

# AUSTRALIAN Anaesthetist

THE MAGAZINE OF THE AUSTRALIAN SOCIETY OF ANAESTHETISTS • JUNE 2019



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# AUSTRALIAN Anaesthetist

THE MAGAZINE OF THE AUSTRALIAN SOCIETY OF ANAESTHETISTS

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

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### WOULD YOU LIKE TO CONTRIBUTE TO THE NEXT ISSUE?

The September issue of *Australian Anaesthetist* will focus on anaesthesia in the digital age. If you would like to contribute with a feature or a lifestyle piece, the following deadlines apply:

- Intention to contribute must be emailed by 7 July 2019.
- Final article is due no later than 17 July 2019.

All articles must be submitted to [editor@asa.org.au](mailto:editor@asa.org.au). Image and manuscript specifications can be provided upon request.

## REGULAR

# ASA EDITORIAL FROM THE ACTING PRESIDENT



DR SUZI NOU  
ASA ACTING PRESIDENT

It is with great delight that I write the editorial for this edition of *Australian Anaesthetist*. Significantly, we commemorate the 85th birthday of the ASA. Deacon<sup>1</sup> describes a proud 85 year tradition of supporting, representing and educating Australian anaesthetists. Within this edition we also celebrate a first time event. Never before has there been an entire issue dedicated to discussing Gender Equity. So why now? There is plenty of evidence to show that there is a systematic difference between women and men in the workplace. There is a pay disparity which is not merely accounted for by a difference in hours worked. As a result, women retire with less superannuation than men. Career trajectories differ, as depicted by the 'gender jaws' (Figure 1)<sup>2</sup>.

There is recognition that a sufficient amount of research has been done and that the focus should instead be toward seeking the systemic solutions that will serve to change this status quo. Dr Bridget Effene, member of the ANZCA Gender Equity Working Group notes that supporting gender equity will improve 'performance and decision-making'<sup>3</sup>. This is also a vision shared by the ASA. Addressing cultures that lead to gender inequity and developing awareness of our unconscious or implicit biases is an important part of the solution. Men undertaking flexible work is one of the greatest drivers of gender equity in a workplace. Yet men are less likely than

women to be successful in applying for flexible work. In this edition, Dr Mike Soares, EAC and PIAC committee member, openly and courageously discusses some of the challenges he faced when undertaking part-time training. Men too are not immune from unconscious bias.

The intersection point of the gender jaws is interesting to consider. It is about this time that women may temporarily leave the workplace to have children. That leave, combined with other systemic factors contributes to the widening of the gap between men and women in their mid-late careers. Enabling men to take parental leave or undertake flexible work could lessen this impact. However other systemic strategies which support women in their professional development are required.

One of these strategies is to develop role models and provide mentorship. In this edition, Monica Cronin describes the important role of women in the history of Australian anaesthesia<sup>4</sup>. We also sadly note the passing of Dr Nerida Dilworth, a pioneer in paediatric anaesthesia and paediatric pain medicine<sup>5</sup>. Su-Jen Yap<sup>6</sup> shares insights from some of our current leaders, namely, the Presidents of the World Federation of Societies of Anaesthesiologists (WFSA), the American Society of Anesthesiologists, Israel Society of Anesthesiologists and the New Zealand Society of Anaesthetists, who all happen to be women. In honour of another

pioneer, Kinnear, writing on behalf of the Overseas and Development Education Committee renames the fellowship that has supported the training of anaesthetists in the Pacific to the 'Sereima Bale Pacific Fellowship'<sup>7</sup>.

After considering our past and present, I hope this edition inspires men and women alike to consider the future. Whilst there have been and currently are women leading our professional organisations, there are still few women who are heads of anaesthesia departments. One of the barriers for women can be a lack of confidence due to a real or perceived lack of leadership or governance training. I do believe that leadership skills are required by men and women at all stages of our careers, whether it be heading a department or private practice group, writing the registrar roster or navigating a return to work after a period of leave. To this end, the ASA National Scientific Congress in Sydney this year features a series of leadership workshops and talks. Join us for the 'World Leadership Panel' which will include the Presidents of the American, Canadian, UK and NZ societies in what will be a fascinating discussion moderated by journalist Sally Warhaft.

We are always looking for other women and men to 'tap on the shoulder' for various committee roles or to represent the ASA on various state and national health forums.

There also needs to be some concrete

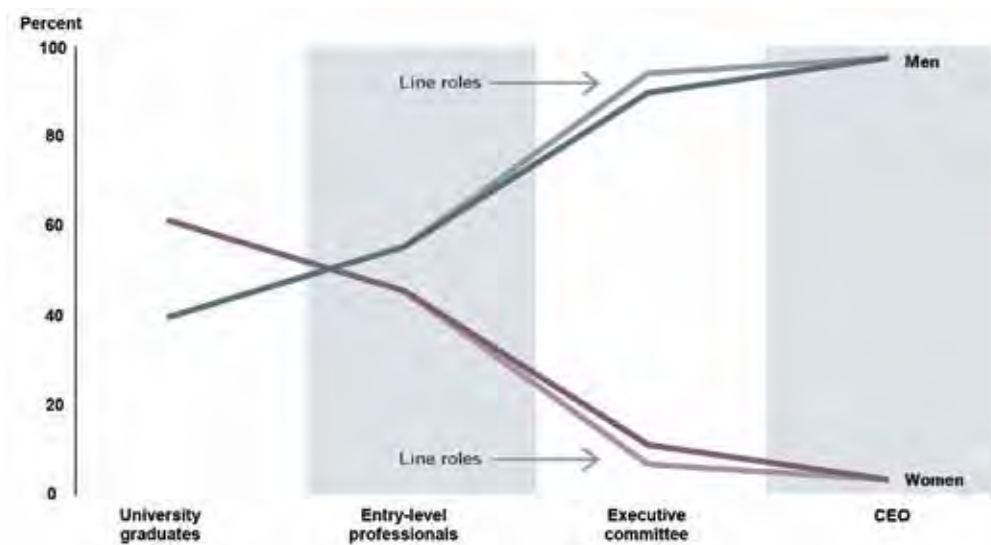


Figure 1: 'Gender Jaws' – representation in ASX 200 companies<sup>1</sup>



Left to right: Dr Hamish Bradley, Dr Suzi Nou and Dr Alistair Park, at the Tasmanian Trainee Day held at Hadley's Hotel, Hobart, birthplace of the ASA

support. One of the biggest drivers of gender equity is for gender balance to be reported to the Board. The first gender report of the ASA was completed in 2018 and is included here in the CEO's report<sup>8</sup>. I am pleased to publicise that the Board and Council has requested ongoing annual reporting of gender equity within the ASA. The Board also introduced a policy to support parents of young children who wish to join an ASA Committee. Yes, the ASA will pay for babysitting! The ASA values the hard work of our committee members and wishes to encourage diversity whilst also recognising the challenges of parenting young children.

As the ASA turned 85, I had the great fortune to visit the birthplace of the ASA, the historic Hadley's Hotel in Hobart to speak at the Tasmanian Trainee Day (Figure 2). The future is looking bright but that doesn't absolve us from our responsibilities toward our trainees. With nearly half of anaesthesia trainees being women, and training commencing at a later age due to the increased numbers of

postgraduate medical students there may be an increase in the number of trainees starting a family during their training years. Richard Seglenieks<sup>9</sup> shares the work of a trainee-led working group on working whilst pregnant and returning to work from leave.

This edition is on gender equity, not women per se, for gender equity is an issue for men as well. I would like to expand on Idit Matot's words that behind every successful woman there is not only a tribe of successful women who have her back but also successful men. It is by standing on the shoulders of giants such as the Past and future Presidents who have supported me in my role that I am fortunate to be in this position to write this editorial and share this edition of *Australian Anaesthetist* with you.

## References

1. Deacon GJ. 'Australian Society of Anaesthetists' 85th Birthday'. *Australian Anaesthetist* June 2019, pp. 34-38.
2. Male Champions of Change, Accelerating the advancement of women in leadership: Listening, Learning, Leading (Australian Human Rights

Commission, 2013), Fig 8 "Gender Jaws" – Representation in ASX 200 companies', p 22

3. Effenev B. 'Gender equity – if not, why not?' *Australian Anaesthetist* June 2019, pp.19-21.
4. Cronin M. 'The rare privilege of medicine: women anaesthetists in Australia'. *Australian Anaesthetist* June 2019, pp. 22-25.
5. Thompson WR. 'Obituary: Nerida Margaret Dilworth AM 1927-2019', *Australian Anaesthetist* June 2019, pp. 94-95.
6. Yap SJ. 'Learning from our women presidents'. *Australian Anaesthetist* June 2019, pp. 12-15.
7. Kinnear S, 'The ASA Sereima Bale Pacific Fellowship'. *Australian Anaesthetist* June 2019, pp. 80-81.
8. Carmichael M. 'Gender equity and diversity within the ASA'. *Australian Anaesthetist* June 2019, pp. 16-18.
9. Seglenieks R. 'Pregnancy and returning to work for trainees'. *Australian Anaesthetist* June 2019, pp. 26-30.

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## REGULAR

# ASA UPDATE FROM THE CEO



MARK CARMICHAEL,  
ASA CEO

How strange it is to be writing a piece at a time when the Federal election has just been called, and knowing that by the time this is read, the result will be known, and in some quarters may have even been forgotten! Like it or not the medical profession is impacted upon greatly by the government of the day, and in the case of the ASA this has been brought home by the long, and at times torturous, engagement in relation to the MBS Review, and its impact on anaesthesia.

It seems eons ago when a delegation from the ASA sat down with the then Minister for Health, The Honourable Sussan Ley to share its views on the mooted MBS Review. Professor Brian Owler was the Federal AMA President and Ms Catherine King, whom we also met, was the Opposition spokesperson for health.

Since that day we have seen The Honourable Greg Hunt, who has been most accessible, replace Ms Ley as Health

Minister, Professor Owler (who may or may not be the Federal member for Bennelong by now) succeeded by Dr Michael Gannon, who in turn has been replaced by Dr Tony Bartone as AMA President, all of whom offered the ASA great support during their Presidencies, while Ms King has retained the position of opposition spokesperson for health throughout this time. During this same period, Dr Guy Christie Taylor, Associate Professor David M. Scott and Dr Peter Seal have all held the role as ASA President and been actively engaged in the process. All of which paints a picture of what a long term exercise the MBS Review has and continues to be.

Despite encouraging signs from the Minister in late 2018, the final determination on the Review in terms of anaesthesia remains unknown. It is still very much a live debate, with uncertainty remaining around any final determination of what changes will be

implemented. Following the release of the Anaesthesia Clinical Committee's Report, the Department of Health in February of this year, formed the Anaesthesia Implementation Liaison Group (AILG). The ASA was offered a seat and chose former ASA President Dr Andrew Mulcahy, as its representative. Dr Mark Sinclair is also on the AILG as the AMA representative. The AILG is in dialogue with the Department, however with the calling of the election it appears that discussions are now on hold until the election result is known, which is extremely frustrating for the ASA and those actively engaged in this discussion. Whether the Federal election changes anything, only time will tell, although it is clear the ASA has and continues to be in for the long haul, advocating for the rights of patients and members alike in relation to this critical matter.

While speaking of elections, I am pleased to inform you all, that Drs Mark Sinclair

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Established in 2001 the ASA Benevolent Trust Fund assists Australian anaesthetists, their families and dependents who are in dire necessitous circumstances.

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and Antonio Grossi have been elected as the two Council elected Directors to the Board of the ASA. These two positions were part of the Governance change implemented in 2016, and I am sure you will all join with me in congratulating them both on their election. They will both now serve a two-year term on the Board.

One of the great joys of working in membership-based organisations, is the many wonderful people you meet. Sadly the ASA lost one of those people recently with the death of Adelaide-based member, Dr Piers Robertson. Piers was a great 'giver' to the Society, in particular through his long-term involvement in the National Scientific Congress, and the specialty at large. To his wife Libby, his three children, Alexa, Caroline and John, I extend the condolences of all the members and staff

of the ASA. Fittingly Dr Simon Macklin, a great friend and colleague of Piers, has kindly offered to prepare an obituary, which will be published in a future edition of *Australian Anaesthetist*.

When speaking of colleagues, I would like to acknowledge the imminent retirement of ANZCA Chief Executive Officer Mr John Illott. ASA and ANZCA do work very closely on many things, and I would like to say that it has, over the past four years been a pleasure working and collaborating with John. I would like to thank him, and wish him and his family, all the best in his retirement.

Once again the National Scientific Congress (NSC) is almost upon us. As always the Congress, set down for September 20-24, in Sydney, looks to

be a tremendous educational and social opportunity. Convenor Dr Anne Jaumees and Scientific Convenor Associate Professor Alwin Chuan, have brought together a tremendous program. Of particular interest will be the World Leadership Panel, featuring the Presidents of four Societies from around the world, three of whom are women. I look forward to welcoming you all to Sydney.

### CONTACT

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



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## NEWS

# MEDICARE CUTS – MBS REVIEW

Members will recall that the long-delayed review of anaesthesia items in Medicare by the Anaesthesia Clinical Committee (ACC) under the MBS Review Taskforce was finally made public in the latter half of last year.

The ACC Report had been delayed by approximately 18 months while the ASA and other stakeholders entered into discussions with the Federal Minister, the Department of Health, and the ACC and the MBS Review Taskforce highlighting the major flaws in the proposed cuts and changes to anaesthesia items that the ACC Report was proposing. Eventually the full ACC report was released for public discussion and **contained 67 recommendations which if implemented would impact on 80% of all anaesthesia services and cut funding to nearly 60% of all anaesthetic services.** The ACC report recommends major sweeping changes to the structure of the RVG and consultation items, along with significant funding cuts.

The ASA and other stakeholders continued discussions with the Government late last year and at that time received what appeared to be positive news (reported to members in December last year) that the majority of recommendations would not be proceeding in the current year (2019) but rather be referred for further consideration by a stakeholder group (the Anaesthesia Liaison Implementation Group – AILG). At that stage it appeared that only a small number of changes would be proceeding this year with minimal impact on anaesthesia services and therefore on the majority of anaesthetists and their patients. **It is important to understand that the ASA has opposed the manner in which this review of Anaesthesia services in Medicare has been conducted by the ACC and the MBS Review Taskforce and has repeatedly pointed out the deficiencies of the review process from**

**the beginning.** Those deficiencies include: a lack of transparency, a lack of expertise in understanding the RVG, a lack of demonstrated consideration of the impact of recommendations on vulnerable patient groups, assumptions that many or most anaesthetists are driven to maximise MBS rebates, an apparent desire to move away from rebates determined by individualised patient care.

The AILG (on which the ASA has a nominee, along with the AMA, ANZCA and other anaesthetists) has had its first meeting but unfortunately the Federal Election was called very soon thereafter and with the Government going into 'caretaker mode' all activity has had to cease pro tem. However, the Department did reveal to the AILG their planned changes to MBS anaesthesia items for implementation on November 1st this year. This list of proposed changes has considerably expanded on what the ASA last year had been led to believe would be the changes for this year and is very concerning to the ASA. **The extent of funding cuts currently being proposed by the Department for this year has now significantly grown (in fact tripled) and will significantly impact on approximately 39 existing items with a total funding cut of approximately \$21M equivalent to a 4.7% cut in Medicare RVG funding.** Of course, this is on top of a nearly seven year Medicare freeze for anaesthesia.

As stated above, the current Federal Election has put the AILG process and all negotiations with the Department on hold, and as a result there remains a high degree of uncertainty as to the final changes that will be implemented in November this year. However, it is certain that there will be changes and that there will be funding cuts. The services listed below summarise the likely changes and their current status where the changes remain under consideration by the AILG and the Department at the current time:

## MBS RVG item deletions

- 22018 – respiratory monitoring.
- 20705 – anaesthesia for upper abdo diagnostic laparoscopy.
- 20805 – anaesthesia for lower abdo diagnostic laparoscopy.
- 20953 – anaesthesia for endometrial ablation.
- 21927 – anaesthesia for barium enema.
- 22001 – autologous blood transfusion.
- 22040, 22045, 22050 – upper/lower limb nerve blocks. Note it is proposed by the Department that these nerve blocks will be covered by a single new nerve block item with 2 RVG units. **This change is not finalised and is still under discussion by the AILG.**
- 22070 – administration of cardioplegia.

## Reductions in base unit allocation

- 20142, 20144, 20145, 20147 – anaesthesia for (various) eye procedures including lens surgery. These items are likely to have a reduction in base units down to 5 base units. Note the new complex eye block item proposed (1 RVG unit – see below) will likely be introduced at the same time. **These changes are not finalised and are still under discussion by the AILG.**
- 20410 – anaesthesia for DC reversion of arrhythmia (from 5 to 4 units).
- 21922 – anaesthesia for CT scan (from 7 to 6 units).
- 21926 – anaesthesia for fluoroscopy (from 5 to 4 units).
- 21936 – anaesthesia for TOE (from 6 to 5 units).
- 21952 – anaesthesia for muscle bx for MH (from 10 to 4 units).

## Changes to therapeutic and diagnostic items

- 22001 – autologous blood collection – to be DELETED.
- 22002 – blood transfusion – restricted to autologous only.

- 22012/22014 – pressure monitoring – restricted to certain patient groups. This change is still being considered by the Department and the AILG including whether the change proceeds and/or if it does, which patient groups should be included. **This change is not finalised and is still under discussion by the AILG.**
- 22018 – respiratory monitoring – to be DELETED.
- 22025 – insertion of arterial catheter – restricted to certain patient groups. This change is still being considered by the Department and the AILG including whether the change proceeds and/or if it does, which patient groups should be included. **This change is not finalised and is still under discussion by the AILG.**
- 22031/22036 – epidural/spinal postop analgesia – restricted to agents producing 4 hours of postop pain relief. It is possible that the final form of this change will involve further significant modification. **These changes are not finalised and are still under discussion by the AILG.**
- 22040, 22045, 22050 – upper/lower limb nerve blocks – to be DELETED. See proposed new nerve block item below. **This change is not finalised and is still under discussion by the AILG.**
- 22051 – ITOE – requirement for credentialing. It is likely that the credentialing will be compliance with ANZCA requirements or equivalent.
- 22070 – administration of cardioplegia – to be DELETED.

### Changes to modifiers

- 25015 – change in age criteria to '75 years or older' and 'less than 3 years'.

### Changes to time items

- Only 15 minute time items for the first 2 hours (removal of the 5 minute time items).

### New items proposed

- Eye block item – 1 base unit for a 'complex eye block'.

- Nerve plexus block – 2 base units for upper or lower limb plexus or nerve block.

**Please note that the above listed items are not finalised nor complete** and remain subject to further discussion and further consideration by the Department and the AILG. There are other proposed minor changes not included in the list above.

As noted above, disappointingly the Department is now proposing some very significant additional changes for introduction this year including **cuts to the following: eye items, arterial lines and pressure monitoring, epidural/spinal items, nerve blocks**. These newly proposed changes have added considerably to the size of the cuts in Medicare funding for anaesthesia services.

Were all 67 of the ACC report's recommendations to be implemented the RVG would lose much of its integrity with a large shift towards simply time-based anaesthesia rebates. But additionally, there would be significant cuts in anaesthesia funding in a non-uniform way, with the result being specific patient groups being targeted for funding cuts. The following examples illustrate the disastrous impact of the full MBS Review recommendations:

- Nearly one million older Australians would be targeted specifically because of their age for a reduction in anaesthesia funding/rebates (*the impact of the change to the age modifier on 940,000 patients aged 70 and over*).
- 95% of the 750,000 Australians undergoing endoscopy for cancer screening and other reasons would be targeted for a reduction in anaesthesia funding/rebates (*change in base units, changes to time units, loss of age modifier*).
- 95% of the 40,000 Australians with mental health issues requiring intensive psychiatric treatment (ECT) would be targeted for a reduction in anaesthesia funding/rebates (*50% reduction in base units, changes to time units, loss of age modifier*).

- 85% of the 35,000 Australian women who give birth by Caesarean section would be targeted for a reduction in anaesthesia funding/rebates reduced (*loss of epidural/spinal items, changes to time items*).
- 170,000 Australians requiring cataract surgery will have their anaesthesia funding/rebates reduced (*change in base units, changes to age modifier, changes to time units*).
- 30,000 Australian women who require infertility treatment under anaesthesia would be targeted for a reduction in anaesthesia funding/rebates (*change in base units, changes to time units*).
- Overall, well over one million patients would be facing reductions in anaesthesia rebates.

It is clear that the massive changes proposed by the MBS Review and the ACC, if fully implemented would result in a high likelihood of either increased out-of-pocket expenses and/or a loss of access to services for patients. Some services such as ECT would be under threat of being completely withdrawn. In either case patients will be the ultimate losers.

The publicly stated goals of the MBS review were to modernise the MBS and to make evidence-based changes to drive better patient outcomes. However, with the review of anaesthesia items, the MBS Review has simply recommended funding cuts to Medicare, with no supporting evidence and which will almost certainly increase costs to patients and reduce access to services.

Members should know that the ASA, working collaboratively with other stakeholders, has been fighting these recommendations for two long years and will continue to advocate for sensible changes to the MBS that do not negatively impact on patients, do not unnecessarily target vulnerable patient groups and are not introduced purely as a cost savings measure.

Dr Suzi Nou  
ASA Acting President  
on behalf of the ASA MBS Working Group

## NEWS

# ANAESTHESIA FOR ELECTROCONVULSIVE THERAPY (ECT) – MBS ITEM 20104

The Anaesthesia Clinical Committee (ACC) under the MBS Review has produced a report containing 67 recommendations for changes to anaesthesia items in the MBS.

The full ACC Report and the ASA response and other documents can be found here: <https://asa.org.au/anaesthesia-mbs-review/>

The current MBS RVG has a total of 503 items but the ACC proposals are truly wide ranging and recommend changes to a total of 494 RVG items.

Breaking that down, the ACC has recommended changes to:

- 167 base items.
- 274 time items (142 existing time item changes and 132 new time items).
- 12 therapeutic and diagnostic items.
- 1 modifier item..

If fully adopted and implemented, these recommendations would impact on over 80% of all Medicare funded anaesthesia services in Australia (>2.5 million patients pa).

This series of articles will examine selected proposals put forward in the ACC report to better understand the likely impacts on service provision, access to health services and overall funding of anaesthesia through the MBS.

## ACC Proposal for ECT – 50% reduction in base units

The ACC has proposed a 50% reduction in the base unit allocation for item 20104 (anaesthesia for ECT) from the current

4 units to 2 units (recommendation 53 – page 98-99 of the ACC Report).

**Of note, no other item in the RVG currently has a base unit allocation of less than 3 units.**

In the 157 page ACC report, despite the proposal to drastically reduce the base units for item 20104 by 50% there is no specific discussion of ECT at all, nor specific reasons for the recommendation. There are several broad general statements in the rationale for recommendation 53 (which includes recommended reductions in base units for 23 other items also) including that *“The items in this section have been recommended for a change in relative value because the Committee agreed they were over-valued in comparison to other basic items in the RVG”*.

The ACC report gives no consideration at all to the clinical aspects of anaesthesia for ECT, nor to the likely impact this reduction of funding might have on service provision for Medicare funded ECT in Australia.

The only data provided in the report shows the total number of services in the 2015-16 year and the 5 year growth to that year of 4.9% (note: background growth for all anaesthesia services over the 5 years to 2017 was 11.1%).

## What does the data show?

The table on the right provides a summary of the available data on the service provision for ECT anaesthesia.

For the 12 months to June 2018 there

were 37,692 services claimed under MBS item 20104. Not surprisingly the average time for ECT anaesthesia is just 18 minutes with the median time item claimed being 23010 (15 mins or less). 94% of all services are covered by the first 2 increments of time up to 30 mins. Looking at the patient population characteristics nearly 15% are aged 70 years or more and would therefore qualify for the age modifier item 25015 (1 RVG unit).

Anaesthesia for ECT – MBS 20104	
Total services (2017-18)	37,692
Total MBS funding (2017-18)	\$3,473,953
Average anaesthesia time	18 mins
Median time item	23010 (1 unit)
Incidence ≥70 yrs	14.8%

## Impact of the ACC recommendations

There would be a massive reduction in funding for ECT anaesthesia should the ACC proposals proceed. Coupled with proposed changes to the age modifier (deleted for >70 yrs) and changes to time items (introduction of 5 minute time intervals and rebates):

The ACC proposals would result in a reduction of overall anaesthesia rebates for ECT of 35-50%. Furthermore, it is likely that 95% of all ECT patients would receive a reduction in their anaesthesia rebate.

It is important to note that patients receiving these anaesthesia services are a particularly vulnerable group. These patients require highly specialised intensive psychiatric care.

The ACC, in its written report, has given no consideration whatsoever to the clinical aspects of anaesthesia services for ECT.

The ACC has focussed solely on MBS rebates. It has simply examined the RVG unit allocation for ECT anaesthesia (generally 4 base units + 1 to 2 time units), extrapolated this to an *estimated* number of patients treated per session, and come to the conclusion that the service is 'over-valued'.

However, in reality an anaesthesia service for ECT patients will rarely fill a whole session. Further it is almost universal practice to bill these patients only to the level of the available rebate (usually the 'no-gap' rate) with out-of-pockets being extremely rare.

If this massive reduction in rebates is endorsed by the MBS Review Taskforce, the implications are:

- It is extremely unlikely that anaesthetists will continue to charge at the current level of fees (the 'no gap' rebate level) as that would result in a large patient gap to pay. It is unlikely that anaesthetists would be willing to expose this very vulnerable group of patients to an immediate and unprecedented level of out-of-pocket expenses.

- Therefore anaesthetists who provide this service will have to decide whether to accept up to a 50% reduction in rebates (and fees) or alternatively, to withdraw from providing the service.

The ASA is very concerned that this poorly thought out recommendation, provided without any justification in the ACC report at all, has the potential to eliminate completely this essential service to a large number of very vulnerable patients in the community in need of intensive mental health services.

The ACC have focussed simply on an artificial extrapolation of 'rebates generated per hour' and completely overlooked the broader, real-world aspects of how the service is provided and the characteristics of the patients who are receiving the service and the likely impact on this extremely vulnerable patient group.

This ACC proposal places the entire provision of ECT in the private sector under threat. It is quite possible that the service could be eliminated as a consequence of this massive funding cut.

## ASA Response to Proposal

This proposal is deeply flawed.

ECT involves an extremely noxious stimulus to the patient, and the physiological stress response involved has been shown to carry significant risks. The procedure also involves the administration of a muscle relaxant, to decrease the

significant and potentially dangerous tonic-clonic movements which are innate to the procedure.

ECT patients have, by definition, a significant mental illness, which in and of itself increases clinical risk. Additionally, there is also a higher incidence of smoking, alcohol use, and use of both prescription and illicit drug use in this population.

The proposal is based on the fact that ECT is almost always a procedure of short duration, which can increase the notional average rebate per hour. However, if the ACC wishes to pursue a decrease in the funding of anaesthesia services, it is taking the wrong approach here. The anaesthesia services are provided overwhelmingly at no out-of-pocket expenses to patients. The result of the ACC's proposal is that the provision of these services will be endangered, to the detriment of this very vulnerable patient group. The proposal must be rejected.

The ASA strongly opposes this recommendation. It must be rejected.

The complete ASA response to the ACC report can be seen here: <https://asa.org.au/anaesthesia-mbs-review/>.

Andrew Mulcahy  
MBS Review Working Group

## FEATURE



# LEARNING FROM OUR WOMEN PRESIDENTS

Have I been wearing a gender equity T-shirt, under a clear raincoat? Can others make out the letters, words? I have been a staff specialist anaesthetist in an urban tertiary hospital for a quarter century, do I really even know what gender equity in 2019 means? Is the raincoat worn for protection? So many questions... This is an opportunity to learn with some of today's women Presidents of our societies of anaesthetists – Kathryn Hagen, New Zealand Society of Anaesthetists (NZSA), Linda Mason, American Society of Anesthesiologists (ASA-US), Idit Matot, Israel Society of Anesthesiologists (ISA) and Jannicke Mellin-Olsen, World Federation of Societies of Anaesthesiologists (WFSA) who shared their work, their personal leadership stories and their communications with ASA Acting President Suzi Nou.

Recent reports from the *Lancet*<sup>1</sup>, McKinsey and Company<sup>2</sup>, *Harvard Business Review*<sup>3</sup> and *ANZCA Bulletin*<sup>4</sup> tell us that whilst still important, achieving gender equity is now beyond just collecting and presenting data on inequality, documenting intentions in policy and programs or adopting strategies targeting an individual's communication skills (e.g. assertiveness training). The think-tanks for advancing gender equity give us a frame of reference for integrating, the experiential and survey information from our women presidents, with the theme of this issue of *Australian Anaesthetist*.

Idit (ISA) shares with us the European Society of Anaesthesiology (ESA) preliminary survey results on gender diversity and leadership. In September-October 2018, 11,000 survey emails

were sent with 3,048 respondents, 1,706 female (56%) and 1,342 male (44%). Of the respondents, 48% of males and 53% of females wish for a leadership career.

Six enablers and four challenges are identified.

Female leadership and gender equity enablers include:

## 1. Capability, motivation, perseverance

We find the motivation and conviction behind Jannicke's global humanitarian work.

*I cannot remember that, as a child, I had an aspiration to be a leader per se. But I had to babysit my younger sister when I was three-and-a-half, while my mother stayed in the hospital with my brother who eventually died due to a medical*



Jannicke Mellin-Olsen, WFSA President



Linda Mason, ASA-USA President



Idit Matot, ISA President



Kathryn Hagen, NZSA President

error. I then became a very serious child who wanted to make important changes in the world... I had this strong drive in me that made me speak up, get involved, stand up for what I believed was right. It is something in me that I cannot silence, and that is a blessing and sometimes feels like a curse. It goes for respect, fairness, improving what is not right.

Jannicke Mellin-Olsen, WFSA

The same commitment, capability, persistence is evident in Linda's advice to her younger self:

My suggestions for leadership success are:

- Pick an area you are passionate about.
- Say yes – be involved.
- Show up.
- Be a good listener.
- Develop good communication skills – give your input.
- Be professional.
- Be ready to move into a different position arena – timing is everything.
- Enjoy your role.
- Don't give up – if at first you don't succeed try again.

And in the words of Winston Churchill  
"Success is the ability to go from failure to failure with no loss of enthusiasm."

Linda Mason, ASA-USA

A second important enabler is:

## 2. Mentorship from the get-go<sup>1,2,3,4</sup>

This most often refers to professional mentorship, systematically applied from early in working life, however in this instance our women presidents also spoke from a young age, learning from the example of their parents.

*When I mentor younger colleagues, I often have to support their self-confidence, particularly for the females. More often than men, I see that they need encouragement and a little push. Males more often need to be a little more 'pushed-back', although there obviously are variations.*

Jannicke Mellin-Olsen, WFSA

*Lots to say about this topic of women in leadership positions. My mother was a leader of anaesthesia in Israel (the first female president of our society, I am the second – 30 years apart...) and she mentored me...*

Idit Matot, ISA

## 2. Opportunities to progress in senior leadership roles<sup>1,2,3,4</sup>

*My role in physician leadership... started in 2000 when I assumed the role of Chair of the Educational Programs Division for the California Society of Anesthesiologists (CSA). I then became President-elect...and President. The next step was alternate director... and*

*Director. In 2009 I ran for the ASA office of Assistant Secretary in a contested election. After four years... I became Secretary... ASA First Vice President... President-elect... and President in 2018.*

Linda Mason, ASA-US

## 4. Male leaders supporting and/or advocating for gender diversity<sup>1,2,3,4</sup>

*As part of the ESA agenda which was initiated and promoted by the ESA president – Stef De Hert, a survey (gender diversity and leadership) was put together... the survey was also sent to male anaesthesiologists in order to find out whether nowadays gender does affect the way anaesthesiologists perceive leadership.*

Idit Matot, ISA

We can all think of good men, and women, of greater experience and standing that have generously nurtured and supported our emerging contributions to the specialty of anaesthesia. Often they become our long-time friends but in earlier days we are drawn to them for their support, credibility, their values, their grace and conduct.

## 5. The utility of gender diversity networks<sup>1,2,3,4</sup>

*hopefully will lead... to [a] new era where women physicians will be represented in leading positions in the ESA and where*

# FEATURE

other societies will come and learn how we paved the way for women not only in the society but also in their own workplace.

Idit Matot, ISA

And,

Behind every successful woman there is a tribe of other successful women who have her back.

Idit Matot, ISA

So, everyone is needed.

## 6. Persistent comprehensive transformational leadership at all levels<sup>2,3,4</sup>

It would be ideal to be the driver for change on issues, but it can be difficult to feel like there is any large impact on the wider anaesthesia community that can be made within the two-year Presidential term. We are a small cog in the large and complex business of health.

Kathryn Hagen, NZSA

Most interesting in the [ESA] survey were the free text notes (704, 23% wrote free text!) mostly related to: Part time position, fair working hours that will enable to "juggle family and work", support from departmental chair and hospital management, coaching and mentoring programs, less discouragement from male physicians and chairs, less hierarchy, female role model, support from colleagues, being offered/considered for different positions. Males get more proposals...

Idit Matot, ISA

This brings us to consider the challenges to progressing gender diversity.

## 1. Being 'the only' in the room<sup>1,2,3</sup>

I have been in a female minority since university... and I was the only female anaesthesiologist during training and later in the hospital where I am working now. I was the first female physician in Norway who completed military

training, the first female president of the European Board of Anaesthesiology when I also for a while was the only female meeting in the Board of the European Society of Anaesthesiology. The last two periods, I have been the only female officer in the Board of the World Federation of Societies of Anaesthesiologists, in addition to several other 'only female' roles.

Jannicke Mellin-Olsen, WFSA

...At that time (2009) there were no women on the 12 person Administrative Council... I am only the third woman to become President of the ASA and the first Board Certified Pediatric Anesthesiologist.

Linda Mason, ASA-US

when asked for reasons why do not wish to be in a leadership position – other items with a gender difference of more than 15%: Missing self-confidence (26% M, 44% F); Missing female role model (21% M, 41% F).

ESA survey

## 2. Recognising the many reasons and ways, intended and unintended, to being made to feel or be excluded<sup>3</sup>

I am aware that when I discuss passionately, I am at risk of being perceived as 'angry'. People comment on my looks and not to what I say. I have been in ICU rounds where surgeons address the male nurse and not me.

Jannicke Mellin-Olsen, WFSA

As for being a woman in the patriarchal medical world, it is hard not to feel disadvantaged by the gender bias that exists (both conscious and unconscious), and to watch with envy as male colleagues, bond over common interests (e.g. golf, cycling, extreme sports events). This envy may seem trite, but these conversations provide opportunities not afforded to those of us who can't participate.

Kathryn Hagen, NZSA

Females face a problem if a group of men are to select 'the best candidate', as we all tend to prefer people who are similar to ourselves. That means that there is often some 'negative quotation' at play, although people think they are neutral. In my country, Norway, #2 on the Global Gender Equality Index, we have seen very good effects of quotations based on 40% of either gender in several areas of life.

Jannicke Mellin-Olsen, WFSA

For many, a major challenge is the competing responsibilities that gives life meaning and makes life rich.

