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LETTERS TO AUSTRALIAN ANAESTHETIST:
Letters are welcomed and will be considered for publication on individual merit. The Medical Editor reserves the right to change the style or to shorten any letter and to delete any material that is, in his or her opinion, discourteous or potentially defamatory. Any major revisions required will be referred back to the author for approval. Letters should be no more than 300 words and must contain your full name and address. Please email editor@asa.org.au to submit your letter or to contribute.

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A MEMBER SOCIETY OF THE WFSA

Would you like to contribute to the next issue?

If you would like to contribute with a feature or a lifestyle piece, the following deadlines apply. Intention to contribute must be emailed by 5 January 2022. Final article is due no later than 16 January 2022. All articles must be submitted to editor@asa.org.au Image and manuscript specifications can be provided upon request.

Anaesthesia and Intensive Care

ANAESTHESIA AND INTENSIVE CARE EDITORIAL FELLOW

Dear Colleagues,

Applications are invited from ASA, NZSA, or ANZICS members within their final year of specialty training or within two years of obtaining their specialist qualification for the position of Anaesthesia and Intensive Care Editorial Fellow, 2022.

As with our current editorial positions, the position would be honorary and would be undertaken alongside the applicant's usual employment or training. The term would be for 12 months commencing February 2022.

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

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

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

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

Applications should be addressed to the Chief Editor, Anaesthesia and Intensive Care via email aic@asa.org.au by 31 December 2021.

Applicants will be notified of the outcome of their application by mid-January 2022.

Kind regards,

A/Prof John Loadsman

Chief Editor, Anaesthesia and Intensive Care

FROM THE ASA PRESIDENT

ANDREW MILLER
PRESIDENT OF THE ASA

I am honoured to become the latest President of the ASA, very pleased to have Dr Mark Sinclair as Vice President, and I take this opportunity to thank the members for your support and for believing in the great cause of anaesthesia. It has become apparent to many during this pandemic that our specialty leads in so many ways. Our rigorous training and focus on safety for patients is legendary and has resulted in Australia having one of the safest systems for patients having procedures in the world. Our diversity, our critical care skills, and willingness to adapt to every challenge in a sensible, pragmatic and logical manner was advanced by the ASA, ANZCA and many members. The work of Prof William Runciman and Prof Alan Merry among many others from the first decade of this century put patient safety on the map, but we have not been as good at protecting ourselves and our colleagues.

During the SARS-Cov-2 outbreak we have been vocal about three main themes that I intend to continue to promote. These align with our heritage and are

1. understanding airborne spread as the key to prevention, with clean air and appropriate PPE in community and healthcare,
2. aiming for best outcomes possible for all groups of patients,
3. workplace safety for anaesthetists and all those we work with.

The formation of OzSAGE, a diverse group of experts who are not conflicted by government appointments requiring censorship of their views to suit employers has made this task much easier (https://ozsage.org).

My predecessor, the longest serving President of the ASA Dr Suzi Nou is an embodiment of all that we aim for in our specialty and I am so pleased to have her continue on the Board and Council as a mentor to us all over the next two years.

In my other roles including as AMA state President in WA I have been keen on change, modernisation and inclusion. Broadening our appeal to those yet to join by understanding and meeting their professional needs and interests is the first order of business for the ASA - and we are always open to your suggestions. If there is a way that we could support you better in your specialty, we will consider it.

Thanks again - let's get on with it,

Dr Andrew Miller

MBBS LLB(Hons) FANZCA
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Contact

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

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FROM THE CEO

MARK CARMICHAEL,
CEO OF THE ASA

Christmas is almost upon us, and again we have lived through another amazing year. For a second successive year, Covid 19 has as we know dominated our lives. Slowly it seems there are some green shoots appearing as Australia reaches very high levels of vaccination among its population and governments take the tentative steps to ease restrictions, allowing the community much more freedom.

It can only be hoped that as our vaccination levels increase right across the country that the hospitalisations and deaths associated with Covid 19 will be limited.

Once again Covid 19 has impacted greatly on the ASA during the year, in particular in relation to educational meetings and events. While in some cases that impact has been frustrating, e.g the postponement of the ASURA meeting for a second time, it is now planned for 2023, other areas of the ASA's have been able to embrace the new technology and provide members with opportunities that were not thought possible previously. Certainly the hybrid version of the National Scientific Congress which was produced out of Brisbane, but had speakers located in all different parts of the country was a wonderful example of how technology is providing us with a new way to do things. It is planned that the Society will be investigating such methods of delivery even more for the years ahead in relation to the NSC.

