTED TO WEBAIRS

Dr Stavros Prineas, A/Prof David M. Scott, Dr Yasmin Endlich and Dr Martin Culwick on behalf of the ANZTADC Case Report Writing Group

In January 2022, a search of the webAIRS bi-national anaesthetic incident database was conducted. This included the search terms "COVID", "CV-19", "Masks", "N95", "PPE", "protect", or "pandemic" over the period from 11/3/20 to 14/1/22, yielding 76 reports.

As it is almost two years since the SARS-CoV-2 Virus (COVID) first reached our shores in late January 2020, this number is fewer than might be expected. However, webAIRS is a voluntary de-identified incident reporting system. Data entry is collected via tick boxes and non-mandatory narrative fields. Therefore, the depth of the data analysis depends on the information provided by the reporters.

WebAIRS is not designed to calculate the incidence rates of anaesthetic events, rather its strength resides in the narrative of how and why an incident occurred, and in either bringing attention to the problems identified, or in devising recommendations to prevent future occurrences.

At the time of writing this interim report for the Australian Anaesthetist, of the 76 reports we identified, there were 54 reports directly relevant to the COVID outbreak and 22 additional reports where the mention of COVID seemed incidental.

TABLE 1 – PATIENT FACTORS*

Criteria name	No.
Aerosol infection risk	5
Confirmed COVID positive	5
Difficult airway	8
Language barrier	1
Morbidly obese	8
Not Covid tested	2
Past medical history	17
Patient near-arrest	5
Patient needing cardiopulmonary resuscitation (CPR)	7
Suspected COVID positive	5
Uncooperative patient	1
Total	**79**

Preliminary results 19 Jan 2021

*The number of patient factors will exceed the number of reports as more than one factor per report can be coded. This applies to tables one through to five.

Two cases were included in the 54 reports that were relevant to COVID but did not actually involve COVID cases. However, they did require similar infective precautions to COVID cases and were directly relevant to the management of COVID cases.

The analysers conducted a Bowtie Analysis of these data sets and noted 79 patient factors among the 54 incident reports selected as shown in Table 1. Fifteen patients were suspected COVID (sCOVID) cases and five were COVID +ve. The remainder were non-COVID patients, whose treatment was affected by delays, or by problems arising from the implementation of routine COVID precautions, or incidents that were related to staff injury or exposure. These factors will be addressed in tables that follow which identify Task Factors, Caregiver Factors or System Factors.

A large proportion of the reports involved patients with high anaesthetic risk (such as significant past medical history, difficult airway, patient near arrest, patient needing CPR or morbid obesity). Five cases were judged to have a high risk for aerosol borne infection. In two of these reports, COVID-19 was not the infective agent. The first involved an emergency call to a bronchoscopy suite where a patient with risk of tuberculosis (TB) was having a bronchoscopy. It was only

after providing emergency treatment to the patient that the responders noticed that everyone in the room was wearing N95 masks. A second case involved a patient with an Extended-Spectrum Beta-lactamase (ESBL) infection that required an emergency intubation during anaesthesia. The anaesthetic trolley was in an adjoining room due to infection precautions, which severely hampered the emergency response to this critical situation. These cases were included as they involved latent factors relevant to the management of COVID or sCOVID patients.

TABLE 2 – TASK FACTORS

Criteria name	No.
After hours procedure	2
Anaesthetic trolley placed outside theatre	4
Different equipment due to COVID	3
Emergency procedure	16
Emergency response	4
Inadequate PPE	8
Inadequate pre-op assessment	3
PPE donning	1
PPE inhibiting vision	4
PPE interfering with management	6
Total	**51**

Table 2 shows the 51 task factors that were identified in the Bowtie analysis. A large number involved an emergency procedure (n=16), an emergency response (n=4), or an after-hours procedure (n=2). Problems associated with Personal Protective Equipment (PPE) were noted in nineteen cases: in eight cases PPE was inadequate, PPE donning created a problem in one case, PPE inhibiting vision in four cases, and otherwise interfering with management in a further six. The anaesthetic trolley was outside the theatre in four cases when an emergency arose. Three of the latter cases involved patients treated under COVID precautions while one case involved an ESBL infection. This raises the dilemma of balancing the paring down of the theatre equipment and discardable products to an absolute minimum against the safety of the patient.

TABLE 3 – CAREGIVER FACTORS

Criteria name	No.
Communication	2
COVID hesitancy	2
Failure to alert other staff of COVID +ve status	2
Lack of procedure for managing COVID +ve patients	1
Total	**7**

There were also three cases where different equipment was used as a result of COVID, and a problem arose. In another three cases there was inadequate pre-operative assessment associated with COVID. This was either because they had been seen in the pre-admission clinic but a delay due to COVID meant that either the history, the investigations, or both were out of date, or alternatively they were not seen at all in pre-admission and pre-operative tests that were required had not been performed.

Table 3 shows the Caregiver Factors that were identified. In two cases there were difficulties with communication while wearing PPE. 'COVID hesitancy' was defined as 'pausing indecisively or without resolution due to feelings of uncertainty and/or vulnerability regarding COVID status, protocols and/or management' and was noted in two reports. In two cases, failure to alert other staff of COVID positive status (e.g. through signage or briefing) resulted in emergency responders performing resuscitations unprotected.

Finally, in one case the emergency transfer of a COVID +ve patient was compromised by staff taking a complicated pathway through the hospital to avoid other people, which made care for the severely ill patient difficult.

Table 4 shows the System Factors identified.

COVID appears to have contributed to a large number of delays, as well as departures from usual clinical procedures due to COVID precautions. Problems with PPE included lack of availability of N95 fit testing and inadequate PPE training. The incident occurred in a remote area in four cases, staff expressed a fear of exposure to COVID infection in eight reports which included two cases of actual staff infection. An urgent procedure was delayed whilst waiting for a COVID test result in three cases, and essential

TABLE 4 – SYSTEM FACTORS

Criteria name	No.
Delay due to COVID	14
Departure from usual clinical procedures due to COVID precautions	16
Extra staff during COVID wave	1
Fit testing inadequate	1
Inadequate PPE training	2
Lack of procedure for managing COVID +ve patients	3
Procedure delayed while awaiting COVID test results	3
Remote area	4
Staff fear of infection	7
Staff redepolyed due to COVID	1
Suspected COVID cases in institution	0
Unavailability of essential equipment due to COVID precautions	7
Unavailability of HCW N95 fit testing	2
Unfamiliar with PPE	1
Total	**62**

equipment was not available due to COVID precautions in seven. In one of these cases, a patient in end-stage renal failure (ESRF) requiring an urgent AV fistula repair was stranded in a hospital without a vascular unit due to COVID travel restrictions; the patient suffered significant fluid overload, and when the procedure was finally performed, the patient deteriorated, went into multisystem failure, and did not survive. In another case, staff redeployed due to COVID resulted in an incorrect connection to an epidural infusion by a staff member not familiar with PACU procedures. Another example was the ENT team pausing to don PPE to perform an emergency FONA in a precarious near-CICO event with marginal patient ventilation.

TABLE 5 - IMMEDIATE OUTCOMES

Immediate Outcome	No.
No harm	9
Temporary physiological effects	25
Case cancelled	7
Extra medication (s)	2
Extra investigations(s)	3
Extra procedures(s)	6
Prolonged length of stay	2
Unplanned ICU/HDU admission	14
Transfer to another hospital	1
Respiratory arrest	2
Cardiac arrest	6
Death	4

The immediate outcomes of the anaesthetic incidents are shown in Table 5 above. Although there was no harm apparent in nine cases, there were temporary physiological effects in 25 cases, the case was cancelled in seven cases, extra investigations were required in three cases and extra procedures were required in six cases.

Some of the cases had an immediate outcome associated with high incident severity such as respiratory arrest (n=2), and cardiac arrest (n=6). In one case, a colleague was called to the Emergency Department (ED) to intubate a patient who

presented with severe bronchospasm. The x-ray looked suspicious, so the patient was treated as sCOVID and the intubating team were all in airborne PPE. Intubation was uneventful but shortly afterwards, the patient suffered a tension pneumothorax. By this stage the goggles on both the anaesthetist and anaesthetic nurse had fogged up, significantly hampering resuscitation efforts. The patient suffered a hypoxic arrest, but through timely needle decompression and chest drain insertion, the patient survived with no long-term sequelae.

In a second case, a patient with severe pancreatitis had symptoms for several weeks but was afraid of catching COVID if they left their home, such that by the time they presented to hospital they were septic and very unwell. The patient underwent an emergency endoscopic retrograde cholangiopancreatography (ERCP).On induction they became hypotensive, developed a broad complex tachycardia, and arrested. They were successfully resuscitated, required a prolonged intensive care unit (ICU) admission including a tracheostomy, but suffered no long-term sequelae.

Death ensued in the immediate outcome of four cases. One case involved a patient with a massive haematemesis arising from an aorto-oesophageal fistula not amenable to interventional radiology, whose (ultimately unsuccessful) resuscitation was conducted in full PPE as the patient was sCOVID. The reporter did not comment on whether or how being in full PPE affected the conduct of the resuscitation.

A second case involved an intubated ICU patient with COVID pneumonia requiring an ET tube exchange, which precipitated a tension pneumothorax, cardiac arrest and unsuccessful resuscitation. In this case the reporter cited the particular fragility of the lungs in COVID pneumonia as a contributing factor.

A third case involved the ESBL patient mentioned above, who had multiple severe co-morbidities including severe aortic stenosis and poorly controlled diabetes, who arrested during a foot debridement under regional block, but whose treatment was hampered by the anaesthetic trolley having been removed from the theatre for infection control purposes.

In a fourth case, a patient in their fifties needed an emergency drainage of a submandibular abscess causing airway compromise. The patient had a 5-day history of fevers and chills, so was treated as sCOVID in the absence of a formal PCR result. En route to theatre the patient was struggling for breath and SpO2 was unrecordable. While the team

was donning PPE, the patient became unresponsive and went into hypoxic cardiac arrest. The patient then appeared to have been intubated promptly without obvious difficulty. CPR was commenced but discontinued after 45 minutes.

There was an unplanned intensive care or high dependency care unit (ICU/HDU) in 14 cases, prolonged length of stay in two cases, and transfer to another hospital in one other.