## 3. Perceived or real lack of capacity due to parenting and carer roles<sup>1,2,3,4</sup>

I am often asked how it all works on the home front as I have three boys aged 10, 7 and 2... I don't always make it to the school interviews, and I usually miss the school trips, so there are compromises, but when they are sick, I stay at home, and they're in no doubt as to how much I love them. Although carrying the financial responsibility for a family of five has its stressors, I love the fact the boys are growing up in a household where your contribution is defined by what best suits you, not by your gender.

Kathryn Hagen, NZSA

On Friday we will celebrate Passover. It means 31 people in my house for dinner.

Idit Matot, ISA

when asked for reasons why do not wish to be in a leadership position – other items with a gender difference of more than 10%: Lack of part time opportunities (53% M, 67% F); Lack of comprehensive and affordable childcare (40% M, 55% F).

ESA Survey

An inter-related challenge is,

# NSC 2019 LEADERSHIP SESSIONS

## Sunday 22 September

1045–1215 | Chair: Dr Suzi Nou  
Moderator: Sally Warhaft

### World leadership panel

Leadership: Presidents from the societies of anaesthesia

Panel:

Dr Kathryn Hagen – NZSA

Dr Kathleen Ferguson – AAGBI/  
Association of Anaesthetists

Dr Linda Mason – ASA (USA)

Dr Daniel Bainbridge – CAS

## Sunday 22 September

1330–1500 | Chair: TBC

### Personal leadership: forging your own path

Research culture and translation  
A/Prof. Lis Evered

Psychology of performance  
A/Prof. Patsy Tremayne

Creating advocacy  
Ms Sally Warhaft

## Sunday 22 September

1530–1700 | Chair: Dr Nicole Fairweather

### Leading health teams

Executive management  
Prof. Viren Naik

Bridging the individuals and the team  
Dr Su-Jen Yap

Effective teamwork  
Dr Jennifer Stevens

## 4. The burden of the work for organisational cultural change falling on under-represented groups, particularly women<sup>1</sup>

*So, what would I say to someone coming through who sees leadership positions in their sights? Only you know how to prioritise your obligations – and therefore which compromises you're prepared to make... If there is only one thing I can change, I hope it is the idea that there are jobs that 'aren't suitable for mother's with young children'... We may not always be able to make that after-work meeting (5-7pm is the most important part of the day!), but if supported, we are capable, we are innovative and we will show you how capably we can lead.*

Kathryn Hagen, NZSA

## So, where to from here?

The work of transformational culture change in our organisations and workplaces for gender equity needs

leadership at the highest levels, it needs to be systematic, and part of the burden can fall on each of us, it can be shared<sup>1,2,3,4</sup>.

Through time and place, the experiences of our societies' female presidents inform us that today's challenge is to systematically create the culture change we need through:

1. Strong leadership and comprehensive multi-level organisational systems that promote inclusive behaviours and participation<sup>2,4</sup> whilst working together towards enhancing patient safety, other quality measures and healthy workplaces.
2. Professional development opportunities for core competencies including diversity leadership<sup>4</sup>.
3. Individuals, by challenging our own thinking and maybe doing a bit more in our day-to-day behaviours to promote freedom from bias and one-sidedness<sup>1,2,3,4</sup>.

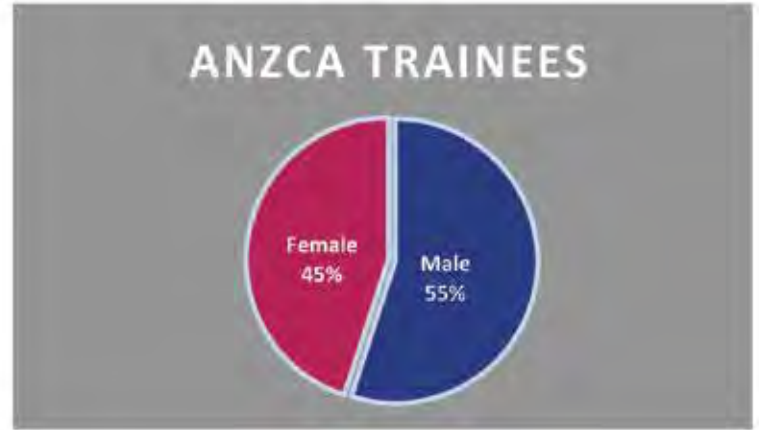
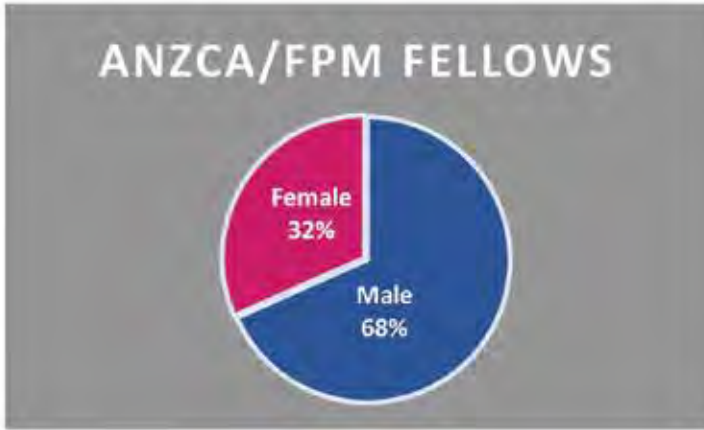
Do come and meet the anaesthetist societies' presidents at the World Leadership Panel ASA NSC in Sydney on Sunday 22 September 2019 and explore leadership and gender equity further, as it may relate to you – your values, beliefs and behaviours – as an individual, a group practice, department, or society.

Su-Jen Yap  
NSC 2019 SGD Coordinator

## References

1. Coe IR, Wiley R, Bekker LG. 'Organisational best practices towards gender equality in science and medicine'. *The Lancet* 2019; 393(10171):587-593.
2. Devillard S, Sancier-Sultan S, de Zelicourt A, Kossoff C. 'Women Matter 2016: Reinventing the workplace for greater gender diversity'. McKinsey Report, January 2017.
3. Rotenstein LS. 'Fixing the gender imbalance in health care leadership'. *Harvard Business Review* October 01, 2018.
4. Watterson L. 'Action on gender equity'. *ANZCA Bulletin*, March 2019.

## FEATURE



ANZCA/FPM Fellows as at December 2017

# GENDER EQUITY AND DIVERSITY WITHIN THE ASA

In 2018 the Council of the ASA approved its Equity and Diversity Policy, CEO of the ASA Mark Carmichael explains.

Within the Policy, one of the objectives is to positively seek to reflect diversity in:

*the composition of our governance bodies, volunteer committees and workforce*

In order to be in a position to address this issue and make plans for the future, the ASA took the step of reviewing the gender

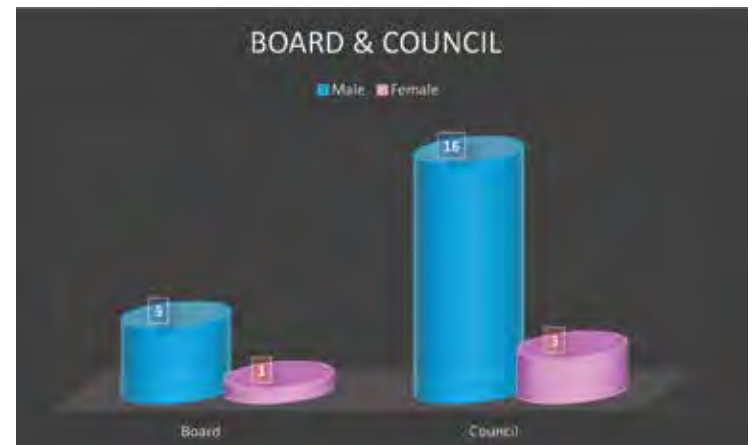
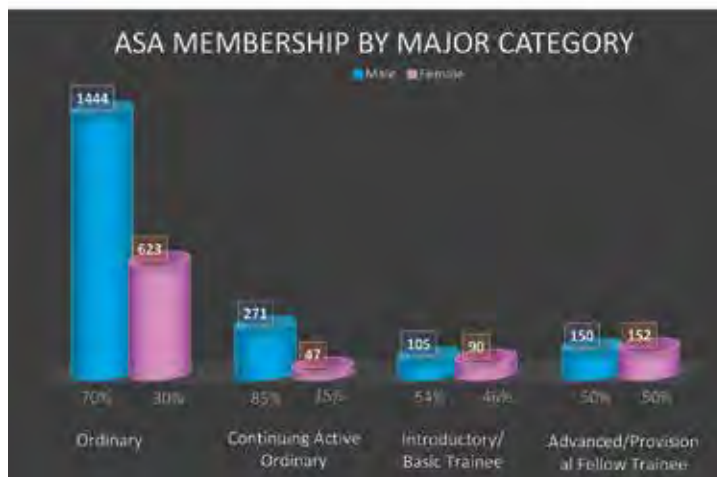
mix within its membership and principal committees as of mid-2018. The findings are explained below.

Member-based organisations such as the ASA rely heavily on the involvement, often on a voluntary basis, of its members. Recognising this, the Society will be able to use the information it is gathering, to encourage and create opportunities across the membership which will allow it to truly reflect the make up of the Society and enact the policy.

## WHAT DOES THE SPECIALTY LOOK LIKE?

As of December 2017, using information provided by ANZCA, the specialty was not surprisingly predominantly male, i.e. 68% male and 32% female. Within reason this is unlikely to have changed significantly since that time.

Looking forward though, and again using data provided by ANZCA, the composition of those undertaking specialty training in



ASA Board and Council – as at April 2018

anaesthesia, is moving very much towards an even mix with 45% of trainees being female.

## WHAT DOES THE ASA MEMBERSHIP LOOK LIKE?

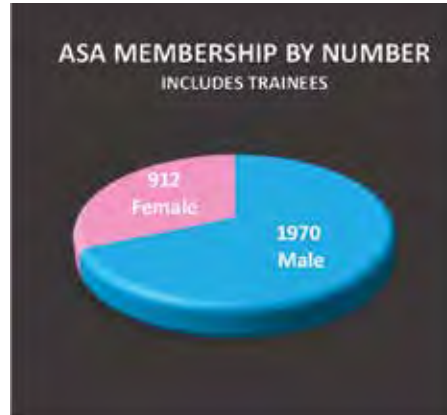
With an overall indication of what the specialty looks like, the next step was to look at what the ASA membership looked like. As at April 2018, total ASA membership stood at 3,500.

The decision was made to focus on the composition of the major membership categories of the ASA, i.e. Ordinary Member, Continuing Ordinary Member (> 30 years) and Trainees along with the gender mix of each, noting that they constitute just over 80% of the 3,500 strong membership.

Not surprisingly the figures show that the ASA membership reflects the composition of the profession as shown by the ANZCA Fellowship data. The membership in the largest category i.e. Ordinary member, is on a percentage basis almost exactly the same, with a clear shift to an equal mix of males and females in the trainee category, which again is reflective of the data. The significant variation in the Continuing Active Ordinary member category i.e. those who have been a member for 30 years or more, is also to be expected if we consider that medicine had until recent times been primarily a male role. It is reasonable to believe that the composition of this category will begin to change over the next decade, as more of our female Ordinary members reach the 30 year membership milestone.

Of great importance is the mix in those undertaking training. As the mix of those in training is shifting to an almost equal number, it would be expected that the specialty may well look different in a relatively short space of time and organisations such as the ASA need to be in a position to capture that change.

The two pie charts illustrate the ASA membership in relation to the



major categories by both number and percentage.

## ASA GENDER MIX PRINCIPLE COMMITTEES

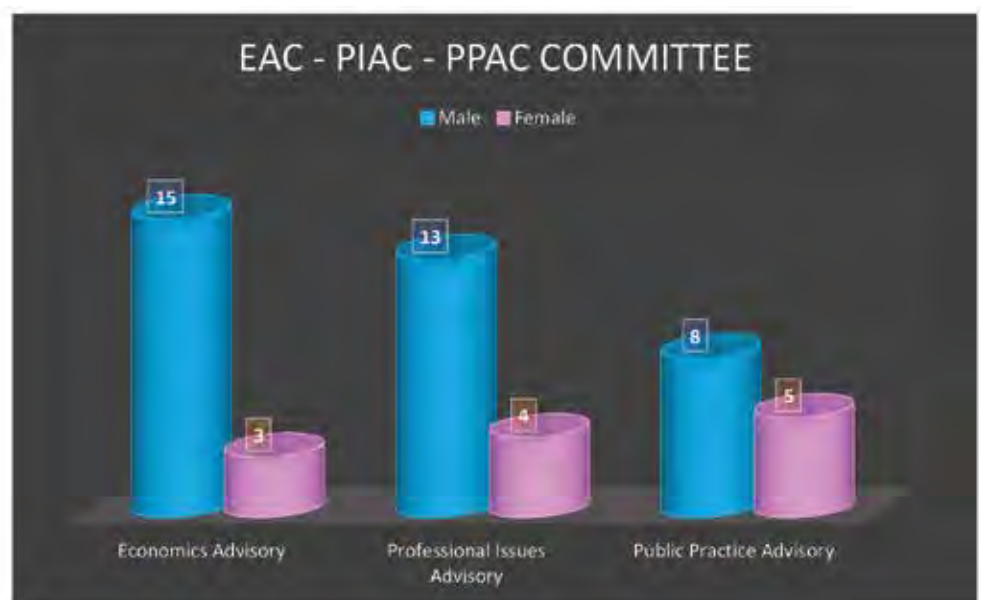
In order to establish a 'start position', Council looked at the gender composition of its major committees. The graphs show the findings. While there has been some slight change since April 2018 in some committees e.g. the Board comprises seven people, with a 5:2 male to female breakdown, the figures are largely unchanged from the April 2018.

This information provides the picture of what the ASA looks like currently.

## COMMITTEE SUMMARY AT A GLANCE:

The table on the next page provides a summary of the number of members involved in committees and the gender mix of each:

1. At the moment there are 261 members actively involved (approximately 9.5%).
2. 73% of those involved are male and 27% are female.
3. Some committees have a more even breakdown than others.
4. Overall in terms of gender, committee composition is reasonably reflective of the current membership.



ASA Committees – as at April 2018

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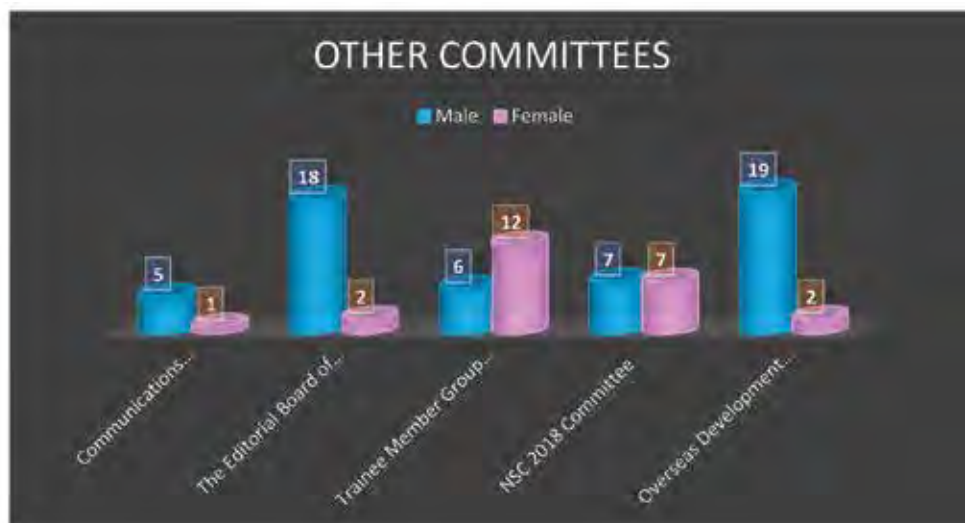
Committees	Total Members	Male	%	Female	%	Comment
Board/Council	25	21	84	4	16	
EAC/PIAC/PPAC	48	36	75	12	25	EAC/PIAC impact
Other	77	55	71	22	29	AIC/ODEC impact
State Committees	111	78	70	33	30	SA/NT ACT impact

5. Female members are strongly represented on the Trainee Committee.

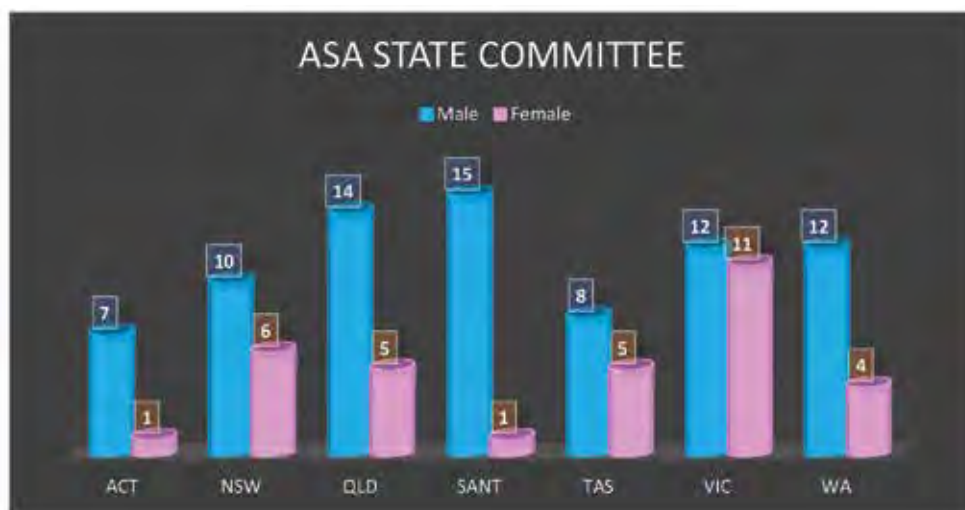
## WHAT DOES THIS TELL US?

The current gender breakdown of the ASA membership is reflective of the specialty.

The variation between the gender mix of existing members (m 72% f 28%) and the trainee members (m 50% f 50%) is significant and indicates the likelihood of a rapid change in the composition of the specialty and therefore ASA membership within in a relatively short period.



ASA Committees – as at April 2018



State Committees – as at April 2018

The overall composition of committees is reflective of the membership as it stands.

## NEXT STEPS

As noted, this information has formed a starting point for the Council as it looks to actively address what ratio is a key consideration for the Society. In December of this year the Council will review the situation and begin considering what may be necessary to ensure the Society remains reflective of its membership. The information gathered won't be limited to that as reported above, other markers such as:

- Breakdown of speakers and workshop presenters at the National Scientific Congress.
- Breakdown of speakers at ASA meetings/events.
- Review of session Chairs at NSC.
- Breakdown on authors whose papers are published in the journal of *Anaesthesia and Intensive Care*.

will be compiled and will be included in the review, to see if the Society is actively ensuring the gender mix within the membership is being represented in all facets of the Society's activities.

Any meaningful change will be evolutionary, and while this data will be re-examined at year's end, some practical initiatives have already been implemented as a way of looking to ensure opportunities are equally accessible to all members.

Simple adaptations such as encouraging the use of skype or teleconferencing for meeting attendance have been implemented, to ease the demand on those with families. A second initiative has been budget allocations included in the State-based budgets to offset the cost of childcare/babysitting should a committee member need it. Simple steps, but steps that will hopefully assist in encouraging participation in the work of the Society is open equally to all members.

Council is committed to making this an ongoing process for the betterment of the Society.



Image: ASA

# GENDER EQUITY – IF NOT, WHY NOT?

It is well established that gender equity has substantial ethical, economic and social benefits in society<sup>1,2</sup>. For individuals, these include job satisfaction, appropriate career advancement, equality in remuneration and work life balance. Organisations that support gender equity have shown improvement in performance and decision-making.

In addition, diversity of opinion at an organisational level contributes to increased productivity and competitiveness.

Given the evidence available, it is time to accept gender diversity as a requirement for success, and move on to more pertinent questions: How do we achieve it in our departments, hospitals and organisations? How do we succeed as individuals to overcome our biases, work inclusively and be leaders in driving change in achieving an equitable medical workforce?

Historically, the specialty of anaesthesia has had many heroines. It is largely a success story for inclusion and advancement of women in medicine in Australia and New Zealand. Perhaps this was by chance, as during the world wars the country was deprived of men who were enlisted to the front line. The remaining male doctors were encouraged to pursue lucrative surgical careers deemed unsuitable for women. The men had to provide for their families. The perceived 'softer' speciality of anaesthesia became available for females. Pioneers such as Mary Burnell, Greta McClelland and Margaret Smith were able to achieve academic and clinical stature partly due to the circumstances of war<sup>3</sup>.

Most recently, the Australian and New Zealand College of Anaesthetists (ANZCA), and Faculty of Pain Medicine (FPM) have strong representation of women in leadership. Four of the past six

presidents being female. Nevertheless in research, departmental leadership roles, supervisors of training, examinations, councils and committees women are still underrepresented.

Based on information available to date, gender inequity in anaesthesia and pain medicine results from the same range of factors that affect people of all occupations, more generally.

Key among these are the following factors:

1. Cultural: Gender stereotyping creates barriers to trainees and fellows seeking non-traditional roles, e.g. leadership for women and primary carer roles for men. Unconscious gender bias influences selection and advancement processes intended to be merit based.
2. Structural: Organisational processes designed to promote good governance can be contrary to their

# FEATURE

purpose when checks and measures are not in place to counter cultural factors that promote gender inequity. These include processes for governing recruitment to training positions, workplace appointments, selection to committees, invitations to conference speaker roles, promotion to leadership roles and support for research. Inflexible rules and expectations regarding part-time work, flexible working conditions and leave, pose substantial obstacles to people who have carer responsibilities.

3. Behavioural: Some research suggests gender-based differences in expressed self-confidence, self-promotion and other self-enabling behaviours that predominantly disadvantage women when seeking workplace training opportunities with supervisors and other career advancing opportunities.
4. Surveillance: Failure to measure and act upon evidence of inequity perpetuates inequity and reduces any likelihood that equity will be achieved.

## GENDER EQUITY POSITION STATEMENT

To address these issues, the ANZCA Gender Equity Working Group (GEWG) was formed in 2017. It comprises a group of co-opted fellows and professional staff with a number of initial aims:

- To examine the gender status quo in the organisation;
- to promote the importance of equal representation of women and men across our fellowship; and
- support an increase in women in leadership and management positions.

Within the first year, a Position Statement, Action Plan and Resource Toolkit were delivered.

The Gender Equity Position Statement articulates ANZCA and FPM's enduring commitment to gender equity for all trainees and fellows across the span and scope of their careers. Acknowledging



personal choice, the position statement seeks to achieve equal opportunity for trainees, specialist international medical graduates (SIMGs) and fellows of all genders.

## GENDER EQUITY ACTION PLAN

The Gender Equity Action Plan sets out how ANZCA and FPM will implement their strategy for gender equity across all aspects of anaesthesia and pain medicine practice over the period of the current strategic plan (2018-2022). The action plan is structured according to five focus areas, each of which is expanded upon with a series of objectives and strategies.

The five focus areas are:

1. Inclusive and equitable culture.
2. Diverse and representative workforce.
3. Flexible and empowering workplace.
4. Attention to gaps.
5. Strategic and accountable leadership.

Actions and steps already undertaken by the GEWG include:

- The ANZCA Annual Scientific Meeting Regional Organising Committee (ROC) has incorporated best practice guidelines for the selection of speakers and panellists into its convenor's guidelines. A benchmark for female speakers that reflects the average proportion of female delegates attending the ASM and other CME events should be set. This will be monitored and adjusted as appropriate.
- Renowned academic speakers, leaders, convenors and all future speakers at the ANZCA ASM will be invited to take the 'ANZCA Panel Pledge' in which they commit to enquire about the gender representation of speakers and panellists at the forum to which they are invited.
- In 2017 and 2018 a crèche facility and


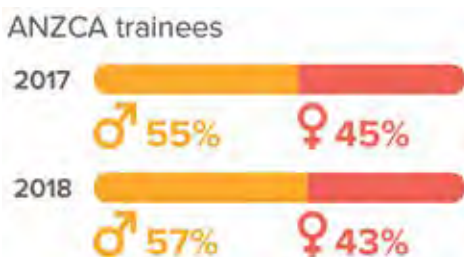
FOCUS AREA	OBJECTIVE	EXAMPLES OF STRATEGIES
 <p><b>Diverse and representative workforce</b></p>	<p>Set benchmarks for gender equity that take into account the current and future fellowship population and fellows' preferences.</p>	<p>Aim to achieve:</p> <ul style="list-style-type: none"> <li>• Equal proportional representation of men and women among trainees and SIMGs.</li> <li>• Proportional representation within groups that is not less than current population-based gender representation.</li> <li>• Proactive management of group membership to ensure proportional gender representation keeps in pace with that of the changing ANZCA and FPM populations.</li> <li>• Equal representation as the long-term target.</li> </ul>

Figure 1

- parents' viewing room have been available at the ANZCA ASM. Where possible, this will continue annually.
- In 2019, at the ANZCA ASM the inaugural Women in STEMM breakfast will be held, providing a scientific and social networking opportunity, celebrating the success and work of women in anaesthesia.
  - Time-based eligibility criteria for research awards including the Gilbert Brown Prize has been extended according to National Health and Medical Research Council (NHMRC) recommendations to take into account parental and other leave.
  - Criteria for application to the Emerging Leaders Conference has been revised, so that parental and other leave which interrupts the time-based eligibility, is accounted for.
  - In March 2019, ANZCA led the initiative of co-signing the United Nations Women's Empowerment Principles CEO letter of support, in partnership with the Royal Australasian College of Surgeons, the Royal Australasian College of Physicians, The Royal Australian and New Zealand College of Psychiatrists and the College of Physicians and Surgeons Canada.
  - A dedicated page on the ANZCA website has been created to annually report gender equity metrics.
  - 2019 International Women's Day was celebrated through the Geoffrey Kaye Museum of Anaesthetic History with a Women and Medicine symposium at ANZCA house.
  - The ANZCA Library team has developed a comprehensive Library Guide containing a large range of resources on gender equity including reading lists, links to articles, podcasts and multimedia.
  - Development of the Gender Equity Resource Toolkit for trainees, SIMGs and fellows who wish to contribute to achieving gender equity within their workplaces, professional roles and personal lives. The toolkit mirrors the action plan and position statement and is deliberately comprehensive to provide users with practical ideas and choices (available via [www.anzca.edu.au](http://www.anzca.edu.au))
  - Endorsement of benchmarked targets to drive monitoring and goal setting as recommended by the Australian Commonwealth Gender Equality Workforce Agency<sup>2</sup>. See Figure 1.



## WHERE TO FROM NOW?

We will continue to monitor and report data – to highlight successes and continue to address deficits. We will investigate

implicit bias training, leadership development programs and the role of mentoring and sponsorship.

The value of self-reflection and guidance in addressing implicit gender biases are particularly important. While we may not be aware of our biases we should take responsibility to question and review our thoughts, decisions, comments and actions. We must ask ourselves have we been prejudiced in any way and how can we take responsibility for change.

Accepting feedback and admitting bias is a significant step in addressing inequity and improving access and opportunities for women. Ensuring our individual thoughts and opinions are equitable, and that these ultimately inform and determine our actions is critical and perhaps this is where the biggest challenges in gender equity in medicine lie.

Dr Bridget Effene, FANZCA  
Member

ANZCA Gender Equity Working Group

## References

1. Doshi TL, Bicket MC. 'Why aren't there more female pain medicine physicians?' *Reg Anesth Pain Med* 2018; 43:516-520.
2. The Australian Commonwealth Government's Workplace Gender Equality Agency. Gender Strategy Toolkit: The business case for gender equality [Internet] Canberra (ACT): WGEA; 2016 pp5-9; [Cited date 11/09/2018] Available from <https://www.wgea.gov.au/content/gender-strategy-toolkit>
3. [GeoffreyKayeMuseum.org.au](http://GeoffreyKayeMuseum.org.au), Women anaesthetists in Australia and New Zealand.



## FEATURE



New York City: Medical College for Women, East Twelfth Street and Second Avenue—the Anatomical Lecture-room. Frank Leslie's Illustrated Newspaper, April 16, 1870, the Library of Congress collection

# THE RARE PRIVILEGE OF MEDICINE: WOMEN ANAESTHETISTS IN AUSTRALIA

This article is based on an article currently in press in the *Journal of Anesthesia History*, as well as numerous presentations and exhibition research.

In March 2018, the Geoffrey Kaye Museum of Anaesthetic History launched an exhibition in an online format, called *The Rare Privilege of Medicine: Women anaesthetists in Australia and New Zealand*. The exhibition got its name from the way Dr Tess Brophy, a former dean of the Faculty of Anaesthetists, often referred to the way in which medicine, and anaesthesia in particular, was a “rare privilege” that gave practitioners the opportunity to provide crucial assistance at critical times in peoples’ lives. It was also a play on the zeitgeist that sought to recognise and call out privilege, and it was

very definitely privilege, and perceived threats to it, that prevented women studying medicine for so long.

The exhibition highlighted 10 early women anaesthetists, many of whom were working in a time before anaesthesia was a recognised specialty. These women’s stories reveal them to have been pioneers and leaders, as well as having the potential to be inspirational in contemporary times.

## WOMEN IN ANAESTHESIA

One of the women included in the exhibition was Janet Greig. Greig finished top six in her graduation year of 1896 at the University of Melbourne. For almost any other student in her year, this would mean automatic eligibility for a 12 month residency at Melbourne Hospital.

A tradition had developed, and had been formalised in the hospital’s rules, where the top six graduates from each year were automatically offered a residency. The hospital argued its living arrangements were inadequate for women residents. Additionally, it was concerned about conversations which may be undertaken at meals, and that the presence of a ‘lady’ during discussions of an anatomical or surgical nature may have an inhibiting effect on the other residents.

Greig, and fellow top six graduate, Ælfreda Gamble, asserted that, rather than have a room each, they could easily share accommodation and turn the second room into a dining room, which would remove them from the men’s dinner conversations. They could also then make use of

the bathroom facilities for the nurses. Remarkably, media and public opinion were on their side. The hospital sought advice and guidance from the university's medical faculty. The university deferred back to the hospital, unwilling to take an active part in the decision making process, suggesting it look to the hospital's medical and surgical staff for guidance. After much discussion, and public censure, the hospital acquiesced and the two women were admitted as residents after the board voted 13 to six in their favour.

...the presence of a 'lady' during discussions of an anatomical or surgical nature may have an inhibiting effect on the other residents.

The women appear to have taken on the usual hospital rounds expected of residents and acquitted themselves admirably. Of particular note, and probably a critical factor in her future career choices, Greig trained in anaesthetics under the renowned anaesthetist, Edward Henry Embley. Within the archive of Dr Gwen Wilson, the former Honorary Historian of the Faculty of Anaesthetists of the Royal Australasian College of Surgeons, is a photocopy of a letter of reference written by Embley for Greig in 1903. He describes Greig as "exceptionally proficient" and how during her residency he regarded her "...as one of the most reliable Resident Anaesthetists of that and previous years".

At the time Embley wrote the letter of reference for Greig, she was applying for the position of Honorary Anaesthetist at the Melbourne Hospital. Honorary positions were, as the name states, without pay, and for a broad range of positions within public hospitals. Honorary appointments at teaching hospitals were considered prestigious, and the prestige made the individual practitioners more attractive to potential paying patients.

Professional relationships were developed and for anaesthetists, this meant direct access to surgeons, who would then use the anaesthetist in their private work. Without the honorary hospital appointment, there would be no access to the surgeons and, therefore, no work and no income.



Janet Greig. Photo collection of the Geoffrey Kaye Museum of Anaesthetic History.

By the time Greig was applying for the honorary position at the Melbourne hospital, she had already gained considerable experience as the Honorary Anaesthetist at the Queen Victoria Women's Hospital for the previous three years. This appointment places her in a distinct position of primacy as Australia's first woman anaesthetist. In a twist of poetic justice, Greig was appointed to the position at Melbourne Hospital and went on to hold both positions until 1917, along with her private practice. In 1917, she resigned from both her appointments as honorary anaesthetist, and took on the position of Honorary Physician at the Queen Victoria Hospital which was, at the time, considered a much more senior position.

## PROFESSIONALISATION

Greig's decision to leave anaesthesia practice also highlights the lack of professionalisation at that time. There was no formal training and no professional body concentrating specifically on the advancement of anaesthesia practice. Anaesthetics was considered a supplementary part of medical practice and, with a few exceptions, not held in particularly high regard. In order to advance her career, Greig needed to move into an already recognised specialty. It would take another 17 years after her resignation for a professional body, charged with advancing the practice of anaesthesia, to be formed. The Australian Society of Anaesthetists (ASA) was founded in 1934.

Dr Gwen Wilson, when describing the need for such an organisation, wrote that "all had come to understand that anaesthetics ... was now itself a science and an art and for its practice there must be training and teaching". The ASA was the first uniquely Australian body which would create a national "forum for discussion of anaesthesia", which many realised was missing.

Anaesthetics was considered a supplementary part of medical practice and, with a few exceptions, not held in particularly high regard.

## WOMEN AND LEADERSHIP

The ASA had 34 foundation members, with one woman amongst their ranks. The members included an executive committee of six and, unsurprisingly for the era, there were no women on the executive committee. Though many women had now made their careers in medicine and, presumably, anaesthesia, during the mid-1930s there was still significant resistance to their presence, particularly if it veered away from maternal and infant health and welfare.

# FEATURE



Mary Burnell. Photo collection of the Geoffrey Kaye Museum of Anaesthetic History.

The woman foundation member was a young Dr Mary Angel, who had graduated from medicine at the University of Adelaide only three years earlier. In the same year the ASA was formed, she was appointed Honorary Anaesthetist at the Adelaide Children's Hospital. This was to be the beginning of an impressive career in anaesthesia which would also see her elected president of the ASA in 1953, although then known as Dr Mary Burnell. 1953 was also the year she invited Dr Bernard Johnson from England to speak at the annual meeting of the society, held in Adelaide. This tradition of invited international speakers continues to this day and is a valuable opportunity for professional development.

Burnell was also instrumental in the formation of the Faculty of Anaesthetists at the Royal Australasian College of Surgeons, with many planning meetings apparently held in her home in Adelaide.

Burnell was also instrumental in the formation of the Faculty of Anaesthetists at the Royal Australasian College of Surgeons, with many planning meetings apparently held in her home in Adelaide. She was also a foundation fellow, one of six women, four of whom were from Australia, within a group of 40 invited fellows. Continuing to be recognised by her peers, she was elected dean of the faculty in 1966. This was early enough that she may well have been the first woman in the world to be elected dean of a specialty medical college faculty; something still to be verified. Alongside her elected positions, Burnell worked tirelessly to promote the professionalisation of anaesthetics in Australia.

The Faculty of Anaesthetists was formed in 1952 as 40 doctors from across Australia and New Zealand were invited to take up foundation fellowship. Of those 40, six were women, and four of those were from Australia. While Burnell and Dr Margaret McClelland are perhaps more recognisable than the other names, it is obvious all of these women were considered leaders in their day.

Dr Florence Marjorie Hughes graduated from the University of Melbourne in 1922. She went to England and gained her Diploma of Anaesthetics (DA) during 1939 and 1940, returning to Australia after the war. Her professional life has been difficult to document, and her contribution to anaesthetics is relatively unknown. However, she gained postgraduate qualifications which enabled her to share new knowledge in Australia and her position as a foundation fellow, which was by invitation from the interim board, tells a story of expertise and professional respect waiting to be rediscovered.