Embracing technology coupled with the enthusiasm of the ASA's Education Officer Dr Vida Viliunas resulted in the creation of an online educational offering for Trainees which proved immensely valuable and popular. The success of this approach has paved the way for a greater consideration to be given to this form of education as we move towards 2022.

This edition of Australian Anaesthetist has as its focus education and I encourage all members to closely read the various articles and appreciate what has happened in an educational sense within the ASA during these pandemic times.

On a very positive note the Society has a new home, located in Naremburn, a lower north shore suburb of Sydney. The article in this edition which focusses on the move, highlights again the difficulties that Covid 19 threw up in relation to our relocation. This was exemplified by parts of Sydney going into lockdown the very morning of the move, meaning that allocated removalists who had scoped the job, weren't able to attend, and whole new teams needed to be engaged! That said the move was very successful and ideally the Chandos Street home will become a vibrant secretariat and meeting place for ASA members.

I would of course like to thank the ASA staff who have all been working remotely since July of this year. It is not easy trying to do your work, in some case home school your children, cope with technology challenges and still deliver. I do believe though that staff have under very difficult circumstances have once again done a wonderful job, in ensuring that members needs and the day to day operations of the Society have been met.

On a different matter, that of membership, many of you will have recently received your 2021/22 ASA membership renewal notice. Looking at our 2021 figures I am delighted to report that 94.4% of our Ordinary members renewed. This does not include those former members who rejoined or those who had their membership on hold, and asked to be reinstated. I would like to say thank you to all those members who renewed. I wonder if that figure can be exceeded in 2022?

At the same time we are always looking to encourage those who aren't yet members to join the Society and participate fully in its activities. If you know someone who hasn't yet joined please ask them to.

In closing I would like to say a final thank you to Dr Suzi Nou who at the recent AGM completed her term as President. I look forward to working closely with our new President Dr Andrew Miller (Western Australia) and his Vice President Dr Mark Sinclair (South Australia).

Mark Carmichael

Contact:

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

THE ASA IS ON THE MOVE

December 2021 marked a significant landmark for the ASA when the doors of our new premises in Naremburn opened for the very first time.

In June 2021, our office staff were packing for the move when the Covid-19 pandemic forced NSW into lockdown.

With everyone working from home, Plan B saw ASA CEO Mark Carmichael with the support of IT Manager Paul Singh manage the logistics of the whole relocation, posting progress reports on the staff WhatsApp, as removalists delivered boxes, and new computer screens were installed at vacant workstations.

"Although the wellbeing of our staff was always our first priority, it was very disappointing that after such anticipation we were forced to wait so many months to celebrate this new beginning," Mark Carmichael said.

"It has been eerie walking around a silent office, with all these empty desks piled with boxes yet to be unpacked. We are looking forward to having everyone together and settling in to ASA's new home."

Naremburn will be the fifth home for the ASA with each new location marking a significant new phase for the Society.

From 1969-1980 the ASA operated out of the Rooms of a group of members at 86 Elizabeth Bay Rd, Elizabeth Bay.

The ASA's first official HQ was established in April 1980 when the Society purchased a terrace house at 50 Gurner Street, Paddington.

Five years later ASA membership growth demanded a larger Secretariat. The Society moved to Edgecliff Towers, initially in unit 604 and then to a larger suite (U603). The ASA remained in Edgecliff for close to 30 years, until an increase in operations once again demanded more space.

In 2013 the Society purchased floors 7 and 8 in an office tower at 121 Walker Street, North Sydney which provided ample space for staff, committee meetings, the museum, library and archives. However, external pressures eventually led to the ASA's latest relocation.

"The ASA has done well out of Sydney real estate, especially with the sale of Edgecliff and North Sydney," Mark said.

"While North Sydney had ample space, the building was old and required significant upgrades. Meanwhile, the North Sydney CBD was going through a significant boom, with developers circling the older style buildings for redevelopment. The Board recognised the opportunity and made the decision to sell our holding in 2019 for $12m. We subsequently purchased a free-standing building in Naremburn for $6.3m, representing a significant savings even after a $1.3m fitout," Mark said.

"Having been part of a commercial complex, I recognise the advantage for the Society to now be sole owner of a building without the encumberment of a body corporate," Mark said.

"86 Chandos street, Naremburn has been fitted-out to meet our needs and accommodate future growth. It offers adaptable, multifunction spaces to meet the needs of members and staff.

"The first level features the museum and library with versatile meeting areas that can expand to accommodate 40 people seated or 60 people in a cocktail setting.

"The upper level is dedicated to office space for the ASA Secretariat, with 17 workstations, meeting rooms and an open plan kitchen lunchroom.

"The building has been designed to maximise natural light and air flow. A key feature is a central atrium that floods the internal spaces with sunlight, and opening windows on the northern and southern walls providing fresh air circulation.