TABLE 6 - FINAL OUTCOME	
Final Outcome	**No.**
Not known	4
Potential hazard	3
Near miss	1
No harm incident	22
Harmful incident	17
Death	7
Total	54

HARM DURATION	
Temporary	14
Permanent	3
Not applicable or not known	37

The final outcomes are shown in Table 6. A 'potential hazard' was defined as a hazard that was identified but a complication did not eventuate in that case (n=3). A 'near-miss' was an incident that did occur but did not reach the patient or staff (n=1). Most of the incidents resulted in no harm (n=22). The authors noted that in some cases the reports were submitted as near misses, whereas an incident did actually reach the patient, but no harm occurred. Harm occurred in seventeen cases (temporary in 14, permanent in three). The outcome was not known, or not applicable, in the remainder (n=37).

Ultimately there were three deaths in addition to the ones noted in the immediate outcomes (n=4), making seven in total. One case involved a patient suffering from ESRF, whose urgent fistula repair was delayed due to COVID travel restrictions. In another case, emergency arthroplasty in a frail elderly patient with a fractured hip was delayed for 24 hours while awaiting COVID clearance. While the procedure proceeded uneventfully, the patient developed an NSTEMI in recovery, and was subsequently palliated. In a third case, another patient with ESRF and multiple cardiac and respiratory co-morbidities requiring insertion of a tunnelled vascath arrested on induction. Resuscitation was hampered by the anaesthetic trolley having been removed from the operating theatre due to COVID precautions. Despite return of spontaneous cardiac output the patient remained unstable and treatment was withdrawn after 24 hours.

Discussion and Recommendations

It is important to remember that it's not just anaesthetists and their co-workers that make anaesthesia safer, but also the organisational and technological context in which they operate. An abundance of College and ASA documents relating to minimum standards in anaesthetising locations serve as testament to this. This analysis outlines multiple reported examples where implementation of COVID precautions (in particular PPE) has interfered with the delivery of standard clinical care. In most of these cases there was no permanent harm; however, many were associated with unplanned ICU admissions, cardiopulmonary arrest, and/or death. Not surprisingly the risk appears to be increased when managing fragile/complex patients. While 'association' and 'cause' are not necessarily the same, and while it is of paramount importance that healthcare workers be protected from exposure, it would seem evident that COVID countermeasures as currently applied across the country are not innocuous to patients. It is therefore not an academic matter to consider how healthcare systems should balance staff safety and patient safety. Interestingly, at the institution of one of the authors (SP) the Emergency Department (where, in the current Delta/Omicron wave, approximately one third of presentations are testing positive) have over the last four months adopted a pared-down PPE protocol (N95 + eyewear + gloves +/- gown) without a single staff member testing positive that can be linked to a patient-mediated exposure (personal communication). It follows that while the 'pre-cautionary principle' remains an important rule-of-thumb, there is an urgent need to replace local fear and conjecture with an evidence-based risk-benefit analysis of COVID/PPE protocols in operating theatre environments, especially where staff triple-vaccination rates approach 100%.

The Degradation of Clinical Environments and Protocols

The broad theme here is that COVID countermeasures may inadvertently lead to degraded clinical environments and protocols in specific ways: lack of readily available equipment/drugs, disorientation, discomfort, impaired visibility, impaired communication etc. These degradations must be proactively mitigated, for while they are mostly inconvenient, they occasionally make procedures very unsafe. In frail, complex patients, failure to compensate may mean the difference between a successful and catastrophic outcome.

There are several ways to manage this. The first is to acknowledge the suboptimal environment in a pre-procedure discussion with the whole team and conduct a verbal walkthrough of the procedure to identify any problem points and how to deal with contingencies. This is more than just a Time-Out Checklist – it's a briefing.

A second approach is the use of checklists as a cognitive aid. In commercial aviation comprehensive pre-flight checklists are standard. What is less well known is that in military aviation there are 'minimums' checklists for emergencies (e.g. six things that must be checked to get a fighter in the air when the base is under attack). A COVID minimum checklist, customised to local conditions, that accounts for degraded theatre environments may be useful – an example is given in Table 7.

With respect to the cases where the standard anaesthetic trolley was placed outside the operating theatre, one practical solution would be to have an emergency plastic grab box (designed and manufactured for easy cleaning) for each type of emergency. For instance, anaphylaxis, cardiac arrest, difficult intubation and so on, each containing a limited number of immediate basics for a first response to these emergencies. This box is not opened unless an emergency arises and if the seal is unopened at the end of the case, then only the exterior of the plastic box requires cleaning.

It is also interesting that only recently have operating theatres been supplied with N95 masks. Prior to COVID, 3-ply (blue) or 4-ply (grey) surgical masks were deemed adequate for cases even where there was a known aerosol risk (TB, ESBL infection etc.).

PHOTOS COURTESY DR MICHELLE HORNE

Towards Standardised Minimally Aerosolising Airway Management Techniques

Staff anxieties (real or imagined) about exposure to COVID-19, lack of familiarity/confidence with PPE, and confusion regarding the COVID status of patients undergoing resuscitation/emergency treatment were featured in a number of reports. The authors advocate the development of standardised techniques for Minimally Aerosolising Airway Management (MAAM), which are destined to become as standard to our training armamentarium, as a Rapid Sequence Induction is for patients with a full stomach.

The current COVID wave might not be the last, and there may be other infectious agents awaiting us in the future. In theory, intubations performed in a particular manner and sequence should only generate minimum amounts of aerosol. A number of national airway societies have published guidelines on this topic, which incorporate elements of both the MAAM concept and the degraded clinical environment concept. There is an interesting comparative analysis of various international protocols including Australia and New Zealand.

Key elements of a MAAM technique for intubation would include:

- As full a pre-oxygenation as clinical circumstances allow, via an anaesthetic face mask with a two-handed 'V-E' grip to provide an optimal mask seal
- Gentle judicious bag-and-mask ventilation (if it cannot be avoided) while maintaining seal
- Deep neuromuscular blockade prior to laryngoscopy
- Allow any positive pressure in the circuit to dissipate before removing mask with filter
- Use of intubating equipment that provides the highest first pass success rate in the hands of the intubator
- Ensure the breathing circuit is closed incorporating a heat and moisture exchange (HME) filter
- Ensure inflation of the endotracheal tube (ETT) cuff before any positive pressure ventilation.

Other elements essential to decrease the risk of contamination of the anaesthetist, the anaesthetic assistant and their working environment include provision for careful disposal of the video laryngoscope blade after laryngoscopy (e.g. not on the patient's chest), and controlled gauze-shielded removal of the bougie (i.e. to prevent flicking secretions).

Attention also needs to be directed to a meticulously planned tracheal extubation, where the risk of aerosol generation (caused by e.g. coughing, increased secretions, suctioning, emergence delirium etc.) is higher than during intubation.

TABLE 7: AN EXAMPLE OF A MINIMUMS CHECKLIST FOR INTUBATION IN A DEGRADED ENVIRONMENT

1. Locality and Timing

a. Is this the BEST place and time to intubate the patient?
   i. Does the patient require an immediate airway?
   ii. Is the patient stable enough to be moved to intensive care unit or operating theatre?
b. Do you have all personnel and equipment available here and now?

2. Personnel (skilled, available, trained as a team)

a. Two anaesthetists
b. One experienced anaesthetic nurse
c. Most appropriately skilled clinician to perform the task – (Need to '**NALE**' it – it's **N**ot **A L**earning **E**xperience)

Attending team in full personal protective equipment (PPE)

Staff not involved in airway management to wait outside the room until airway secured.

3. Team Briefing

a. Identify tasks/degraded elements of the environment
   i. Equipment ii. Drugs
   iii. Staff iv. Communication
b. Discuss how to compensate
c. Practice/discuss sequence of events
d. Ensure properly fitted PPE – buddy check

4. Equipment and Technique

(**'First Go = Best Go':** Choose equipment and technique that offer the highest chance of first pass success with minimal aerosolisation) e.g.

a. Plan A: Video laryngoscopy and bougie
b. Plan B: Supraglottic airway:
   i. Two operator facemask ventilation
   ii. Laryngeal mask
c. Plan C: Emergency front of neck access (FONA)
d. All reasonable contingency drugs (for anaesthesia/securing airway/ respiratory or cardiovascular rescue) need to be available and to hand
e. Safe control and disposal of S8 drugs

5. Post Procedure

a. Safely dispose of/decontaminate all contaminated drugs and equipment
b. Hand over care to ICU team
c. Safely Doff PPE with buddy (using a stepwise read-do checklist)
d. Complete relevant documentation
e. Standard team debrief (what went well, what could be improved)
f. Reset and restock all relevant PPE and equipment

Quantitative studies measuring the aerosol generation of SADs suggest that the routine, uncomplicated use of supraglottic airway device (SAD) does not appear to carry an increased risk of generating aerosol[6], provided there is scrupulous attention to ensure perfect positioning and a leak-free seal. Avoidance of positive pressure ventilation and instead the use of spontaneous ventilation, might further reduce the risk of aerosolization. In addition, SADs offer smoother emergence and less coughing, which in itself is aerosol generating. Keeping the HME filter attached to the SAD during transfers significantly reduces ejection of aerosols and droplets into the clinical environment. Reliable performance of a precise sequence of events requires team practice and rehearsal. Focussed, regular, iterative training of the whole anaesthetic team is recommended. However, it is recognised that in some circumstances complete avoidance of aerosolisation might be impossible, and patient oxygenation takes precedence.

Other Considerations

There were two webAIRS reports associating COVID/sCOVID patients with tension pneumothorax, one of which was fatal. This is consistent with a conspicuous association between respiratory COVID-19 infection and pneumothoraces which is now well established in the literature; [7,8] a high index of suspicion for this differential should be prompted by any COVID/sCOVID patient who deteriorates acutely after intubation, during manual/mechanical IPPV, with deep airway toileting, or after ETT exchange.

In one case, Medical Imaging staff treating a non-COVID patient decided to don airborne PPE as a training exercise, but without giving prior notice to the Medical Emergency Team (MET) on-call. A medical emergency arose during the procedure, resulting in a MET call. The MET arrived and seeing everyone in airborne PPE, set about donning the same, only to be told after some time that this was unnecessary, as the patient was 'not COVID positive', resulting in confusion, stress, and treatment delay.

As noted above, donning full PPE without a clear indication may have compromised ideal patient care prior to (as well as during) the MET call, but aside from this, the authors maintain that training/simulation exercises should not, in general, be contemplated on real patients, and certainly not without due notice given to all team members potentially involved (including the patient), consents elicited and adequate preparations made, and in any case should be promptly abandoned if an actual emergency arises.