Another graduate of the University of Melbourne, Margaret 'Gretta' McClelland moved to the UK in 1936, continuing to live there throughout the war years, and was awarded her DA in 1942, in the middle of World War II. In 1946, she

returned to Melbourne and was later appointed Director of Anaesthesia at the Royal Children's Hospital. She was also elected president of the Australian Society of Anaesthetists. Her postgraduate qualifications and extensive work experience from the UK considerably boosted her career, and allowed her to play a very important role in developing the first exams for the Faculty of Anaesthetists, Royal Australasian College of Surgeons.

The Faculty of Anaesthetists was formed in 1952 as 40 doctors from across Australia and New Zealand were invited to take up foundation fellowship. Of those 40, six were women, and four of those were from Australia.

Lucy McMahon graduated from the University of Sydney in 1924. She was also the most elusive of the six women faculty foundation fellows, and yet she must have been a respected anaesthetist in her time, as she was invited to fellowship by the interim board. Much of the information about her was gained from the social



Margaret McClelland. Photo collection of the Geoffrey Kaye Museum of Anaesthetic History.

pages of Australian newspapers. After graduation she travelled, worked at the Canterbury District Memorial Hospital, and later at the Lewisham Hospital in Sydney. In 1938 she moved to England and remained there during World War II. On return, she worked closely with her two brothers, who were surgeons, and appears to have entered into Harry Daly's private practice.

## THE PROFESSIONAL STATUS OF WOMEN

During a visit to Australia in 1969, American anesthesiologist Professor Emanuel Papper, commented on the apparent equality of status of women anaesthetists in Australia and New Zealand. He declared it unique. This comment prompted both Dr Gwen Wilson and Dr Tess Brophy (later Cramond) to investigate. Wilson prepared a paper for the 1970 scientific meeting in Brisbane. As part of her presentation, she asked "What is status?". She narrowed it down to a twofold concept determined by academic stature and executive participation. Wilson concluded that women anaesthetists in 1970 had achieved professional status.

This sentiment was reiterated by Dr Brophy, then Dean of the Faculty of Anaesthetists, when she presented a paper on a similar topic in 1972. Brophy looked to the high standards of early women entrants to the specialty to explain the status of women. She cited career milestones from the likes of Drs Burnell and McClelland to illustrate those standards. A mere glance at the careers of these women certainly gives weight to her claim.

## LEADERSHIP TODAY

In 2015, some 43 years after Brophy's presentation, Professor Kate Leslie conducted a 'health check' on the status of women in anaesthesia. She noted that women represented almost 30% of fellows, and 45% of advanced trainees. There

had also been four consecutive women presidents of ANZCA, and over its 81 years, the ASA had also had four female presidents. Women have played strong leadership roles in medicine in general, and in anaesthesia in particular. However, to truly understand that role, it takes a re-evaluation of what leadership means. Historian, Carolyn Rasmussen, reminds us that early women entrants to medicine "...were usually among the top performers in their class, and exceptionally determined. As pioneers they had to be". In turn, their mere presence within the profession made them into leaders, and for many years the newest generation of medical women looked directly to the previous generations of medical women for leadership.

### Women have played strong leadership roles in medicine in general, and in anaesthesia in particular.

These women's stories happened at the coalface. They didn't necessarily put their names to research papers, invent anything, or take up directorships or other formal roles of leadership, and yet they were leaders nonetheless. We find them at the coalface because this was the space they were able to carve out for themselves in an often openly hostile work environment. The authority and expertise necessary to invent, research and publish, the traditional hallmarks of greatness, came much later, when their mere presence within the profession was no longer considered unusual or absurd.

However disenfranchised medical women were in the early years, when professional bodies for anaesthesia were developed, women were not just included but invited to participate. Their expertise and leadership was recognised and sought, and the fledgling specialty could only benefit from that.

The Geoffrey Kaye Museum of Anaesthetic History is still conducting research into early women anaesthetists. If you have any additional information about any of the women mentioned in this article, or other early women anaesthetists, please contact the museum by email [museum@anzca.edu.au](mailto:museum@anzca.edu.au).

Monica Cronin  
Curator, Geoffrey Kaye Museum  
of Anaesthetic History

## Sources and further reading

- 'Lady Doctors at the Melbourne Hospital', *The Argus*, 27 April 1892.
- Edward Embley, 'Letter of Reference for Janet Greig (copy)', in Gwen Wilson Archive (Geoffrey Kaye Museum of Anaesthetic History, 1903).
- Gwennifer Wilson, 'Janet Lindsay Greig: A Pioneer', *Anaesthesia & Intensive Care* 13 (1985).
- Geoffrey Kaye, Gwenneth Wilson, Garry Phillips, Barry Baker, *One Grand Chain: The History of Anaesthesia in Australia 1846-1962*, ed. Jeanette Thirlwell Jones, 2 vols., vol. 2 (2004).
- 'Lady Doctors and the Melbourne Hospital: Interview with Miss Gamble', *Weekly Times* 1896.
- Carolyn Rasmussen, 'Medicine', <http://www.womenaustralia.info/leaders/biogs/WLE0133b.htm>
- Prof Kate Leslie, 'Status report – women in anaesthesia in Australia and New Zealand', ANZCA Annual Scientific Meeting, Adelaide, 2015.
- Dr Tess Brophy, 'Women in Anaesthesia', Faculty of Anaesthetists, Royal Australasian College of Surgeons General Scientific Meeting, Hobart, 1972.
- Dr Gwennifer Wilson, 'Women in Anaesthesia', Faculty of Anaesthetists, Royal Australasian College of Surgeons General Scientific Meeting, Brisbane, 1970.
- Lives of the Fellows, online exhibition, Geoffrey Kaye Museum of Anaesthetic History, <https://anzca.online-exhibition.net/fellows/>

## FEATURE



# PREGNANCY AND RETURNING TO WORK FOR TRAINEES

## BACKGROUND

Training in anaesthesia can be a busy and stressful experience. The hours can be long and there are multiple priorities to juggle in order to meet the demands of both work and non-work roles. For many, the training years coincide with the time in life when they are starting (or growing) a family. In order to promote an inclusive and equitable work culture, it is important to identify and address issues facing trainees before and after the birth of a child (or children!).

A considerable amount of research has been conducted on the topic of maternal and pregnancy outcomes in relation to the work environment (both medical and non-medical), yet most of us know

relatively little about it. Where possible, it is important to use this research to further our understanding and guide recommendations, rather than relying on anecdotal reports, hearsay or opinion. For many, though, there is a very personal story behind the impetus to delve into the scientific foundation underpinning this subject and their experiences can also inform us about the current state of affairs and where improvements could be made.

In recent years there has been significant progress in our understanding of welfare issues for anaesthetists and trainees, with a corresponding growth in the availability of welfare resources. Pregnancy is a common life event and can be a time of significant additional pressure for

trainees. Combining the strenuous work of critical care medicine with pregnancy may put both mother and fetus at risk of adverse outcomes. Evidence regarding a link between adverse pregnancy outcomes and occupational activities is inconclusive, however, a meta-analysis has demonstrated an association between preterm birth and prolonged standing, shift and night work, and a high cumulative work fatigue score<sup>1</sup>. Pregnant anaesthetists also face other occupational hazards, such as exposure to anaesthetic gases, ionising radiation, and manual handling. Information about these risks and advice on how to mitigate them should be easily accessible. There are, however, limited resources available for the pregnant

anaesthetic trainee or their department to refer to, making it difficult to identify common issues and pro-actively plan for optimal support for pregnant trainees (or anaesthetists).

Returning to clinical work following parental leave can also be a challenging time. Despite paid parental leave entitlements in Australia ranging from ten to 16 weeks, it is common for longer periods of leave to be taken. There is no data for ANZCA trainees but a survey of RANZCOG trainees found that 13.1% experienced difficulties upon return to work<sup>2</sup>.

Upon return to work the trainee must negotiate a different set of circumstances that may include juggling work, childcare, altered sleep patterns, breastfeeding, and a change in family dynamics. Biological mothers, non-biological mothers and partners face common challenges and some that are unique to their situation. ANZCA has produced some resources designed to assist fellows and trainees returning to clinical practice, namely *PS50 Guidelines on Return to Anaesthesia Practice for Anaesthetists*<sup>3</sup> and *Guidelines on re-entry to training in clinical anaesthesia following an absence from anaesthesia practice*<sup>4</sup>. These resources can be applied to clinicians returning to work following an absence for a multitude of reasons, however, they are limited in scope and contain relatively few practical tips and guidance for the trainee.

In an article published last year in the *American Journal of Surgery*, Rangel and colleagues found that over 200 surgical trainees in the USA identified six recurring themes in relation to pregnancy, parental leave and return to work<sup>5</sup>:

1. The desire for work modifications during the late stages of pregnancy due to health concerns.
2. Inadequate length of parental leave.
3. Perceived stigma of pregnancy.
4. A need for greater lactation and childcare support.

ANZCA and FPM founded the Gender Equity Working Group in November 2017 and released its first Gender Equity Position Statement earlier this year as part of its commitment to advocate for gender equity. The Position Statement acknowledges that without recognition and positive action gender inequity will become more pronounced due to the increasing number of female anaesthesia trainees<sup>6</sup>. In 2017, 45% of trainees were female, and among the 31 to 35 year old cohort there were more female anaesthetists than male<sup>7</sup>; there is likely

to be a corresponding increase in the number of pregnant trainees. Two of the five focus areas of the Position Statement are particularly relevant to trainees that are starting or expanding their families: achieving a 'flexible and empowering workplace' and an 'inclusive and equitable culture'. Our working group have developed two resources that will aid positive progress towards these common goals and will ensure trainees can be consistently offered support during pregnancy and in their return to work.

5. A desire for mentorship on work-family integration.
6. The value of supportive colleagues and faculty.

While Australia and New Zealand tend to have better support and entitlements than the USA, the same themes resonate here and hence these areas must be addressed if we are serious about tackling all aspects of doctor's health and wellbeing. This critical time in a person's life and career can be a potentially vulnerable one – while there is a real risk of harm to parents and their babies, it is also an opportunity to support and strengthen our vibrant and diverse profession.

## WORKING GROUP

Having identified the importance of the issues facing individuals and families during pregnancy and following the birth of a child, we formed a working group of interested and enthusiastic people. This group included people with personal experiences navigating parental leave (both as primary and non-primary carers) and working while pregnant. A number of options were discussed for how to advocate for and promote positive change in this area, with the decision to initially develop a document outlining the facts and providing evidence-based recommendations.

As there are a number of separate but related issues and thus extensive material to cover, we decided that it would be most practical to divide this into two documents. The focus of the documents are *Pregnancy and the Anaesthetist* and *The Trainee Returning to Work*. These documents summarise relevant background evidence and provide recommendations of best practice for anaesthetists, trainees and their employers.

The objectives of these documents are:

- To raise awareness of issues related to pregnancy and returning to work.
- To advocate on behalf of pregnant workers, especially trainees.
- To advocate for a cultural shift towards a more evidence-based approach to dealing with pregnancy and return to work issues.
- To ensure inclusivity, acknowledging that parental leave encompasses many 'non-traditional' models including but not limited to stay-at-home fathers, foster parents and our LGBTIQ+ colleagues.

Thank you to all who contributed or provided feedback, including the ASA TMG Committee, ASA Vice-President Dr Suzi Nou, and particularly the ASA *Trainees Pregnancy and Return to Work Working Group* members – in alphabetical order:

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- Georgina Cameron (Provisional Fellow, Princess Alexandra Hospital, Brisbane).
- Izzie Cooper (Advanced Trainee, Royal Melbourne Hospital).
- Olivia Millay (Consultant Anaesthetist, Royal Women's Hospital & Alfred Hospital, Melbourne).
- Anna Pietzsch (Provisional Fellow, Sunshine Coast University Hospital, Birtinya).
- Emilia Reece (Consultant Anaesthetist, Princess Alexandra Hospital, Brisbane).
- Richard Seglenieks (Advanced Trainee, St Vincent's Hospital, Melbourne).
- Daniel Trevena (Provisional Fellow, Royal Melbourne Hospital).
- Maryann Turner (Provisional Fellow, Queensland Children's Hospital).
- Rosmarin Zacher (Advanced Trainee, Wesley Hospital Brisbane).

## **Pregnancy and the anaesthetist – Dr Isabelle Cooper (Advanced Trainee, Royal Melbourne Hospital)**

During my first pregnancy I was primarily concerned about the impact on my ability to safely and effectively perform my job, but also how my family planning choices and impending career break would be perceived. What would my colleagues think about the changes to the roster? Do my supervisors think I am serious about my job? Ultimately, I was worried about the effects of starting a family during training, despite knowing that pregnancy is a life event that the majority of women in the workforce experience and men contribute to.

I was reluctant to voice these concerns, especially to colleagues who had not experienced pregnancy, due to an irrational belief that I should be able to continue working in the same way, ignoring the effects of the human I was concurrently growing. I felt I was unable to adhere to the generic pregnancy advice of 'reducing stress' due to the inherently stressful nature of our job and additional hurdles such as exams and night shifts, and thus was failing at being pregnant

too. In summary, I was unprepared for how challenging being pregnant, sitting the primary exam, and working would be and I was neither offered nor did I ask for any additional support.

My baby swiftly arrived five weeks early at the end of a particularly intense day – a complicated aortic valve replacement followed by an awake fiberoptic intubation for an obstructing airway. My waters broke whilst I was looking after the latter patient and I was taken from my non-obstetric hospital to the conveniently located adjoining obstetric hospital by a consultant who kindly waited with me for my husband whilst my precipitous labour progressed. In hindsight there were a lot of things I should have done differently (working night shifts at 34 weeks, failing to call in sick with 'back pain' the day I had my baby), however, the irrational beliefs about pregnancy being grossly inconvenient to your colleagues and that your ability as an anaesthetist is already in question prevented me.

...I was unprepared for how challenging being pregnant, sitting the primary exam, and working would be...

Whilst it is impossible to know if my working patterns had any impact on the timing of delivery, I promised myself that my second baby would have a better in utero experience and would not need to make such a dramatic entry into the world. I was more prepared for the overwhelming fatigue and the recurrent syncopal episodes of the first trimester and felt more confident in making requests to have breaks, to change my shift patterns, and to ensure I was not exhausted prior to the arrival of my baby. I sat my Fellowship Exam early on in pregnancy and set realistic expectations about the amount of effective study I could achieve. Subsequently, I was able to comfortably

work to 36 weeks, delivered a healthy baby one week later, and most importantly had no niggling regrets.

In hindsight, I realise that taking the breaks you are entitled to and needing some flexible rostering in the third trimester is not a reflection of your ability as an anaesthetic trainee. Pregnant trainees should be reassured that they will be supported throughout pregnancy, enabled to voice any anxieties and concerns, and feel safe and confident in their clinical practice.

We hope that our document on Pregnancy and the Anaesthetist will help all anaesthetic trainees to have positive pregnancy experiences. The document is for both anaesthetic trainees and their departments and aims to provide evidence-based practical advice to help support the pregnant anaesthetist and to ease the process of navigation through the necessary formal requirements. It will help trainees save time and energy looking for answers to commonly encountered questions and ensure they feel empowered to prioritise their wellbeing during their working pregnancy journey. Some key points include:

- Acknowledgement of the strenuous and stressful nature of our work, and the potential impact this may have on the pregnant anaesthetist given the highly variable pregnancy experience.
- Considerations to make whilst planning a family and suggestions as to how to minimise the effects of potential stressors, such as rural rotations and exams.
- Rights and responsibilities of the employer and employee and where to find further information on state-based entitlements.
- ANZCA requirements for interrupted training.
- Summary of occupational hazards specific to anaesthesia, e.g. exposure to anaesthetic gases and ionising radiation, and psychological hazards.

- The many benefits of a 'pregnancy-friendly' workplace, and some of the universal components of this as outlined by the Royal Australasian College of Physicians in their Guide to Pregnancy and Work.
- Parental leave including information on partner's leave and a summary of state-based entitlements in terms of number of weeks full pay.
- Financial matters and details of government funded entitlements.
- List of relevant resources and links to further information.

### **The trainee returning to work – Dr Anna Pietzsch (Provisional Fellow, Sunshine Coast University Hospital)**

When I returned to work as an introductory trainee after a year of maternity leave, I felt overwhelmed and out of my depth. There was no formal process for a trainee returning to work after a period of absence, and I started on the on-call roster in my first week. I constantly had the feeling that the other registrars were on top, riding the wave while I was falling behind, clinging on with my fingertips. The words 'work like you don't have children, and parent like you don't have a job' were always echoing in my mind.

One particular event in which I did not leave work to collect my son who had a minor head injury at daycare, will always stand out to me as a reminder of my conflicting commitments. We were new to the daycare game and had so much time off work with URTIs and then hand foot and mouth that I did not feel I could leave work again and let my department down. Daycare was so concerned about the fall that the director sent me a photo of his head and it was a terrible bump. Despite my requests to keep him awake and observed, when I collected him he was asleep and my heart skipped a few beats as I went to gently wake him.

In the early phase of balancing new family commitments and the steep

learning curve of introductory training, I was drowning and did not know where to turn for support. Not only was I struggling to be present at work both physically and mentally, but there were the added pressures of starting in a study group in my first week of work, with the concern that if I didn't then I would be left behind. It was during my second return to work that I realised some of the processes that could have made my first return to work a more supported, safe and deliberate process. As a member of the ANZCA Queensland Trainee Committee, it has become even more apparent that trainees do not know where to turn for help or guidance when returning to work, and often hospital departments and SOTs lack experience in how to smoothly facilitate this process.

#### **Before Leave**

- Plan leave (start date, duration, return to work full-time or part-time).
- Review current needs assessment if still training and negotiate as required.
- Notify supervisor and head of department, HR, college (need approval for interrupted training).
- Notify medical indemnity provider and AHPRA.
- Negotiate access to paid leave, consider Centrelink.
- Investigate access to pre-natal leave if pregnant.

*The Trainee Returning to Work* document has evolved from a sizeable volume of feedback sourced from trainees and fellows Australia-wide. The document is primarily about the return to work process, but importantly we felt that planning for this event by first addressing the period prior to leave and time during leave was critical. Due to the rotational nature of training, it is common for trainees to take leave from one department and then

complete the return to work process in a new department, hence the need for standardisation of the process across training sites. Ultimately, the success of this process relies on trainees taking ownership and accountability for their training journey.

Before leave, the trainee should think about how long they will be away and in what capacity they hope to return to work. There are a number of documents to complete which include applying for interrupted leave from ANZCA and notifying your head of department, SOT and rotational co-ordinator (as appropriate) regarding your plans. Performing a needs analysis prior to leave will allow the trainee to have a long-term outlook on when they will complete specialist SSUs and exams, and how they can meet their VOP and WBA requirements. While on leave the trainee will not have access to their TPS, so having everything up to date prior to leave is a must.

Maintaining flexibility about return to work plans will be important, not just because parenting can be unpredictable but also because each department will have a different structure and plan of how leave and return to work can be

#### **During Leave**

- Enjoy leave!
- Revise return-to-work plan (be flexible).
- Keep in touch (meetings, education sessions, maintain contact with department/supervisor).
- Consider maintaining skills (courses, conferences).
- Start planning return-to-work (schedule meeting with supervisor, negotiate increased supervision on returning, etc.).
- If choosing to continue breast-feeding, plan for practicalities of feeding/expressing at work.

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accommodated. It is impossible to plan for and predict the unpredictable, like illness and poor sleep, and both trainees and departments should be as adaptable as possible within rostering constraints. While on leave, people may be able to do some 'keeping in touch' activities and maintaining email correspondence with the department will be helpful for this. The main focus during leave should be wellbeing and bonding, but some people may want to explore conferences and courses to maintain currency of knowledge.

Before returning to work, the trainee should aim to speak to their SOT to discuss the type and timing of supervision required and also to negotiate the capacity in which they will return to work. A planning CPR on return to work will allow for a formal discussion with the SOT, and this is a time for the trainee to confirm level 1 supervision, case mix, discuss return to after-hours work, plan for up-skilling courses like ALS and CICO, find out about expressing facilities and ideally the allocation of a mentor. This person, who hopefully has been through a return to work and is a member of the welfare team, can be a solid support to the trainee returning to work. The CRASH course run at Royal Melbourne Hospital is a course targeted at trainees and fellows returning

to work in critical care medicine and recognises the need to relearn skills and build confidence after a career break.

My second return to work to the Royal Brisbane and Women's Hospital was much more successful than my first. I negotiated part-time hours that fit really well with my family life and was not allocated to after-hours work for the first eight weeks, to allow time to regain my skills and confidence. The department had a large number of parents (both trainees and anaesthetists) who were managing the work/life juggle and were happy to offer advice and support as required. This department has a very active welfare group and already has a return to work document that is used as a guide for trainees and SOTs, which has been part of the inspiration for this national document. The support I received not only from the department but also my family, allowed me to attack my fellowship exam with maximal confidence and I believe this was crucial in receiving the Cecil Gray Prize for my fellowship exam performance.

## CONCLUSION

Balancing the demands of work, training and the rest of life is often challenging. This can be exacerbated by the additional pressures associated with pregnancy, parental leave, family duties and returning to work after leave. The ASA Trainees Pregnancy and Return to Work Working Group has developed two documents covering *Pregnancy and the Anaesthetist* and *The Trainee Returning to Work*. We hope that these documents will be useful resources for anaesthetists, trainees and their employers.

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Dr Anna Pietzsch  
Dr Richard Seglenieks  
Dr Rosie Zacher  
on behalf of the

ASA Trainees Pregnancy and  
Return to Work Working Group

## References

1. Mozurkewich EL, Luke B, Avni M, Wolf FM. 'Working conditions and adverse pregnancy outcome: a meta-analysis'. *Obstet Gynecol* 2000 Apr; 95(4):623-635.
2. de Costa CM, Permezel M, Farrell LM, Coffey AE, Rane A. 'Integrating parental leave into specialist training: experience of trainees and recently graduated RANZCOG Fellows'. *Med J Aust* 2013 Sep 2;199(5):359-362.
3. ANZCA. PS50 Guidelines on Return to Anaesthesia Practice for Anaesthetists 2017. <http://www.anzca.edu.au/documents/ps50-2016-guidelines-on-return-to-anaesthesia-prac.pdf>.
4. ANZCA. Guidelines on re-entry to training in clinical anaesthesia for trainees following an absence from anaesthesia practice 2017. <http://www.anzca.edu.au/documents/ta-guidelines-on-re-entry-to-training-in-clinical>.
5. Rangel EL, Castillo-Angeles M, Changala M, Haider AH, Doherty GM, Smink DS. 'Perspectives of pregnancy and motherhood among general surgery residents: A qualitative analysis'. *Am J Surg* 2018; 216(4):754-759.
6. ANZCA. Gender Equity Position Statement 2019. [http://www.anzca.edu.au/documents/gender-equity\\_statement\\_final.pdf](http://www.anzca.edu.au/documents/gender-equity_statement_final.pdf)
7. Watterson L. 'Endorsing gender equity'. *ANZCA Bulletin* 2018. March; pp. 18-21.
8. ANZCA. Re-entry into anaesthesia training program plan for ANZCA trainees 2017. <https://www.anzca.edu.au/documents/ta-trainee-re-entry-to-training-needs-assessment-t.pdf>.

### After Leave

- Meet with supervisor in first week to complete placement review and ANZCA return-to-work plan<sup>8</sup>.
- Increased supervision initially → assessment → gradually decreased level of supervision.
- Scheduled and regular meetings with mentor or welfare advocate.
- Discuss access to specific required facilities (e.g. for breastfeeding or expressing).
- Attend relevant courses e.g. ALS, CICO.



# PARENTING DIFFICULTIES AND ANAESTHETIC TRAINING

It's an overwhelmingly difficult decision to submit this article for publication. I received advice from close colleagues and friends to publish anonymously or not submit at all.

And yet I can't truly applaud those that have had the courage to tell their story of vulnerability, whilst I hide my own.

I make specific reference to the article written by Dr Steve Robson in *Insightplus* last year. Twenty years later I also received the same advice "Under no circumstances tell anybody..."

I do submit this article echoing Dr Robson's statement, "...to use my own example to point out that mental health problems are nothing to be ashamed of."<sup>1</sup> Be they as a result of the stress of training, the difficulties of parenthood, or just because.

I started in a Post Graduate Medicine program at what felt at the time as being relatively late in life. I had barely finished internship when my wife wanted to start our family. She had patiently waited through "I just want to finish medical school", "I just want to finish internship" and was no longer listening to "I just want to get onto a training program".

To her credit, and with hindsight "I just want to get onto a training program" would have then become "I just want to pass the primary exam" and so on until I established a specialist practice.

The above culminated in our eldest son being born during my first week of anaesthetic training.

Neither of us look back on this as being a happy time. I was participating in an ICU 24/7 roster with three other registrars and

no capacity for taking leave. I was by far the most junior, and was left to cover ICU alone at night in a tertiary hospital before having learnt to intubate or insert invasive monitoring. Long 14 hour rostered night shifts would finish with an extra one hour handover. Adding return travel time home, I would have eight hours to eat, sleep, shower and repeat.

My wife started describing herself as a single mother and struggled with our newborn who had constant colic. My wife's days, that first week, were spent hiding with a newborn at the back of our small duplex, trying not to make noise so I could sleep.

I am sure our story is not unique, I only tell it to give context to my motivation for part-time training.

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At this point, part-time training was not a realistic option as job-sharing was difficult to coordinate and organise and it was certainly frowned upon by both HR and the SOTs. Part-time training would have limited the exposure to clinical workload, complex cases and to develop expertise and fluency in routine cases. Finally, part-time training would not have been economically realistic so early on in specialty training.

## EXAMS

With or without children the exams are a difficult and stressful process. For me, part-time training would have been disadvantageous in the lead up to either exam.

I benefitted from my wife taking over the vast majority of childcare, and time with my children was a 'luxury' as compared to a logistic necessity.

Between initially studying for and then re-sitting a failed Primary Exam, finishing the Research Module and sitting the Fellowship Exam as soon as I was eligible, I studied and worked full-time without pause for two-and-a-half years.

In that time, my son had learnt to walk, talk and was attending 'Early Learning Daycare'. My daughter was born between exams and was 15 months old by the time I had completed the Fellowship Exam. Unfortunately, the priority during these years was working first, then studying over parenting.

I don't consider it was to the detriment of the relationship I have with my children now, and I agree with the advice given at the time that they will be (and were) too young to remember.

Having said the above, I poignantly remember returning from Melbourne clutching my piece of paper from the College with a large 'P', triumphantly telling my three-year-old, "no more study, I passed my exam." The next morning as I tried to enter my study to catch up on emails, the door was barred by a defiant

child arms widespread scowling "no more study, Daddy, no more study". As much as I like to console myself it has no effect now, certainly my absence was felt at the time.

## SKILL ACQUISITION

I cannot understate the importance of clinical exposure, unofficial time with examiners in theatre and maintaining a connection with colleagues through a study group that comes with full-time work. I changed to part-time training after successfully passing my fellowship exam.

On more than one occasion I was told it takes 10,000 hours to become an expert and that it was to my detriment I had chosen to train part-time. By coincidence or design, working a 40 hour week, for 50 weeks per year equates to 10,000 hours in five years; the minimum time for training in anaesthesia. Ten thousand hours is only mentioned once in Ericsson et al's article 'The role of deliberate practice in the acquisition of expert performance'.<sup>2</sup> Subsequent meta-analysis by McNamara et al found accumulated amount of practice explained less than 1% of the variance in performance by professionals.<sup>3</sup>

The key issue in both papers, relative to anaesthetic training, is 'a measure of performance reflecting level of skill' was required.<sup>2,3</sup> The overall outcome of an episode of anaesthesia cannot be arbitrarily reduced to a single measure of performance. Quality is hard to define.

It is deliberate practice, not hours of accumulated practice, that determines the variance in performance.<sup>4</sup> The skill acquisition of a part-time trainee is reflective of the trainee and the quality of their experience than the number of hours worked per se. It is likely that more hours at work increases the probability of exposure to higher quality teaching. External influences, such a distracting home life can also affect the quality of the learning experience.

## GENDER EQUITY

It was only after I failed my primary exam that I realised none of the inspirational quotes on failure take into account looking your spouse or child in the face and telling them "it's not over, I failed". There is no accounting for the sacrifice made by those around you when Roosevelt orated:

*"...The credit belongs to the man who is actually in the arena, whose face is marred by dust and sweat and blood; who strives valiantly; who errs, who comes short again and again..."*<sup>5</sup>

Coming short again and again is all well and good in the acquisition of knowledge and skill, not so much when parenting.

However I spent my time, I felt guilty. Guilty that I might fail the exam through a lack of study or guilty I was failing as a parent. Note, that time with my wife almost wasn't thought of, let alone time with other family, friends or supports.

With an overall pass rate of less than 100% for examinations, trainees will fail exams. I can happily admit I failed the primary exam, and yet, almost ten years later it is still with some shame I admit to difficulty completing my training.

According to Cooklin et al,<sup>6</sup> I had managed the perfect combination of work characteristics associated with increased distress in post-partum fathers. My version of part-time was 0.75FTE giving two quarantined days per week from my training job. I was still on the roster for after hours and nights as was appropriate. The Head of Department was extremely supportive but there is a limit to how flexible a trainee roster can be and still provide a reliable service to the hospital.

*"Long and inflexible work hours, nightshift, job insecurity, a lack of autonomy and more children in the household were associated with increased work-family conflict, and this was in turn associated with increased distress."*<sup>6</sup>

I had no idea anything was wrong with my work performance at my training site; I had been in the same department for the previous 12 months with "All in all a good assessment". There was no initial interview or mid-term interview. I had passed all my exams. Unexpectedly I was pulled aside and told that at my final interview I would be receiving a 'does not meet expectation'.

I was suspicious all was not well as I would sit in the driveway crying after driving home. I couldn't bring myself to walk through the front door. But as with so many before me, with so many varied issues of their own, I thought it was just me, and that it wasn't affecting my work.

I had post-partum depression.

I suspect that remediation would have been completely different had this been a mother struggling with under-performance. In the various meetings that subsequently occurred, even though I identified difficulty at home following the birth of our child, I was dismissed with "There did not appear to be any temporal relationship between the underperformance... and the subsequent increase in childcare."

## REMEDIATION

Remediation for me was not the supportive, holistic and collaborative process it is made out to be in the Trainee Handbook. Instead, it was a period of increased surveillance with the goal of accumulating enough evidence to trigger a Trainee Performance Review (TPR), rather than improving sufficiently to avoid it. It felt like the principles of natural justice were lacking.

Defining my under-performance was difficult, and I do not deny there were inconsistent examples. Thankfully the number of examples were low, and as far as I am aware no patient outcome was compromised. But as is the nature of anxiety and depression, it was impossible to identify a pattern or obvious point to

remediate. Looking for patterns at work did not account for what was happening at home.

I was mandatorily forced to give up part-time training. I understood why I should return to full-time training and didn't otherwise object. It was specifically intimated that the TPR process, which was described to me as 'brutal', would be initiated if I did not act in accordance.

I was given two weeks written notice that I was to restructure my work (and finances) or face a notification to AHPRA for impaired performance. I regarded the notice as predatory, bullying and intimidating. Threatening an AHPRA notification felt overly punitive and completely unnecessary as I was being compliant in every way that I could.

The Head of Department was unwavering in their support. The department assisted in creating a clinical mentor and a separate support person who also became an advocate. Having a clinical mentor separate to the support person became extremely important. There were times I needed an objective clinical evaluation for training purposes, and there were other times I just needed someone to say 'you got this', someone I could spend time in theatre with and not feel judged. I am grateful to the SOT at the time who I believe negotiated a very difficult situation. The SOT met with me regularly and did their best to guide me, but was under external pressure.

I finished my training without further incident. As awful as the experience was, it made me both a better anaesthetist and more importantly, a better father.

Earlier identification of at risk trainees, and indeed, at risk doctors will be to everyone's benefit. We do not practice medicine in isolation from the rest of our life as much as we like to think.

I lacked both the training and insight to realise not coping at home can influence what happens at work and how the

process can continue feeding on itself. I was stuck in the mentality of trying to get through exams and finish training to the exclusion of all else, including my own mental health. It was always the perpetual loop; once I complete x, then I'll be able to look after my health, then I'll be able to catch up with friends, then I'll be able to take my spouse out, then I'll make up for lost time with my kids, without appreciating that looking after your own health, catching up with friends and spending time with your spouse and children is not only protective, but brings meaning to what we do.

Mike Soares

## References

1. Robson S. 'Learn from me: speak out, seek help, get treatment', *Insight Plus*, 2018; 41.
2. Ericsson KA, Krampe RT, Tesch-Römer C. 'The role of deliberate practice in the acquisition of expert performance', *Psychol Rev* 1993; 100:3. <https://doi.org/10.1037/0033-295X.100.3.363>.
3. Macnamara BN, Hambrick DZ, Oswald FL. 'Deliberate practice and performance in music, games, sports, education, and professions: a meta-analysis'. *Psychol Sci* 2014; 25:8. <https://doi.org/10.1177/0956797614535810>, <https://www.ncbi.nlm.nih.gov/pubmed/24986855>.
4. Hambrick DZ, Altmann EM, Oswald FL, Meinz EJ, Gobet F, Campitelli G. 'Accounting for expert performance: The devil is in the details', *Intelligence* 2014; 45. <https://doi.org/https://doi.org/10.1016/j.intell.2014.01.007>, <http://www.sciencedirect.com/science/article/pii/S0160289614000087>.
5. Roosevelt T. 'Citizenship in a Republic', (Speech, Paris, April 23 1910).
6. Cooklin AR, Giallo R, Strazdins L, Martin A, Leach LS, Nicholson JM. 'What matters for working fathers? Job characteristics, work-family conflict and enrichment, and fathers' postpartum mental health in an Australian cohort', *Soc Sci Med* 2015; 146:214-222. <https://doi.org/10.1016/j.socscimed.2015.09.028>, <https://www.ncbi.nlm.nih.gov/pubmed/26520473>.

## FEATURE



# AUSTRALIAN SOCIETY OF ANAESTHETISTS' 85TH BIRTHDAY

## THE FOUNDATION

This year the Australian Society of Anaesthetists (ASA) celebrates 85 years since its foundation in January 1934. It seems timely to reflect on the history of the creation of the Society and its development to the present day.

The ASA was the third Australian medical organisation to be established. Its founding was preceded only by the Royal Australasian College of Surgeons in 1927 and in 1930 by the Association of Physicians, later to become the Royal Australasian College of Physicians.

Prior to the establishment of these associations, only an Australian branch of the British Medical Association had existed, the AMA not being founded until 1962.

The BMA was critical of the formation of the ASA – in 1929 the BMA, Australian Branch, had itself established an Anaesthetic Section at its National Congress in Sydney. An American anaesthetist, Dr Frank McMechan, attended this meeting where he met and inspired 26-year-old Dr Geoffrey Kaye to consider establishing an Australian Society of Anaesthetists.

Over the next five years, Dr Geoffrey Kaye came to believe there was a need for an independent Australian Society of Anaesthetists, rather than merely a section within an Australian branch of the BMA. He argued that this would improve the status of anaesthetists and would enable the formation of regulations and committees that would have the sole purpose of promoting the affairs of

anaesthetists. Eventually, it could have its own research and education programme, museum, library and journal.

It was during the 1934 Australasian Medical Congress (BMA) that the ASA was founded by seven men of great vision who met at Hadley's Hotel in Hobart, most likely on January 19 of that year.