"Located in close proximity to St Leonards station and RNSH, the building has parking for 10 vehicles.

"We welcome members to visit the ASA Museum and Library and make use of our meeting room facilities. Please contact asa@asa.org.au to make a booking"
Mark Carmichael said.

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THE ASA HONORS DR VIDA VILIUNAS

by awarding her the Gilbert Brown Award for outstanding services in Anaesthesia and Education

This award was established in 1969 following a suggestion and donation by Dr Mary Burnell, a Past President of the ASA. It perpetuates the name of the first President of the ASA. Professor Douglas Joseph and Dr Judith Nicholas were the first recipients of the award. They were both awarded the Gilbert Brown Medal in 1969 and were presented with it at the annual dinner in 1970.The ASA Board introduced the ASA Medal in 2006.

The award is made to an individual who has made outstanding and particularly meritorious service to the ASA and to anaesthesia in Australia. This service is normally in one area.

Dr Viliunas has devoted many years of service to the speciality of anaesthesia particularly in the area of education notably in many areas.

Dr Viliunas has been a member of the ASA since June 1995. She was ACT representative to Council from 2003–05 and has been Vice- Chair since 2015. She was Executive Councillor from 2006-08.

Dr Viliunas has held the role of National ASA Education Officer since 2012 and has served on the ASA CPD committee since 2012. She is very active in running Part 3 courses (for trainees) as well as being an adjudicator for various ASA awards, prizes and research grants. She has helped organise many meetings on behalf of the ASA including the NSC in Canberra 2001 & 2013 and Darwin 2015.

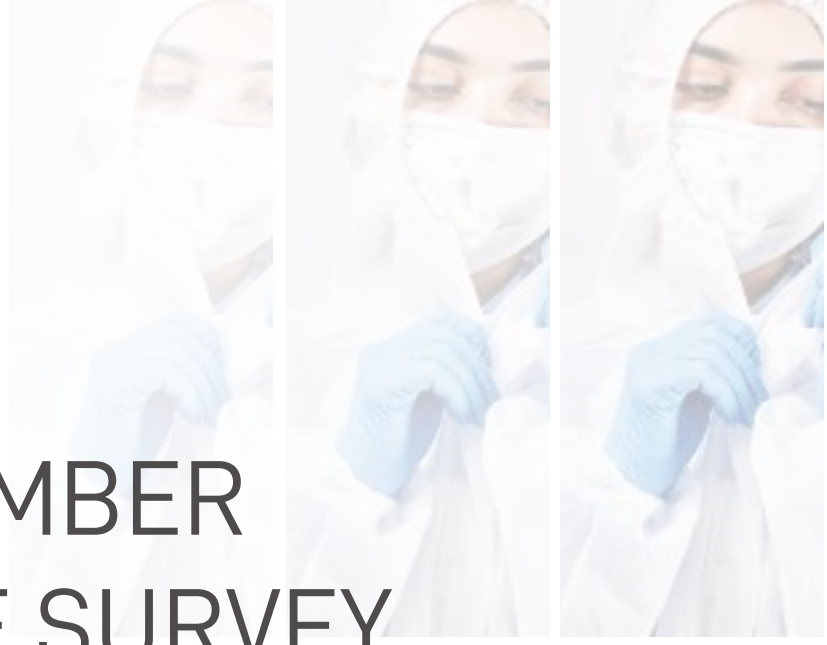
Dr Viliunas has also made a significant contribution to Australian and New Zealand College of Anaesthetists (ANZCA) having served as a final ANZCA fellowship examiner for 12 years (2002–13) and Chair of the final examination committee from 2011–2. She has been an International examiner for the Kuala Lumpur Master of Anaesthesia Course and the Hong Kong College of Anaesthetists.

Dr Viliunas is a lecturer and examiner for the Australian National University Medical School.

Dr Viliunas has also served on the ACT Medical Board (2005–14), as a member of its Notifications Assessment Committee and Registrations Committee chair.

Dr Viliunas continues to tirelessly contribute to the education and advancement of the careers and professional development of her colleagues. She has a focus on assisting her younger colleagues cope with the rigours and process of passing examinations and a passion for helping her contemporaries comply with the requirements for revalidation.

The ASA congratulates Dr Viliunas, an outstanding recipient of this distinguished award.



2021 ASA MEMBER WORKFORCE SURVEY

The 2021 ASA Member Workforce Survey was targeted at ASA members in active specialist practice: registration with the Medical Board of Australia as Specialist Anaesthetist was required for eligibility to respond. Dr James Bradley (Specialty Affairs Adviser) summarises some of the findings.