Conclusion

In relation to strategy, various aphorisms might be applicable. For instance, it often said that "generals are always fighting the last war", not the next, and that modern healthcare environments worship efficiency (Taylorism, 'scientific management', 'Lean', 'Six-sigma', KPIs, dashboards etc.). However, with ever greater efficiency comes greater inflexibility and fragility when systems come under stress. The COVID-19 pandemic, through its various permutations, has challenged healthcare organisations around the world to be more agile and adaptable. Clear, concise, collaborative, and frequent communication within the speciality and amongst other specialities and stakeholders involved in the care of health care workers and our patients, and work processes that value adaptability as much as efficiency, will be vital in breaking down silos and improving outcomes. This approach is one of the central themes of 'Team of Teams' by Stanley McChrystal[9], where agile thinking and networked communication transformed the US military approach to so-called 'VUCA' (volatile/uncertain/complex/ambiguous) war environments. This communication culture is well understood by medical retrieval teams. Moreover, we live in times where our faculty for critical thinking, and the popular validity not just of science and reason but of the notion of reality itself, are being tested. Professional, mindful, rational analysis of our sources of information is essential to avoid fear, stress, and misguidance; and we need to prepare as best we can for what may come next.

We believe the findings in the webAIRS database provide important insight into some of the challenges Australian and New Zealand anaesthetists have faced during the early stages of the pandemic. We encourage our colleagues to keep reporting, so that we can continue to analyse, share, and learn from each other's experiences, to improve patient care as well as our personal and professional resilience.

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CPD IN THE TIME OF COVID

Dr Michelle Horne
Chair, ASA Victoria

Sometimes Continuing Professional Development (CPD) sounds easier in theory than it is in practice. Conferences and events have been continually cancelled during the last two years. Face-to-face events are unpredictable at best. Some of you have been in theatre less because of lockdowns, so may be feeling more out of touch or despondent at the lack of opportunities for engagement in person. Maybe the end of your CPD triennium is nearing and there are some categories missing points.

For others, you will have loved the changes COVID-19 has brought. More education events accessible than ever before, even without the disruption and expense of travelling. Speakers from overseas are more accessible. Many sessions are now recorded and available afterwards.

The good news is that some of the required CPD can be done face-to-face. Upcoming major conferences will continue to be virtual, allowing you to target your learning, either to interest or required CPD.

For many the most difficult CPD to acquire is the Practice Evaluation section. The requirement is for 100 credits to be accumulated over the triennium. For this component several major activities are required, worth twenty credits each. The remaining credits can be accumulated in smaller quantities. The more straightforward of these credits are departmental or hospital morbidity and mortality (M&M) meetings, at two points an hour, many of which are now virtual. In Victoria we have found these to be quite successful virtually. M&M meetings can also be held as part of a Q&A event with small group discussions. This session has been very popular at the last two Melbourne Winter meetings. The virtual version of this session in 2021 was very well received.

Practice Evaluation: major activities in the time of COVID

Of the four significant activities listed in the practice evaluation section of anaesthetic CPD requirements, some are more straightforward than others. A minimum of two of these activities are required. I would encourage consideration of Peer Review of Practice as a particularly rewarding choice of activities - assuming it is approached with appropriate curiosity and a learning mindset, rather than simply seeing it as a tick box activity.

COVID times, when theatres are less busy and some anaesthetists have less lists than usual, is an ideal moment in time to pursue this learning activity. Simply arrange with a colleague to shadow their list or them yours for a session with follow up reflection, discussion/feedback and paperwork at the end. Over a coffee if you desire. This is logistically easier in an institution at which you both have accreditation and regularly work at. This is an activity that is seemingly easier in the public system. However I have completed this activity in both the public and private hospital systems and found both to be more rewarding than anticipated.

Slowdowns in the private system and free sessions due to elective surgery volume restrictions provides an ideal time to invest in reflective practice. I learnt from one colleague to drop the height of IV paracetamol when infusing it intraoperatively to prevent air entrainment in the line at the patient's level. From another, to reconsider the role of a co-induction in frail patients with both IV and volatile.

In private, a modicum of planning may be involved to coordinate an appropriate session that fitted in with both your schedules. Discuss ahead of time with the surgeon you are working with and theatre staff in the morning. Introduce the observer to your patients. Several of my colleagues have found the activity a welcome change - as consultants most of us do not spend time in theatre with other anaesthetists, or at least not at the same frequency we did as trainees. This means that in the usual course of events we have little cause to reflect on why we do things the way we do and compare and contrast how our colleagues do the same things. This includes theatre flow, patient communication, drug choices, list management etc. I myself found this activity rewarding both as the observer and the observed.

To really maximise the benefit from this activity it would be feasible to identify sub-specialty areas to focus on and seek out a colleague with experience and regular lists in this area. Perhaps you already have a busy practice in this area. Or perhaps you have had less exposure since your trainee days and wish to upskill in preparation for on call shifts where anything goes. For example, paediatrics? Thoracics? Bariatric surgery? Neuroanaesthesia? ENT? A certain area of regional anaesthesia? Opioid-free anaesthesia?

Both recipient and reviewer earn twenty credits. Note that the same activity can be repeated during the triennium, two different activities are not required.

Surveys

Carrying out a survey is another relatively straight forward major Practice Evaluation activity worth twenty credits in one fell swoop - either the Patient Experience survey or multisource feedback. Designing and implementing a patient experience survey may initially sound overwhelming. However several efficient mechanisms exist and feedback from our patients can be very valuable. This is one that is possibly more straightforward in private practice. Some colleagues send a patient survey sent via private rooms, others use google forms or platforms such as Cast (Clinical anaesthesia survey tool). Google forms takes some effort to set up however then is efficient.

Cast is a purpose built survey platform designed for following up patients and can be set up to create an anonymous patient survey compliant with CPD requirements. Cast has a cost per message (from 52c) however no ongoing monthly fees.

The activity involves carrying out a follow up survey of patients, discussion with a colleague/facilitator and some time

Attend the upcoming Melbourne Winter Anaesthetic Meeting July 30–31, 2022 for a small group Q&A session to follow the scientific program: save the date.

spent reflecting on practice. The activity may include some specific aspect of patient care/practice evaluation if you choose. Examples could include patient satisfaction with pre-op information or communication; ponv rates or patient acceptance of pre-operative carbohydrate drinks. Inform the patient preoperatively you will be sending them an electronic survey to fill out. Will you use a paper survey delivered in person or an electronic version delivered via sms or email? Making the survey anonymous improves response rates. Some anaesthetists choose to add a photo of themselves which is well received by patients and helps them identify who is sending them the survey. Cast is available at www.castme.com.au (author has no affiliations). Cast can also be used to send multisource feedback forms to colleagues.

Euroanaesthesia will be held 4–6 June 2022 www.euroanaesthesia2022.org

Knowledge and Skills

Good news: the next two NSCs (National Scientific Congress) will have hybrid elements. Following on from Brisbane 2021, overseas conferences including SOAP and Euroanaesthesia and ANZCA ASM last year, major conferences are set to continue to deliver virtual or hybrid learning opportunities. Euroanaesthesia will be held 4–6 June 2022 www.euroanaesthesia2022.org/

Virtual learning can now include Emergency Responses as well as Knowledge and Skills and small group learning. COVID shutdowns and restrictions have driven adaptation and innovation. At small and large meetings, workshops and lectures are being delivered virtually. For virtual conferences, in your home city or away from home, can you meet with colleagues as your own minihub? Perhaps a beach or mountain retreat and get out of the house to have a conference experience together. Allows protected time, opportunities for discussion, individuals may watch different streams or watch together, and reflect and connect in a more intimate environment.

ASA and NZSA are proud to host the next Scientific Congress in Wellington, New Zealand. Save the date and apply for conference leave (21–24 October 2022).

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ASA and NZSA are proud to host the next Scientific Congress in Wellington, New Zealand. Save the date and apply for conference leave (21–24 October 2022). The format will enable both face to face and virtual engagement by attendees. Prof Levett from Southampton UK, Prof Devereaux from McMaster in Canada and Prof Shafer from Stanford are keynote speakers. www.csc2022.co.nz

PHOTOS COURTESY DR MICHELLE HORNE

NSC 2023 Melbourne

4-8 October 2023 - with a focus on engagement with colleagues and global perspective we will welcome you to come and attend in person or join us online for the virtual event. Perhaps from a minihub/local retreat with colleagues, attending scientific program and workshops virtually.

Led by Associate Professor Laurence Weinberg, the Melbourne organising committee are conjuring up a scintillating program of workshops and scientific content. We are excited to welcome you to the 2023 Congress.

Emergency Responses

Emergency Responses can be completed online at any time via the Major Haemorrhage and Anaphylaxis online learning packages. Additionally did you know that recognition of virtual delivery of objectives for the other CPD emergency response activities has been extended to 1 January 2023? Including ALS and CICO. In addition, COVID-19 airway management has been added as an acceptable Emergency Response. anzca.edu.au/news/cpd-news/updates-to-cpd-emergency-response-standards

Further CPD inspiration

Practice Evaluation: Incident Reporting/ Monitoring. Can be recorded online via WebAIRS (two credits per hour).

Peer groups

In addition to M&M meetings hosted virtually in anaesthetic departments, private hospitals, at ACE meetings or forthcoming NSCs, another option for build your own CPD is to instigate your own peer group. Peer groups are self selected groups of colleagues who meet and discuss relevant aspects of anaesthesia and medical practice and support each other. Peer Groups can run case conferencing or morbidity/ mortality sessions independent of formal departments (two credits per hour).

The requirements for morbidity/mortality meetings are that the meeting should be an interactive format and an attendance record should be kept. Instead of waiting for someone else to instigate, why don't you invite colleagues and form your own Peer Group in 2022 www.libguides.anzca.edu.au/ld.php?content_id=48703566

Other non-conference CPD options

Workplace based assessment of trainees accrues you CPD points under Knowledge and Skills. Or journal reading (one credit per hour, maximum of ten credits per year). Or review of Patient Care Pathways - are you meeting with working groups and writing pathways for COVID management in your hospital?

New MBA CPD rules

The Medical Board of Australia (MBA) will bring in new Registration Standards from 21 January 2023. The main changes for us will be a change to annual cycles rather than the current triennium and a change to a time-based system, with a minimum fifty hours per year in place of the more flexible credits. Doctors will need to meet the requirements of an accredited CPD "Home". Yearly written professional development plans will be required.