At its foundation the objectives of the ASA were recorded as:

1. To improve the status of anaesthesia in Australia.
2. To facilitate the exchange of ideas between Australian anaesthetists and between them and overseas anaesthetic organisations.
3. To encourage research into questions appertaining to anaesthesia.

4. To arrange the publishing of articles on anaesthesia.

Those seven men were: Dr Gilbert Brown, Provisional President; Dr Geoffrey Kaye, Provisional Secretary; Dr Harry Daly; Dr Cedric Duncombe; Dr Ivor Hotten; Dr G. Leonard Lillies; Dr Gilbert Troup.

There were very few full-time anaesthetists in Australia at that time – general practitioners provided most anaesthesia. Hence these founding fathers worked hard and with great enthusiasm to establish the ASA from scratch.

The first Official Memorandum of the Society was dated 18th September 1934, and it held its first national meeting in September 1935.

Dr Gilbert Brown, in his Embley Memorial Lecture of 1939, outlined his idea of the organisation of anaesthesia in Australia, which included a Professorial Department at each university and a Department of Anaesthesia at each hospital. These were ideas far in advance of their time.

## EDUCATION

From its inception education was the core business of the ASA. Each of its original objectives was based on education.

As those founding fathers knew, the status of anaesthesia and anaesthetists is based on the quality of the anaesthesia



Dr Frank McMechan

being provided. From excellence all else will flow, including, if combined with top-grade advocacy, improvements in remuneration.

In 1934 there was a great need for the ASA. Anaesthesia was very hazardous.

Dr Geoffrey Kaye researched anaesthesia related deaths in Melbourne in 1936; he surveyed 500,000 operations at 14 hospitals and found mortality rates of 1:1000. This research was published in the *Medical Journal of Australia* and the *British Journal of Anaesthesia*.

Today's Australian anaesthesia mortality figures are 1:220,000 where anaesthesia was the direct contributor to death.

Such a vast improvement is, above all else, based on the education of anaesthetists in which the ASA has been involved since its inception.

## National Scientific Congress

The first ASA AGM was in Melbourne in 1935. This meeting immediately followed the BMA's annual Australian Congress which was also on this occasion, the BMA's Annual General Meeting, being held outside of the UK for only the second time in its 103-year history. There were over 1000 delegates. As such the ASA had an excellent opportunity to utilise some of these delegates as speakers at its meeting.

In 1935 the Society commenced the tradition of inviting an overseas speaker. Dr Zebulon Mennell was the first invited speaker of the Society. He was a Senior Anaesthetist at St Thomas's Hospital, London and Treasurer of the Association of Anaesthetists of Great Britain and Ireland. This tradition continues to this day.

The ASA NSC has grown to be an extraordinarily well-organised annual event combining excellent science with interesting social events.

## Regional meetings

The one-day meeting or evening meeting organised by the State Sections has been



Dr Zebulon Mennell

an activity of the ASA since its inception. Since 1980 the Faculty, later College, and the ASA have combined to produce regular meetings in all states. At times, if the subject matter is mainly medico-political or industrial, the ASA runs the meeting independently. This joint ANZCA/ASA Continuing Education is the way of the future with the two organisations working together.

## Special interest groups

In 1998, in conjunction with ANZCA and the New Zealand Society of Anaesthetists (NZSA), the ASA established special interest groups which allowed particular academic areas of anaesthesia to be pursued. These groups are another example of the close relationship which has steadily developed between the ASA, ANZCA and the NZSA. These special interest groups hold separate educational meetings as well as contributing sessions to major meetings.

## Anaesthesia and Intensive Care

From its inception, the ASA has had, as an objective, the publishing of articles on anaesthesia.

January 1935 marked the publishing of the first of a series of 'Anaesthetic Numbers' in the *Medical Journal of Australia*.

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Hadley's Hotel, Hobart

Later the ASA Newsletter commenced, which was part scientific and part informatory. It was primarily the work of Dr Geoffrey Kaye who was its driving force for 20 years.

At the 12th AGM in Perth in 1954, a resolution was passed that the "Society should take steps to institute a Journal of Anaesthesia in Australia". Unfortunately, it did not eventuate until 18 years later.

In 1970 the Honorary Federal Secretary, Dr Benedict Barry, developed a plan to establish an Australian Journal of Anaesthesia. In August 1972 the first issue of *Anaesthesia and Intensive Care* was published with Dr Ben Barry the editor.

One of the key factors in the early success of the Journal was the very major decision by the Faculty of Anaesthetists to officially support the Society's new journal, *Anaesthesia and Intensive Care* as the sole scientific publication in Australia for anaesthetists and to withdraw its active

participation in the College of Surgeons' scientific journal, *The Australian and New Zealand Journal of Surgery*.

The Journal has flourished and, 47 years later it remains the 'Jewel in the Crown' of the Society.

## AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS

In 1944 the University of Sydney introduced a course for a Diploma in Anaesthetics, the University of Melbourne followed in 1945. Before the University of Melbourne introduced its Diploma it invited the Society to develop and run a national Diploma in Anaesthetics. The ASA declined the invitation, not wishing to, at the time, have two categories of membership, one for those with a diploma and the other for those without one. Nevertheless, the need for a national Australian anaesthesia qualification was

a major Society activity for the next 10 years. In 1946 the Executive established a subcommittee charged with commencing informal discussions with the College of Surgeons and the College of Physicians

Discussions ensued for years between the Australian colleges and their English counterparts in order to find a way forward. Finally, ASA Past President Dr Harry Daly made a breakthrough in January 1950 when the College of Surgeons expressed some interest in his proposal to have a Faculty of Anaesthetists within the College of Surgeons. At the ASA AGM of May 1950, a motion was passed to formally approach the College of Surgeons to found a Faculty of Anaesthetists within the College. This Faculty would be responsible for producing a national Diploma of Anaesthesia.

The College of Surgeons' response was favourable, so the ASA appointed a subcommittee to commence the detailed discussions with the College. In August 1952 the Faculty of Anaesthetists was formally inaugurated, and the first examinations were held in 1956.

Undoubtedly one of the greatest achievements of the ASA was the formation of what is now the Australian and New Zealand College of Anaesthetists. It has become a superb College and in combination with the ASA serves to support excellence in anaesthesia and raise the profile of anaesthetists.

## INDUSTRIAL ADVOCACY

Interestingly the idea of the Society having a medico-political or industrial role was quite foreign to Dr Geoffrey Kaye and the other founders. It was assumed the BMA would undertake this. Today, of course, this is core Society business.

From its commencement in 1934, ASA members were required to be BMA members. The Society was formally affiliated with the BMA from 1945 to 1951

to better direct its industrial advocacy for anaesthetists.

The BMA was the only body with which jurisdictions would communicate over industrial issues; unfortunately, the BMA failed to represent anaesthetists adequately.

The Colleges were also hamstrung as they had had legal arrangements in place since 1943 not to participate in medico-political discussions.

On 12th March 1953, the National Health Service Act was gazetted, and the Commonwealth National Health (Medical Benefits) service was introduced from 31 July 1953.

The schedule of Medical Benefits of 1953 for anaesthesia was considered by the ASA Executive of 1953 to be:

1. Far too low.
2. No benefit existed for the pre-anaesthesia consultation.
3. The items were inappropriate.
4. The time taken for the anaesthetic received minimal consideration.

There were innumerable anomalies for anaesthetists in this schedule, some of which were to be perpetuated for over 50 years.

With the founding of the AMA in 1962, the ASA began to have an industrial voice; however, progress was extremely slow.

In the 1960s the ASA came to recognise the American Relative Value Guide (RVG) as a vastly superior fee and rebate schedule to that used in Australia, as it was based on the anaesthesia performed, not on the surgery that was done. It took nearly 40 years of lobbying by the ASA to have the RVG adopted as the system to determine anaesthesia fees and rebates by first, the AMA, then Third Party and Workers Compensation insurers, and finally by the Medicare Benefits Schedule (MBS) in 2001. This was complemented by a new time-based consultation structure in the MBS in 2006.

The ASA has grown to be a strong industrial advocate for its members. However, there is still much to achieve. Anaesthetists are still shackled by the rebate relativities that existed when the Society was founded in 1934. Today however more anaesthetists are charging what they are worth.

## INTERNATIONAL RELATIONS

Well before the Society was founded the influence of anaesthetists from other countries has been very significant. Dr Frank McMechan inspired Dr Geoffrey Kaye to establish a Society and enabled him to meet many of the most influential anaesthetists of the era.

One of his lifelong friends became Dr Ralph Waters, founder of the Post-Graduate School of Anesthesiology at Madison, Wisconsin and doyen of anaesthesia.

The sharing of ideas with anaesthetists from other countries was one of the original objects of the ASA, and it remains invaluable both in improving our knowledge and skills and in the imparting of knowledge to others, particularly in developing countries.

From the beginning, international visitors to the National Scientific Congress were seen as a vital component of the meetings. Visitors were often asked to travel to two or three cities to lecture and teach after the NSC. This established contact with some of the best anaesthetic departments in the world, which in turn allowed young Australian fellows and registrars to travel to work and study abroad at centres of excellence including Oxford and Harvard.

The ASA was a foundation member of the World Federation of Societies of Anaesthesiologists (WFSA) in 1954 and has been very active ever since, culminating in the Society hosting the 11th World Congress in Sydney in 1996. It had 10,000

in attendance and was the largest medical meeting ever held in Australia up to that time.

The ASA has supplied many office bearers to the WFSA including its President in 2000, Dr Kester Brown.

In 1971 the ASA established the ASA Action Fund with funds being allocated to assist anaesthetists in developing regions. This anaesthesia educational aid to third world countries has steadily grown under the direction of the Overseas Development and Education Committee (ODEC). This committee has made an enormous contribution through a succession of selfless anaesthetists who have given large quantities of their time and energy to educate anaesthetists in developing countries.

Rather than bringing anaesthetists to Australia, the Society's approach has been to send Australian anaesthetists to the countries in need for between three and 24 months. This aims to give local practitioners the skills to provide and teach anaesthesia.

The ASA has long had a special relationship with the Association of Anaesthetists of Great Britain and Ireland (AAGBI). At its first AGM in 1935 Dr Mennell, the Treasurer of the AAGBI, formally invited the ASA to enter into affiliation with the AAGBI; the ASA accepted. In 1949 the AAGBI inaugurated a travelling scholarship for a young ASA member to study in England for a year. This was in thanks for all the food parcels sent by the ASA to the AAGBI for distribution amongst its members during WW2 and through to 1952.

Similar close relationships have existed particularly with the New Zealand Society of Anaesthetists (NZSA), the American Society of Anesthesiologists (ASA, USA) and the Canadian Anesthesiologists Society (CAS).

The sharing of ideas with anaesthetists from other countries was one of the

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original objects of the ASA, and it remains invaluable both in improving our knowledge and skills and in the imparting of knowledge to others, particularly in developing countries.

## FINANCES AND MEMBERSHIP

Today the ASA is in a sound financial position; in 1934 there was nothing. Annual subscriptions were initially set at 10 shillings and sixpence, 7% of the seven guineas charged by the College of Surgeons, a reflection of comparative incomes of the day.

In 1948 Dr Geoffrey Kaye estimated that anaesthesia fees were much the same as they were 40 years earlier despite the 40 years of inflation. Anaesthetists did not earn a significant wage, so the subscriptions had to be low.

By 1962 there were 420 members, in 1984, 1559, while today there are 3552 members.

*The original aims and objectives of the Society remain current to this day. The Society was founded to represent and support anaesthetists.*

The continuing growth in membership in the future will be dependent on the Society continuing to be relevant, remembering that the reason for its existence is to serve its members.

## ANAESTHESIA WORKFORCE

In 1934 there were very few full-time anaesthetists, most anaesthetists were General Practitioners who anaesthetised their patients when they required surgery. With the founding of the Faculty of Anaesthetists in 1952, there was a progressive increase in the number of specialists and a reduction in the proportion of anaesthetics given by non-specialists.



Richard Bailey Library

The ASA has always been inclusive, welcoming both specialist and non-specialist anaesthetists as members along with trainees and retirees. It therefore truly represents the entire anaesthesia workforce.

The risk to patient safety by the introduction of inferiorly trained non-doctors to provide anaesthesia is one of the biggest challenges facing the Society in the future. This threat is not new and was spoken of by Dr Gilbert Troup in a paper he delivered at the Society's first NSC in 1935 when he said of nurse anaesthesia, "It is a phase of anaesthesia of which we in Australia are fortunately free".

## LIBRARY AND MUSEUM

The library and museum have always been important components of the Society. In 1939 the library and museum were officially founded. Dr Geoffrey Kaye was by far and the most significant contributor to both. In 1945 the Society inaugurated its film library. The museum grew steadily even during WW2.

The College of Surgeons were asked if they would temporarily house the museum and library in 1955 when the Society had

to vacate its headquarters in Melbourne. They agreed on the condition that it was not a loan but rather a donation to the new Faculty of Anaesthetists.

Despite this loss, the ASA Museum and Historical Library now housed in the ASA headquarters in North Sydney have grown to substantial proportions.

## SUMMARY

The original aims and objectives of the Society remain current to this day. The Society was founded to represent and support anaesthetists. Those original aims and objectives are worth remembering.

1. To improve the status of anaesthesia in Australia.
2. To facilitate the exchange of ideas between Australian Anaesthetists and between them and overseas anaesthetic organisations.
3. To encourage research into questions appertaining to anaesthesia.
4. To arrange the publishing of articles on anaesthesia.

Dr Gregory J. Deacon

## REGULAR

# DAY CARE ANAESTHESIA OUTCOMES

The DayCOR Registry has just celebrated its first birthday, having surveyed over 11,000 patients at two hospitals. With the release of our new website, interest has increased markedly and it is now time to consider ongoing funding of management and expansion into the future.

Speak to your colleagues. Get your hospital interested in the future.

A great deal of time has been taken over the new year to complete a website which should provide an excellent guide to understanding the process of setting up the Day Care Anaesthesia Outcomes Survey in your hospital. It provides:

- a single source for information;
- the importance of a universal registry;

- an explanation of the function and full use of the registry;
- full understanding of the processes with the ability to immediately send by email a question which will be answered promptly;
- availability at all times for reading or reference.

The website will become a vital resource for not only advice, but the dissemination of outcome results and improvement in care, particularly at the hospital level.

We will consult with all stakeholders: anaesthetists, hospital administration, health departments, private hospitals including group owners and Health Funds, which may make fairly arbitrary decisions on the cover which they offer.

Reports of results will be issued regularly to colleagues and outcomes reported at least yearly to anaesthetists, hospitals, health authorities, health funds, and to the community. Community reports could become a media event to show the value of our experienced care.

Ken Sleeman  
Chairman

ACE Day Care Anaesthesia SIG  
DayCOR Registry

**For more information:**  
**[www.daycorregistry.com.au](http://www.daycorregistry.com.au)**



## REGULAR

## WEBAIRS NEWS



### A CASE REPORT FROM WEBAIRS

WebAIRS is a web-based anaesthetic incident recording system which has been designed by ANZTADC to improve the safety and quality of anaesthesia by providing an enduring capability to capture, analyse and disseminate information about incidents, relative to the safety and quality of anaesthesia in Australia and New Zealand ([www.anztadc.net](http://www.anztadc.net) [anztadc@anzca.edu.au](mailto:anztadc@anzca.edu.au)).

#### Case 2019:1 Look-alike ampoules

WebAIRS has received a recent report concerning look-alike ampoules. The report stated that "A Xylocaine® ampoule was found in one of the block trolleys in the Marcain® section today." And added "Please remember to verify all drugs before administration and take care when stocking the trolleys and returning unused ampoules."

It can be seen that if the Xylocaine® ampoule were inadvertently placed in the Marcain® compartment, as happened in this case, it would be easy to misread the label, especially if working in a busy area where distractions might occur. This report also highlights "the similarity between Marcain®/adrenaline 0.5% and Xylocaine®/adrenaline 0.5% ampoules. The ampoules are nearly identical except for the dark blue band at the top on the Marcain® ampoule. The concentration of 0.5% highlighted in green and adrenaline in a red font which distracts attention from the drug name and contributes to



Photo of the ampoules concerned, which was supplied by email

the similarity. The close similarity thus poses a risk for potential drug errors." The report also noted that it was suspected that the error occurred whilst restocking the compartment from unused ampoules that had been left on the trolley, and stated that "Only a final ampoule check, after the medication had been drawn up, prevented the incorrect drug from being administered to the patient".

The analysers assumed that the green highlighting around the 0.5% might have been an initiative by the manufacturer to assist in distinguishing between different concentrations of the same medication. reduce possible errors arising from differing concentrations of the same drug. Also, they assumed that the red font was designed to distinguish between similar preparations with or without adrenaline. In reality, these features appear to increase the similarity of these two different local anaesthetics, thus having the unintended

consequence of creating a latent factor for look-alike errors.

Although on this occasion it was Xylocaine® and Marcain® involved, substitution errors of look-alike medications are common, and a search of the webAIRS database yielded many other comparable reports suggesting a similar failure mechanism, probably involving an unused ampoule left on the trolley and then placed into an incorrect compartment. Placing two things that have different functions close to each other is known as component proximity and is a recognised design fault in human factors literature. There was a previous such instance at the same institution where GTN was re-stocked into an unlabelled section of the anaesthetic trolley that contained tranexamic acid. GTN is normally stored in a separate 'emergency drug' drawer of the trolley.

Look-alike errors arise when similarities in ampoule or packaging colour, size and design (used to emphasise the manufacturer's brand rather than distinguish between two different products) predispose clinicians to mistake one medication for another<sup>1</sup>. There are challenges to implementing systems in anaesthetic practice that mitigate the risk posted by look-alike medications. For example, packaging from manufacturers may change without notice, and brands of drugs that are purchased by a health service often change frequently due to cost and availability considerations. As occurred in the case described above, preconceptions through position coding are introduced by the location of drugs in

the anaesthetic drug trolley<sup>1</sup>, and errors made during the restocking process may further amplify the downstream error risk posed by look-alike packaging and ampoules through such end-user confirmation bias.

Look-alike ampoule errors are explicitly mentioned in the ANZCA document PS 51<sup>2</sup> and have been identified in previous journal publications<sup>3</sup>. There is value in raising awareness of this continuing risk to safe practice, although doing so is a relatively weak intervention that relies on human memory and attentiveness to be effective. Interventions to distinguish ampoules could involve colour coding of the label by class of medication or the writing to an agreed upon national or international standard, to ensure that at least the correct class of drug is given. However, colour coding alone would not have prevented this particular incident which involved medications of the same class. From other reports in the webAIRS database, it is notable that where two syringes of the same class of drug are drawn up and placed in syringes with colour coded labels, there is still a potential for a look-alike syringe error. This has happened on more than one occasion where suxamethonium and a non-depolarising relaxant have been drawn up and placed in close proximity. For instance, where suxamethonium is routinely drawn up as an 'emergency drug' and then accidentally given instead of the intended relaxant. In general, within class substitutions are less likely to have serious consequences than between class substitutions, but the present case is an important exception to this rule (and there are other exceptions, of course). Thus, colour coding of labels might be very useful in reducing errors between midazolam and either atracurium or cistracurium. In this respect placing one of these classes of medication (midazolam) into clearly labelled and colour-coded pre-filled syringes has been used in many New Zealand hospitals to address this particular

risk, with apparent success.

These are some quotes from case reports to webAIRS where atracurium or cis-atracurium has been given instead of midazolam:

- Atracurium drawn up and labelled as midazolam. Ampoules look similar and are in the same drawer.
- Realised that I had mistakenly labelled the atracurium as midazolam.
- The ampoule opened was found to be cis-atracurium (with no open midazolam ampoule).
- The anaesthetic nurse identified the ampoule I used, was in fact Atracurium 50mg in 5ml. Two such ampoules had been left out due to expiry being on that day.

There are other examples where atracurium has been given instead of other drugs for instance instead of protamine or local anaesthetic.



The risk described in the present report would not have been ameliorated by colour coded labels on the syringes, because the mistaken identity occurred prior to drawing up the drug due to the similarities between the ampoules. More attention is needed to ensure clearer labelling of medication ampoules. Much effort has been made by ANZCA and others over the years to persuade manufacturers and others to address this need. EZ Drug ID is an international campaign to improve the safety of medication packaging and more information about other similarities can be viewed at the website<sup>4</sup>.

Queensland Health Medication Services has recently developed a "look-alike/sound-alike" (LASA) register to raise awareness of potential similarities between drugs based on reports received. At this early stage, the register describes the relevant medication formulations along with a photograph, the context of any associated drug error or near-miss, the site from which the notification was received, and any action taken at a local or central level to discuss the incident and put in place risk mitigation strategies.

Frequent change of the brands of drugs without adequate warning is one of the problems cited in the webAIRS reports. Where a hospital changes a brand there should be a circular that shows the new ampoule and other similar ampoules. This would warn practitioners of the introduction of a potential risk of look-alike error. ANZCA document PS 51 also has recommendations relating to drug purchasing decisions and look-alike ampoules which should be considered by healthcare administrations<sup>2</sup>.

Finally, a new intervention could be the creation of a register or bulletin, similar to the Queensland Hospitals look-alike medications register, but dedicated to anaesthetic drugs and designed to raise awareness of the problem at a bi-nation level.

Dr Gerard Eames, Dr Martin Culwick  
for the webAIRS case report writing group

## References

1. Marshall SD, Chrimes N. 'Medication handling: towards a practical, human-centred approach'. *Anaesthesia* 2018; 74(3):280-284.
2. Guidelines for the Safe Management and Use of Medications in Anaesthesia. ANZCA Document PS 51. 2018. <http://www.anzca.edu.au/documents/ps51bp-2017.pdf> Accessed 7th March 2019.
3. Webster CS, Merry AF, Larsson L, McGrath KA, Weller J. 'The frequency and nature of drug administration error during anaesthesia'. *Anaesth Intensive Care* 2001; 29 (5):494-500. From: <https://www.aaic.net.au/Document/?D=2000210>. Accessed 7th March 2019.
4. EZ Drug ID website [http://ezdrugid.org/EZDrugID/Look-alike\\_Drugs.html](http://ezdrugid.org/EZDrugID/Look-alike_Drugs.html)

## REGULAR

# ANAESTHETISTS IN TRAINING

## POLISHING YOUR CURRICULUM VITAE

So, you've been successful in the final fellowship exam and you have prepared for the job interview. Part of the preparation for the job interview includes reviewing or writing your Curriculum Vitae (CV). What follows are some suggestions as to how you might optimise the impression that your CV creates.

### COVERING LETTER

Just as you prepared your 'script' for the job interview, weave your past achievements into your covering letter. Its purpose is to show how you match the job description. Your research of the hospital or facility, its staff and the particulars of the job description will help you to match and highlight your special skills to the needs of the department.

This letter is where you make a case for how you can give expression to your particular interests and motivations. That is, your research of the department/facility indicates that your special professional interests/anaesthetic specialty/research/academic/workplace management might be of mutual benefit.

### YOUR ONLINE IDENTITY

After you send off your CV and before you enter an interview-room, someone somewhere may research your background.

It is important to clean up your cyberspace presence:

- Facebook, Twitter, Insta, Tinder, blogs, product evaluations: take a good look and ensure that public content is appropriate; check your privacy settings. Delete abandoned accounts. Think before you post and assume it will all become public.

- LinkedIn: if you use this make sure that it is current and comprehensive.
- Website: if you have a website or an 'About Me' page, ensure the information is accurate, grammatically correct, spell-checked and photos are appropriate and of high quality and any posts are intelligent.

Make an assessment:

- google yourself and take control of the information written about you;
- use multiple search engines;
- include an image search (be conscious of where you may have had a photo tagged).

Then clean it up. There are many online tools to help you clean up your internet presence – of course, you can google that too!

### GENERAL COMMENTS

Just like your first impression in the interview room, your CV has about ten seconds to make a first impression.

Your CV should be visually clear, concise, complete and current. It should be two or three pages. Use bullet points – make it easy for the reader to absorb the content. The format should be consistent and error free.

Consider a template or whatever you need to create a logically ordered document that summarises your achievements to date. There are many free templates online and they all have common headings as listed here.

Do not lie. The concept of a 'small world' applies equally to our regional centres, the nation and the planet.

If applying for an international position,

do some research on the particular expectations of a CV for that country.

Send an electronic copy of your CV with your job application and bring along a few extra printed copies to the interview.

Be prepared to walk the interviewers through your CV. Do not just read it. Highlight the parts that make you the best pick for the job for which you are applying.

Create a professional signature for your email communication. Include mobile, website, postal and email addresses. Consider creating a logo.

**Dr G.A. Smith**

**MBBS FANZCA**

**SPECIALIST ANAESTHETIST**

**Provider number 123ABC**

**Box Y, CITY, STATE 1000**

**M 0408 000 066 F 6271 1000**

**DRGAS@gmail.com • www.DOCTORGAS.com.au**

### LAYOUT

Select a layout that ensures visual clarity – you can use a CV template, your own creation or that of a colleague. The one you choose should satisfy sensible guidelines for CV writing. A sans serif font is easier than a serif font to read.

Ensure that the file size is less than 10 MB (or otherwise manageable) and in PDF format.

Number the pages, consider using a header and include a table of contents.

Use spell check, grammar check and get someone to proof read your document.

Consider including a small photograph.

### CONTENT HEADINGS

- **Contact information:** name (include post-nominals), address, mobile, email, website, other.

- **Table of contents:** make it easy for the reader to find what they are looking for.
- **Personal information:** date and place of birth, citizenship, visa status, gender (marital status, spouse and children – should be irrelevant).
- **Education and training history:** in chronological order: high school, university (undergraduate and graduate and non-anaesthesia qualifications), anaesthesia training\*: include subspecialty exposure, subspecialty courses
  - \* For this section, itemise the training type, facility and date:
    - Basic training
    - Advanced training
    - Provisional Fellowship training
- **Skills:** in addition to specialist anaesthetic skills (e.g. advanced airway techniques, paediatrics etc.), include computer or other technical skills, languages spoken, teaching experience.
- **Community contribution:** If you have made any significant social, environmental, ecological or other contributions mention them. Mention volunteer work on a domestic or international scale (even if unrelated to anaesthesia).
- **Awards:** honours, grants, scholarships.
- **Publications:** articles, books, chapters; include unpublished reports or protocols that you have authored.
- **Presentations.**
- **Professional memberships.**
- **Other:** interests/ achievements/ talents (keep this brief).
- **Referees.**

## REFEREES

Choose referees carefully. Decide on who to ask for a reference based on the job for which you are applying. Evaluate referee 'gaps' in the range of people you have in mind.

For example: consider whether you choose all anaesthetists (and their subspecialties) or add a researcher, manager, pain specialist, statistician, surgeon etc.

A referee should be able to comment in a meaningful (and hopefully positive) way about the characteristics and talents you intend to highlight. Make sure to contact them to remind them of you and thank them in advance for any burden on them that may result. Referees are usually required to respond to phone calls, fill out on-line forms or be required to write a reference.

Recency of reasonably significant exposure to a referee gives practical credibility to their endorsement.

## FOR THE FUTURE: MAINTAINING A CURRENT CV

Make it easy on yourself: regularly update your CV document.

Create a diary alarm to enter courses, conferences, lectures (as participant or presenter), articles contributions to research/ literature, teaching, volunteer work, committee work or other enterprise.



This can be the same time that you enter your CPD activities.

## SHORT FORM CV

For some purposes, a one-page short form of your CV might be sufficient:

## HAVE YOU DONE THIS YET?

Do it today!

For tips on self-control and motivation: <https://www.youtube.com/watch?v=PPQhj6ktYS0>

Vida Viliunas and Jen Moran

**Dr Vida Viliunas** is a specialist anaesthetist currently working in both public and private practice in Canberra. She served for 12 years as an examiner for the final fellowship exam and for two years as Chair of the final examination subcommittee. She is currently the Education Officer for the ASA.

In this issue, Vida has refreshed her advice to help ASA members and especially trainee members prepare for provisional fellow or junior consultant job interviews with specific focus on CV polishing.

**Dr Jen Moran** is an Anaesthetic Fellow at the Children's Hospital at Westmead. Prior to medicine, she completed her undergraduate degree in Canada and worked as a Research Scientist in Forest Ecology and Productivity for two years. She went on to study medicine at the Australian National University (ANU) and remained in Canberra for her Anaesthetic training. She has also developed an interest in Retrieval Medicine as a member of the Aeromedical team for the Capital Region Retrieval Service (CRRS).

## ADVERTORIAL

# WHAT IS INCOME PROTECTION INSURANCE?

Working in a busy, hazardous environment with acute exposure to disease and infection can put your health and wellbeing at risk. Even with modernised safety and hygiene precautions in place, you should consider options to help safeguard your income in case of sickness or injury.

In this short guide NobleOak provides some information on income protection insurance and how it can help manage the threat of loss of income from injury or sickness jeopardising your immediate and long-term financial circumstances.

## WHAT IS INCOME PROTECTION INSURANCE?

Income protection is a type of life insurance product that helps provide financial security in the event of a loss of income when you are unable to work as a result of injury or sickness. Unlike term life cover which pays out a lump sum upon the death of the policy holder, income protection insurance will pay you a monthly benefit to replace a share of your salary if you can't go to work because of severe sickness or injury. Income protection insurance is also sometimes referred to as IP.

Some of the main features of a typical income protection insurance policy include:

- Maximum monthly benefit.
- Benefit period.
- Waiting period.
- Maximum entry age.

Also, some income protection policies such as those offered by NobleOak

provide guaranteed renewable income protection cover up until a certain age (which in the case of NobleOak's cover, means that if all premiums are paid as they fall due, the cover is renewed each year up until the age of 65).

## HOW INCOME PROTECTION INSURANCE WORKS

If you suffer a serious illness or injury and have income protection insurance you will receive a regular monthly income for a specified period known as the benefit period. The payments are designed to help support you and your family and cover essential living expenses while you are unable to work.

Income Protection insurance typically covers you for up to 75% of your before-tax income from your work up to a maximum monthly benefit, which varies depending on your choice of insurance product. As an example, NobleOak offers cover of up to 75% of your income (up to a maximum monthly benefit of \$25,000 for NobleOak's Premium Life Direct product). Within these guidelines, you can tailor the benefit to suit your requirements and budget.

Premiums are the amount you pay for your policy per month. They are calculated based on your age, income and occupation, among other criteria including lifestyle factors and medical history. Premiums also depend on the level of cover you choose.

The waiting period refers to the number of days you have to wait after becoming unable to work before eligibility for

payments begin. This is usually between 30 and 90 days.

Benefit period is the maximum length of time you'll receive payments whilst you are unable to work as a result of illness or injury. This timeframe is generally two or five years, or in some cases when you reach a certain age. When purchasing IP from NobleOak for example, you can choose a benefit period of two years or until 65 years of age.

## IS INCOME PROTECTION TAX DEDUCTIBLE?

It's important that you know how income protection and tax works if you are self-employed or own a business. Premiums for income protection insurance are generally tax-deductible although it's wise to obtain accounting or tax advice relating to your specific circumstances. Typically, however, you cannot lay claim to a tax deduction for a premium or any part of a premium in the following scenarios:

- where a policy outside of income protection (term life cover, TPD insurance or trauma insurance) compensates you for physical injury. For example, if you have a combined term life and income protection insurance policy, you may claim a tax deduction for the portion of premiums paid for the income protection cover only;
- where IP cover is purchased through superannuation and insurance premiums are taken out of super contributions. Here, the premiums cannot be claimed as a tax deduction.

## HOW MUCH DOES INCOME PROTECTION COST FOR ANAESTHETISTS?

As well as your occupation, the cost of your income protection premiums will be determined by how much cover you select, alongside key factors such as your age, gender, medical history and the waiting period and benefit period you opt for.

One important factor to consider when choosing a level of cover is how much savings you have to fall back on, in case you were unable to work due to sickness or injury. NobleOak offers cover up to 75% of your pre-tax income, to a maximum benefit of \$25,000 per month. These funds can be used to help manage living costs, pay off a mortgage or car loan, or continue financially supporting dependents.

Find out how much cover you may need with the NobleOak calculator: [www.nobleoak.com.au/life-insurance-calculator/](http://www.nobleoak.com.au/life-insurance-calculator/)

## WHAT ARE MY OPTIONS FOR OBTAINING COVER?

Income protection insurance for anaesthetists can be purchased directly from the insurer or through an adviser or insurance broker.

The first step to getting insured is to apply for a quote or speak to an adviser. At NobleOak, you can apply for cover by contacting us directly. Insurers like NobleOak provide award-winning direct cover with no hidden fees. If you know what level of cover you want, you can start the application process straight away.

For more information about NobleOak's income protection insurance visit the NobleOak website at [www.nobleoak.com.au/anaesthetists](http://www.nobleoak.com.au/anaesthetists) or speak with NobleOak's team on 1300 108 490.

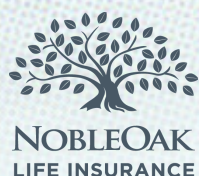
## Important information

Information provided by NobleOak Life Limited ABN 85 087 648 708 (AFS Licence 247302) which is the product issuer of the NobleOak products mentioned. This is general information only and has been prepared without taking into account your objectives, financial situation or needs. Always read the Product Disclosure Statement (PDS) available on our website at [www.nobleoak.com.au](http://www.nobleoak.com.au), for information on what cover is included and what exclusions might apply to any policy you're considering. NobleOak cannot provide you with personal advice which takes into account your specific circumstances but their staff may provide general information about NobleOak Life Insurance products including income protection cover. People who seek to replace existing life insurance cover including income protection cover should consider their circumstances including continuing the existing cover until the replacement policy is issued and cover confirmed.

# INCOME PROTECTION COVER FOR ASA MEMBERS

**1<sup>st</sup> MONTH  
FREE\***  
Offer Ending Soon

- ✓ Choose cover of up to 75% of your income (max \$25,000 per month)
- ✓ Premiums are generally tax-deductible
- ✓ Save with the 2018 life insurer of the year\*
- ✓ Customer satisfaction rating of 95.8%<sup>#</sup>
- ✓ No surprises - claims processed within 5 business days on average



Get an instant quote at:  
**[nobleoak.com.au/anaesthetists](http://nobleoak.com.au/anaesthetists)**

Or call NobleOak for a quote:  
**1300 108 490** mention 'ASA' to switch and save.



\* Visit [www.nobleoak.com.au/anaesthetists](http://www.nobleoak.com.au/anaesthetists) for full terms and conditions including details of cost savings. NobleOak Life Limited ABN 85 087 648 708 AFSL No. 247302  
Information here is general only and does not take into account specific needs or circumstances. Consider the PDS - Available at [www.nobleoak.com.au](http://www.nobleoak.com.au) <sup>#</sup>Pureprofile Customer Satisfaction Survey 2018

## FEATURE

# THE 2019 NATIONAL SCIENTIFIC CONGRESS

**The time has come for the ASA NSC to return to Sydney. It will be an exciting time after three years of hard work, lots of thought, perspiration and preparation.**

Before I go on to tell you why you will want to come to the NSC this year I thought I would take the opportunity to introduce you to our incredible Scientific Convenor Associate Professor Alwin Chuan. Alwin, although overworked and overcommitted, has taken some time out to answer my questions which includes a bit about himself and his motivations. I think these reflect in turn, on why we have such a great program this year.

**Hi Alwin, being the Scientific Convenor is a big job, why did you want to do this role for the ASA NSC 2019?**

It is an honour to help run the Society's major scientific event for the year. I have been involved in many organising committees, and each time I have the pleasure of meeting amazingly talented colleagues. By and large, committee work is unpaid and done after-hours. The individuals you meet are enthusiastic, passionate, altruistic, motivated and generous. You also have the privilege of meeting colleagues who contribute – away from the limelight – to the Australian and New Zealand anaesthetic community.

These include the SIG chairs, chairs of the various Society committees, and subspecialty heroes.

**You have a lot of interests. What are the main ones and why is that?**

The "why" is easy: I am forever curious, and love new intellectual and physical challenges. My current interests include bedside ultrasonography by anaesthetists, regional anaesthesia, and perioperative medicine. Technology and other forces will disrupt the traditional notions of what anaesthetists do, and I enjoy pushing those boundaries. Outside of work, I indulge in photography, muscle car road trips, cooking and being a foodie, skiing and travelling. I am an opera tragic and plan holidays around the performances at Covent Garden and The Met. A recent passion is scuba diving, which is opening up the wonders of the underwater world for me.

**Research is one of your big interests. What are the challenges for you with that? How can a new doctor do research?**

Being involved in research is fascinating. I've had the opportunity to collaborate with some of the smartest and most insightful individuals I know. As a clinical researcher, I can immediately see the benefits of my research in everyday



practice. Research is also difficult: funding your projects, feasibility, overcoming cultural and bureaucratic inertia, apathy and antipathy from other staff. Yet, because of these challenges, research is also immensely rewarding. My advice for new researchers is: find what you are passionate about, and then surround yourself with mentors who can provide a framework for that passion to blossom.

**What would make it a successful conference for you?**

As the scientific convenor, a successful conference is one where there are many learning and interactive opportunities.



The Sydney NSC 2019 has a broad range of lectures, workshops and PBLs catering to nearly all subspecialties. These are anchored by our international and national speakers, and we strove for topical, interesting, refresher, and cutting edge content. For those seeking CPD activities, especially those ending their triennium, the NSC 2019 has multiple Emergency Response workshops and Practice Evaluation/Audit sessions.

**Have you had any mentors along the way? How did they influence you?**

I have had the privilege of being mentored at several times during my career: when I was a registrar, a provisional fellow, during my PhD, and post-doctoral research program. The lessons they taught could be distilled into structured thinking, determination, and enjoying the journey.

Thanks Alwin.

The theme of our 2019 congress is an 'Eye to the Future'. Our profession is multifaceted in nature both in the everyday performance of our job and in the many influences on our profession now and into the future. As such our program aims to enhance and improve on the knowledge and skills we use every day in our work while preparing us for the innovations, changes and challenges that are ahead of us.

To reflect this, some of the themes that run through our conference include research, education, leadership, communication, evidence-based practice, perioperative and pain medicine. We have something for everyone from the generalist to the uber specialist.

We are very excited to welcome our international and Australian invited speakers who bring to the conference a wealth of fascinating knowledge and insights that reflects the best of international practice and research. We also hope to provoke some active thought and discussion in what we cover.

I'm very excited to welcome presidents from major world anaesthesia societies who will be joining together for an inspirational session on leadership on Sunday.

We are very fortunate to have a great pre-congress program with two Special Interest Group (SIG) meetings of the Medical Education SIG and the Trauma/ACCUTE SIG as well as the chance to improve on our effective negotiation skills and two simulation sessions working through obstetric emergencies.

In our congress program, in addition to our great speakers and SIGs we have

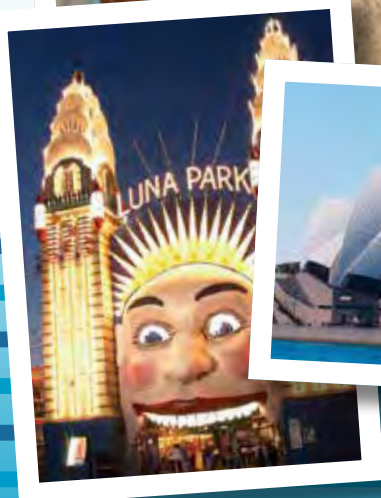
a fantastic workshop program. We are aware that a majority of Fellows will be completing the triennium of their CPD program in 2019 and we have catered accordingly to allow people to have as many opportunities to complete this within the conference program as possible. We have numerous excellent emergency response workshops and three practice evaluation/audit workshops aimed at securing those valuable quality assurance points.

In addition we have something for everyone in the diverse range of over 20 Small Group Discussion (SGDs) that cover a myriad of topics. Our SGD facilitators come from diverse backgrounds and bring great knowledge and enthusiasm to the discussions. It will be a great opportunity to troubleshoot those tricky non-textbook situations and questions that often arise from them.

Our social program takes in some of the icons not just of Sydney but of Australia. Who has not heard of Sydney Harbour, the Opera House, Luna Park and Taronga Zoo? There are wonderful opportunities for delegates and their families to get together in these great locations. Following Adelaide's example in 2018 we have moved the fabulous Gala dinner to Saturday night to allow weekend and whole conference registrants the chance to dress up and enjoy the glamour, fun and excitement of our Great Gatsby-themed Gala dinner. This will be held on site in the new International Convention Centre overlooking Sydney Harbour and the lights of Sydney's CBD.

The above are just some highlights of our program. We look forward to welcoming you and your families to beautiful Sydney for the 78th ASA NSC in 2019. Come and join us.

Anne Jaumees  
Convenor



# NSC 2019 SPEAKER ABSTRACTS



## A/PROFESSOR GLENN WOODWORTH | MD

**Assistant Professor and Director of the Regional Anesthesia Fellowship,  
Department of Anesthesiology and Perioperative Medicine, Oregon Health  
and Science University, Portland, Oregon, USA**

Technology and competency-based education are disrupting medical education for both trainees and postgraduates. Current trainees were born after the internet revolution and rely heavily upon cloud-based information for both personal and educational use.

As educators we want to believe that our students are receiving an education from our renowned institution; when in reality they are attending Google University. Unfortunately, the quality of material retrieved from internet searches may not be of sufficient quality to be used for training physicians (trainees or postgraduates). Several studies have demonstrated omissions and outright errors in videos identified in internet searches. More worrisome is the popularity of videos based on the number of clicks or other measures of engagement that do not correlate with the quality of the videos as scored by medical educators. Also, the rank order of information

returned in a search cannot be relied upon as an indicator of quality. It is not likely that medical trainees will have sufficient knowledge to screen internet retrieved information they are using for training. You don't know what you don't know.

This situation argues for the use of curated information for medical education. We cannot stop users from accessing the internet for information to supplement their education, but we can point them toward content that meets some sort of quality standard. Internet searching is an example of learner-centric education where the learner is driving the direction their education is taking. This is one of the principles of competency-based education, an educational framework that is sweeping across medical training. An important element of this framework is that training programs should identify highly granular and specific knowledge, skills, and behaviours (educational outcomes that can be measured) that can

be used to guide trainees. The defined competencies and milestones let trainees know what they are striving for. They can also receive feedback from educators when they miss the mark on specific milestones of competency achievement.

The biggest challenge for training programs is to implement a practical system for competency assessment and feedback. The system must not be too burdensome and yet provide meaningful feedback to the trainee and be able to support summative assessment. Although the importance of documenting competency is obvious in training environments, it is also important for postgraduates.

Numerous stakeholders including the public, payers, and hospitals have an interest in physician competency. Even with new developments in competency assessment for trainees, ongoing competency assessment for postgraduates is still in its infancy. One current area



that meshes competency assessment with learner-centric education for both trainees and postgraduates is the use of quiz banks. Quiz banks can help users to identify knowledge gaps and point them towards educational resources to address those gaps. Just-in-time learning can take place in the form of presenting the user with detailed answers for questions that serves as a teachable moment. Users can do a deeper dive on the topic if they access linked resources like key articles or online learning modules. This is feedback and learning at an individual level. Groups

could also use analytical data from quiz bank performance at the group level to target educational programming.

In summary, internet resources and competency-based education are merging to reshape education for both trainees and postgraduates. Both groups can benefit from defined educational goals and objectives, as well as timely feedback on competency. Gaps in competency can then be addressed in part by access to curated internet-based educational resources.

## SESSION TIMES

### **Competency-based medical education**

Sunday 22 September

Pymont Theatre

0830–0915

### **Regional Anaesthesia SIG: Blocks for thoracic, breast surgery and chest trauma**

Sunday 22 September

Room C2.5 & C2.6

1530–1700

# NSC 2019 SPEAKER ABSTRACTS



## A/PROFESSOR LIZ EVERED | BSc MBiostats PhD

**Scientific Head of Research, Department of Anaesthesia and Acute Pain Medicine, St Vincent's Hospital, Melbourne, Victoria; Associate Editor, *British Journal of Anaesthesia*; Senior Editor, *Anesthesia & Analgesia***

Many elderly patients suffer perioperative neurocognitive disorders (PND) including delirium and neurocognitive disorder (NCD)-postoperative (previously described as postoperative cognitive dysfunction or POCD) in the short and medium-term postoperatively.

Delirium is known to increase the risk of subsequent dementia, but it is not known if short and medium-term cognitive decline postoperatively lead to long-term decline including dementia. It is known that subtle baseline cognitive impairment is associated with further postoperative cognitive decline, but the identification of true preoperative cognitive trajectories has been overlooked. Additionally, any overlap between perioperative neurocognitive disorders and cognitive disorders identified in the community has not been considered until very recently.

We recently published work by the international nomenclature consensus working group which has recommended diagnostic criteria that are consistent with terminology and definitions used in the wider medical community to assess and report cognitive impairment associated with the perioperative period. This will assist interpretation, management and treatment of individuals in the perioperative period.

The role of baseline cognitive function and its impact on postoperative delirium and NCD will be considered. The role of intraoperative surgical and anaesthetic factors will be discussed, together with pre-existing patient characteristics, including frailty, that impact outcome. Overlap between perioperative neurocognitive disorders and community cognitive disorders will be addressed,

and consideration given to the new terminology. Recent work on biomarkers identifying neuronal damage associated with the perioperative period and consequent PND will be discussed.

Many studies identify detrimental effects of anaesthesia and surgery on cognition in a significant proportion of elderly individuals. Animal models demonstrate an association between anaesthetic agents and Alzheimer's disease (AD) pathology. Work in humans suggest a high incidence of mild cognitive impairment (MCI) preoperatively, and further decline postoperatively, particularly likely in patients with baseline impairment. Delirium is common and is associated with further cognitive decline and poor outcomes. Frailty is associated with medium term cognitive decline, but may be a modifiable factor in some patients



demonstrating improvement over 12 months.

Cognitive decline in the elderly ultimately leads to a decline in function and independence, and associated healthcare and social costs. PND including delirium and NCD-postoperative are associated with preoperative vulnerabilities including baseline cognitive impairment, increasing age and poor cognitive reserve, but it is unclear if this postoperative change represents a change in cognitive trajectory. Preoperative cognitive assessment is

essential to identify at-risk individuals, and offer the opportunity to intervene and prevent decline and poor postoperative outcomes. The opportunity to discuss, define and interpret these disorders with aligned nomenclature and definitions will allow understanding of how the perioperative period exists in the overall spectrum of aged care.

### Funding

Lis Evered is funded by a NHMRC/ARC Dementia Research Fellowship.

## SESSION TIMES

### Research culture and translation

Sunday 22 September  
Pymont Theatre  
1330–1500

### Defining cognitive dysfunction

Sunday 22 September  
Room C2.2 & C2.3  
1530–1700

### Cognitive vulnerability and frailty

Monday 23 September  
Pymont Theatre  
0830–0915

# NSC 2019 SPEAKER ABSTRACTS



## PROFESSOR IAIN MOPPETT | MB BChir MA MRCP FRCA DM

**Professor of Anaesthesia and Perioperative Medicine, University of Nottingham; Consultant Anaesthetist, Nottingham University Hospitals; Deputy Director, Health Services Research Centre, National Institute of Academic Anaesthesia, UK**

### STANDARDISING ANAESTHESIA CARE

*Standardise until you need to improvise –*

Martin Bromiley, MBE,  
Patient Safety Campaigner  
and Commercial Pilot

On the one hand, anaesthesia and perioperative medicine are desperately complex. Every patient is different: different genetics and lifetime environment; different disease processes; different personalities and home circumstances. On the other hand, every patient is remarkably similar: most have the normal number of limbs and organs; surgical approaches are pretty much the same; and the drugs and techniques we use have largely predictable effects.

This generates a perceived tension between standardisation and individualised care. Where should our practice sit?

In the industrial world, standardisation

of processes improves product quality, minimises error and defects and reduces costs. All admirable and desirable aspects of high-quality patient care. But sometimes medicine exists in the 'non-normal' space – where there is insufficient information, where there is no single right answer, where there is no standard operating procedure. John Clarkson, Professor of Engineering in Cambridge, likens this to the distinction between the production engineer and the designer. Lillrank and Liukko, from Finland, talk about standard, routine and non-routine processes. Standard processes such as handwashing, or checking of the anaesthesia machine warrant little if any variation. Most care processes are routines – care is pretty standard but flexibility is required to adapt to the inevitable situational variation. Only rarely is care truly non-routine – the practitioner must use their experience, training and judgement to create a new solution to an often-messy problem. In any one day an

anaesthetist may find themselves moving from standard to non-routine and back again.

Current evidence would suggest that anaesthesia and perioperative medicine has not got the balance right. Over-reliance on checklists and standard operating procedures without understanding their purpose and limitations puts patient safety at risk – but so does the arrogance of assuming that checklists are tools for fools – not needed by the expert. The Getting it Right First Time (GIRFT) initiatives in the UK have highlighted numerous examples of clinically unwarranted variation in care – but even in this clinically-led approach there are grumblings of lack of understanding of service complexity.

Over-standardisation risks boredom, disengagement and an inability to problem-solve when required. A lack of standardisation leads to inefficiency, waste and likely patient harm.



Perhaps the challenge for the next generation of anaesthetists is not to find a wonder drug or the perfect laryngoscope, but to create the conditions for training and working that balance standardisation with the need for improvisation.

### **Best evidence for hip fracture management**

The perioperative management of the older person with hip fracture is an opinion-heavy, evidence-light arena. There are precious few high-quality trials to inform our decision-making despite the huge numbers of people undergoing hip fracture each year – 70,000 in the UK, 19,000 in Australia.

The perennial question seems to be general or spinal anaesthesia? Although there are at least four ongoing or recently completed randomised clinical trials in this area, these seem inherently unlikely to give a definitive answer, not least because 'general' and 'spinal' anaesthesia are so undefined, and the patients not included in the studies may be the ones for whom the question is most relevant. A far more useful set of questions to evidence our practice may be – what does good general anaesthesia look like, and what does

good spinal anaesthesia look like? Even then, these are likely to be subsumed by more significant factors such as pain and haemoglobin management, timely access to surgery and nutrition.

This begs an even more important question – what are the outcomes that matter? Mortality may or may not be affected by perioperative management, but rehabilitation and function after discharge may be.

An area of growing interest is the prevention or mitigation of post-operative delirium a common and devastating complication. To date, the best evidence doesn't relate to the mode of anaesthesia nor pharmacology, but to standardised, organised, well-delivered basic ward care.

Clinical trials are costly and involve a significant time-lag. National registries such as the Australian and New Zealand Hip Fracture Registry and the UK National Hip Fracture Database are likely to become increasingly important tools in understanding what works and what doesn't. But for this to work, anaesthetists need to be involved and ensuring that relevant questions are asked and answered.

## **SESSION TIMES**

### **Standardising anaesthesia care**

Saturday 21 September  
Pyrmont Theatre  
1045–1130

### **Best evidence for hip fracture anaesthesia**

Sunday 22 September  
Room C2.5 & C2.6  
1045–1215

# NSC 2019 SPEAKER ABSTRACTS



## PROFESSOR COLIN ROYSE | MBBS MD FANZCA

**Professor of Anaesthesia, Department of Surgery; Co-director Ultrasound Education Group; University of Melbourne; Consultant Cardiac Anaesthetist, Royal Melbourne Hospital; Melbourne, Victoria**

### PERIOPERATIVE ULTRASOUND

Australian anaesthetists have been world leaders in the adoption of clinical ultrasound into anaesthesia practice. It started with TOE for cardiac surgery and followed with ultrasound guided procedures such as nerve blocks and vascular access. The most useful echocardiography examination, however, is that performed before induction of anaesthesia as it allows the anaesthetist to plan their management better.

The concept of point-of-care ultrasound (POCUS) has emerged to describe a brief, goal-focused examination to answer specific clinical questions, performed by the anaesthetist at the patient's bedside in real-time. The initial emphasis was on cardiac ultrasound but has spread to more generic uses such as lung ultrasound, basic abdominal and gastric ultrasound as well as assessment of deep vein thrombosis. Emphasis is still on performing

discrete ultrasound examinations (for example cardiac or lung ultrasound). As the knowledge and skill of practitioners increases, we should stop considering separate organ specific ultrasound studies but rather consider POCUS as "ultrasound assisted clinical evaluation" or "ultrasound guided procedures". In practice, the anaesthetist or perioperative physician of the future needs to be capable of performing basic ultrasound examination for multiple organs as part of their clinical evaluation. It does not mean they have to perform every ultrasound examination on every patient, but rather use the ultrasound to assist evaluation where indicated.

A famous cardiologist Eugene Braunwald wrote in an editorial,<sup>1</sup> "It is time to add a fifth pillar to bedside physical examination". We are all familiar with inspection, palpation, percussion and auscultation, with the fifth being 'insonation'.

Why is this important? The problem with conventional clinical evaluation is that it is often only 50% accurate<sup>2</sup>. The addition of clinical ultrasound increases the diagnostic accuracy enormously. The rest is quite simple – better information leads to better decision-making. The literature is quite clear that the use of perioperative ultrasound will improve diagnosis and that in turn will improve will change management<sup>3,4</sup>. However, does the change management affect patient outcome?

There's much less literature examining outcomes in anaesthesia from the addition of clinical ultrasound. The highest-level data is a randomised pilot study performed by my group<sup>5</sup> examining the impact of goal-focused cardiac ultrasound prior to surgery in patients undergoing fractured neck of femur surgery. This study showed a 39% relative difference favouring ultrasound for a composite of morbidity and mortality outcomes at 30 days. At one year, the mortality difference persisted. Further definitive studies are required to



demonstrate an outcomes benefit just for cardiac ultrasound but for perioperative ultrasound, and in a variety of patient cohorts.

So how do we rapidly upskill our anaesthetists and perioperative physicians to become proficient at basic perioperative ultrasound? The first step is psychological – accept that not everyone has to be an expert. Second is to “own our space” and determine what is acceptable scope of practice in our specialty. Step 3 is to define pathways to competency in the three key areas of knowledge, hands on learning, and practice. Step 4 is to teach on scale. No single group or organisation will be capable of teaching all of our anaesthetist and perioperative physicians, and so multiple pathways to competency should be facilitated. However, use of digital learning to deliver knowledge and interpretive practice, combined with experiential learning through workshops, simulators, and bedside teaching will improve the ability to scale training. Finally, it is important to remove practical and political roadblocks to encourage our specialties to adopt this technology.

Perioperative ultrasound is arguably one of the most important developments in

anaesthesia and perioperative medicine, and will continue to be important until basic ultrasound is taught to all medical students and becomes the ‘normal practice’. Many universities worldwide are already incorporating clinical ultrasound into their curricula. This is an exciting challenge for all of us in the next decade.

## References

1. Narula J, Chandrashekar Y, Braunwald E. ‘Time to add a fifth pillar to bedside physical examination: Inspection, palpation, percussion, auscultation, and insonation’. *JAMA Cardiol* 2018; 3(4):346-350.
2. Heiberg J, El-Ansary D, Canty DJ, Royse AG, Royse CF. ‘Focused echocardiography: a systematic review of diagnostic and clinical decision-making in anaesthesia and critical care’. *Anaesthesia* 2016; 71(9):1091-1100.
3. Canty DJ, Royse CF, Kilpatrick D, Bowman L, Royse AG. ‘The impact of focused transthoracic echocardiography in the pre-operative clinic’. *Anaesthesia* 2012; 67(6):618-625.
4. Canty DJ, Royse CF, Kilpatrick D, Williams DL, Royse AG. ‘The impact of pre-operative focused transthoracic echocardiography in emergency non-cardiac surgery patients with known or risk of cardiac disease’. *Anaesthesia* 2012; 67(7):714-720.
5. Canty DJ, Heiberg J, Yang Y, Royse AG, Margale S, Nanjappa N et al. ‘Pilot multi-centre randomised trial of the impact of pre-operative focused cardiac ultrasound on mortality and morbidity in patients having surgery for femoral neck fractures (ECHONOF-2 pilot)’. *Anaesthesia* 2018; 73(4): 428-437.

## SESSION TIMES

### Perioperative Ultrasonography

Sunday 22 September

Pymont Theatre

0915–1000

### Near infrared spectroscopy: measuring oxygenation where it matters

Monday 23 September

Pymont Theatre

1045–1215

### Inhaled pulmonary dilators for cardiac surgery

Monday 23 September

Room C2.5 & C2.6

1530–1700

# NSC 2019 SPEAKER ABSTRACTS



## PROFESSOR PAM MACINTYRE | BMEDSC MBBS FANZCA MHA FFPMANZCA

**Director, Acute Pain Service, Royal Adelaide Hospital, Adelaide, South Australia;  
Foundation Fellow, Faculty of Pain Medicine (FPM), Australian and New Zealand  
College of Anaesthetists (ANZCA)**

### THE OPIOID CRISIS FROM THE FRONT LINE

The marked rise in the prescription of opioids over the past couple of decades has been associated with a corresponding increase in fatal/non-fatal harm to both patients and those who access these drugs for non-medical use.

At the front line it means that the proportion of opioid-tolerant patients has increased, affecting both patient care and the healthcare system more widely. In the acute care setting for example, management of pain can be more complex. Regular opioid use prior to surgery is associated with longer hospital stays, an increased rate of complications, higher readmission rates and higher healthcare costs after many types of operations.

We at the front line have also aided in this crisis, albeit often unknowingly. Opioids were increasingly prescribed for

chronic non-cancer pain, despite no good evidence of long-term benefit. Excessive amounts have been prescribed when patients leave hospital and following discharge, and appropriate de-prescribing has not occurred.

Actions taken to curb opioid prescribing have resulted in a decline in many countries. Unfortunately, the death rate from opioids continues to rise, at least in the USA, because of increased abuse of heroin and illicitly manufactured fentanyl and its analogues.

In attempting to deal with this crisis and reduce opioid use, it is important not to introduce other risks. For example, prescribing rates for gabapentinoids have risen markedly over the past few years (often used for non-neuropathic pain) as has the rate of abuse and number of deaths involving these medications. And few can be unaware of the campaigns to prescribe medical marijuana for the

treatment of pain, despite no good evidence that it is effective and despite evidence of harm.

### SESSION TIMES

#### The opioid crisis from the front lines

Saturday 21 September  
Pymont Theatre  
1130–1215

#### Acute pain crises in chronic pain patients – how can we get it right?

Saturday 21 September  
Room C3.5  
1530–1700

#### Opioids through the ages

Sunday 24 September  
Pymont Theatre  
0830–1000





# SYDNEY NATIONAL SCIENTIFIC CONGRESS

AN EYE TO THE FUTURE

AUSTRALIAN SOCIETY OF ANAESTHETISTS | 20-24 SEPTEMBER 2019

## TRAINEE PROGRAM SYDNEY INTERNATIONAL CONVENTION CENTRE

**Friday 20 September**  
1830-2000

Trainee Members Group Drinks  
Sponsored by *Global Medics*

**Sunday 22 September**  
1045-1215

Chair: A/Prof. David M. Scott  
Trainee Audit/Survey Prize

**Saturday 21 September**  
1530-1700

W8 Part 2 Exam boot camp  
*Dr Vida Viliunas*

**Sunday 22 September**  
1215-1330

Trainee Members Group Luncheon  
Sponsored by *Avant Mutual*

**Sunday 22 September**  
1330-1500

Chair: Dr Malcolm Bannerman  
Trainee Members Group Session 1  
Getting started in private practice  
*Dr Matt Coady*  
Duty of disclosure and navigating AHPRA  
*Mr Paul Tsaousidis*  
Wellbeing after adverse events  
*Dr Ken Harrison*

**Sunday 22 September**  
1530-1700

Chair: Dr Malcolm Bannerman  
Trainee Members Group Session 2  
Exam stress *A/Prof. Patsy Tremayne*  
Where did my audit go wrong? *Dr Scott Fortey*  
Getting through the Part II *Dr Sarah Skidmore* | *Dr Harry Laughlin*

**Other benefits:** ASA members are entitled to claim one complimentary National Scientific Congress (NSC) or Combined Scientific Congress (CSC) registration during their Advanced/Provisional Fellow Training or in their first year as an Ordinary Member, provided they have been a financial APFT member for two years. This is claimable once and excludes travel, accommodation, sundry expenses, supplementary activities and workshops.

**[www.asa2019.com.au](http://www.asa2019.com.au)**

# ASURA 2019 REPORT

This year's Australasian Symposium on Ultrasound and Regional Anaesthesia (ASURA) was bigger and better with more speakers and workshops added to the programme.

Noosa was once again a popular venue, and even Cyclone Oma didn't deter the attendees and their families. The Symposium was a combination of plenaries, workshops and discussions.

Our international keynote speakers offered a wealth of expertise in pain medicine, research, and teaching of regional anaesthesia.

Associate Professor Ki Jinn Chin is a well-published and internationally recognised expert in regional anaesthesia, with an academic focus on ultrasound guided truncal and central neuraxial blocks. He participated in a Masterclass and a Plenary on regional anaesthesia.

Associate Professor Chad Brummett, Director of Pain Research at the University of Michigan, shared his knowledge on the role of acute care prescribing in the opioid epidemic.

Professor Sandra Kopp is a Professor of Anesthesiology at Mayo Clinic, USA whilst her colleague Associate Professor Rebecca Johnson, is a clinical researcher

and regional anesthesiologist. Professor Kopp's topics included a Masterclass on pathophysiology, aetiology, and diagnosis and management of peripheral nerve injury. As well as a PBLD and workshop, A/Professor Johnson spoke about the impact of neuraxial anaesthesia use in a plenary on outcomes in regional anaesthesia.

Associate Professor Jens Børglum's main interest is in ultrasound-guided nerve blocks, ultrasound and airway. He participated in two plenaries on RA techniques for hip arthroplasty and quadratus lumborum, TAP and rectus blocks.

In order to maximise the workshop options for ASURA 2019, there were several alternatives for delegates on day one of ASURA. For novices and less experienced delegates, introductory workshops were offered in Noosa on the Thursday morning.

Two modules were offered featuring an ultrasound needle-imaging skills training session plus a scenario-based small group teaching session – All Around the Block.

Two cadaver workshops were held at Queensland University, Brisbane. The morning session was aimed at

anaesthetists who wanted to improve their anatomical knowledge and clinical skills for RA. The afternoon session was for more experienced practitioners, and focussed on anatomy and sonoanatomy for advanced techniques.

Day 2 featured plenary sessions and Day 3 focussed on small group workshops and PBLDs. A total of four plenaries, five masterclasses, 11 PBLDs and 48 workshops were conducted over the four days.

Delegates enjoyed a social program that included welcome drinks at View Restaurant; cheese and wine tasting at Miss Moneypenny's, and the sunset cruise followed by the Symposium dinner at Woodfire Grill.

Thanks to the exhibitors Admedus, B. Braun, Fujifilm Sonosite, LifeHealthcare, Philips, Priority Life, Seqirus, Surgical Specialties and Teleflex for their support and sponsorship.

Special thanks to Convenors Dr Neil MacLennan, Liz Maxwell, Helen Lindsay, Chris Nixon, David McLeod and A/Prof David M. Scott.

We look forward to seeing you again at ASURA 2021 to be held in Adelaide, South Australia.





Convenor Neil MacLennan welcomes delegates



Maurice Lee gives the Memorial for Dr Darcy Price



International speaker Ji Kinn Chin



International speaker Sandy Kopp



International speaker Rebecca Johnson



International speaker Chad Brummett



International speaker Jens Børglum



Kelly Byrne, PECS block, Plenary 2



David M. Scott, Chair Plenary 3



Justin Holbrow, LAST updated guidelines, Plenary 4



Liz Maxwell, Plenary 4



Charlie Warren, Rib fracture algorithm



Plenary 1: Chair Michael Barrington with panel



Panel, Plenary 3: Lower limb arthroplasty



Peter Hebbard has questions for the panel



Panel taking questions



Questions from the floor



Skills training



Skills training



All Around the Block



Attentive audience



WS16, paravertebral, retrolaminar, elector spinae plane



Phil Cowlishaw, Workshop 21 – front of leg



Ross Peake, Workshop 5 – knee joint



Stephanie Clark, Workshop 23



David McLeod, Workshop 39 on knee joint



Katrina Webster conducts Workshop 46 on breast (PECS, serratus plane)



WS34 Dr Matt Levine conducts a workshop on brachial plexus below clavicle



Problem-Based Learning Discussion 11



Exhibitors



Chatting with industry rep



Checking out the latest equipment



Families enjoying ASURA



Barry Lim, David McLeod, Ki Jinn Chin, Melissa and Peter Hebbard



Catching up with friends



Delegates at the welcome function



Welcome function at View Restaurant



Enjoying a chat



Delegates enjoy the wine and cheese tasting



Early morning yoga



Boarding the Catalina for sunset cruise



Cheers!



Enjoying the cruise



Is that a crocodile?



All smiles

## FEATURE

## ASA ONLINE FORUM

In October 2018 the ASA launched an Online Forum.

### WHAT IS AN ONLINE FORUM?

An online or Internet forum, or message board, is an online discussion site where people can hold conversations in the form of posted messages. Online forums provide a variety of online discussion groups, in which participants with common interests can exchange open messages. Forums are sometimes called newsgroups (in the Internet world) or conferences. It takes about two years on average for a forum community to establish itself.

### WHAT IT ISN'T

The online forums differ from social media channels or chat rooms in that messages are often longer than one line of text, all conversations are archived and kept together in one single organised place, and users can upload multiple documents/files. Also, depending on the forum set-up, a posted topic might need to be approved by a moderator before it becomes visible or it could be edited by moderators after it has been posted by a user.

Forums have a specific set of jargon associated with them; for example: a single conversation is called a 'thread', or topic.

### PURPOSE

The ASA Forum is for sharing your ideas, interacting with other members of the ASA and wider anaesthesia community, networking with members of the ASA, asking and answering questions about the ASA's activities and membership benefits, learning about the ASA and also contributing your knowledge and experience to the ASA and wider anaesthesia community.

Forums are a great way for the ASA and its members to establish thought leadership in their area of expertise.

### STRUCTURE

A discussion forum is hierarchical or tree-like in structure: a forum can contain a number of subforums, each of which may have several topics. Within a forum's topic, each new discussion started is called a thread and can be replied to by as many people as so wish.

Depending on the forum's settings, users can be anonymous or have to register with the forum and then subsequently log in to post messages. On most forums, users do not have to log in to read existing messages. The ASA Forum differs in this regard.

The ASA Forum is a secure online group for ASA members and other key stakeholders who have requested to join the discussion group. Members need to log in using their ASA credentials in order to access the forum discussion groups.

There are two types of discussion groups created: open and closed discussion groups.

Open discussion groups are groups where members are automatically joined once they sign in to the members website, while closed discussion groups are restricted to ASA committee members only.

All discussion groups have moderators.

Currently there are two open discussion groups set up on the ASA Forum.

1. Open Forum
2. Long Lives, Healthy Workplaces

We also have 16 closed Committee discussion groups set up on the ASA Forum:

1. TMG closed discussion group
2. EAC closed discussion group
3. PIAC closed discussion group
4. RVG review closed discussion group
5. MBS review closed discussion group
6. ODEC closed discussion group
7. Communications committee closed discussion group
8. Board closed discussion group
9. Council closed discussion group
10. NSW Committee closed discussion group
11. ACT Committee closed discussion group
12. VIC Committee closed discussion group
13. QLD Committee closed discussion group
14. SA and NT Committee closed discussion group
15. WA Committee closed discussion group
16. TAS Committee closed discussion group

### OTHER DISCUSSION GROUPS

If you are not a committee member and would like to start a separate open or closed discussion group, please fill in the join form <https://asa.org.au/join-the-asa-forum/> and we'll be in contact with you shortly.

## STEPS TO JOIN THE FORUM

1. Go to <https://asa.org.au/asa-forum/>
2. Enter your membership credentials (username and password)
3. All available forums will be shown in this area. If you are a member of a private forum/closed discussion group, you will also see these groups. Note: the forum has its own
4. Click on the name of the forum/discussion group.

Username

Password

☐ Keep me signed in

**Sign In**

[Forgot username?](#) | [Forgot password?](#)



## WHAT TO DO NEXT?

5. View all topics



6. Add a new topic using the 'New topic' web button:



7. Reply to an existing topic:



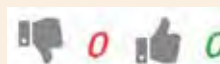
8. Use the 'Quote' feature to respond to a specific reply:



9. Reference other users in the forum – use @mentions:

Suzi Nou  
(@26879)

10. React to a post – 'like' or 'unlike' a post:



# FEATURE

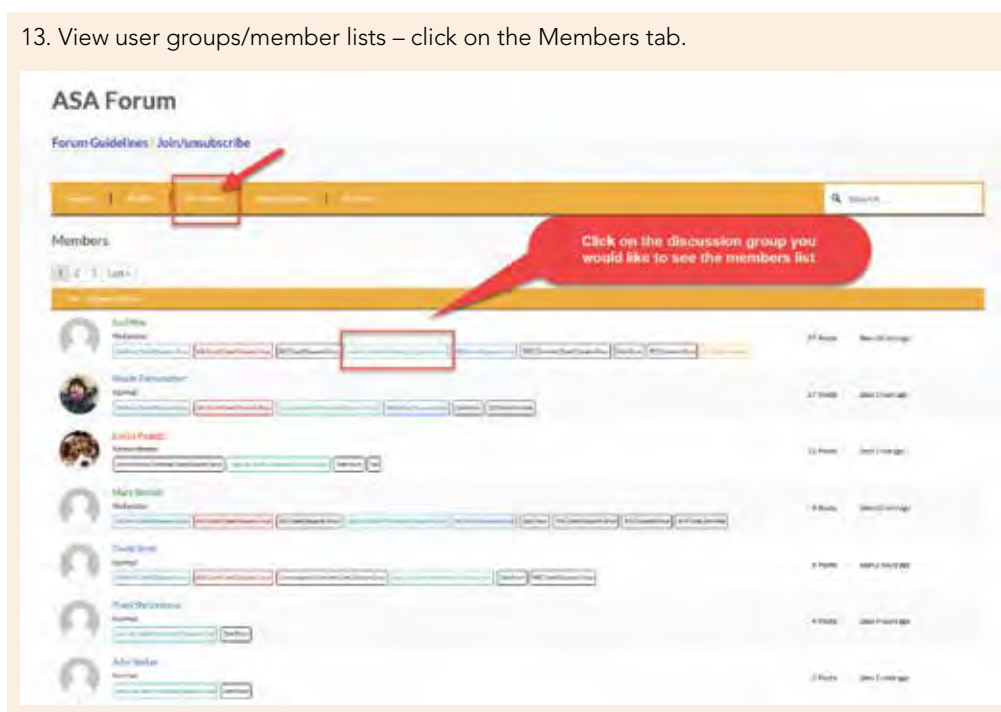
11. Manage subscriptions – click on the subscriptions tab to manage your subscriptions.