At least twenty five hours (fifty per cent of the minimum) will be required to be carried out in activities focused on reviewing performance and measuring outcomes, which may be similar to our current Practice Evaluation category. This will be broken down into five sub categories, with a minimum of five hours required for each category.

MBA are yet to release all the specific details about sub categories and the type of activities which will comply. Trainees will meet the CPD requirements by participating in an accredited specialist training program via their medical college.

They have indicated that a variation from the standard may be granted by CPD Homes of up to twelve months for parental or carer leave, serious illness or other approved circumstances. We anticipate that the new standard will require a similar number of hours spent on practice evaluation per year however this will need to be completed every year. Watch this space!

Dr Michelle Horne


CANADIAN ANESTHESIOLOGISTS' SOCIETY
Mark your calendars!
CAS 2022
ANNUAL MEETING
June 24 - 26
Halifax, NS
Book your time off now!
Registration information and virtual options available soon
Check our website for regular updates
www.cas.ca/annual-meeting

PHOTO COURTESY DR VIDA VILIUNAS

WORKFORCE SUPPLY DURING THE COVID PANDEMIC

"Workforce supply" can be defined as the number of registered specialist anaesthetists. It is accepted that a small percentage of the anaesthesia caseload is met by non-specialists. The number of registered specialists is published quarterly by the Medical Board of Australia (MBA) (medicalboard.gov.au/news/statistics.aspx), accompanied by breakdown by states and territories, and by gender.

The MBA reports that there were 5825 registered specialist anaesthetists as at 30 September 2021. This compares with 5630 and 5339 on the same date in 2020 and 2019 respectively. The net increases of 195 and 291 represent the sum of new Fellows and Specialist International Medical Graduates (SIMGs) minus retirees.

It is apparent then that the workforce has continued to increase including during these first two "COVID years".

What do we know about the workload of the practising specialist anaesthesia workforce? Fortuitously perhaps, the most recent ASA members survey took place at the one time over the last two years when there were no restrictions on clinical practice – that is, during the second quarter of 2021.

At that time, members who responded to the survey told us;

- One third in all locations of practice (capital cities, large non-capital cities, and locations with a population of 10,000 – 100,000) could increase their workloads "without difficulty"
- A further third in all locations could increase their workload "with some difficulty"
- About one quarter in locations with a population of 10,000 – 100,000 were working at full capacity, compared with 20% in major non-capital cities and 16.4% in capital cities.

This can be qualified by the responses of the 80% of responders in capital cities who felt that there was an appropriate or excess number of anaesthetists in their location of practice, decreasing to 65% in large non-capital cities and less than 20% in the smaller centres.

Beyond these findings, analysis of the responses demonstrated clearly that on average older anaesthetists and female anaesthetists worked two sessions (a session being taken as a half-day) less per week than younger anaesthetists and male anaesthetists.

IN SUMMARY

The specialist anaesthesia workforce continues to grow

There would seem to be reserve capacity in all locations of practice

This capacity could meet the workload demand that would be occasioned by absences due to COVID illness or quarantine requirements.

Those groups currently working less than others may be able to increase their workload in the short-term to meet demand due to absences.

Dr James Bradley
Specialty Affairs Adviser

ECONOMIC ISSUES ADVISORY COMMITTEE REPORT

DR MICHAEL LUMSDEN-STEEL
EAC CHAIR

Change in Economic Advisory Committee leadership

Greetings Everyone! I am Dr. Michael Lumsden-Steel the new Chair of the Economic Advisory Committee (EAC). I will be replacing Dr Mark Sinclair who is now the new Vice President of the ASA. Mark has been an invaluable source of knowledge, wisdom and support for the Society over the years and luckily, we get to retain his expertise. He had left quite big shoes to fill but I shall do my best to serve the economic committee and its members in my capacity as the Chair.

I am currently based in Tasmania and have been an active member of the Australian Medical Association (AMA) there as well. I am a specialist anaesthetist with subspecialty interests including regional anaesthesia, obstetric anaesthesia and trauma anaesthesia. I have also been a reserve and permanent air force officer with the Royal Australian Airforce since 1994. Outside the profession, I enjoy spending time with family, exploring the outdoors, cycling and the occasional game of golf.

Some of the issues we will be working on this year include billing time and hours, issues around telehealth, remuneration for public in private and upcoming changes to

Medicare Benefits Schedule (MBS) Telehealth Item Numbers

As members will be now be aware, the MBS telehealth numbers were introduced temporarily to help reduce the risk of community transmission of COVID-19. They were then drastically reduced and essentially limited to video conference services for anaesthetists from 01 Jan 2022. The ASA, together with the AMA and other specialist representative bodies urgently contacted the Department of Health (DoH), and fortunately item 92712 for telephone consultations has now been temporarily reinstated for the period 01 Jan 2022 to 30 June 2022.

For many reasons, continuing effective telehealth for many patients by telephone remains an essential pre-anaesthetic service, and is becoming more acceptable and preferred by patients who are reducing their own movements and exposures to prehospital consultations. In-person consultations have become even more difficult as the result of COVID-19 due to staggered admission times, preadmission screening processes, limited appropriate consultation areas and restrictions on visitors.

The current outpatient MBS telehealth items available for anaesthetists are a replacement for a face-to-face 17615 are 92701 for video conference and 92712 for telephone consultation. The item number 17609 which was used to charge for an outpatient service videoconferencing has been removed as the result of the most recent MBS review. This 17609 was location based (mainly for those in rural/ remote areas outside the 50km radius). This item number can no longer be added to 17610 (brief consultation less than 15 mins) or 17615 (advanced surgery consultation).

The current Inpatient MBS telehealth numbers available for anaesthetists where Public Health Orders prevent a face-to-face in hospital review of admitted patients are telehealth replacements

PIP patients' anaesthetic assessment is often complicated by difficulty contacting and obtaining medical records preoperatively, for example from public hospital electronic medical records or when records appear on lists at short notice. Whilst this may seem like an acceptable occasional arrangement, it does contribute to undermining the value and the integral role and contribution by anaesthetists when enabling PIP, particularly on weekends and after hours

for a face-to-face 17615 are 92702 for video conference and 92713 for telephone consultation. These too were deleted on 1 Jan 2022 but reinstated, through to 30 June 2022. Note that the reinstated telehealth items are not for basic consultation but rather for a more complex specialist consultation to perform anaesthesia on a patient undergoing advanced surgery or who has complex medical problems.

The ASA has been consulting with the Department of Health (DoH) regarding those telehealth numbers and the committee will keep members updated as and when new information comes to light.

Anaesthesia Billing Time and Hours Items

From time to time, members approach the ASA for assistance where anaesthesia claims are rejected by the health funds on the basis of anaesthesia times. In any theatre complex there is a large variation in time reported, and the times entered in the hospital theatre software are very rarely precise.

Common reasons for rejection of a claim arise when there are differences between an anaesthetist's documented start time and that provided by the hospital. On further investigation, it becomes apparent that the start time can be incorrectly recorded as being the time of commencement of anaesthesia on table induction, and not the time that the anaesthetist commenced insertion of IV access. This can be quite complex and potentially require the use of an ultrasound (which is rarely immediately available), or vascular access, or a regional nerve block performed for post-operative analgesia.

Other reasons for rejection of claim could be due to a difference in the recorded anaesthesia end time, usually explained by the appropriate handover to the recovery nurse for complex patients that required continued attendance of the anaesthetist. In situations where it is not possible to handover care to a trained recovery nurse and the anaesthetist must remain in attendance, it is important for the anaesthetist to make a note of this in the anaesthetic record.

The ASA representatives met with DoH Medicare billing and compliance staff in Oct 2021. At that meeting, DoH presented specific data looking at the time units being billed, and where there was overlapping time unit activity and more than 24 hours billed in a 24-hour period. Whilst there may be some explanations for the long duration of hours billed in a 24-hour period, including errors, and emergency cases, it is clear that the DoH is putting anaesthesia time units and hours worked under the microscope.

The ASA representatives took the opportunity to outline the nature of theatre flow from recovery to the anaesthesia waiting bay and commencement of anaesthesia time.

There is often a very short gap between the anaesthesia waiting bay and commencement of anaesthesia. We also noted that it is not possible to bill for separate services for different patients concurrently, each episode must be exclusive and not overlap. The ASA has become aware that there are special circumstances where patients undergoing specific procedures may require more than one episode of anaesthesia within the day admission. Where this is occurring, we are recommending that the anaesthetists keep a record of all start / stop times and an explanation why this is occurring. The ASA will continue working with DoH and present them with the documentation of such cases.

Remuneration for Public In Private (PIP)

The remuneration and process of outsourcing public patients to private hospitals has varied across Australia even before the pandemic. Since the pandemic, the need for public in private (PIP) surgery has further increased as public hospitals struggle to keep public elective surgical waitlists under control and manage elective surgery wait list blow outs. This has put pressure on those working in private practice and the private hospital theatre capacity to undertake PIP work (in hours, after hours and weekends).

Different jurisdictions have paid different RVG unit values, influenced by economic and earning opportunities, local workforce capacity and political incentives to manage public hospital elective wait lists. Unfortunately, it is not rare for the surgeon / proceduralists being paid up to the AMA fee for service OR a significantly higher percentage of the AMA fee than the anaesthetist for each PIP case. There are examples where the anaesthetist is paid a sessional fee and the surgeon a fee for service.

PIP patients' anaesthetic assessment is often complicated by difficulty contacting and obtaining medical records preoperatively, for example from public hospital electronic medical records or when records appear on lists at short notice. Whilst this may seem like an acceptable occasional arrangement, it does contribute to undermining the value and the integral role and contribution by anaesthetists when enabling PIP, particularly on weekends and after hours.

During the pandemic, the impact on private hospital activity has been highly variable around the country. Some anaesthetists have found that their work has remained largely unchanged due to their being limited local lockdowns and restrictions on elective surgery. Whereas in other States, NSW and Victoria in particular, some anaesthetists found their work significantly reduced. Private anaesthetists had to face many challenges as the result of public health directives, hospital and medical supply logistical challenges, shortages and redirection of personal protective equipment (PPE) and consumable supplies, staff sick leave and staff self-isolation, all compounded by short notice patient cancellations.

Some private practicing anaesthetists have been able to gain and/or increase public hours to help with anaesthesia and ICU demands, where this has been requested. Different jurisdictions have had varying approaches to how public elective surgery is maintained. This creates significant challenges and pressures on those anaesthetists that have been unable to work due to public health directives, with many forced without any negotiation to undertake outsourced work at the MBS rate in some jurisdictions. This has not been the case for other medical professionals. The ASA have been advocating for anaesthetists at a State level with varying degrees of response from health jurisdictions. It seems that PIP remuneration has returned to pre-pandemic remuneration levels for most jurisdictions.

However, this is not the case everywhere. I believe it is important to reflect the current economic and pandemic reality in how private practice anaesthetists are renumerated and the treatment needs to be universal across all States. For instance, many private practice anaesthetists have been required (since 2015) to source and arrange their own fit testing of N-95's. Furthermore, with the pandemic private practice anaesthetists are also required to meet testing and isolation requirements or wear personal protective equipment (PPE) at their own cost.

In addition, there has been a lack of consistent annual indexation for private practice anaesthetists.

The MBS RVG is now $20.60 - just 23.7% of the AMA and ASA RVG unit value is $91.00. When calculating what one's RVG unit value should be – anaesthetists should consider an annual review to reflect on what their practice and work arrangements are, and what provisions have to be made to cover the annual inflation costs, practice running costs, medical indemnity costs, income protection insurance, continual professional development, self-funded

annual leave, self-funded sick leave, provisions for isolation leave, and the costs of fit testing and sourcing PPE.

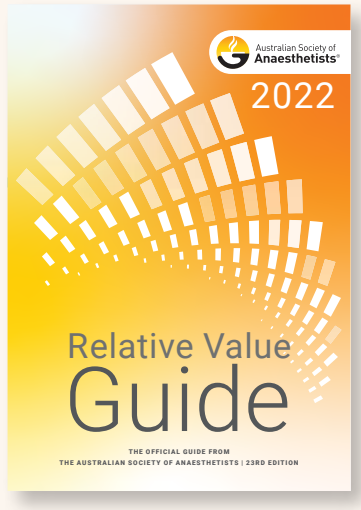
When anaesthetists are considering their RVG unit value for PIP, anaesthetists need to consider the complexity of the patients often being treated, and as well as what they are normally charging.

I am certainly not advocating for anaesthetists to seek payment at RVG unit values above what is usually and reasonably charged.

PIP payment should be based on the RVG, with a fair and reasonable RVG unit value, especially when this work is being done after hours and on weekends. Reduced elective surgery in both public and private will result in increased wait times for public and private patients. If the PIP contracts and RVG values being offered to you grossly undermine your value and the work being done, the ASA may be able to provide some support through your local State ASA Committees and the EAC. Feel free to reach out to us and we will do our best to support you.

The updated ASA RVG for 2022 has been finalised and released to coincide with the MBS updated Anaesthesia item numbers from 1 March 2022.

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



New features also include:

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

For more information, please access the RVG app or visit the ASA member's website .

ANAESTHESIA TRAINING

DR VIDA VILIUNAS

DR KAYLEE JORDAN

Final Exam Practice	SIMG Exam Practice
Hosted by Dr Vida Viliunas and Dr Kaylee Jordan.	Hosted by Dr Vida Viliunas and Dr Kaylee Jordan.
WHEN: Friday 11 March, 2022 TIME: 7:30-8.30pm AEDT via Zoom	WHEN: Friday 18 March, 2022 TIME: 7:30-8.30pm AEDT via Zoom
Primary Exam Practice	**Final Exam Practice**
Hosted by Dr Vida Viliunas and Dr Kaylee Jordan.	Hosted by Dr Vida Viliunas and Dr Kaylee Jordan.
WHEN: Monday 28 March, 2022 TIME: 7:30-8.30pm AEDT via Zoom	WHEN: Friday 8 April, 2022 TIME: 7:30-8.30pm AEDT via Zoom
Primary Exam Practice	**SIMG Exam Practice**
Hosted by Dr Vida Viliunas and Dr Kaylee Jordan.	Hosted by Dr Vida Viliunas and Dr Kaylee Jordan.
WHEN: Monday 11 April, 2022 TIME: 7:30-8.30pm AEDT via Zoom	WHEN: Friday 22 April, 2022 TIME: 7:30-8.30pm AEDT via Zoom
Final Exam Practice	**SIMG Exam Practice**
Hosted by Dr Vida Viliunas and Dr Kaylee Jordan.	Hosted by Dr Vida Viliunas and Dr Kaylee Jordan.
WHEN: Monday 16 May, 2022 TIME: 7:30-8.30pm AEDT via Zoom	WHEN: Friday 27 May, 2022 TIME: 7:30-8.30pm AEDT via Zoom

Exams are a source of stress for trainees. Help is available!

Join the national community of registrars preparing for primary and final exams. The opportunity to see how others are doing is a valuable check on your progress. In COVID times, it is a way to have true fellowhip with other trainees, share resources and the journey to exam success.

We have already started primary and final practice exam sessions (see www.asa.org.au/events/?_sft_category=trainee).

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

Dr Kaylee Jordan
Deputy Chair, ASA Education Committee

TOP TIPS

For written and viva sections

Use formal language. Take the opportunity to eliminate abbreviations and euphemisms (anaesthesia is not"sleep") and practice using precise, formal language every time you answer a question

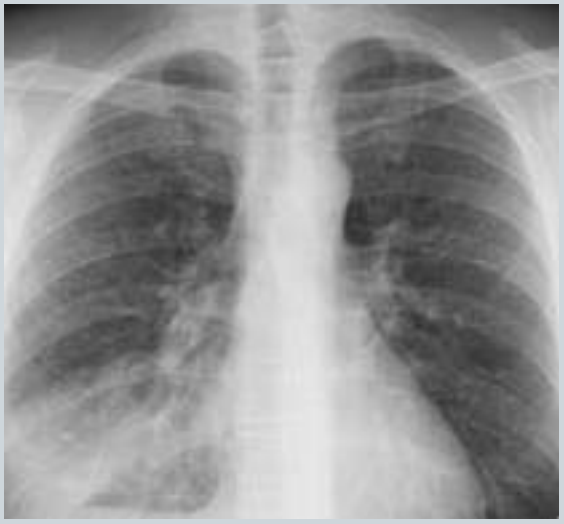
Use a simple construct to organise your thoughts: categorise (physical, chemical, pharmacokinetics, pharmacodynamics or equipment, personnel, landmarks, aids or a physiological systems approach). Think not only about content, but about how the construction of your answer can improve your response and signal that you have knowledge and know how best to communicate it.

Practise the use of formal languange and the use of constructs every time someone asks you a question about anaesthesia - whether it's a neighbour, nurse or consultant.

When asked a question about complications of "x" and how to manage them cries out for a table! Use a construct of physiological systems (CVS, Respiratory, CNS, metabolic) along with their detail (effects on blood pressure, heart rate etc) and the management in the next column.

Aristotle said it better than I ever could: "We are what we repeatedly do. Excellence, then, is not an act, but a habit."

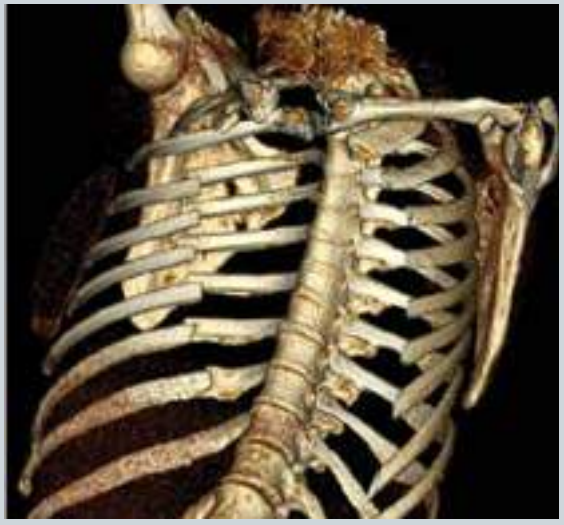
PRACTICE QUESTIONS



You have intubated a patient with respiratory failure due to severe bacterial pneumonia. They remain hypoxaemic with an Sp02 of 80%.

DESCRIBE your immediate actions and JUSTIFY your strategies to improve oxygenation whilst awaiting the patient's retrieval to another hospital for definitive care.

Try a table with the headings 'immediate actions' and 'justification for my strategies'.



LIST the factors associated with increased mortality following rib fractures.

Try a simple construct:

PATIENT FACTORS (age, co-morbidities, drugs, condition on presentation).

FRACTURE FACTORS (multiple ribs, flail, bilateral fractures, associated lung damage).

TRAINING IN TIME OF COVID

DR ALEX COURTNEY
ASA TMG CHAIR

For the specialty trainee, the pandemic has been an uncontrollable source of stress. Anaesthetic trainees are not alone in feeling the disruption to practice, our surgical colleagues have had entire exams cancelled without an option of a second sitting, similar also for our medical colleagues.

Welcome to 2022!

I do hope you managed some rest over the new year period and had some well deserved celebrations with family and friends.

Unfortunately, as I write this, we are in the early days of an Omicron wave in Australia. Hospitalisations are at a pandemic high and climbing, elective surgery in Victoria and New South Wales is at a stand still again and the road ahead appears rocky. This edition of Australian Anaesthetist aims to provide guidance and resources for Anaesthetists around Australia on how to deal with COVID in their local environment. From the trainee perspective, I hope to provide some advice from trainees in NSW and Victoria on how they pushed through the changing landscape of a pandemic wave.

For the specialty trainee, the pandemic has been an uncontrollable source of stress. Anaesthetic trainees are not alone in feeling the disruption to practice, our surgical colleagues have had entire exams cancelled without an option of a second sitting, similar also for our medical colleagues. ICU trainees have been recalled from their anaesthetic rotations to bolster the ICU workforce in times of high demand. For many anaesthetic trainees some anecdotal estimates of greater than 50% reduction in surgical cases compared to years past is now a reality. Locally, we are doing extra shifts in ICU which soon will include emergency departments and medical wards. I have been told of hospitals where anaesthetists are roaming wards offering assistance with patient care, from documenting observations through to IV cannulas and blood draws. On top of all this uncertainty, the ever present 'exam' looms in the distance. I have had an excellent discussion with a VTC co-chair recently, they are doing a lot of work behind the scenes ensuring that trainees voices and concerns are heard by ANZCA.

Colleagues of mine put on a brave face as they step up to assist for short staffed anaesthetics or ICU shifts. But in the sanctity of the registrar office, many are concerned about the impacts of the pandemic on their training, their exam preparation and more importantly their preparation for practice as a provisional fellow and junior consultant in the future. I will be the first to admit that at times over the past two years I have struggled with the pressure of work, study and COVID, I certainly feel more anxious at baseline than in the years prior. But, there are a wealth of resources out there, designed to help us make sense of all the emotions and give us techniques to build strength to face the uncertainty. Please do not forget your friends and family who I'm sure will be there to help you through the difficult days ahead. My department also has a friendly and approachable welfare group who are always happy to listen and support.