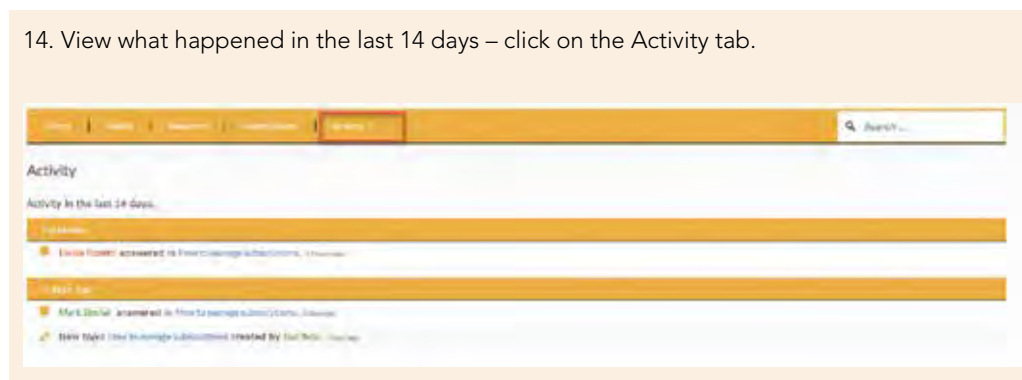
12. Updating your user profile – click on the Profile tab to update your profile.

[Edit Profile](#)

13. View user groups/member lists – click on the Members tab.



14. View what happened in the last 14 days – click on the Activity tab.





## SUBSCRIPTIONS

Forum email notifications can be customised by each forum user to suit their own interests and preferences.

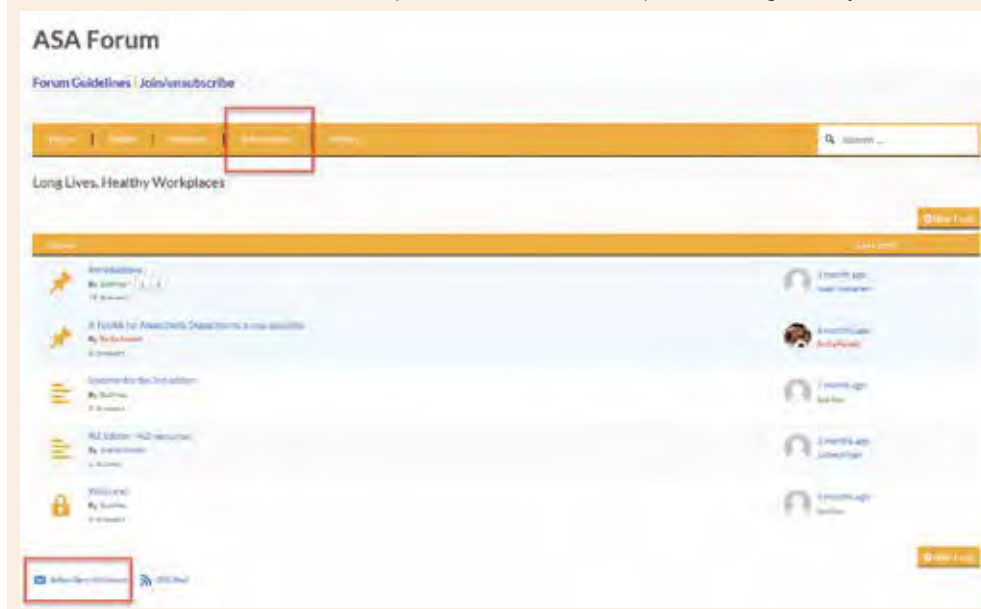
There is a global subscriptions tab at the top of the Forum menu which determines

whether you receive notifications for all new topics and posts (select 'New topics and posts'), all new topics only (select 'New topics') or if you wish to get notified only about activity in the forums and topics you have subscribed to (select 'Individual subscriptions').



The default setting is 'Individual subscriptions', which means users are currently not receiving email notifications unless they subscribe themselves to a specific forum and topic. If you would like to receive email notifications from a specific forum/discussion group, you need to go to that forum and topic and click 'Subscribe to this forum'  and then you can choose which topics within each discussion group you'd like to be notified about. 

If you'd like to receive an email notification about all new topics and posts on the Forum, you simply select the third option 'New topics and posts'. Note that when selecting this option, you will get an email notification every time a user posts anything on the forum. Active board, council and other committee members may have this subscription option enabled. Note that each user can update their own subscription settings at any time.



We hope this summary has provided some useful guidance for members who wish to engage on the forum. We're looking forward to reading your messages on the forum.

Emilia Podetti  
ASA Digital Marketing Coordinator

## References

1. How to guide, ASA Forum <http://bit.ly/2DiRB5g>
2. Individual and social benefits of online discussion forums, Louise F. Pendry and Jessica Salvatore <http://bit.ly/2GvoXjy>
3. [https://en.wikipedia.org/wiki/Internet\\_forum](https://en.wikipedia.org/wiki/Internet_forum)

## FEATURE



# THE JOYS AND TRIALS OF AN ANAESTHETIST/INVENTOR

Throughout my life, I have had an urge to make things which work and have a useful purpose.

My early life on a farm was a perfect environment for satisfying this urge as there was space, facilities and encouragement. For a few years I attended a school where the emphasis was on woodwork, metalwork, pottery and art. The headmaster was a science graduate, who enjoyed explaining how things worked. It was a fascinating time, and it gave me direction. I constructed radios and amplifiers, and later renovated an old car from a car-breakers yard and went on to convert it to run on paraffin to give cheap motoring.

My hobbies included sailing, which

involved the restoration of an old wooden boat, and photography which involved setting up and equipping a dark room.

As a result, a strong sense of what worked and what didn't, became natural to me and my anaesthetic career was studded with ideas and efforts to improve techniques and equipment.

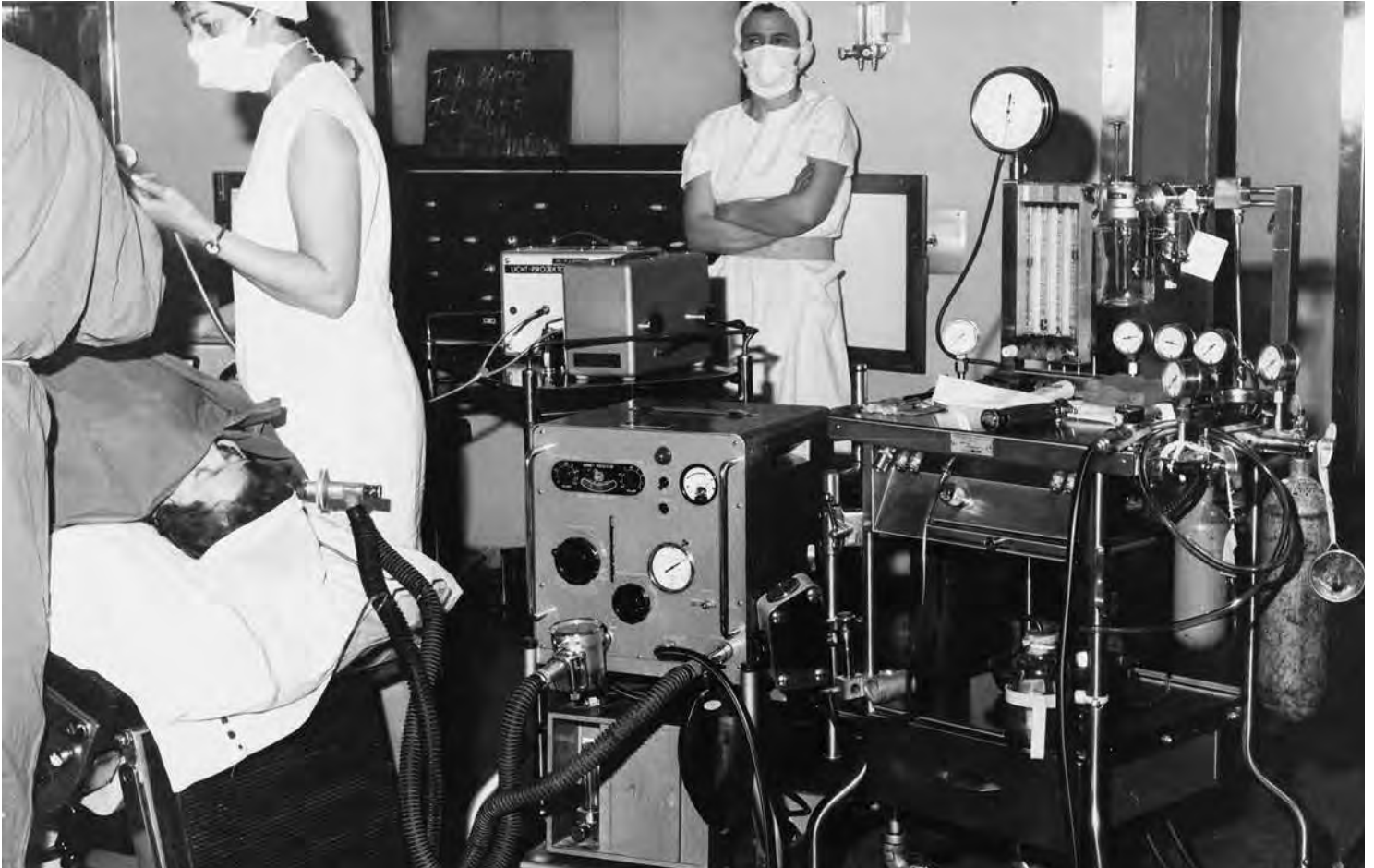
In 1964 I was appointed the anaesthetist in charge at the Oldham Hospital on the outskirts of Manchester, UK.

The obstetrician was Patrick Steptoe, a powerful committee man and a dynamic individual who was the pioneer of laparoscopy; at the time of my arrival it was at a very early stage of development. A cystoscope type instrument was used. Illumination was poor and there was

a danger of burns from the hot bulb. Laparoscopy was only used for a quick visual inspection to decide if a laparotomy was necessary. No surgical procedures could be done laparoscopically at that time.

Patrick was convinced that laparoscopy had a future, but the anaesthetists were reluctant to anaesthetise these patients as it was not then an accepted procedure, with concerns that the inflated gas would greatly restrict respiration, would cause hypotension from blocking the venous return to the heart, also the fear of gas embolism.

At the interview, my appointment was based on my stated willingness to anaesthetise these patients. I also



Laparoscopy in progress at Oldham in 1967. Of anaesthetic interest:

1. The Barnett ventilator occupies as much floor space as the anaesthetic machine.
2. The only monitoring available was (a) blood pressure manometer on the anaesthetic machine; (b) Drager Volume Meter on the expiratory line; (c) circuit pressure gauge on the ventilator; and (d) skin colour from part exposed face.
3. High gas flows with condenser humidifier unit.
4. Ether vaporiser, cyclopropane and carbon dioxide cylinders still exist on the anaesthetic machine.
5. Steep head down tilt of the patient.

expressed the view that a carbon dioxide pneumoperitoneum would be no problem so long as there was full relaxation with controlled ventilation. And so I became the anaesthetist to work with Patrick Steptoe, and was the only anaesthetist to work with him during the whole of my five years at Oldham. Happily, no anaesthetic morbidity occurred with any of these cases.

...Robert Edwards, a biologist, had seen Patrick's laparoscopic photos and realised that eggs could be collected from the ovaries.

Patrick was delighted at the conditions provided by my anaesthetics, but the lighting was poor and needed improving. Soon after my arrival he set about investigating a way to improve the lighting. He found a German company which could construct a high intensity light source in a box with a fiberoptic cable to transmit this as 'cold' light to the abdominal cavity. The excellent view allowed him to take many coloured slides to show at various meetings and astonish the audience. Patrick now realised that operative procedures were possible as there was good lighting, good access

and no need to hurry. Apparatus was developed for surgical procedures and soon there were several laparoscopies on every list. By 1968 I had become the first anaesthetist to have given more than 50 anaesthetics for laparoscopic sterilisation<sup>1</sup>.

It was around this time that Robert Edwards, a biologist, had seen Patrick's laparoscopic photos and realised that eggs could be collected from the ovaries. They collaborated, and so began research into in-vitro fertilisation and I became the first to anaesthetise patients for egg collection. Patrick had many disappointing

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Duncan Campbell taking delivery of the first fluidic controlled ventilator at the Ulco Factory, Marrickville, Sydney

years of research with in-vitro fertilisation until at last in July 1978 the world's first 'test tube' baby was born. By then I had left Oldham and was in Australia.

While in Oldham I had two projects of my own. The first was instigated by my sister who complained about rough handling for a minor operation when transferred from bed to trolley to operating table and back again to bed. I set about making a patient lifting trolley which eliminated manual lifting, operated by only one person and powered by a carbon dioxide gas cylinder<sup>2</sup>. It worked well, was used in the hospital and remained there when I left.

My second project was to make a small versatile ventilator for use in the operating theatre. An electrically powered model was constructed, but the controls required a high voltage. This was of concern because of shock danger, so the project was abandoned.

The Oldham summers were cold, wet, windy and the atmospheric pollution was so bad that the white sheep in the surrounding countryside were black. The



winters were worse: the sun rarely shone, fogs were frequent, and the snow often piled up on our driveway and had to be shovelled off.

My interest was in research, so when an opportunity presented for a staff specialist appointment at an Australian teaching hospital, it was accepted immediately. In 1969 my family and I moved to Sydney and I started work at the Royal Prince Alfred Hospital.

Soon after my arrival I was involved with the design of a drug tray as there were delays in accessing the routine drugs from the multiple sources during an anaesthetic. The design was agreed by the department and a batch was manufactured by Ulco, a local engineering company, and so began my long association with this company and the managing director, John Uhler.

My interests still lay in pulmonary mechanics with a special interest in non-electrical control systems which could

be used to operate a ventilator. Fluidic control systems were used on rockets, and when there was news of a rocket motor failure and then finding that the fluidic control system was still intact when it was dug out of the crater, suggested to me that this would be the ideal control system for a ventilator. With some difficulty the required components were obtained, and a ventilator was constructed. It worked perfectly, but the requirement was for an engineered robust unit, so Ulco was contacted, and at personal expense, the first unit was built. Unknown to me they made a second one as they became convinced it would have a commercial future. This second one was used for demonstration purposes and soon had multiple requests for purchase. Altogether over 3,000 were sold with many going overseas.

My ventilator accompanied me and was used on my anaesthetic lists. I presented a paper at the ASA meeting in Hobart. It was later described fully in *Anaesthesia and Intensive Care*<sup>3</sup> in 1976. Around that period I also had several other publications in conjunction with



Duncan Campbell beside his ventilator which is attached to an anaesthetic machine



Cardiac output monitor – recording of Campbell's cardiovascular status

other anaesthetists on various aspects of pulmonary mechanics<sup>4-6</sup>.

After my retirement, this very first ventilator was presented to the Harry Daly Museum together with a full account of development details. It was in good working order, so it would be fun to connect it up to an air line and see if it still works.

Before Ulco became involved in ventilators they made several of my patient lifting trolleys. Manufacture and assembly took up much of their limited floor space, so they discontinued this product when the demand for ventilators occurred, and production of these trolleys was never resumed.

About ten years after the first ventilator was produced, low voltage electrical control became available and acceptable for use in the operating theatre, so this was adopted and gave better control, and also precise 'read out' of ventilation parameters.

A problem existed with all ventilators at that time regarding unrecognised

disconnections. The alarms which were fitted took about 20 seconds before they sounded. Such a delay was unacceptable. A new system was devised to ensure that the alarm sounded at the first inspiratory phase after the disconnect. I presented the patent as a gift to Ulco. The system was incorporated in all their alarms and after that any disconnects were immediately recognised. My letter was published in *Anaesthesia and Intensive Care*<sup>7</sup> to inform users of the available safety feature.

There were multiple 'spin-offs' from the ventilator technology and from my research on pulmonary mechanics.

I devised a system for measuring airway resistance in the anaesthetised patient and used this on many occasions to measure the effects of the various anaesthetic drugs used. I presented a paper on this topic at the ASA meeting in Melbourne in 1975, and with Colin Shanks it was published in *Anaesthesia and Intensive Care*<sup>8</sup>.

Another 'spin-off' was a horse ventilator delivering tidal volumes of up to 14 litres<sup>9</sup>. This was used at the University Veterinary Teaching Hospital at Camden, NSW.

Also produced was a 'leg inflator' with a greatly slowed timing, used for over a year at Baulkham Hills Hospital on post-operative spinal surgery patients to prevent DVTs.

The same cycling control module was used to control a gas driven pump for kidney perfusion prior to transplantation. This was used at RPAH for perfusing kidneys prior to transplant. It was used for over a year until a survey revealed that compared with keeping kidneys in ice, there was no difference in outcome.

John Uhler had an interesting request from a local engineering company which was working with a physician studying sleep apnoea. They were interested in using our patented CPAP system for making apparatus for use in these cases. We thought the demand would be small and happily agreed to their request. The company later became ResMed.

In the early 1990s I was concerned that we were unnecessarily polluting the atmosphere with our halogenated hydrocarbon anaesthetics. Retrieval from the expired waste gas and re-cycling

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was possible, so I had fun constructing a system comprising the low levels of halothane that would be present in waste gas, and then demonstrating effective retrieval by monitoring with a photo-acoustic spectroscope. This was presented in Adelaide at an ASA meeting and reported in *Anaesthesia and Intensive Care*<sup>10</sup> in 1993. I had hopes that a pilot system could be set up at a hospital, but I was unable to get any interest.

My final 'spin-off' was a cardiac output monitor as the equations used in pulmonary mechanics also apply to the arterial vascular system, so that by measuring systemic vascular resistance (thought to be impossible) and dividing this value into mean arterial pressure, cardiac output is accurately derived<sup>11</sup>. This seemed astonishing as it meant that cardiac output could be measured by an entirely non-invasive method. A literature search revealed that Professor Otto Frank (of Frank/Starling fame) had published this equation<sup>12</sup> in 1899, but technology to exploit the method did not exist at that time so it was ignored.

In the year 2000, together with Ulco, work began on constructing this monitor, but after a year it was abandoned: the computers and other electronic equipment took up a whole trolley, so that the bulk and cost would make this an impractical commercial proposition.

I still had an interest in cardiovascular problems<sup>13-14</sup>, and in 2014 realised that computers were now small enough, with enormous computing power and cheap, so that an accurate non-invasive cardiac output monitor could be constructed and be commercially viable. Sadly, John Uhlir had died, and Ulco no longer existed.

I contacted Mark Littlejohn of Electrolab, a brilliant electronic engineer who had masterminded the successful conversion of the ventilator fluidic controls to electronic, had constructed the ventilator alarm and was still servicing the ventilators. Together with his son James, a simulator

monitor was constructed to confirm feasibility. This was demonstrated at the ASA meeting in Canberra in September 2013 and attracted considerable interest. At the same meeting I presented a paper and a poster<sup>15</sup> on this topic. My Australian patent was granted the following year<sup>16</sup>.

Alas, bureaucracy had now overtaken us, and work came to a halt. Mark's premises did not comply with the strict regulations imposed for hospital equipment manufacture, although he was free to service and sell these products.

Genesys at Pymble had the required certification, so they were contacted, and Jon Eggins worked his magic and constructed a functioning prototype which exceeded all expectations. Ideal for the operating theatre, it had a non-invasive, continuous display of cardiac output, tidal volume, vascular resistance, force of ventricular contraction and many other features. I took great delight in trying it out on myself, family and friends and confirmed spectacular function, but once again bureaucracy blocked further progress.

Although production models could be made to retail at about A\$15,000, the requirement was for Therapeutic Goods Administration compliance. The cost of this was \$300,000; well beyond my means. Major companies had no interest unless backed up by clinical trials, but clinical trials could not be done without Therapeutic Goods Administration compliance. We came to a complete halt in producing a monitor which would be of great value for monitoring high risk patients undergoing major surgical procedures.

In spite of problems, when I look back over the years, I realise that I have been very lucky, and it has mostly been great fun.

Duncan Campbell  
Retired anaesthetist/inventor

## References

1. Edwards R, Steptoe P. 'Laparoscopy comes of age'. *A Matter of Life*, Hutchinson and Co 1980 p. 73-77.
2. Campbell DI. 'A pneumatic lifting trolley'. *Anaesthesia* 1970; 25:274-277.
3. Campbell DI. 'A new compact versatile fluidic controlled ventilator'. *Anaesth Intensive Care* 1976; 4:7-15.
4. Campbell DI, Shanks CA, Flachs J, Austin P. 'Accurate volume ventilation of neonates with maintenance of humidification'. *Anaesth Intensive Care* 1975; 3:295-298.
5. Shanks CA, Campbell DI, Telford H. 'Respiratory mechanics with constant flow inspiration'. *Br J Anaesth* 1976; 48:1157-1162.
6. Shanks CA, Campbell DI, Telford HJ. 'Airway pressure changes observable with constant flow inflation and an end-inspiratory pause'. *Anaesth Intensive Care* 1977; 5:41-46.
7. Campbell DI. 'Disconnect alarm failure'. *Anaesth Intensive Care* 1999; 27:318.
8. Campbell DI, Shanks CA. 'The effect of atropine on inspiratory flow resistance in geriatric male patients'. *Anaesth Intensive Care* 1977; 5:81.
9. Brownlow MA, Campbell DI, Hutchins DR. 'The development of a fluidic controlled ventilator for the horse'. *Aust Vet J* 1982; 58:200-204.
10. Campbell DI. 'Recycling volatile anaesthetics'. *Anaesth Intensive Care* 1993; 21:238.
11. Campbell DI. 'Cardiac output determination using compliance'. *Anaesthesia* 2002; 57:185.
12. Jhanji S, Dawson J, Pearse RM. 'Cardiac output monitoring: basic science and clinical application'. *Anaesthesia* 2008; 63:172-181.
13. Campbell DI. 'Anaesthesia and isolated systolic hypertension'. *Anaesth Intensive Care* 2004; 32:592.
14. Campbell DI. Vascular compliance, resistance and cardiac output. Poster session ASA & NZSA Melbourne 2003 October 2-5.
15. Campbell DI. 'Optically derived cardiac output'. *Anaesth Intensive Care* 2014; 42:512.
16. Campbell DI. Method and apparatus for non-invasive determination of cardiac output. Australian Government IP Australia Patent 2012318248. Granted 2014 January 9.

## INSIDE YOUR SOCIETY

# PROFESSIONAL ISSUES ADVISORY COMMITTEE

## WHEN THINGS GO WRONG IN ANAESTHESIA... A SUGGESTED FRAMEWORK

Anaesthetists are well trained in the detection, prevention and management of anaesthesia crisis but are we adequately advised about protecting the secondary victims (the clinicians involved), and the tertiary victims (subsequent patients who will be cared for by these clinicians)?<sup>1</sup> A suggested framework is provided to assist anaesthetists in dealing with these distressing and often devastating circumstances.

Anaesthesia crisis management is a core part of training and continuing professional development. Dealing with the aftermath of an anaesthesia catastrophic event is part of this process. A catastrophic event<sup>1</sup> may include an intra-operative or peri-operative death, a major event such as anaphylaxis, airway disaster, major neurological deficit, perioperative visual loss, end organ ischaemia/damage. It may also include other situations such as post-dural puncture headache, wrong-sided block, aspiration, awareness or other drug reaction causing significant distress for patients and carers. The immediate management includes organising transfer to a suitable place, which often involves transfer to a tertiary intensive care unit. A process of open disclosure is then followed and this is well described.<sup>2</sup> The next phase is about debriefing and on-going psychological support. This seems more nebulous and deserves clarification.

### Emotional impact

In a survey of anaesthesiologists Gazoni et al<sup>3</sup> found 62% of respondents recall a

perioperative catastrophe in the past ten years and 84% over the course of their career. White<sup>4</sup> found that over a third of respondents felt personal responsibility for intra-operative deaths. Anaesthetists may be at risk of psychological distress by the very nature of their practice. Production pressure reflected by excessive demands for complex tasks with strict time constraints, often lead to feelings of isolation and inadequacy.<sup>5</sup> Poor working conditions, lack of autonomy, being responsible for patient outcomes that may be beyond one's control and the fear of harming patients may lead to chronic stress and burnout.

The emotional impact of a catastrophe may include reliving the event, anxiety, guilt, fear of litigation, depression, sleeplessness, fear of judgement by colleagues, anger and professional self doubt.<sup>3</sup> Some respondents even admitted to considering a career change, having suicidal ideations or substance abuse which makes this group 'high risk'.<sup>6</sup> Risk exists for potential personal physical or psychological harm, damage to personal and professional relationships, and harm to other patients if the anaesthetist is temporarily impaired.<sup>1</sup> Without the appropriate support, an anaesthetist's recovery may be prolonged and incomplete.<sup>7</sup>

### Time to emotional recovery and impact on quality of subsequent care

In the Gazoni et al<sup>3</sup> survey, over 51% of respondents felt their ability to provide

safe anaesthesia over the next 24 hours was compromised. Twenty-seven per cent felt it was impaired by a week, 16% felt it was impaired for a month and some (19%), felt they never fully emotionally recovered. The deleterious effects of excessive stress on human performance, has been well documented.<sup>5</sup> There may be physical, psychological and cognitive impairments that compromise subsequent patient care for the complex multi-faceted task of anaesthesia. Following a catastrophe, the anaesthetist should not proceed with scheduled surgery and should have at least the next 24 hours off to implement an aftermath action plan.

### A suggested framework for managing the aftermath of an anaesthetic catastrophe

1. Manage the immediate aftercare of the patient:
  - a. Initially the patient may need to be transferred to a high dependency area, intensive care unit or palliative care ward. This will require a thorough handover with a plan to manage on-going care and clear instructions of responsibilities.
  - b. In the event of a death, the coroner will need to be notified and there may be logistic requirements such as quarantining of equipment, monitors and pumps for further interrogation.
  - c. One should ensure appropriate provisions have been made for the family to visit the patient.



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2. Documentation:
  - a. Ensure the anaesthesia record and other aspects of the medical record are accurate and complete.
  - b. Document a timeline of events, actions taken and key observations and investigations.
  - c. Be mindful not to speculate or blame others.
  - d. Keep a copy of all records.
3. Initiate open disclosure protocol:
  - a. The healthcare facility will have an open disclosure protocol. This may already have been initiated by another senior team member, once the crisis was detected. There are many excellent open disclosure frameworks available. The Australian Commission on Safety and Quality in Healthcare principles include:
    - i. "Open and timely communication"<sup>2</sup> providing families with accurate real time information about what is known and what is still undetermined.
    - ii. "Acknowledgement"<sup>2</sup> of any adverse event.
    - iii. "Apology or expression of regret"<sup>2</sup> for any harm or adverse event without speculation or attribution of blame.
    - iv. "Supporting and meeting the needs and expectations of patients, their families and carer(s)."<sup>2</sup> This will involve an initial meeting with the family. The anaesthetist may lead this meeting or at least be part of the senior team that conducts the meeting. It is important to demonstrate genuine empathy, regret and on-going concern for the welfare of the patient and their carers. An opportunity for asking questions and follow up meeting should be provided.
    - v. "Supporting, and meeting the needs and expectations of those providing health care."<sup>2</sup> Working collaboratively and maintaining healthy team dynamics is important.
  - vi. "Integrated clinical risk management and systems improvement."<sup>2</sup> There will be a review of the incident such as a root cause analysis, which focuses on any system issues that may be corrected to prevent this from recurring to someone else.
  - vii. "Good governance"<sup>2</sup> to provide the resources and follow up to ensure quality improvement and risk reduction.
  - viii. "Confidentiality"<sup>2</sup> maintaining privacy laws.
  - ix. Communicate<sup>2</sup> any findings to the family and stakeholders to assist in closure.
4. Initial debriefing with staff involved in catastrophe. It is important to acknowledge the significance of the event, thank staff for their assistance and maintain healthy working relationships. There may be areas of disagreement regarding management and this can be openly acknowledged while still preserving the relationships.
5. Notify and debrief with anaesthesia department director or medical director in private hospital setting.
  - a. In a public hospital setting, there may be an established protocol for dealing with a catastrophe. Resources may be accessed for further management of the clinical work and relieving the anaesthetist to concentrate on the immediate aftermath recovery.
  - b. In the private sector, the anaesthesia craft group leader may provide some assistance. Usually the medical director, CEO or hospital manager will have already been informed of the event. It is necessary to provide the senior hospital management with a brief description of the event and the further management plan. This may include some reassurance about what steps are being taken to avoid further harm to the anaesthetist or subsequent patients.
6. Notify medical indemnity.
  - a. A copy of the anaesthesia record, other relevant documents and your own timeline of events will be useful. Most policies will only cover the anaesthetist if the indemnity company has been adequately informed.
7. Notify statutory authorities and regulatory agencies as appropriate.
  - a. The coroner or health department may need to be notified.
  - b. In the case of suspected anaphylaxis, in addition to further tryptase investigations, mandatory reporting and referral for drug testing will be required.
  - c. Adverse drug reactions should be reported to the TGA.
  - d. Reporting to WebAirs and local morbidity groups such as the Victorian Consultative Council on Anaesthesia Mortality and Morbidity.
8. Discuss that an event has occurred with family/ personal support person without discussing the case.
  - a. After a catastrophe, the anaesthetist will need support. It is important for family and friends are made aware of the significance of this experience. There is an opportunity for those close to the anaesthetist to assist in their general care and to be vigilant for any abnormal behaviour that may indicate deterioration or impairment.
9. Confidentially discuss the details of case with a mentor or trusted colleague.
  - a. It is important to have a meaningful, detailed and genuine discussion of the case with an experienced and trusted colleague. Often, an adverse event or anaesthesia catastrophe

- arises due to exceptional circumstances, major patient comorbidities, extenuating surgical factors and other system factors that have contributed to the poor outcome. Another anaesthetist not involved in the case may be better placed to adopt a 'helicopter' view and frame the events in a more positive light.
- b. Stop discussing the case with anyone else. There may sometimes be a temptation to 'absolve' oneself by re-telling the story, or searching for obscure details that may somehow change the interpretation of the outcome. This merely promotes rumination and reliving the experience. It may be more helpful to compartmentalise the events as a protective strategy. There will be formal opportunities to re-examine elements of the case as more information becomes available.
10. Consider how much leave from clinical duties will be required.
    - a. The anaesthetist requires at least twenty-four hours to implement the open disclosure, collate the documentation, make the necessary notifications and get some rest. It is important for anaesthesia departments to provide as much support as is required.
    - b. In the private setting, anaesthetic groups or colleagues should be able to cover lists so the anaesthetist can deal with these matters. The ASA may be contacted if required and will assist in providing support.
  11. Access further support as required.
    - a. 'You are not alone!' There are many avenues for support and resources available. Most anaesthetists will experience a peri-operative death or major catastrophe in their career.
    - b. It may be worth considering professional counselling if you are not making a timely recovery.
  12. Formally present the case at an appropriate forum.
    - a. Once the dust has settled, and more relevant information has become available such as a coroner's report, it may be appropriate to formally present the case. This is part of continuing professional development by reflecting on adverse events and considering how clinical practice may be improved.
    - b. Completing the quality improvement cycle in this fashion may provide some degree of closure.
  13. Follow up further investigations, professional peer review and meetings with family.
    - a. Formal RCA and professional review may be part of this process. It is best to view this through a positive lens as an opportunity for further professional development. Anaesthetists do not intend to cause harm and yet adverse events do occur. It is important to learn from these events.
    - b. It is important to offer families and carers the opportunity to re-explore the details of the case especially in light of any new information. Families appreciate honesty, transparency and due process. Often their main concern in the context of an adverse event, is that steps have been taken to prevent it from recurring to someone else.
  14. Regularly check yourself over the next six months.
    - a. It takes time to bounce back from an anaesthetic catastrophe. Utilise the resources available to ensure you are on the right track. Be kind to yourself. Consider reducing your clinical load. Consider reducing any extra curricula professional activities.
    - b. It may be worth seeking assistance if you are experiencing:
      - i. excessive memories, dreams or ruminations of the events,
      - ii. prolonged lowered mood, sleep disturbance, exhaustion, somatic disturbances,
      - iii. problems with accidents, impairment, relationship problems or isolation.

## Conclusion

Although anaesthesia catastrophes are relatively rare events, most anaesthetists will experience one at some point. In addition to risk mitigation, avoiding serious sequela and managing the acute crisis, the clinician will need to deal with the aftermath. Having an emotional reaction is normal. Having a framework for managing it is smart. What is at stake is one's health and the safety of future patients. The framework described here is merely a suggestion and should be adapted and modified to suit your personal circumstances and local context. These are the author's views and do not reflect the Society's view. If you have any concerns at any stage, feel free to ask for help. The ASA is here to support members and promote patient safety.

## References

1. Steigler MP. When things go wrong in medicine: The second and third victim. [2019] Internet. Available at: <https://www.marjoriestieglermd.com/adverse-events-second-victim-and-third-victim-ethics-of-care/>
2. Australian Commission on Safety and Quality in Health Care. Australian Open Disclosure Framework. Sydney. Commonwealth of Australia. 2013:11.
3. Gazoni FM, Amato PE, Malik ZM, Durieux ME. 'The impact of perioperative catastrophes on anaesthesiologists: results of a national survey'. *Anaesthesia and Analgesia* 2012. March; 114(3): 596-603.
4. White SM, Akerele O. 'Anaesthetists' attitudes to intraoperative death'. *European Journal of Anaesthesiology* 2005. Dec. 22:938-941.
5. Nyssen A-S, Hansez I. 'Stress and burnout in anaesthesia'. *Current Opinion in Anaesthesiology* 2008. 21:406-411.
6. Aitkenhead AR. 'Anaesthesia disasters: handling the aftermath'. *Anaesthesia* 1997. 52: 477-482.
7. Wee M. *Catastrophes in Anaesthetic Practice – dealing with the aftermath*. The Association of Anaesthetists of Great Britain and Ireland. London. 2005 (revised 2010).

## INSIDE YOUR SOCIETY

# ECONOMICS ADVISORY COMMITTEE



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### MEDICARE BENEFITS SCHEDULE (MBS) REVIEW

As ASA members will have noted in recent e-news releases, the review of anaesthesia MBS items continues to raise new issues.

As it stands at the time of writing this article, 19 of the 67 recommendations of the Anaesthesia Clinical Committee (ACC), responsible for the original review of some 528 items for anaesthesia services, will progress in November 2019. After much discussion, numerous face-to-face meetings, teleconferences, and emails, the Department of Health (DoH) has set up an Anaesthesia Implementation Liaison Group (AILG). The AILG will have the task of handling the logistics of the implementation of various recommendations, as well as continuing to work on the range of other ACC recommendations with which the ASA had major concerns. The group has representation from the ASA, AMA, DoH, and the Health Minister's office. Dr Andrew Mulcahy and myself are included in the Group.

So far, the AILG has only had one meeting, by teleconference. Unfortunately, we were informed at that meeting that another 15 recommendations are also intended to be implemented in November. This was quite unexpected. However, it must be kept in mind that all 67 ACC recommendations have been accepted by the MBS Review Taskforce. As a result of the work of the ASA, the numerous recommendations causing significant concern are not formally

approved for implementation, but neither have they been formally rejected.