RESOURCES THAT I HAVE USED THROUGH THE PAST TWO YEARS:

ASA Welfare of Anaesthetists: asa.org.au/welfare-of-anaesthetists-2/

ANZCA Doctors Health and Wellbeing: anzca.edu.au/fellowship/doctors-health-and-wellbeing-(1)

Dept of Health - Head to Health: headtohealth.gov.au

My friendly GP!

As a final exam candidate, studying for my upcoming exam has been disrupted to say the least. I'm sure we all have our methods for dealing with this disruption and managing to find the time to get some study in. Most I know use the downtime in longer cases or during shifts to get a few MCQ questions done on their phones or revise a few flashcards. Don't forget about the plethora of resources

ASA Sereima Bale Pacific Fellowship Vacancies for 2022

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 for 2022. 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.

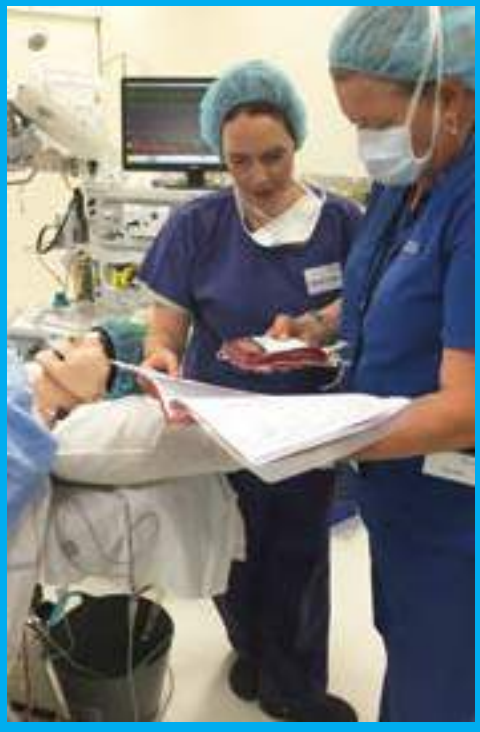
Please contact Justin Burke for further information. Email: j.burke@alfred.org.au

available at the ASA Ed website (asa.org.au/asaeducation/) in particular the Viva Videos by Vida! An excellent resource for new trainees and old trainees alike is the ASA Trainee Member Handbook (available here https://asa.org.au/trainee-membership-benefits-2/), it is a wide ranging repository of information relevant to all stages of anaesthetic training. Please be sure to check the events page for sign ups for the Viva zoom sessions. Other resources I have used: Anki cards (plenty of ANZCA related decks out there), BMJ On Examination (you have to pay, but it's pretty good!) and ATOTW (resources.wfsahq.org/anaesthesia-tutorial-of-the-week/).

On the topic of training disruption, do make sure you are familiar with ANZCA's 'COVID-19 - information for trainees' webpage (anzca.edu.au/education-training/covid-19-trainee-info). Restrictions on face-to-face meetings have certainly hampered training courses like EMST, CICO and scholar role requirements such as Teach a skill'. ANZCA put together guidance around options for moving these requirements to future 'Core units' (e.g. Advanced Training, etc) or alternative approaches to achieving the requirements. Links to forms required to apply are provided. Your local SOT or DSRT are certainly knowledgeable in your options here so please make sure you talk to them. Applications for consideration open 13 weeks prior to rotational change, so you certainly have some time.

For the ITs and BTs out there, I would suggest you put your name down on a waitlist for courses like EMAC, EMST/ATLS early. I have had my name on a waitlist for most Melbourne based 2022 EMST courses since last year, no news yet! As much as procrastination is a skill most people excel at naturally, don't put these applications off until the last minute.

You are not alone. We're all in this together. Make sure you don't suffer in isolation. Talk to your colleagues, your mentors, your friends and family. Take each day as it comes. Take breaks as you need them. Stay safe! We'll all be sipping Piña Colada's on a beach in Fiji again one day.



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

The ASA has 20 CRASH scholarships a year available for members

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

What is CRASH?

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

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

CRASH virtual is accredited for one emergency response.

What is the ASA CRASH Scholarship?

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

Who can apply for an ASA CRASH Course Scholarship?

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

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

How do I apply?

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

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

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

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

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

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

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

ASA RESEARCH GRANTS & SCHOLARSHIPS

Applications are welcome at any time

2022

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

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

FOR FURTHER INFORMATION APPLICATION & FORMS LOG IN TO

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

or contact sdonovan@asa.org.au

MEET YOUR ASA POLICY TEAM

Jason Alam
Policy Manager
Professional Affairs

Katya Sadetskaya
Policy Manager
Economic Affairs

Patrick Gifford
Senior Policy
Administrator

ASA Policy Team

In a very exciting and pivotal time for Australian Healthcare, the Policy team is dedicated to meeting this challenge by strengthening our advocacy efforts as we move through 2022

I'm sure I have met most of you already but if not, my name is Jason Alam and I am the Policy Manager – Professional Affairs, here at the ASA.

I am quickly coming up to celebrating my first year at the ASA and have been extremely lucky to join the Society at such a pivotal and exciting time. I bring with me over 12 years' experience in leading and managing teams dealing with policy issues across multiple Government areas as well as within the Private Sector.

I am also able to utilise both a Bachelor in Medical Science, as well as a Master's in Public Policy and Administration in my role as Policy Manager. Personally, when I am not advocating on your behalf, I would be immersed in any form of cricket you could find, movies, food, fishing, or exploring a new destination!

We have been faced with many unique and unprecedented challenges over the past two years, due mostly to the pandemic, but also due to the imminent threat of managed care encroaching on the Australian market and the issues surrounding Public in Private Hospital's.

In modern times, sound policy-making must often come to grips with numbers. Due to the significant landscape changes, we at the ASA felt it prudent to strengthen our stocks and provide significant coverage across both Professional and Economic Affairs. We believe that both fronts (Professional and Economic) deserve a strengthened and focused direction, one that provides dedicated advocacy on both topics respectively.

While we have essentially now divided the role, we have enhanced it by utilising a cohesive policy team methodology, inclusive of retaining the extensive knowledge and services of our Senior Policy Administrator, Mr Patrick Gifford.

In short, we now have two Policy Managers, and I extend a warm welcome to my colleague and Economic Affairs Manager, Katya Sadetskaya.

"Thanks Jason, and I'm excited to now be part of ASA. It has only taken three months to get here from New Zealand. Due to COVID-19 my moving plans from Wellington to Sydney have been significantly delayed but I'm glad I made it.

"Similar to Jason, I have a strong background in policy and working for central Government in New Zealand. I managed innovation policy and the role of innovation in the health sector at the Ministry of Business, Innovation and Employment for the past six years prior to coming to Sydney in December 2021.

"I have experience writing for Ministers and Government, and can help the committee with submissions and position statements. I also completed a PhD in Economics on the health and wellbeing of New Zealanders in the 19th Century. It was interesting but not very practical!

"I did gain some data and analytical experience and broader understanding of different ways to measure wellbeing. Outside of work I'm a keen trail runner and have tried (and failed) surfing, and I love anything outdoors!

"In terms of my work at ASA, I will be mainly working on the economic issues (anything that has an impact on payments, rebates or fees that Anaesthetists charge) and assisting our new Economic Advisory Committee chair.

"Please don't hesitate to send me an email if you need policy assistance or just to say hi. I look forward to working with all of you. I'm only new and I'd love to learn and help you as much as I can!"

"Hi everyone, my name is Patrick Gifford and I've been working with the ASA for the last two and a half years as the Senior Policy Administrator. For that time, I've

been handling the administrative work of the Policy Team, interacting directly with members through email and phone and helping to answer any questions about the world of anaesthesia that come through our inbox.

"My background in policy is primarily academic, having studied it at university in my undergraduate degree, and studying it currently at a masters level. I'm overjoyed to have two great co-workers join me on the team, and looking forward to embracing 2022 in the revamped ASA Policy Team!"

A Hive of Activity

The Policy Team is at the heart of every undertaking done by the Society and serves with the pure intention of strengthening our voice as the peak body, on behalf of our Anaesthetist Members across Australia.

We are involved in all major topics and issues that continue to emerge throughout our Health landscape.

It is important to note this, as we feel its important to share a bit about what we do on a day-to-day basis and what we are involved with in regards to our advocacy efforts.

RVG

The ASA RVG provides a comprehensive guide on the issues of fee-for-service billing developed by the Policy Team in conjunction with our Economics Advisory Chair and Committee, as well as liaising with stakeholders (Insurance providers, state and federal Government departments). We collate all of this information on your behalf and are also able to provide applicable Medicare and private insurance rebate information, as well as information on other third-party payers such as workers' compensation and 3rd party motor vehicle accident authorities.

In fact, most of our queries come from our flagship document. The updated 2022 RVG will look shortly be released with a brand-new look. A significant amount of design work has gone into it on your behalf and we hope that you enjoy our new look signature product.

Advocacy

The Policy Team advocates across a myriad of issues which are both state and federal based. We provide support for issues that are affecting our profession across many different areas, such as ongoing informed consent issues and strengthening that for Anaesthetists.

We liaise with State Committees and hospital providers in developing guidance and support on behalf of our members on Public in Private Hospital arrangements. This issue specifically has been prevalent in Victoria and NSW and is now becoming a developing issue in other states such as South Australia and Tasmania. We are committed to finding the best policy direction and advice for our members to provide guidance for contractual arrangements, advocating for appropriate fee based renumeration, support for elective surgery requirements, and facilitating collective bargaining agreements with our members.

The Policy Team has also flagged the significant burden of Managed Care on the Australian Health System. The Government is convinced that the trend towards managed care is irreversible but it is likely to have a different form in Australia. We are monitoring developments closely to ensure that anaesthetists are not disadvantaged.

We are also advocating on behalf of our members to the state and federal Government. For example, recently we have engaged with the Department of Health regarding the reinstatement of telehealth numbers that allow for phone and video conferencing to continue to take place post-COVID-19. There is broader work happening on updating the Medical Benefits Schedule (MBS) item numbers by the MBS Taskforce. As the medicines evolve and new pain medicines and procedures become safer and more beneficial for patients - there is an opportunity to build a case for updating some of those item numbers. We will continue working with the Government and other agencies to ensure those changes are reflected in the MBS.These issues will be ongoing throughout 2022 and beyond, and the Policy Team is dedicated to continuing our advocacy efforts on your behalf to ensure we retain a strong, vibrant and fair health system that is available to all Australian citizens.