Very soon after the first AILG meeting, the federal election was called. All government departments immediately went into 'caretaker' mode, as required during an election campaign, meaning no further decisions on matters such as the MBS Review could be made. This meant a planned face-to-face meeting between stakeholders (including the ASA) and Department of Health officials, at which the issue of these 'extra' changes would certainly have been prioritised, had to be cancelled with only one business day's notice. In fairness, the DoH officials, several of whom we have been working with for the duration of the MBS Review, were keen to attend. However, they were not permitted to do so under 'caretaker' obligations. It is now unlikely that the AILG will meet again before July.

If implemented, these 15 extra changes would result in an overall decrease in Medicare expenditure on anaesthesia of approximately 5%. At this stage there is no formal plan for re-investment of such savings back into the MBS. This would be a matter for the AILG to consider, but would be very unlikely to be finalised by November. This 5% cut would immediately follow the seven year Medicare rebate freeze, and would clearly be unacceptable.

Matters are obviously progressing quickly, with hard-copy media such as *Australian Anaesthetist* generally being behind the times upon distribution. Members will be kept up to date via

regular 'e-news' releases, as well as via material added to the ASA website on a regular basis. Members are urged to keep up to date with such releases, and to bring concerns or ideas to the ASA via [policy@asa.org.au](mailto:policy@asa.org.au)

Recent additions to the website include a letter from the Chair of the MBS Review Taskforce, Prof. Bruce Robinson, to the ASA President. This letter, and our reply, can be viewed by logging on to the members' section of the website [asa.org.au](http://asa.org.au), and following the links Represent/MBS Review. Both documents give a clear picture as to the processes involved in the Review to date, and the concerns of the ASA.

Other information on this page includes the new initiative 'MBS Review in Focus'. This will involve regular releases of discussion papers on individual recommendations of the ACC, and specify the ASA's concerns. Dr Andrew Mulcahy has written a paper on the ACC recommendations for anaesthesia for electroconvulsive therapy (item 20104, for which the ACC recommends a 50% cut). This paper has just been posted at the time of writing this article (<https://asa.org.au/anaesthesia-for-electroconvulsive-therapy-ect-mbs-item-20104/>). Soon to follow will be an analysis of the ACC recommendations for massive changes to anaesthesia consultation items in the range 17609 to 17655.

The late April 'e-news' release goes into more detail about the current status of the various recommendations for change. It can be viewed in the members' section

of the website, on <https://asa.org.au/medicare-cuts-mbs-review/>

The ASA initially welcomed the MBS Review and the opportunity it afforded to conduct a thorough review of the RVG, 15 years after its introduction into Medicare. Unfortunately, it appears that the opportunity for useful changes, representing modern anaesthesia practice, was squandered. The ACC approach appeared to be directed by the pursuit of cost savings, and an apparent notion that anaesthetists are using MBS items for non-genuine reasons. Changes which are clearly needed in this day and age, such as expanding the indications for an assistant anaesthetist, or providing appropriate items for the new and growing area of percutaneous vascular and cardiac procedures, were not even considered.

So, it is essential to note that while the majority of the 67 ACC recommendations (which would have impacted on over 80% of anaesthesia services and cut funding to nearly 60%) are on hold, they have not been eliminated. There is still more work to do. The title of the MBS Review update address, at the EAC session at the upcoming Sydney NSC, is 'It isn't over yet'. This is an accurate summary.

## MEDICAL SERVICES TO DEFENCE FORCE PERSONNEL

As members will recall, for approximately the last seven years, Medibank Health Solutions has held the federal government contract to fund health services for defence force personnel. While serving, defence force personnel are ineligible for Medicare rebates. The Department of Defence takes full responsibility for their health care and its funding.

Anaesthetists who signed an agreement with MHS have been paid at a rate of \$55 per Relative Value Guide (RVG) unit. (This has never been indexed). Many anaesthetists did not sign this agreement. They have continued to bill defence

personnel in the way they always had in the past, when medical accounts were paid directly by the Department of Defence, at AMA rates. The ASA is unaware of any such accounts being rejected.

However, at the time of writing, we are unaware of exactly what the situation will be from July 1, when Bupa takes over the contract. Enquiries have been made, and updates will be provided as soon as possible. Again, members should watch for their regular e-news releases, and visit the ASA website.

## PRIVATE HEALTH INSURANCE

The federal government initiative to attempt to simplify health insurance, in

particular to allow health consumers to understand exactly what their insurance policies cover, was implemented in April.

Private health insurers are now required to classify their policies into four categories – basic, bronze, silver and gold. A list of 38 'clinical categories' (for example, rehabilitation services, palliative care, cataracts, joint replacements) has been created. Regardless of the specific insurer, patients with 'basic' cover will only receive guaranteed funding for three clinical categories (rehabilitation, psychiatric care and palliative care), with the rest being 'optional' for insurers to cover. Those with 'bronze' cover will be automatically eligible for 22 categories, 'silver' for 30, and 'gold' for all 38.

	BASIC	BRONZE	SILVER	GOLD
Rehabilitation	✓(R)	✓(R)	✓(R)	✓
Hospital psychiatric services	✓(R)	✓(R)	✓(R)	✓
Palliative care	✓(R)	✓(R)	✓(R)	✓
Brain and nervous system	○(R)	✓	✓	✓
Eye (not cataracts)	○(R)	✓	✓	✓
Ear, nose and throat	○(R)	✓	✓	✓
Tonsils, adenoids and grommets	○(R)	✓	✓	✓
Bone, joint and muscle	○(R)	✓	✓	✓
Joint reconstructions	○(R)	✓	✓	✓
Kidney and bladder	○(R)	✓	✓	✓
Male reproductive system	○(R)	✓	✓	✓
Digestive system	○(R)	✓	✓	✓
Hernia and appendix	○(R)	✓	✓	✓
Gastrointestinal endoscopy	○(R)	✓	✓	✓
Gynaecology	○(R)	✓	✓	✓
Miscarriage and termination of pregnancy	○(R)	✓	✓	✓
Chemotherapy, radiotherapy & immunotherapy for cancer	○(R)	✓	✓	✓
Pain management	○(R)	✓	✓	✓
Skin	○(R)	✓	✓	✓
Breast surgery (medically necessary)	○(R)	✓	✓	✓
Diabetes management (excluding insulin pumps)	○(R)	✓	✓	✓
Heart and vascular system	○(R)	○	✓	✓
Lung and chest	○(R)	○	✓	✓
Blood	○(R)	○	✓	✓
Back, neck and spine	○(R)	○	✓	✓
Plastic and reconstructive surgery (medically necessary)	○(R)	○	✓	✓
Dental surgery	○(R)	○	✓	✓
Podiatric surgery (provided by a registered podiatric surgeon)	○(R)	○	✓	✓
Implantation of hearing devices	○(R)	○	✓	✓
Cataracts	○(R)	○	○	✓
Joint replacements	○(R)	○	○	✓
Dialysis for chronic kidney failure	○(R)	○	○	✓
Pregnancy and birth	○(R)	○	○	✓
Assisted reproductive services	○(R)	○	○	✓
Weight loss surgery	○(R)	○	○	✓
Insulin pumps	○(R)	○	○	✓
Pain management with device	○(R)	○	○	✓
Sleep studies	○(R)	○	○	✓

✓ Minimum requirement of the product tier  
 (R) Insurers are allowed to offer cover for this clinical category on a restricted basis/with limited benefits  
 ○ Optional for insurer to include – not a minimum requirement of the product tier

## INSIDE YOUR SOCIETY

Insurers are able to offer 'restricted' cover to three categories for those on 'bronze' and 'silver' cover (rehabilitation, psychiatry and palliative care) and to all categories for 'basic' policies. This would mean patients are liable to have potentially large out-of-pocket costs for hospital accommodation or theatre services.

Insurers cannot provide restricted cover to any 'gold' policy holders.

The full table can be seen on the previous page.

The creation of the clinical categories, and what would be covered in each of the four classifications, was subject to much discussion, and in some cases, to much controversy. For example, the AMA strongly urged for the 'pregnancy and birth' clinical category to be available to all but 'basic' policies. It is only automatically available under 'gold' policies.

It is likely that the new system will be subject to teething problems, as many health consumers almost certainly remain unaware of the implications of these major changes. Members are welcome to contact the ASA with any concerns.

## Anaesthesia & You

Anaesthesia & You is a brochure the ASA produces to assist anaesthetists and patients in explaining and understanding the anaesthetic details of surgery. Our brochure describes the different types of anaesthesia that can be used and reassures patients what their anaesthetist's role is post-surgery.

Anaesthesia & You is now available for free download by members:

<https://asa.org.au/anaesthesia-you-brochure/>



# POLICY UPDATE

## AUSTRALIAN PRIVATE HEALTH ASSOCIATION (APHA) 38TH NATIONAL CONGRESS, MELBOURNE 17-19 MARCH 2019

ASA Acting President Dr Suzi Nou and ASA Policy Manager Ms Jacintha Victor John represented the Society at the Australian Private Health Association (APHA) 38th National Congress in Melbourne. It was an excellent opportunity to hear directly from the major private and political parties about health policies and current Government reforms.

The Congress discussions covered important health issues such as Private Health Insurance (PHI) Reforms, the introduction of the National Safety and Quality Health Service (NSQHS) Standards, an overview of Labor's Health Policy including its Health Reforms and Coalition Health Policy.

The discussion about PHI has continued in 2019 with the introduction of the

Federal Government's Private Health Insurance Reform Package measures, the continuation of the Medicare Benefits Scheme (MBS) Review and finalisation of the Improved Models of Care process.

Mr Danny Sims, President of the Australian Private Hospital Association (APHA), addressed the Congress on key focus areas for the future: affordability, customer experience and the health sector's ability to adapt. Through the introduction of the Gold, Silver, Bronze and Basic categorisation, the health industry is about to experience the most significant reforms to private health insurance in 20 years.

As the peak national body representing private hospitals and day surgeries, the objectives of APHA are to improve public, government and industry understanding of the private hospitals industry within the Australian health care sector. APHA official figures indicate almost one in six public hospital patients are admitted on a private basis. In individual hospitals, the numbers are higher (up to 40 per cent). This contributes to longer waiting lists, bed shortages and increased health insurance premiums.

Another area of concern was the workforce issues within the health industry. It is crucial for Australia to have a cohesive strategy to address workforce issues. The majority of skill shortages in the hospital sector (both private and public) which are addressed through the use of migration visas, are for occupations that require degree level qualifications.

A National Medical Workforce Strategy (NMWS) is an essential long-term guide as well as a collaborative medical workforce planning across Australia. The NMWS is necessary to address the current workforce concerns. The Council of Australian Governments (COAG) Health Council established a Steering Committee under the National Medical Training Advisory Network to address a range of workforce health matters.

**Medibank Chief Executive Officer**  
Mr Craig Drummond provided his perspective on the strategic direction of the sector. Medibank advocates the need for transparency with the PHI, especially around Out-Of-Pocket (OOP). However, inefficiencies in the health system, including poor information transparency and well-intended regulations are resulting in higher costs and poorer outcomes for consumers; as is low-value care, with the PHI Australian Labor Party Productivity Commission estimating that 10 per cent of healthcare spending either has no effect, causes harm or is not worth its cost.

Addressing the OOP costs for consumers, promoting greater cost and quality transparency for patients, tackling higher than necessary prostheses prices, and pursuing alternative models of care (particularly for chronic disease) are readily achievable reforms that will make the private health system more sustainable.

The number of customers who indicate affordability as the key reason for dropping their private health insurance has more than tripled over the past five



Danny Sims, President of the Australian Private Hospital Association

# INSIDE YOUR SOCIETY



Private Health Insurance (PHI) Panel Actuary Haydn Bernau, PHA CEO Dr Rachel David Tony Lawson CHF Chair and AMA Vice President Dr Chris Zappala.

years. If treatment costs and quality data is more readily and universally available, Australians will be in a better position to make more informed choices about their healthcare.

The recommendations put forward by the Government are a good start; however, the problem is the lack of essential data necessary to gauge the level of spending.

Medicare and anaesthesia representatives are collaborating to reduce the gap in surgical procedures. There are significant issues with the framework, and it is important to be clear on the upfront costs. Medibank has encouraged customers to be proactive and question their practitioners about cost. This will assist customers to understand the estimated payment before undergoing a procedure.

Mr Drummond also claimed that five to fifteen per cent of doctors bill 'egregiously' and queried whether there should be punitive action for doctors that charge a 'booking fee'. He also mentioned that aggregator websites that compare various health insurers account for 30 per cent of private health insurance sales. Significant commissions are paid to these sites, including trailing commissions and when switching of health funds occurs.

The 13.5 million Australians with PHI cover are dissatisfied with rising premiums and higher out-of-pocket costs. This dissatisfaction by the public has led the Australian Labor Party (ALP) to introduce a policy to cap insurance at a two per cent premium should the party be elected in the upcoming May 2019 election.

**Finity Consulting principal actuary, Mr Haydn Bernau**, examined the prudential risk to capital in PHI in Australia. In order to determine the viability of the ALP policy cap, Mr Bernau utilised secure insurer's data to analyse how consumers could make better pricing decisions in relation to selecting medical insurance coverage.

Mr Bernau predicted that there will be "significant headwinds for health insurance in the next three years". He also asserted the ALP's planned two per cent premium cap is a better policy in the "long-term with some short-term pain". The ALP policy will have a big impact on the not-for-profit insurance providers. The two per cent cap will benefit customers at the capital cost of the not-for-profit insurers including shareholders, and interestingly, will cost the government \$0.6 billion more via insurance rebates.

**Private Healthcare Australia (PHA) Chief Executive Officer Dr Rachel David** stated affordability was the number one issue for consumers with PHI. This issue has broader implications because of the risk to the public health system posed by people dropping out of private insurance. There are no simple solutions for PHI problems.

According to Dr David, PHI differs from the public health system because there is a direct price signal every year in terms of a premium increase, which increases pressure on all stakeholders. In Australia two-thirds of elective surgery is done in private hospitals. Another two-thirds of surgery is gap free, without an extra charge to patients.

It is estimated that less than two per cent of doctors bill 'egregiously', however, eight per cent charged booking fees.

**Mr Tony Lawson, Chair of the Consumer Health Forum (CHF)** of Australia, states that the changes to the PHI system which the ALP intends to enforce, will be beneficial to Australians. He asserts that the ALP Productivity Commission will achieve the best possible outcome for the current issues within the health industry. This is a complex area, and there are issues with cost implications which need to be addressed.

The ALP Productivity Commission proposal opens the way to a potentially more integrated and long-term approach to resolve pressing health challenges, including obesity, primary care, chronic disease and to overcome the current disjointed reality of federal-state divisions.

In terms of specific reforms, Mr Lawson indicated this is a positive one which will improve the health system. However, he also stressed that improving health services will take time and is often compromised by time-constraints. He also highlighted the importance of considering the public-private health mix and the role private health insurance plays in the overall system. The CHF strongly supports the ALP Productivity Commission which



Minister for Health Greg Hunt

has a central place in the overall health system.

**Dr Chris Zappala, Vice President of the Australian Medical Association (AMA),** raised the question of how much longer PHI will be affordable to consumers. The AMA believes the Government reforms may have an impact to create some confidence in people towards seeing real value in their insurance. However, the reforms do not address the key issue of affordability: "Private health insurance is in trouble, with a dozen or so successive quarters of decreasing coverage to 44.6 per cent."

In 2016-17 nationally, Australians spent \$29.4 billion on Out-Of-Pocket (OOP) health-related expenses. Medical costs make up 21 per cent of OOP expenditure for individuals. In comparison to the amount spent on doctors, the outlay of funds for private specialists reflects a small overall percentage. For the quarter ending December 2018, of the \$3,965 million paid by insurers for hospital treatment benefits, only \$613 million (around 15 per cent) was for medical services.

From 2010 to 2018, PHI premiums increased by a cumulative 49 per cent –

compared with the health CPI cumulative increase of 40 per cent. By contrast, doctors were faced with a 5.7 per cent increase in the Medicare rebate.

In 2005, the 'for profit' health insurers made up 16 per cent of the market. This figure is now 70 per cent – the profit before tax for the year ending December 2018 was \$1.6 billion.

The AMA hopes that by transitioning existing policies over to the new classifications, insurers can improve health literacy, and minimise covert reductions in coverage.

**Australian Labor Party (ALP) MP, Mr Tony Zappia** delivered the ALP speech on behalf of the Honorable Ms Catherine King MP. The ALP believe that their commitment to Medicare relies on the balance between the private and public systems. Australia's medical costs account for 20 per cent of all out-of-pocket fees. He emphasised that should the ALP be elected, the Productivity Commission will be charged to review the insurance market.

The ALP policy will cap the PHI premium increase at two per cent for two years and to task the Productivity Commission to undertake a comprehensive inquiry into the private sector.

The Productivity Commission will be independent and legislated with the capacity to consider key principles that will inform Labor's approach to any potential reform of the private sector. The purpose of the Commission will be to identify and examine critical issues within private hospitals.

The introduction of the ALP policy will go ahead although as it is a short-term measure. Private health insurance premiums have been increasing since 2017. The ALP will work towards engaging with insurers and highlight the importance not to use the two per cent premium cap as a reason to raise insurance prices.

**The Honorable Minister for Health, Mr Greg Hunt,** discussed the significant contribution to health and the economy of the private health system. The Liberal Health Policy has four pillars: access to primary care, the hospital systems, psychiatric and preventive care and medical research.

In terms of the hospital health system, he said that reform was required. If caps to insurance premiums are imposed without reform, this could lead to a collapse of private health. For example, premium increases have a greater impact on those with lower incomes, as rebates only increase with Consumer Price Index (CPI). He also targeted private patients in public hospitals as an area for reform, claiming that this leads to a two-tiered public system which undermines what should be a universal system.

In April 2019 the new system for categorisation of hospital products with new product tiers was introduced by the Government. This will give consumers greater certainty about the services covered by each type of hospital product.

This change is the first step undertaken by the Government, designed to assist consumers to compare hospital treatment more easily and shop around for a better deal.

The 38th National Congress was an excellent forum with a variety of health experts who addressed key current health issues. There will be drastic changes with the upcoming Federal Election (May 2019) which will impact PHI, Australian consumers and the insurance industry.

The impact of the 2019 major health reforms will only be understood in the years ahead.

Jacintha Victor John  
Policy Manager

## INSIDE YOUR SOCIETY



Sereima Bale with CWM Anaesthetic team

# THE 'ASA SEREIMA BALE PACIFIC FELLOWSHIP'

The Overseas Development and Education Committee (ODEC) has decided to rename the ASA Pacific Fellowship. It will henceforth be called the 'ASA Sereima Bale Pacific Fellowship'.

ODEC has been assisting the independent countries of the South-West Pacific with continuing education and training since the late 1980s. Initially this was with annual refresher courses, which were held in Fiji, and later in other Pacific Island countries. Then, in 1995, a regional anaesthetic training programme commenced, based in Suva at the Colonial War Memorial Hospital. Long-term (usually two years per

term) tutors from Australia, New Zealand, and the UK, as well as Fijian teachers, were recruited to provide young Pacific island doctors with anaesthesia training and education.

Since 2003, ODEC provided further assistance in the form of a recently graduated ANZCA Fellow, the 'ASA Pacific Fellow', who would spend three months in Suva, assisting with teaching and also helping with the clinical load. Since then there has been a steady stream of between one and three 'ASA Pacific Fellows' per year, who have assisted with training, and have themselves benefited

from the experience of working in a Pacific island nation.

Just one Pacific island anaesthetist has been there – from the start until the present time – Dr Sereima Bale.

Dr Bale has been working as an anaesthetist at the CWMH since she returned from overseas training in the late '80s. She took over as Head of the Department in the early '90s from Dr Tua Mua.

Just one Pacific island anaesthetist has been there – from the start until the present time – Dr Sereima Bale.



Sereima Bale and the late Kester Brown at first DA Graduation



Sereima Bale with PSA delegates 2013

In 1994, Dr Bale co-wrote the proposal that was jointly accepted by the Fijian Ministry of Health, and AusAID (the Australian Government aid agency at the time), which resulted in funding being made available to set up a regional anaesthetic training programme, based in Fiji. This was a groundbreaking step forward, as at that time there were no specialist medical training programmes of any kind in existence in the Pacific region.

When the first tutor from Australia arrived, Dr Bale sorted out his accommodation and all the official paperwork, provided orientation, and most importantly, provided friendship and moral support. She even organised new clothes and furniture for him when, shortly after his arrival, his house was burgled and everything stolen.

In the years that have followed, Dr Bale has been the 'go-to' person for all expatriate long-term tutors. Their requirement ended at the end of 2012, when they were replaced by the Dr Kenton Biribo, a Fijian M. Med (Anaesthesia) graduate.

Since that time, Drs Bale and Dr Biribo, along with Dr Luke Nasedra, the HOD of Anaesthesia at the Colonial War Memorial Hospital in Suva, have been the primary Fijian anaesthetists who have provided all the 'on the ground' support for the stream of over 30 ASA Pacific Fellows who have each spent one to three months in Suva assisting the Diploma and Masters anaesthetic training programme. They have also both been active in the formation and running of the Pacific Society of Anaesthetists, and continue to assist and support the Pacific Anaesthetic Refresher Course, an annual week-long course that is often held in Suva.

.....  
 ...Dr Bale has been the 'go-to' person for all expatriate long-term tutors.  
 .....

Apart from all the above, Dr Bale is also a mother, and a grandmother, who continues to support her extended Fijian family. She was also, in her earlier years, one of Fiji's top female golfers,

and represented her country on several occasions. Be warned, if you every get the opportunity to 'play a round' with her!

It is hard to over-state the amount of time and effort that Dr Bale has put into the promotion of anaesthesia as a specialty, in Fiji and the Pacific region. She remains coy on the matter of when she might retire from her academic position at the Fiji National University. However, whenever it is, she will have made an indelible contribution to anaesthesia in the Pacific region.

Steve Kinnear

## INSIDE YOUR SOCIETY

# OVERSEAS DEVELOPMENT AND EDUCATION COMMITTEE

## MYANMAR SOCIETY OF ANAESTHESIOLOGISTS 13TH BIENNIAL CONFERENCE

6-9 February, 2019

The Australian Society of Anaesthetists (ASA), led by Dr Amanda Baric has been collaborating with the Myanmar Society of Anaesthesiologists (MSA) in order to improve training for anaesthetists in Myanmar.

Anaesthesia in Myanmar is a medical specialty performed by doctors with formal postgraduate education and training in anaesthesia. As in Australia, the formal postgraduate education program is undertaken while working in a teaching hospital as a trainee in anaesthesia. Myanmar does not have an independent specialist medical college system to provide postgraduate training;

instead, specialist training is provided by the university system. Anaesthesia training in Myanmar is provided by four university medical schools and their affiliated teaching hospitals, located in the country's two largest cities, Yangon and Mandalay. Each university has a Professor of Anaesthesia. The professional body is the Myanmar Society of Anaesthesia (MSA).

Currently for a population of 52 million, Myanmar has only 700 physician anaesthesia providers, requiring the training of 2,600 new physician providers now, to reach the WFSA modest interim goal of at least five specialist physician anaesthesia providers per 100,000

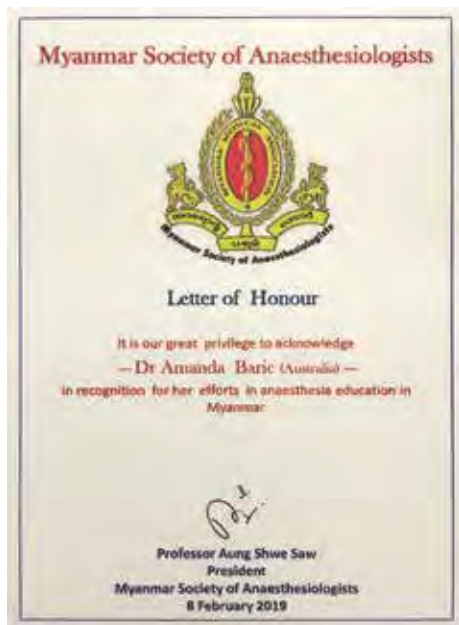
population. Anaesthetists are in demand and work for long hours in difficult and largely unsupported environments over 1,000 hospitals. Most of these hospitals are small regional centres without piped medical gases, or even oxygen cylinders. Therefore, up to 800 hospitals have no anaesthetic service. There are no assistants (nurses or technicians), and no recovery staff.

In 2013, Dr Amanda Baric and A/Prof David Pescod, who established the Mongolian Anaesthetic training program, were invited to assess the state of anaesthetic practice in Myanmar. It was found that basic medical and anaesthetic training were of a high standard despite the conditions over the past 50 years. However the challenges faced by anaesthetists in Myanmar included an overwhelming lack of anaesthetists, poor pay, mandatory allocation of location of practice, lack of anaesthesia assistance and recovery staff, lack of some basic anaesthetic equipment, lack of a continuing education program, years of isolation from international education and practices.

Over time, close relationships have been forged with the professors of the universities that train Masters of Medicine (Anaesthesia) students. The ASA has developed and run training courses, participated in the biennial conference as invited speakers since 2015 and advised on curriculum development. In 2018 Melbourne-based anaesthetists supported



Prof Mu Mu Nai and Prof Aung Htet presenting Dr Amanda Baric and A/Prof D Pescod with 'Letters of Honour'.



a brief visit by Myanmar anaesthesia professors to a teaching hospital and the University of Melbourne in 2018. This year a large contingent of Australian anaesthetists participated in the 13th Biennial Conference as speakers for the conference and facilitators for the pre-conference workshops.

The following anaesthetists generously donated their time to facilitate the pre-conference workshops (paediatric anaesthesia and airway management) and to speak at the 2019 13th Biennial conference:

- Prof Roger Goucke, anaesthetist and pain specialist, Perth.
- Dr Debra Devonshire, anaesthetist, Monash Medical Centre, Melbourne.
- Dr Andrea Yap, anaesthetist, Princess Margaret Hospital, Perth.
- Dr Rodney Wilson, anaesthetist, Bendigo, Melbourne.
- Associate Professor David Pescod AO, anaesthetist, Northern Health Melbourne.
- Dr Amandeep Sarai, anaesthetist, Northern Health Melbourne.
- Dr Amardeep Nanuan, anaesthetist, Northern Health Melbourne.
- Dr David Dolan, anaesthetist, Brisbane.
- Dr Philip Ragg, anaesthetist, RCH Melbourne.
- Dr Adam Skinner, anaesthetist, RCH Melbourne.
- Dr Linda Weber, anaesthetist, Canberra.
- Dr Brigid Brown, anaesthetist, Adelaide.
- Dr Amanda Baric, anaesthetist, Northern Health Melbourne.

Dr Sathi Seevanayagam, anaesthetist, Northern Health Melbourne, coordinated the airway workshop but was unable to travel.

In addition to leading programs to Myanmar, Dr Amanda Baric and other ASA anaesthetists developed and introduced the Emergencies in Anaesthesia (EIA) course for the MMed program participants in 2014. The EIA course was developed to allow anaesthetists to develop and practice their skills in the management of emergencies

related to anaesthesia and advanced life support. The course has now been formally included in the University MMed training program with a local faculty delivering the course without Australian support since 2018. (With the commencement of the MMed program at Magwe University, there is a need to develop further faculty and there has been a formal request from Magwe to assist with the delivery of EIA in 2020 for the MMed students).

During the formal presentations of the 13th Biennial Conference of Anaesthesia and Intensive Care, Dr Amanda Baric's sustained and significant contribution to anaesthesia in Myanmar was recognised by the awarding of the Myanmar Society of Anaesthesiologists 'Letter of Honour'. The certificate reads, "It is our great privilege to acknowledge Dr Amanda Baric (Australia) in recognition for her efforts in anaesthesia education in Myanmar".

A/Prof David Pescod

On 16 February Associate Professor David Pescod presented the ASA with a gift of appreciation from the Myanmar Society of Anesthesiology.

As one of the countries that the ASA assists as part of their ODEC work it is wonderful to see the long-term relationships develop as their tireless volunteers educate the anaesthetists, future anaesthetists, nurses and technicians of developing countries.



## INSIDE YOUR SOCIETY



Completion of pre-course MCQ Bangladesh

## VOLUNTEERING WITH LIFEBOX

Having been aware of Lifebox for a number of years, I first saw the pulse oximeters in clinical use whilst working in Malawi in 2016. I had travelled to the region to assist with the training of anaesthesia clinical officers, where each of these providers had been supplied with a pulse oximeter through the Lifebox programme. These units were often the only piece of monitoring equipment during surgery and served a vital role in providing safe anaesthesia. Every single anaesthesia provider had found that having this pulse oximeter had significantly improved the safety of anaesthesia and surgery. Many other pieces of donated equipment do not have such an impact on care, nor do they integrate easily into practice, which struck me as especially important. After learning more about the organisation and their growing global impact in a variety of areas specific to safer surgery and anaesthesia, I have subsequently been fortunate to be given the opportunity to help Lifebox in the field.

I was excited when I was able to support them by travelling to the Philippines

in 2018. I delivered the inaugural 'train the trainer' workshop to 20 attendees, including: anaesthetists, surgeons, and operating room assistants. The workshop comprises five modules to cover the use and maintenance of the physical Lifebox units. Additionally it incorporates the physiological rationale, a hypoxia algorithm, case examples and importantly the integration of the WHO surgical safety checklist into routine practice. This enabled the attendees to learn how to utilise Lifebox as a clinical tool for themselves but also to train others. Each attendee would subsequently go on to volunteer to distribute the oximeters and train staff at over 300 hospitals throughout the Philippines. Each participant felt that Lifebox was empowering significant improvement in care, through the provision of a simple and robust piece of equipment that makes a major difference to patient safety in anaesthesia and surgery.

Once again this year I had the opportunity to facilitate a 'train the trainer' workshop, this time in Bangladesh. This course was a follow-up to the type of

workshop that I had conducted in the Philippines, which had the aim to enable the Lifebox program to become self sufficient within Bangladesh in the training of local providers. This was a much larger workshop with 75 attendees, and once



Lifebox in use in Malawi



again the feedback was universally positive as to the impact that Lifebox is making. There was a strong drive and enthusiasm to roll-out the use of Lifebox modules and the additional training in each of the attendees hospitals, with a real passion that they were making a positive change to patient safety.

I believe that Lifebox has a very real ability to make a significant improvement



Small group session covering hypoxia management in Manila

in patient safety, and it is already demonstrating this right now. The program uses a simple and powerful model of empowering local health professionals to become the main tool for change, alongside the provision of the Lifebox pulse oximeter itself. This works by being physically extremely robust as well as relatively simple to operate, and represents a vital piece of equipment



Small group session on practical use of lifebox units in Bangladesh

wherever it has (and can) be deployed too. It is this combination of positives that, I believe, makes Lifebox so unique and important, and I plan to continue to assist in this program wherever and whenever possible.

Dr Cat Goddard FANZCA FRCA MBBS  
Sir Charles Gairdner Hospital, WA

Since 2011 Lifebox has distributed more than 20,000 oximeters to anaesthesia providers in over 100 countries. The ASA has been actively involved in Lifebox from day one. In 2015 the ASA united with the New Zealand Society of Anaesthetists, ANZCA and Interplast Australia and New Zealand to form Lifebox Australia and New Zealand. This arrangement has increased our capacity to deliver oximetry and education in perioperative safety throughout the Asia Pacific region.

Lifebox is not only involved in oximeter provision and education. For many years Lifebox has been instrumental in the introduction of the WHO Surgical Safety Checklist, to which oximetry is integral. Recently Lifebox has developed the SAFE OR course, which is a short course devoted to perioperative safety for operating room teams. Other Lifebox projects include the 'Clean Cut' project aimed at reducing surgical site infections

and the 'Lifebox Light' a battery powered head lamp for surgeons.

Whilst the Pacific Islands and Papua New Guinea have been a major focus, Lifebox ANZ has also placed oximeters in Myanmar, Bangladesh, Bhutan, Timor Leste and Mongolia. Our work in Bangladesh continues, as described by ASA member Dr Cat Goddard.

We have just had a request from the Laos Society of Anaesthesiologists (LSA) to provide up to 1,000 oximeters and we will be working with the LSA and the Laos Ministry of Health over the next few years to fulfil this request.

This year will also see our involvement in Maharashtra State in India, where Lifebox will be working with the local branch of the Indian Society of Anaesthesiologists to provide oximeters, education in their use and the SAFE OR course.

Lifebox ANZ is extremely grateful for the

generosity of ASA members. The major contribution in 2018/19 to Lifebox ANZ was from the Adelaide NSC. The NSC committee through personal contributions and the 'Wine Wall' raised \$26,000! In addition to individual donations, many departments and private groups have made contributions and raised funds through bake-offs and cycle rides.

Donations can be made via the Interplast website and all donations are tax-deductible.

Rob McDougall  
Representing the ASA on  
Lifebox ANZ committee



## INSIDE YOUR SOCIETY

## ASA MEMBER'S GROUPS UPDATE

Gender inequity is an important issue that impacts upon all of us, whether we are consciously aware of it or not. It is highly topical and has been receiving increasing attention and interest in recent years. Given the lack of good data about intersex and non-binary trainees, I will discuss this using a binary paradigm, though I acknowledge not all individuals will identify with this.

Anaesthesia in Australia is seen as relatively progressive and among the leaders in gender equity. ANZCA and FPM have released a Gender Equity Position Statement, in which they "strongly endorse gender equity because of its ethical, social and economic benefits to fellowship and the broader community."<sup>1</sup> This document includes an excellent brief summary of 'The case for gender equity' – I encourage you to read it if you haven't already, especially if you're unconvinced of the existing inequity or the benefits of promoting greater equity.

ANZCA and FPM are formulating a Gender Equity Action Plan, which "sets out how ANZCA and FPM will implement their strategy for gender equity across all aspects of anaesthesia and pain medicine practice,"<sup>1</sup> and a Gender Equity Resource Kit, to provide practical strategies for trainees and fellows.<sup>2</sup> They have also published gender equity metrics on their website.<sup>3</sup> It's heartening to see our College taking positive steps towards improving gender equity in anaesthesia.

I recently had the privilege of attending the AMA Gender Equity Summit in Sydney. Organised by the AMA Council of Doctors in Training, this was a one-

day event bringing together a broad range of stakeholders to discuss gender equity in medicine. The program opened with a series of speakers and panels from within and outside of the medical world. These covered topics from 'Why achieving gender equity in the workplace is important' to 'What can we learn from how other industries have successfully shaped culture and systems to encourage gender equity in their workplaces and how this might translate to changing medical workplaces and culture.' It's impossible to do these talks justice in this brief piece, but among the key themes were:

- The difference between equity and equality – equity acknowledges and recognises difference, the individual and the individual need.
- Central role unconscious bias plays in creating and perpetuating inequity.
- Importance of organisational culture in combating inequity, including accountability and protected avenues for reporting problems.
- Setting targets for equal representation is useful to crystallise an intent to make institutional change.
- Flexible work options for both women and men are important.

This was followed in the afternoon by small group discussions to brainstorm practical approaches to improving gender equity. These were grouped into the following categories:

- Increased presence of women in academia, leadership and management roles.
- Work-life balance.
- Pregnancy and parenthood.

- Changes in organisational culture.
- Workforce planning and research.