Website

Another interesting aspect of our work is the ongoing drive to improve and provide an even better service for our members. We are constantly looking for ways that we can improve and provide services that our members deserve and expect to make it easier for them.

One of the ways we are doing this is a restructure of our website, as well as ensuring that the resources on our website are up-to-date and useful for our members The Policy Team is currently undertaking efforts to streamline our website offerings with a sleek new look that will allow not only Policy materials, but member resources a better home and an easier way to access the content you need at your fingertips.

We are always open for feedback and are here to support our members. Whether you have a query about RVG, need advocacy support or believe that you have been treated unfairly, please do not hesitate to reach out to us.

INSIDE YOUR SOCIETY

AROUND AUSTRALIA

Queensland

Dr James Hosking

Chair of the Queensland Committee of Management

COVID-19

Since the opening of borders in Queensland in December there have been a significant number of admissions to Queensland hospitals. This has impacted public hospitals to the extent of only Category 1 and Urgent Category 2 surgery going ahead. Certain private hospitals have had to introduce some restrictions on elective surgery due to furloughing of staff or the assignment of some of their inpatient beds to public medical patients or their own COVID patients. ASA Queensland has supported the establishment of the Queensland COVID Preparedness Virtual Forum. This online meeting approximately every two weeks is run out of ANZCA Queensland offices and is open to all Department Directors or private hospital Anaesthesia MAC Chairs or their delegates.

PPE

The ASA continues to advocate for the availability of appropriate PPE and for appropriate fit testing of anaesthetists including in private hospitals. in most private hospitals there has been ability for VMOs to be fit tested but unfortunately there have been some notable holdouts, which have resulted in practitioners arranging their own fit testing.

QSCRIPT

The ASA continues to hold multiple reservations about the implementation and use of QSCRIPT in everyday practice. It is our belief that nothing short of an exemption in the Medicines and Poisons (Medicines) Regulations 2021 will satisfactorily resolve our issues. The ASA will support any member who decides not to, or is unable to check QSCRIPT in their everyday practice of administering anaesthesia, prescribing inpatient medications, or with any other reasonable excuse. Where QSCRIPT is available to be used and outpatient medication is to be prescribed it is unlikely a reasonable excuse exists.

Induction of anaesthesia or ICU or Emergency situation	Yes ➡	No check due to reasonable excuse, will most likely be tolerated
No then		
Administering	Yes ➡	Not regulated in hospital - no check will most likely be tolerated
No then		
Prescribing for outpatient use	No ➡	Not regulated in hospital - no check will most likely be tolerated
Yes then		
Another reasonable excuse	Yes ➡	No check due to reasonable excuse, document reason
No then		
Check QSCRIPT technologically feasible	No ➡	No check due to reasonable excuse, document tech failure
Yes then		
Check QSCRIPT		

Well done Wesley Hospital Brisbane (Uniting Care)

Dr Phil Melksham and the team at The Wesley Hospital have led the way in COVID awareness in Brisbane since the beginning of the pandemic. Aided by the information for members on the ASA website, Phil, along with Steve Bruce, Andrea Nowitz and Kate Brunello have provided relief for anaesthetists who need to train in COVID case management.

The hospital actively manages all visitors to the hospital and polices eligibility to enter, as well as vaccination status. It is difficult to enter the hospital without authorisation. They preoperative test all elective surgical patients. The hospital has retrofitted a dedicated negative pressure anaesthetic workspace with dedicated entry - bypassing most theatres. They have also written and practiced drills for AGP and different categories of cases in their theatres. Most importantly they have invited all credentialled staff, along with the multi-disciplinary team to run the drills, and shared protocols with all so that they are familiar with the routines before the need to undertake cases arises. Fit-testing is also offered for VMOs.

New South Wales

Dr Lan-Hoa Lê

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

Warm greetings from the ASA NSW Committee of Management (COM).

I hope this lunar year of the tiger brings what it represents: strong relationships with families and associates, courage and ambition with a drive to aid others

and seek justice. Certainly, it's an accepted recipe for me as the pandemic transits to endemic.

SUPPORT

The NSW COM continues its commitment in advocacy and delivering networking and education events to support members and the profession.

New Fellows Forums

NSW joins other States/Territories to connect New Fellows across Australia. Victoria COM is hosting the first national 2022 New Fellows Forum virtually on 17 March. Our NSW COM and Economic Advisory Committee member, Helen Leggett, will deliver further education on the RVG and billings.

Directors of Department Development Day (4D)

For past, present and potential Directors of Departments and Anaesthetic Representatives on the Medical Advisory Committee, look out for the Public Practice Advisory Committee (4D) events. NSW will kick off on 12 March with a foundation on change readiness, and leadership and change management. It's a topic that resonates strongly.

Wellbeing First

ASA Wellbeing Advocates Working Group prioritised proactive wellbeing as a strategy for the Society and formed an inaugural Wellbeing Advocates Subcommittee (WASC). The goal is to foster the personal health and welfare of members, associates and their families.

Our Immediate Past President, Dr. Suzi Nou remains as ASA executive representative on the Wellbeing Special Interest Group (SIG) Tripartite.

ASA connects with Psychiatrist Specialists at *Hand-n-Hand for Peer-to-Peer Support* training for Anaesthetists. All fellows and trainees interested in wellbeing or becoming a wellbeing advocate are welcome to join our workshops.

A recent *Wellness forum* for trainees preparing exams was a highlight on 9 February. I wish you all the best for your exams!

Workplace safety involves looking at and understanding individual and system factors affecting performance. A safe doctor is a safe patient.

Read here or more *WASC news*. www.asa.org.au/the-inaugural-asa-well-being-advocates-subcommittee-wasc-welcomes-you-to-our-enews/?_zs=HoPdk f

REPRESENT

ASA President, Public Issues Advisory Committee (PIAC), Economic Advisory Committee (EAC) and NSW COM

We have been working closely with hospital executives to represent members on matters concerning voluntary rostering and contracts.

Public in Private Contracts

Members are becoming active in seeking ACCC exemption for group negotiations of contracts and remuneration for public patients in private hospitals.

COVID-19 Representation & Resources

We continue to represent members in NSW Health and private sectors. Find here up-to-date COVID-19 resources. www.asa.org.au/covid-19-updates-2

SIRA Value-Based Healthcare

The State Insurance Regulatory Authority (SIRA) has published the implementation plan for value-based healthcare in the workers compensation and compulsory third-party schemes. It can be viewed on: www.sira.nsw.gov.au/hub/implementation-plan-for-better-health-outcomes

Last year, ASA joined multiple peak bodies, medical and allied-health representatives to the co-design of the plan.

The final plan outlines 21 initiatives across the following four workstreams:

1. Measuring health outcomes and costs and improving data quality
2. Embedding evidence-based clinical practice to maximise recovery
3. Streamlining administration and reducing payments leakage
4. Providing education, advocacy and knowledge about value-based healthcare across all scheme participants

SIRA will continue to collaborate with scheme participants to co-deliver these initiatives.

SCIDUA

The NSW Special Committee Investigating Deaths Under Anaesthesia (SCIDUA) latest publication 2019 Annual Report is available on their website. Like the 2018 report, it represents a leap forward in the way information is shared for the sole purpose of improving patient outcomes. All cases are consented by the anaesthetists involved and learning points are highlighted which gives the reader a chance to reflect upon their own practice.

This report has been approved for release by the Secretary, NSW Health

www.cec.health.nsw.gov.au/__data/assets/pdf_file/0006/699522/SCIDUA-Annual-Report-2019.pdf

NSW Committee

We thank and farewell our Trainee Representatives, Dr Lukeman Anderson and Dushyant Iyer for their contributions (in particular with the Part 1 Boot Camp mock written exam) during their term. We wish them all the best in their career, and we welcome Dr Jared Ellsmore as the incoming Trainee Representative.

We also welcome sharing ideas, issues and expression of interests in joining the NSW Committee to advocate for our Society.

EDUCATE

1 March Hand-n-Hand Peer-to-Peer Support training – full.
This workshop will be repeated.

12 March PPAC (4D) Directors of Department Development Day www.asa.org.au/4d-day/

17 March New Fellows Forum www.asa.org.au/new-fellows-forum-billing-and-the-rvg/

12 June *Save the date – Part 1 Boot Camp Mock Exam (Written)

Also visit ASAEd library www.asa.org.au/asaeducation/exam-tips/ specifically designed for members' CPD and trainees preparing for exams.

For event dates and registration go to: www.asa.org.au/events

ASA Registered Practice Managers Network

Australian Society of Anaesthetists®

The ASA has long recognised the value, contribution and support that practice managers give our ASA members and as such we are moving to create the new ASA Registered Practice Manager Network.

We are offering ASA Registered Practice Managers dedicated online resources including:

- Access to the RVG app
- Complimentary registration to the 2022 Practice Managers conference in Hobart on the 13th August
- Dedicated Practice Manager E-newsletter
- Access to podcasts
- Events and Wellness resources.

Receive all these benefits while paying an annual fee of only $258.72 (includes GST).

We are offering our existing Practice Managers a FREE trial of the online resources until 31st March 2022 (excludes RVG app).

After which they will need to sign up for ASA Registered Practice Manager network to continue to access the resources.

Please encourage your practice manager to join the ASA Registered Practice Managers Network by submitting the online application form.

For more information please visit www.asa.org.au/practice-managers

An ASA Registered Practice Manager, has access to dedicated online resources that support you and your workplace.

- Access to the RVG App
- Practice Managers Events and Conferences
- Wellness Resources
- Online Education
- Practice Managers Newsletter
- Podcasts and presentations
- My Health Record and much more ...

JOIN NOW!

For more information call 1800 806 654
www.asa.org.au/practice-managers

NEW AND PASSING MEMBERS

The ASA would like to welcome all new members from October 2021 to February 2022.

Introductory/Basic Trainee	
Dr Andrew Brazier	NSW
Dr Philip Choi	NSW
Dr Lachlan Cormick	NSW
Dr Brigid Doolan	NSW
Dr Douglas George Falconer	NSW
Dr David Lam	NSW
Dr Rachel Ruth Ping Lee	NSW
Dr Han Liu	NSW
Dr Laura Mackenzie	NSW
Dr Rakshinder Singh Sangha	NSW
Dr Ali Abbosh	QLD
Mr James Boyle	QLD
Dr Phoebe Brandis	QLD
Dr Alexandra Kanowski	QLD
Dr Daniel Kwanwoo Kim	QLD
Dr Jerome Wei Jian Tan	QLD
Dr Tim Tran	QLD
Dr Jordan Luke Anderson	SA
Dr Oliver Barker	SA
Dr Jessica Dalwood	SA
Dr Tristan Leigh Frank	SA
Dr Damien Bernard Kearney	SA
Dr Kenny Lean	SA
Dr Christine Li	SA
Dr Corinne Lee Tching Teh	SA
Dr Misha Yadav	SA
Dr Ellie Grace Cash	TAS
Dr Bi Wen Lau	TAS
Dr Rudi Daniel Falovic	VIC
Dr Brad Mereine	VIC
Dr Victor Yuan	VIC
Dr Merredith Cully	WA
Dr Isabella King	WA
Ordinary Member	
Dr Nerida Anne Robinson	ACT
Dr Christopher John Bell	NSW
Dr Benjamin Dal Cortivo	NSW
Dr Sumati Joshi	NSW
Dr Phoebe Jeanette Rose	NSW
Dr Nadine Yamen	NSW
Dr Mahesh Ganji	NT
Dr Alexandra Mary Anderson	QLD
Dr Garrett Thomas Benson	QLD
Dr Victoria Elizabeth Lingard	QLD
Dr Konara Samarakoon	QLD
Dr Stacey Swinkels	QLD
Dr Miriam Tohill	QLD
Dr Perry Fabian	SA
Dr Richella Lea Falland	SA
Dr Anthony Guterres	SA
Dr Louise Caroline Boyle	VIC
Dr Nicholas Cameron	VIC
Dr Tristan Mark Coleman	VIC
Dr Rafsan Halim	VIC
Dr Gary Katzman	VIC
Dr Harry Idris Marsh	VIC
Dr Andrew Melville	VIC
Dr Juan Luis Rodriguez Varga	VIC
Dr Will Watson	VIC
Dr Gary Devine	WA
Advanced/Provisional Fellow Trainee	
Dr Michael Iskander	NSW
Dr Lawrence Yeow Chung Law	NSW
Dr Asani Saidi	NSW
Dr Daniel Brooks Reid	VIC
Dr Charles Martin Chilvers	VIC
Dr Luis Cuadros	VIC
Dr Brendan James Flanders	VIC
Dr Lisa Gu	VIC
Dr Shaun Hutchinson	VIC
Dr Ambujaan Raviendran	VIC
Dr David Wang	VIC
Dr Keat Meng Chan	WA
Associate International Medical Graduate	
Dr Juliana Caicedo Salazar	NSW
Dr Catherine Mary Curran	VIC
PMET	
Dr Eka Peng Cox	NSW
Dr Joshua Djarlarnbah Tobin	NSW
Dr Lucy Yeung	NSW
Dr Leon Joel Rothberg	QLD
Dr Theseus Tan	QLD
Dr Wei Fong Kee	SA
Dr Lynette Lau	SA
Dr Michael Ryan D'Silva	VIC
Dr Hamish Kelly	VIC
Dr Grace Maree Kennedy	VIC
Dr Gillian Cotter	WA

IN MEMORIUM

The ASA regrets to announce the passing of ASAmembers

Dr Kevin Finegan	NSW
Dr Richard Edward Fear	NSW
Dr Joshua Lionel Hovey	NSW
Dr Srinivasan Narasimhan	NSW
Dr Colin Montague Orr	NSW
Dr Donald George Runcie	NSW
Dr Paul Ritchie	QLD
Dr Frank Phillips	QLD
Dr Barry Graham Schultz	SA
Dr Terence Bourke	WA

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

DR TERENCE DESMOND BOURKE

MBBS, DA, FFARCS, FFARACS, FANZCA

1927-2021

Dr Terrence (Terry) Bourke died in Perth on the 9th of December 2021 at the age of 94. Terry was a highly regarded anaesthetist, an astute clinician, teacher, polymath, confidant and elder statesman to generations of anaesthetists in Perth.

Terry was born in Perth in March 1927 to Patrick Mathew Bourke (a farmer) and Doris Gwendoline (nee) Hall. The family lost the farm in Northam during the depression and his father died when Terry was just seven years old, leaving Doris to raise Terry and his brother on her own.

Terry attended Mary's Mount Boys School as a boarder from 1933 and then moved to Aquinas College. Terry flourished at school. He was academically gifted, very hard working and a natural sportsman. He realized at an early age that he "needed to have a plan" and that set him on a lifelong commitment to education, self-improvement and service.

He was a boarder at Aquinas from 1938-1943. In addition to being a brilliant student, he excelled at a wide range of sports and he represented the College for some six years in "under age events" in athletics. Terry was Dux of the school in 1942 at the age of 15, but was considered too young to sit for the Leaving Certificate. So, in 1943 he went for 'gold'. He won honours in the swimming, captained the First XVIII, led them to victory in the Alcock Cup for football (AFL) and won the Fairest and Best award. Terry captained the champion Interschool Athletics Team and won the 100 yards Open Blue Ribbon race. That year he was the Head Prefect and was once again Dux of the school (gaining first in the class in 6 subjects and equal first in the seventh).

He attained excellent results in the Leaving Examination and decided to study Medicine. There being no medical school in Perth, Terry decided to go to Sydney University because he had the opportunity to board with his widowed aunt. He studied hard, made lifelong friends and enjoyed the time with his aunt. His teaching hospital was St Vincent's Hospital. Interestingly, students attending there at that time were required "to administer twelve open ether anaesthetics under supervision". His supervisors included; Dr. Harry Daly, Dr. Stuart Marshall and Dr. Len Shea (visiting Honorary Anaesthetists).

Terry graduated from Sydney University in 1949. He returned to Perth, spending three years at Royal Perth Hospital in various resident appointments followed by six months at Princess Margaret Hospital for Children. It was there that he met a trainee nurse, Ellen (Nell) Sheehan and they married in 1952. Terry by then had decided to specialise and his 'plan' included travel, formal training and attaining a postgraduate qualification. England was the obvious choice, Nell was to work to help support them while Terry studied. So Terry and Nell left Perth for post-war England and the hospitals in the London area. Circumstances were to change and lead him to anaesthesia and he set about navigating the training requirements and the changes that were occurring to the '2 part' Diploma in Anaesthetics (DA) and the proposed Fellowship examination (FFARCS).

Life was hard but they loved the adventure and they were blessed by the arrival of their first two children. Michael, in 1954 when Terry was working at St Helier Hospital in Surrey, and Jennifer, in 1956 while they were at Chase Farm Hospital in Middlesex. Terry obtained his '2 part' DA in 1955 and then gained the Fellowship of the Faculty of Anaesthetists of the Royal College of Surgeons in 1956. Harry Cohen and 'Jock' Hocking invited him to join 'the Group' that they had formed in 1954. So in 1956 the family returned to Perth. Elizabeth was born in Perth in 1959.

Dr. Bourke was the first anaesthetist in Perth with a Fellowship by examination. He was a modest gentleman who was extremely hard working, highly skilled, versatile, conscientious, knowledgeable, approachable and collegiate. He steadily built up a thriving private anaesthesia practice. He carefully selected his surgeons and while he had a varied practice over the years, he came to prefer plastic and reconstructive surgery and also oral surgery. Operating theatre staff were said to prefer to work in his theatres as the atmosphere was "calm and controlled". He championed the needs of private anaesthesia practices and saw the need for private hospitals to provide infrastructure and support for anaesthesia.

In the Public Hospital system his main loyalty was to Royal Perth Hospital (RPH).

A colleague recently noted Terry was "the anaesthetist's anaesthetist." He was a highly respected, clinically excellent, astute and approachable person, who would provide assistance, expertise and support in a collegiate manner. He was a great exemplar and he will be fondly remembered.

Terry was an honorary (later visiting) consultant to the RPH Department of Anaesthesia from 1956-1992. His years of dedicated and distinguished service to the hospital were recognised when he was appointed an Emeritus Consultant Anaesthetist on his retirement from the Royal Perth Hospital in 1992. He also held appointments at Princess Margaret Hospital (1956-1964), King Edward Hospital, Fremantle Hospital and the Repatriation Hospital, Hollywood at various stages.

Terry was involved with various volunteer and overseas aid programs from 1964-1990. In the main they were with plastic surgery teams. Firstly to India but later followed by Afghanistan, Bougainville, Northern Ireland and the Kimberley. In addition, he had been a long serving member of the Citizen Air-Force and the Air-Force Reserve. He attained the rank of Wing Commander. In 1971 he served for 3 months at The First Australian Field Hospital in Vung Tau and for a time he was the Commanding Officer.

He was always interested in professional issues, anaesthesia training, the advancement of anaesthesia as a specialty, continuing medical education, patient safety, service to the broader community and current affairs.

He was:

- An active participant in local, national and international educational meetings, always providing pithy and up-to-date comments.
- An examiner in anaesthesia for 5th year medical students for many years.
- An early advocate for the 'rotating anaesthesia training program in Perth.
- A prime mover in the formal foundation of the Department of Anaesthesia at St John of God Hospital, Subiaco.
- A Committee Member for the WA Section of the Australian Society of Anaesthetists (ASA) for many years and served as Chairman of the WA Section and a member of the Federal Executive in 1963-1964.
- A Committee Member of the WA Section of the Faculty of Anaesthetists and served a term as Chairman during which he had a co-opted role on the Board of Faculty.
- Appointed as a Founding Member of the WA Anaesthetic Mortality Committee in 1979 and served until 1994 (he was re-appointed for subsequent 3 year tenures by the Health Ministers of the day).

Terry continued to work in private practice until his 70th birthday, when he retired from the Group. To the end, his enquiring mind, vast knowledge, superb clinical skills, ability to work with colleagues and his ongoing interests in the advancement of the specialty, meant that he had contributed greatly to the maturation of anaesthesia practice in WA.

A colleague recently noted Terry was "the anaesthetist's anaesthetist." He was a highly respected, clinically excellent, astute and approachable person, who would provide assistance, expertise and support in a collegiate manner.

He was a great exemplar and he will be fondly remembered.

Terry is survived by his devoted wife, Nell, his children Michael, Jennifer and Elizabeth and their families.

Dr. W R Thompson AM

February 2022.

Australian Society of Anaesthetists

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Learning Resource Hub

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