The atmosphere at the summit was extremely positive and optimistic. It was heavily focused on developing real solutions rather than just being a talkfest. I'm excited to see where it leads and how the AMA chooses to move forwards on the issue. Stay tuned.

A 'grand round' panel discussion was also recently held on Health Advocacy: Women in Medicine at the Royal Women's Hospital in Melbourne, supported by the AMA, University of Melbourne and RANZCOG. Topics covered included the benefits of diversity in leadership, equitable access to parental leave, mentorship, rotating leadership roles, sexual harassment, and systemic factors that promulgate the status quo of inequity. A clear take-home message for me was that simply waiting for increased numbers of female trainees to progress through the medical training pipeline and expecting

Many events now have an associated Twitter hashtag. Engaging with these can be a great way to further disseminate information or to follow an event that you aren't attending. For example, the AMA Gender Equity Summit used #AMAEquity, the Health Advocacy: Women in Medicine grand round panel discussion used #HealthAdvocacyWIM, and the upcoming Combined SIG Meeting is using #CombiSIG19. You can also use the hashtag #ANZCAtrainees for tweets relevant to anaesthetic trainees.

that to automatically flow on to greater representation in leadership positions is not working – or at least not working fast enough. We need be proactive if we want to achieve meaningful change. For anyone interested, you can watch a recording of the discussion at [bit.ly/2G7SUpS](http://bit.ly/2G7SUpS)

For what it's worth, the ASA Trainee Members Committee has been predominantly female throughout my time as Chair (a little over 1.5 years now).

Our current composition is eight women and seven men, which very closely reflects the gender mix of anaesthetic trainees in Australia. The majority of the 2019 ANZCA Trainee Committee is also female, including the two co-chairs. Trainees are the future of the profession and the future looks bright!

Dr Richard Seglenieks  
Chair, ASA Trainee Members Committee

## References

1. ANZCA, FPM. Gender Equity Position Statement. 2019. [http://www.anzca.edu.au/documents/gender-equity\\_statement\\_final.pdf](http://www.anzca.edu.au/documents/gender-equity_statement_final.pdf).
2. ANZCA, FPM. Gender Equity Resource Kit. 2019. [http://www.anzca.edu.au/documents/gender-equity\\_resources-kit\\_final.pdf](http://www.anzca.edu.au/documents/gender-equity_resources-kit_final.pdf).
3. ANZCA, FPM. Gender Equity Metrics. 2018. <http://www.anzca.edu.au/about-anzca/gender-equity/gender-equity-metrics>.

## BOOT CAMP PART 1 MOCK EXAM, GOSFORD HOSPITAL, NSW 2 FEBRUARY, 2019



Left to right: Alex Wang, Richard Davey (JMO Gosford volunteers), Katherine Jeffrey, Neil Warwick.  
At front: Lan-Hoa Le



# INSIDE YOUR SOCIETY

## THE ANZCA PART 1 EXAMINATION: DON'T PANIC GUIDELINES

**Congratulations – you have chosen to become an anaesthetist/anaesthesiologist!**

After the first month of excitement in finding the vocal cords and forgetting to turn the volatile on, you will find yourself in the pre-contemplation stage of the ANZCA Part 1 (primary) examination – what is often regarded as the first hurdle in anaesthesia training and a major test of your dedication and commitment to this specialty!

It may need a lot of hard work but the sense of achievement (and relief) once you knock the exam over is amazing. So never fear, as this too shall pass, and with these helpful tips, so shall you!

### Start early

This seems obvious, but leaving it too late is one of the most common pitfalls. There's no sugar-coating the fact that you will need to put in some serious hours in preparation for this exam, and it will be *that* much less stressful if you spread those hours over most of the year and not just the last couple of months.

### Don't be a lone wolf

Join a study group. Even if you were never a study group person during med school, *now* is the time. The curriculum is *huge* and there will undoubtedly be a time when one of your buddies will be able to explain something to you that you just couldn't get from the textbook. More importantly, you will become each other's support people during a tiring and stressful time, and that is truly invaluable. Closer to the exam, you will probably spend more time with these people than your own family, so make sure you can get along.

### Make a plan

With such a huge range of topics to cover

and at times in great detail, good planning is vital. Spend the first couple of weeks making a study plan with your group, and stick to it. Make sure the plan allows you to cover the important things three times – the third time is a charm! As much as it seems to be unbelievable when you start studying, towards the end things do start coming together.

On the topic of time-management, try to make the most of your time at work rather than leaving all the study for after-hours. Ask people you're working with to quiz you on a topic (you might need to give them the material for encouragement). Practice drawing graphs and explaining them to your supervisor in theatre. Pull out a drug from the anaesthetic trolley and talk about it in a structured way. The options are endless!

### Resources

A good place to start is the recommended texts list for the primary exam published by ANZCA and a lot of these are available on the college online library which means you don't need to spend hundreds of dollars on books. Few texts are practically essential to know back to front (e.g. *West's Respiratory Physiology* – and check out his youtube channel if that's your thing), while others will serve as good reference texts for the finer details. You may find one text style suits you better than another, so check a couple of different ones out online if you're struggling to understand a certain topic. The College Network's website also has some educational material and guides on how to approach the primary exam.

### Practice makes perfect

Apart from texts, you *must* access past exam papers to practice. Some are published on the college website, while others will be available on various online resources – ask colleagues in your area who have just done the exam to share their collections. Apart from past papers, there are also many sets of past candidates'

practice answers and notes that you may wish to reference.

Looking at past exams allows you to identify major topics to focus on (those that get asked over and over again) and by looking at exam reports, you can see which questions are answered poorly in recent years, and therefore may be more likely to be asked again. Get used to writing out your SAQ answers, and in the weeks leading up to the exam try to set a day where you do a whole exam – writing for that long is tiring and you should train your hand! Ask around in your department to see if anyone is able to mark your answers – past examiners can be really helpful to guide you in the right direction.

### Courses

There are several exam preparation courses run across Australia and New Zealand. The ones further out from the exam (four months or so before) tend to be didactic with a lot of content coverage, whereas those closer to the exam (weeks before) tend to focus more on technique and start offering viva practice as well. In addition, depending on where you are training, certain training schemes offer 'long courses' or weekly/fortnightly tutorials across the year.

### Look after yourself

This is important! The primary exam is a stressful time of training, and life, so make sure you look after yourself. Take a night off regularly to re-set and make some time for your loved ones. Get enough sleep and exercise regularly. You'll likely never feel 100% ready to sit the exam, but trust that you've done the work and don't panic.

Good luck!

Dr Natalie Akl  
ASA TMG WA Representative

## RETIRED ANAESTHETISTS' GROUP

### NATIONAL AND NEW SOUTH WALES

#### Dr Donald C. Maxwell

The concept of a 'Retired Anaesthetists Group' for Australian anaesthetists was first suggested by Dr Des O'Brien, who for many years, was very active in the ASA, first in Victoria and later in New South Wales. Many retired anaesthetists had developed close friendships over their years in practice and Des realised that occasional lunches and social gatherings would be a very enjoyable way for them to continue to see old friends. There are now over 400 members of RAG with regular gatherings, frequently with an invited speaker, particularly in the larger states and these are occasions that are looked forward to on a regular basis. In this edition of *Australian Anaesthetist* you will see reports of very successful RAG lunches from several other states.

Anaesthetists are an interesting group, in that they often have lives separate from anaesthesia which enables them to contribute to Australian life in very different ways of interest and value to others. Classic examples of this are Dr Richard Harris of the Thai cave rescue fame and now Australian of the Year and Dr John Tucker (former ASA Treasurer, now deceased) who pioneered blueberry farming in Australia. I am sometimes asked in my capacity as RAG National Chairman how anaesthetists might prepare for retirement. One very important area is to develop, while still in active practice, another interest in life outside anaesthesia or perhaps a side interest. Many of us have done that. It makes for a more satisfying retirement.

Realising that some of us have done just that, I decided when I became RAG Chairman that I would organise a series of lunches during the year at which we would have an invited speaker who was a RAG member to speak on a non-anaesthetic

subject with which they had some special expertise. It has been a great success. It is amazing how interesting your fellow RAG members are! And it leads to great camaraderie to have our fellows showing their talents in unexpected areas.

In NSW we meet for lunch three times a year at The Cruising Yacht Club in Rushcutters Bay and for the last three years lunch has been preceded by a very interesting talk from one of our RAG members.

In March 2019, Dr Graham Grant, biomedical engineer and anaesthetist, spoke on 'The Abbey Jazz Band and all that Jazz', with accompanying examples. Graham was a founder member of this band of very accomplished medical jazz players. What a blast!

Professor Bob Wright spoke in November 2018 on the topic for which he received an OAM: 'Ambulance men to expert paramedics – a revolution'.

In August 2018, Dr Joe McGuinness spoke about 'Trout fishing in Australia and New Zealand' with some very special photographs, and in March, Dr Bill Herlihy an accomplished painter spoke of 'From anaesthetist to artist'.

In addition to all this, there was of course the well attended National RAG lunch held at the Adelaide NSC and organised through the ASA and also the College RAG lunch in May in Sydney.

### VICTORIA

#### Dr Michael Davies

This year started well for the Victorian Retired Anaesthetists Group (RAG) with a wonderful lunch in early February. Terry Little had recommended Professor Greg Barton to speak at the lunch. Professor Barton is an expert on terrorism at Deakin University. He summarised the problems that had developed since the 9/11 attacks in a clear and concise manner. The

presentation was very well received by the 33 members who attended.

Our second lunch will be held in May, when we have invited a jeweller, Adrian Dickens, who will speak on a subject entitled 'A Menagerie of Jewels'.

Sadly three of our members passed away recently. Dr Ralph Clark and Dr Ian McDonald passed away in February, their obituaries were published in the March *ANZCA Bulletin* and Dr McDonald's in the March *Australian Anaesthetist*. Dr Herb Newman passed away in March. All of them had very prominent anaesthetic careers and survived into their 90s.

Special thanks to David Crankshaw our honorary secretary who organises the details for our lunches at the Lyceum Club.

Retired Anaesthetists' Group – South Australia/Northern Territory: April 2019 Report.

### SOUTH AUSTRALIA/ NORTHERN TERRITORY

#### Dr John Crowhurst

Our group meets for lunch on the second Monday of every odd month at the Kensington Hotel, where we have our own private dining room, and from time to time, a guest speaker. Our membership, comprised of colleagues from Anaesthesia, Intensive Care and Pain Medicine, now numbers more than 80. Some 20–30 colleagues regularly attend our meetings and guests are welcome.

At our November 2018 meeting, Professor Warren Jones, retired Professor of Obstetrics and Gynaecology at Flinders University updated us on the so-called 'Transformed Health Services in SA'. The re-sited Royal Adelaide Hospital, now some 12 months old continues to have major problems with many inefficient systems and long delays with ambulance 'ramping' and Emergency Department admissions. Similarly several other

# INSIDE YOUR SOCIETY

hospitals are experiencing such delays and the present government is planning to increase ambulance and paramedic services and ED facilities across the State. The re-establishment of the former Repatriation Hospital too is planned to accommodate many medical services.

Because the changing Public Health policies are of such widespread interest, partners/wives were invited for the first time and some 16 joined us. The group has agreed that in the future, we will include them at least twice a year

In March, our guest speaker was Dr Rod Mitchell, senior consultant anaesthetist at The Queen Elizabeth Hospital and recently elected ANZCA president. For some nine years Dr Mitchell practised in Central Australia, initially as a remote area

primary health care physician, and then subsequently as the Director of Anaesthesia at the Alice Springs Hospital. During his many years on ANZCA Council, he chaired the committees for Indigenous Health and Professional Affairs and Continuing Professional Development. Now, during his Presidency he is hoping to improve equity of access to the world-class anaesthesia, pain medicine and perioperative care that is available to most of us. This relates particularly to our rural communities, marginalised members of our community, and low/middle income countries.

Rod updated us on the need to develop the practice of perioperative medicine, to promote a healthy and diverse workforce, the increasing administration of anaesthesia by non-specialist anaesthetists, our international

relationships, and the increasing use of artificial intelligence.

A show of hands vote on the question of 'Anaesthesia or Anaesthesiology' showed a small majority for no change.

Prof. Don Moyes, former director of Anaesthesia at TQEH thanked Rod on our behalf and presented him with a John Snow Society commemorative coffee mug.

Any retired or semi-retired colleagues in SA who have not joined the RAG are most welcome to do so, and any visiting colleagues from other states are most welcome to join us on the second Monday of each odd month.

For further information, please contact: (Dr) John A. Crowhurst, Convenor, SA Retired Anaesthetists' Group. Tel: (08) 7225 1390 or 0400 804 294. E: jacrow43@gmail.com

# UPCOMING EVENTS

## JUNE 2019

### History of Anaesthesia Seminar

Date: 2 June 2019

Venue: ASA, Level 7, 121 Walker Street, North Sydney

Contact: mwade@asa.org.au

### Queensland Part 3 Course

Date: 8 June 2019

Venue: ANZCA office, West End, Qld

Email: j.burgess@amaq.com.au

## JULY 2019

### Final Exam Preparation Course 2

Date: 8-12 July 2019

Venue: ANZCA office, West End, Qld

Contact: kshah@anzca.edu.au

### 40th Annual ANZCA/ASA combined CME meeting 2019

Date: 27 July 2019

Venue: Sofitel Melbourne, Victoria

Contact: vic@anzca.edu.au

## 2019 Combined SIG meeting

Date: 25-28 July 2019

Venue: Novotel Manly, Sydney, NSW

Contact: schezan@anzca.edu.au

## AUGUST 2019

### The Thai Cave Rescue: Anaesthesia in the Dark

Date: 1 August 2019

Venue: National Ballroom, Hotel Realm, Canberra ACT

Email: qldevents@anzca.edu.au

### 2019 Practice Managers Conference

Date: 16 August 2019, 8am-5pm

Venue: Canberra, ACT

Contact: events@asa.org.au

### Queensland ACE Regional Meeting

Date: 31 August-1 September 2019

Venue: QT Gold Coast, Surfers Paradise

Email: qldevents@anzca.edu.au

## SEPTEMBER 2019

### ASA NSC 2019

Date: 20-24 September 2019

Venue: Sydney International Convention Centre

Contact: events@asa.org.au

## NOVEMBER 2019

### Shared Decision Making for the Perioperative Clinician Workshop

Date: 6 November 2019, 8.30am-5.30pm

Venue: Brisbane Sofitel

Website: <https://www.pshaustralia.com.au/plan4surgery>

### CPET and Prehabilitation Workshop

Date: 6 November 2019, 12-6pm

and 7th November, 7.45am-12.15pm

Venue: Brisbane Sofitel

Website: <https://www.pshaustralia.com.au/prehab-cpet>

## INSIDE YOUR SOCIETY

# AROUND AUSTRALIA



### SOUTH AUSTRALIA

#### Brigid Brown, Chair

##### Northern Territory Upcoming CME Meeting – June 1

The Northern Territory annual Continuing Medical Education meeting will be held on June 1 titled 'Hot Topics in the Tropics' with keynote speaker Robyn Gillies from the Royal Melbourne Hospital discussing malignant hyperthermia; changes in presentation and an update on diagnosis and management. CPD workshops will also be taking place on ALS and CICO. For more information and registration details please see [http://www.anzca.edu.au/documents/2019\\_nt\\_ace\\_conference\\_program\\_a4\\_p4.pdf](http://www.anzca.edu.au/documents/2019_nt_ace_conference_program_a4_p4.pdf)

### WESTERN AUSTRALIA

#### Dr Philip Soet, Chair

The MBS Review Anaesthesia Clinical Committee Report was released in December 2018. If you haven't read it already I recommend that you do so. If you have feedback to give to the MBS Review Taskforce then I encourage you to do so by using the email address on the Taskforce website.

Look out for the following ACE CME events in WA this year.

The WA Country Conference will be held at Cable Beach Resort in Broome on 14-16 June 2019. The theme of the meeting is Perioperative Pearls.

The Airway Cadaver Workshop of WA is a comprehensive half-day airway workshop

utilising fresh frozen cadavers. It will be held on Saturday 14 September 2019 at CTEC Clinical Training and Evaluation Centre, The University of WA, Entrance No. 2 Hackett Drive, Crawley WA.

A fund has been established at the ASA to raise funds for Dr Andy Heard. If you would like to contribute to this fund please follow the EFT instructions below:

Account name: The ASA Benevolent Trust  
Bank: Westpac  
BSB: 032 323  
Account number: 167960  
SWIFT Code: WPACAU2S

Please email a copy/details of the transaction including your name to [fiona.seroney@health.wa.gov.au](mailto:fiona.seroney@health.wa.gov.au)

A receipt will be provided and contributions are tax deductible.

### TASMANIA

#### Dr Mike Challis, Chair

At our recent AGM the committee was re-elected unopposed, but this will be my last year as State Chair.

##### Support

We have welfare officers in all teaching hospitals across Tasmania, thanks to Dr Lia Freestone (current ANZCA Tas Chair). We are trying to develop a welfare network to support welfare officers with information and resource sharing. I have ensured they are aware of the 'Long Lives, Healthy Workplaces' toolkit resources.

##### Represent

There are some threats to the Private

Practice Scheme (PPS) at the Royal Hobart Hospital, which funds 35% of participating staff specialist's salaries. A recent article by a prominent and vocal Tasmanian health analyst in the local paper was unflattering to specialist doctors as a whole (particularly surgeons in regard to waiting lists), but also painted the PPS in a poor light. Unfortunately it made claims that are not factually correct, but it seemed to go under the radar. Dr Michael Lumsden-Steel (a passionate AMA and ASA member, and member of EAC) has taken over as Chair of the PPS, and I am confident he will ensure the PPS remains healthy and functional.

##### Educate

Our Emergency Response Workshop Day was held in March, with all emergency response workshops provided. It was a fantastic success, with places filling quickly. Attendees were predominantly from interstate, despite our intention to provide workshops for local anaesthetists. Feedback has been very positive, and I want to thank the instructors who gave up their Saturday to teach, but also many hours in preparation. The day was well supported by the trade, and we are considering running a similar event again.

Our winter meeting is at Josef Chromy Winery in Launceston on 24th August, and the theme is 'Matured'. Talks will focus around the ageing patient, the ageing practitioner, and no doubt some aged wines! Speakers include a former ASA president, and current RACS president. We would love to see you there!

## INSIDE YOUR SOCIETY

# THE ORIGIN OF THE ASA'S MUSEUM AND LIBRARY – AND WHERE TO FROM HERE?

### THE HARRY DALY MUSEUM

In 1947 the *British Journal of Anaesthesia* reported that the ASA had established "the third museum of anaesthesia in the world... The only other known museums of its kind are in New York and London" (Vol. 20, No. 4, pp.132-136). This collection, which consisted mainly of Geoffrey Kaye's personal collection went in the 1950s to the Royal Australasian College of Surgeons in Melbourne.

Harry Daly in Sydney, another founder of the Society, encouraged by Kaye to collect, donated much of his collection to the New South Wales branch of the society in the 1950s. It is thought that some of Kaye's sectioned reducing valves were included in this donation.

Problems of accommodation were solved in 1961 when Commonwealth Industrial Gases offered to house the potential museum material. Questions of how to exhibit it satisfactorily were partly solved when the Department of Anaesthesia at the Royal Prince Alfred Hospital housed and added many items to it. By 1990 the museum was stored in somewhat unsatisfactory conditions in the ASA's offices at Edgecliff in Sydney. But at least the collection was safe and was added to considerably by donors and by donations of discarded equipment from hospitals, as and when they were forced to move premises. In due course a salaried part-time curator was appointed. But there was still little space to exhibit the collection.

The Society purchased an additional unit at the Edgecliff premises in 2005 and the

author, then the curator of the collection, designed a professional exhibition space including internally lit display cabinets, 55 open storage drawers and moveable plinths on which to display floor standing items. The ASA in 2011 awarded the author Honorary Membership of the ASA, an honour rarely awarded to other than anaesthetists.

In 2013 the Society moved its headquarters from Edgecliff to a multi-storey building in North Sydney. The Museum was relocated to a space on a floor adjacent to the main office.

### THE RICHARD BAILEY LIBRARY

From the foundation of the ASA in 1934, a declared aim was to have a working reference library for the use of members. In 1937 Dr I.C. James, a founder member, was appointed to add to the collection housed in Geoffrey Kaye's house which was also the home of the Society. At the 1937 AGM a circular was released about the Library (and the Museum) specifically stating it was to be available for members and was to include recent publications. In 1946, after the disruption of World War II, the Library (and the Museum) were housed in a room at the Department of Physiology at the University of Melbourne. From there they went to 49 Mathoura Road, Melbourne, premises rented by the Society from Kaye who served as Curator and Librarian from 1951 to 1955. In 1955 the collections were moved to the Royal Australasian College of Surgeons as Kaye was selling his building.

For some years the ASA's headquarters moved from state to state while the Library remained static; however in the early 1970s the society established its permanent headquarters in NSW and much of the Library came to Sydney. Soon after the society decided its Library would concentrate on historical works because by that time anaesthesia journals were widely available in most academic libraries. However, when the ASA's *Anaesthesia and Intensive Care* commenced publication in 1972, exchange copies from other journals arrived in the society's rooms and these were saved and bound.

In 1980 the ASA bought a rare book, 'On the Inhalation of the Vapour of Ether in Surgical Operations' by John Snow to firmly establish and celebrate its Library. Richard Bailey was appointed Honorary Librarian, as his interest in the history of anaesthesia through his own purchases of rare books was well known. Indeed over the succeeding years he presented many books to the ASA Library and the library was named the 'Richard Bailey Library'. In 2005 the ASA purchased part of his private collection and since then he has donated the rest to the Society.

Richard Bailey and Alison Holster, a retired Librarian from the Royal Australasian College of Physicians, started the job of cataloguing around 3000 items. In 2008 Alison died and the cataloguing temporarily ceased, later to be taken over by the author, who had previously been Curator of the Harry Daly Museum. Gradually all the precious volumes emerged from the basement storage to line newly purchased

bookshelves. By the time the Society moved from Edgecliff to North Sydney, The Richard Bailey Library was in its present form.

## HALMA AND THE HONORARY STAFF

The Library, Museum (and the Archives) are presided over by the History of Anaesthesia Library Museum and Archives (HALMA) Committee, presently chaired by Reginald Cammack. Over the years several members of this Committee have provided important advice and valuable service as Honorary Curators, Librarians or Archivists including Richard Bailey, Rajesh Haridas, Jeanette Thirlwell and Michael Cooper. Reg Cammack has compiled a continuously updated timeline of the History of Anaesthesia with more than 1000 entries. This and the catalogues of

the Museum and Library are available on the ASA's website.

HALMA functions as a historical research unit for Society members and other researchers of the evolution of anaesthesia.

## PLANS FOR THE FUTURE

The more important libraries and museums are increasingly collaborating for the benefit of their publics. Complimentary information resides in both museum objects and books in a way that enhances both. Museums and libraries are becoming less formal places and often are united in one area which brings enlightenment, quicker understanding of structure and form, a sense of the evolution of subjects over the years, a quality of harmony and even entertainment to visitors. In the

same way that good gardens provide as well as plants other aspects which enhance the whole (scents, colours, relaxation, memories, sounds of nature, a sense of wellness), so a greater whole can be achieved by 'interleaving' libraries, museums and archives so that an expanded range of related resources, interest and creative emotion are stimulated.

HALMA organises an annual History of Anaesthesia seminar each year in June, and from these and the other trends mentioned above, hopes to evolve their services for the greater benefit of ASA members and researchers in associated fields.

Peter Stanbury OAM, PhD  
Hon. ASA Member.



Above: The HALMA Committee with the plans for the new museum (2005)

Above right: The Richard Bailey Library at the Edgecliff premises (2011)

Right: The Harry Daly Museum at Edgecliff (2011)

Below: Museum and library material stored in a triple garage at Edgecliff (2000)



## INSIDE YOUR SOCIETY

# NERIDA MARGARET DILWORTH AM 1927-2019



Nerida Margaret Dilworth was born in 1927 and grew up in Perth. She won a scholarship to Perth Modern School and always wanted to be a doctor. Nerida was amongst the top ten matriculation students in WA in her 'Leaving' year, and then like other West Australians of her day she went to Adelaide to study medicine.

Dr Dilworth graduated from the University of Adelaide in 1950 and then spent three years in junior posts at Royal Perth Hospital (RPH) before becoming an anaesthetic registrar. She subsequently undertook anaesthetic training in the United Kingdom, obtaining her FFARCS in 1959. Dr Dilworth returned to RPH in 1960 and in December of that year she was appointed the inaugural Director of

Anaesthetics at Princess Margaret Hospital (PMH), a post that she held until her retirement in 1992.

Dr Dilworth established the first Department of Anaesthesia at PMH and was soon recognised as a gifted clinician (both as an anaesthetist and as a physician), a superb organiser and a natural leader. Paediatric anaesthesia at PMH flourished, and she steered the department to a central and pivotal role in the hospital. She worked in collaboration with Mr Alasdair MacKellar, the paediatric surgeon, to establish the Surgical Department, the Intensive Care Unit, the burns unit, the neonatal studies and data collection systems.

Under her leadership and assisted by Dr Peter Brine, the department introduced Same Day Care in the mid-1970s. In the early 1980s Nerida was an early and very ardent advocate for adequate pain relief in children. She considered that children were an underprivileged group in relation to pain management. She introduced and trialled the early protocols and published on the management of acute pain relief in children.

Probably the most significant contribution was that she fought for and started the first Intensive Care Unit, initially for the treatment of acute respiratory illnesses requiring intubation. Nerida had to overcome the intense opposition of the paediatricians and the medical superintendent of the day, who were initially unwilling to accept that anaesthetists could appropriately care for critically ill patients. That, of course,

was just the sort of challenge that Nerida loved. Her persistence, determination, logical arguments and example (aided and abetted by Dr Peter Brine and the Senior Surgeon Mr Alasdair MacKellar) won through in the end. They were amongst the first in Australia to introduce nasal intubations for critically ill children and developed a remarkable service, given the isolation of Perth in the 1960s. Her skill, dedication and extraordinary work ethic plus the expertise of the staff that she trained, soon meant that the intensive care under the care of anaesthetists was accepted in the hospital.

In hindsight, many of these developments may seem trite, but it must be remembered that at the time they were groundbreaking and required considerable effort and foresight.

Nerida made many contributions to PMH, serving and Chairing on many Committees and the Hospital Board in addition to her teaching commitments. She even chaired the Division of Surgical Services for six years! The PMH community recognised the astute judgement, integrity, honesty, common sense, dedication and kindness which accompanied her medical knowledge, clinical prowess and commitment to paediatric patients and the hospital. She retired in 1992 after 32 years as Director of the Department and in the words of her successor Dr G. Mullins, "she left an excellent department of anaesthesia with a national reputation, a well-coordinated team with excellent relationships and respect within the hospital. All created by Nerida".

Dr Dilworth was elected to Fellowship of the Faculty of Anaesthetists RACS in 1966. She served on the WA Regional Committee of the Faculty from 1972-1984 and was the Chair from 1974-76. Nerida became a final fellowship examiner for the Faculty of Anaesthetists RACS in 1968 and examined until 1980. Dr Dilworth was elected to the Board of Faculty in 1976 and served until 1984. Her interests were focused on education, professional standards, patient safety, anaesthesia standards and Faculty regulations. From 1979-84 she was the Assessor for the Faculty, a position that was suited to her meticulous attention to detail, her integrity and sense of fairness. This is perhaps best demonstrated in her 1981 submission on 'Part-Time Vocational Training in Anaesthesia', in which she sought to address some of the anomalies that were occurring. Dr Dilworth declined to seek the Deanship, but there is no doubt that she made significant contributions to the Faculty at an important time in the development of the specialty.

Dr Dilworth was always active in the anaesthesia community in Perth and Australasia. Whether it was training anaesthesia registrars, interacting with colleagues, continuing medical education or supporting the College and the Society. In recent days I have been struck by the number of colleagues who said that Nerida had supported them and provided encouragement, advice or direction (often at pivotal times in their careers). Many saw her as a role model for women in medicine, and also noted that "gender was



Dr Nerida Dilworth presents Dr Lisa Hill with the Nerida Dilworth Prize

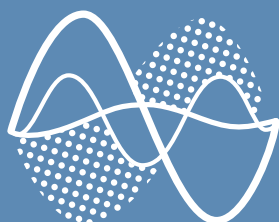
never an issue for her". They all held her in high esteem and valued their interactions with her. She was highly regarded for her professionalism, judgement, fairness, clinical acumen and skills.

Dr Dilworth was a consummate clinician and a gifted teacher, who was happy to encourage others to do research. The ASA/Faculty WA Registrar Prize was initiated in 1985 and in 1987 it was decided to name this prize in honour of Dr Dilworth in recognition of her contributions to teaching and the support of research in WA. She supported the prize over the years and presented the award in person on many occasions. In 1993

Dr Dilworth was awarded Membership of the Order of Australia in recognition of her services "to Medicine and particularly the field of paediatric anaesthesia". In 2006 Dr Dilworth was awarded the inaugural ASA Medal in recognition of her contributions to "the development of paediatric anaesthesia, paediatric intensive care and the education of several generations of anaesthetists in WA".

Nerida will be fondly remembered and the legacy of her achievements will live on and will continue to benefit future generations of children in WA.

Dr W.R. Thompson AM



# DayCOR Registry

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## INSIDE YOUR SOCIETY

# NEW AND PASSING MEMBERS

The ASA would like to welcome all new members from March to May 2019.

### TRAINEE MEMBERS

Dr Alison Clark	NSW
Dr Mansi Khanna	WA
Dr Laura Fay McDermott	QLD
Dr Tony Vuong	NSW
Dr Hayley Marie Adams	SA
Dr Katarina Arandjelovic	VIC
Dr Cayley Jayne Bush	WA
Dr Andrew Thomas James Chong	SA
Dr Ellen Kathryn Coonan	QLD
Dr Thomas David Cordery	WA
Dr Yannick Yves Cucca	WA
Dr Rohit Daswani Daswani	WA
Dr Clinton Dillon Ellis	WA
Dr Sharon Eow	WA
Dr Nicola Alison Fracalossi	TAS
Dr Patrick Galloway	TAS
Dr Taaibos Cilliers Human	NSW
Dr Julia Madelaine Inman	WA
Dr Eunmaro Ju	NSW
Dr Teck Hock Khoo	VIC
Dr Matthew John Kilpin	VIC
Dr Jason Bob Kong	VIC
Dr Joel Michael Krause	SA
Dr Shruti Krishnan	NSW
Dr Claudia Marcelle Lagrange	WA
Dr Caroline Weiling Law	VIC
Dr Chia Yuan Shelly Lee	QLD
Dr Michael John Leith	WA

Dr Adam Levin	VIC
Dr Ivy Thuy Lien	NSW
Dr Jolene Shu Ning Lim	WA
Dr Amy Liu	NSW
Dr Amy Louise Lumb	WA
Dr Jingjing Luo	WA
Dr Daniel Ly	SA
Dr Sophie Jane Maslen	TAS
Dr Angela Alex Mathew	SA
Dr Ross Michael Mcnaught	WA
Dr Todd Anthony Miller	NSW
Dr Mitchell Peter Nolan	NSW
Dr Fionn ÓLaoire	WA
Dr Sally Christina Perks	TAS
Dr Kara Lee Ritchie	WA
Dr Declan Charles Jolley Sharp	WA
Dr Dylan Antony Siejka	TAS
Dr Elliot Karl Coyle Smith	WA
Dr Katherine Pixley Smith	WA
Dr David Edward Somerville-Brown	TAS
Dr Casey Luke Steele	QLD
Dr Henry David Upton	SA
Dr Anurag Vijay	VIC
Dr Lucas Wheat	VIC
Dr Hoi Sang Wong	NSW
Mr Yuan Yi	VIC
Dr Kevin Wei Yu	SA
Dr Eileen Linlin Zhang	WA

### ORDINARY MEMBERS

Dr Gerard Stuart Ariotti	QLD
Dr James Battye	NSW
Dr Philip Bearfield	NSW

Dr Christopher Alexander Brunsdon	NSW
Dr Andrew Alexander Campbell	VIC
Dr Samuel Timothy Costello	VIC
Dr Jonathan Dutt-Gupta	SA
Dr Douglas Gray	NSW
Dr Stuart Lachlan Hastings	VIC
Dr Andrew Michael Heard	WA
Dr Andrew James Iliov	VIC
Dr Rebecca Helen Kamp	QLD
Dr Yeow-Kwong Kendrick Ling	WA
Dr Jason Ma	VIC
Dr Phuong Lam Markman	SA
Dr Lachlan Nave	NSW
Dr Mary Catherine O'Shea	QLD
Dr Adi Pavan Prabhala	NSW
Dr Tim Rance	QLD
Dr Bethany Jane Reeve	QLD
Dr Farnaz Rouhani	NSW
Dr Tonis (Tony) Antonios Sousalis	NSW
Dr Rhys Thomas	NSW
Dr Evangelos Tziavrangos	SA
Dr Derrick Nathan Wong	VIC

### IN MEMORIAM

The ASA regrets to announce the passing of ASA members Dr Piers William Robertson, SA; Dr Nerida Margaret Dilworth, AM, WA; Dr Herbert Claus Newman, VIC; Dr Robert Ernest Steele, SA; Dr John Radford Horne, NSW; Dr Bernard Leslie Dunn, VIC.

If you know of a colleague who has passed away recently, please inform the ASA via [asa@asa.org.au](mailto:asa@asa.org.au).

# Aspirations INTO Action

## 2019

COMBINED NEW ZEALAND  
ANAESTHESIA ASM + AQUA

EARLY BIRD  
REGISTRATION  
CLOSE:  
14 JULY 2019

AUGUST 21-24, 2019  
MILLENNIUM & COPTHORNE HOTELS  
QUEENSTOWN, NEW ZEALAND

The New Zealand ASM is joining this year with the Annual Queenstown Update in Anaesthesia (AQUA) to provide a stimulating conference in one of the world's alpine wonderlands. The theme is "Aspirations into Action" and the organising committee have put together an aspirational and wide ranging program with an exceptionally fine array of local and international speakers. As well as the usual AQUA update sessions on a number of topics, you can expect to be challenged to ensure your practice is the best it can be.

### INTERNATIONAL KEYNOTE SPEAKERS

#### DR ED MARIANO

Professor of Anaesthesiology,  
Perioperative and Pain Medicine  
Stanford University School of Medicine  
USA

#### PROF MARY DIXON-WOODS

Director  
The Health Improvement Studies Institute  
University of Cambridge  
United Kingdom

#### DR ANDREW KLEIN

Cardiothoracic Anaesthetist  
Editor-in-Chief, Anaesthesia  
Royal Papworth Hospital  
Cambridge, United Kingdom

ABSTRACT SUBMISSION CLOSE: 7 JULY 2019

🐦 #NZASM19 #AQUA19



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**SAVE THE DATE 20-24 SEPTEMBER 2019**



**Professor  
Iain Moppett**

**ENGLAND**



**A/Prof. Glenn  
Woodworth**

**USA**



**Professor  
Colin Royse**

**AUSTRALIA**



**A/Professor  
Lisbeth Evered**

**AUSTRALIA**



**Professor  
Pam Macintyre**

**AUSTRALIA**

**REGISTRATION NOW OPEN**

For all enquiries please contact: Denyse Robertson

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**THE ASA NSC  
FUTURE DATES**



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