A total of 898 responses were received (about a 40% response rate, in line with the preceding and similar surveys in 2014, 2016 and 2018). Several hundred of the responses offered comment which can inform future ASA activity.

This report offers an assessment of responses to the 2021 survey, and draws some comparisons with the three previous surveys

In prefacing response analysis, the validity of the survey needs to be considered. A 40% response rate can be considered sound, and reassuringly the geographic, age and gender metrics captured by the initial demographic questions align closely with the current quarterly data published by the Medical Board of Australia (which noted 5,736 medical practitioners registered as Specialist Anaesthetists as of 30 June 2021[1] as well as with the data in the previous surveys.

In relation to survey timing, the survey ran from the start of the second 2021 school term during a period in which no States or Territories were undergoing COVID lockdown. Examination of Medicare statistics suggest that clinical activity was normal at this time.

TABLE 1	2014	2016	2018	2021
Male	74.3%	73.8%	73.4%	70.0%
Female	26.7%	26.2%	26.6%	28.5%
Prefer not to say				1.5%
Practising in MMM1 (Modified Monash model classification)				
MMM1		80.6%	81.7%	83%
MMM2		11.4%	10.1%	11.8%
Practising anaesthesia exclusively	89.3%	88.5%	88.9%	88.8%
Commenced practice within previous 5 years	16.3%	18.7%	16.2%	14.4%
Planning to retire within the next 5 years	20.1%	19.3%	22.2%	29.6%

TABLE 2	2014	2016	2018	2021
Wanting more public practice	11.5%	15.7%	12.3%	10.8%
Wanting more private practice	36.8%	37.6%	35.5%	20.8%
Wanting to work fewer sessions	18.4%	18.6%	19.5%	23.2%
Wanting to work more sessions	30%	30.1%	25.9%	16.9%
Able to increase professional workload without difficulty	34.9%	34.7%	36.2%	34%
Able to increase professional workload with some difficulty	39.6%	40%	38.8%	38.1%
Number of anaesthetists being trained				
Too many	73%	70.6%	58.4%	38.8%
Appropriate Number	17.9	17.7%	26.1%	36.9%

In 2021, 86% reported that they enjoyed practising anaesthesia. This is a drop from the 90% previously reported, and may reflect a 'COVID' effect.

Consequently, the responders are considered as with previous surveys to be representative of the specialist anaesthesia workforce, and the 2021 survey is considered to again valuably inform our knowledge of the specialist anaesthesia workforce.

Demographically, there are no appreciable differences over the four successive surveys in relation to location of practice, type of registration (Specialist Anaesthetist, or Specialist Anaesthetist plus Pain Medicine and/or Intensive Care Medicine) and years since beginning practice (Table 1). However, 29.6% expressed an intent to retire from practice within the next five years. This could be considered significant - perhaps an expression of COVID uncertainties. The age profile of members is unchanged. Among members aged less than 40, 60% were male and 40% female. Thirteen out of 898 declined to nominate their gender.

In 2021, 86% reported that they enjoyed practising anaesthesia. This is a drop from the 90% previously reported, and may also reflect a 'COVID' effect.

In relation to 'public' as opposed to 'private' practice, 37% identified themselves as 'private anaesthetists', 37% as both public and private, and 25% as 'public'. Deeper analysis shows that 89.2% of all responders receive some degree of Medical Benefits Schedule (MBS) supported income, and that 67.6% of responders receive salaried income by undertaking public hospital practice The MBS then is immediately relevant to almost 90% of responding ASA members, with two thirds undertaking salaried practice in the 'public' sector.

Almost half (45%) of female ASA members identify as 'public hospital anaesthetists', but almost two thirds undertake a degree of private practice. Of those females identifying as 'private anaesthetists', 60% undertake sessional public work. One quarter of male ASA members identify as 'public hospital anaesthetists', with two thirds again undertaking a degree of private practice. Of those males identifying as 'private anaesthetists', 50% undertake sessional public work.

In relation to professional workload, three quarters of members (as in 2014, 2016 and 2018) worked 45 to 48 'sessions' per four weeks (equating approximately to 4.5 full days per week), and much less commonly, 40-44 and 49-50 approximating 4 and 5 'full days' per week. (Figure 1).

In the 2014, 2016 and 2018 surveys, while half were satisfied with their current workload, the remainder were more likely to want to work more sessions than fewer, with three quarters able to increase their professional workload, half without difficulty.

In 2021, members were for the first time more likely to want to work fewer sessions then more, though as previously, half were satisfied with their current workload. Further, in 2021 20.8% reported wanting more private work, an appreciable decline from the 36–38% seen in the three earlier surveys.

If both findings are real, this could represent a significant turnaround in sentiment.

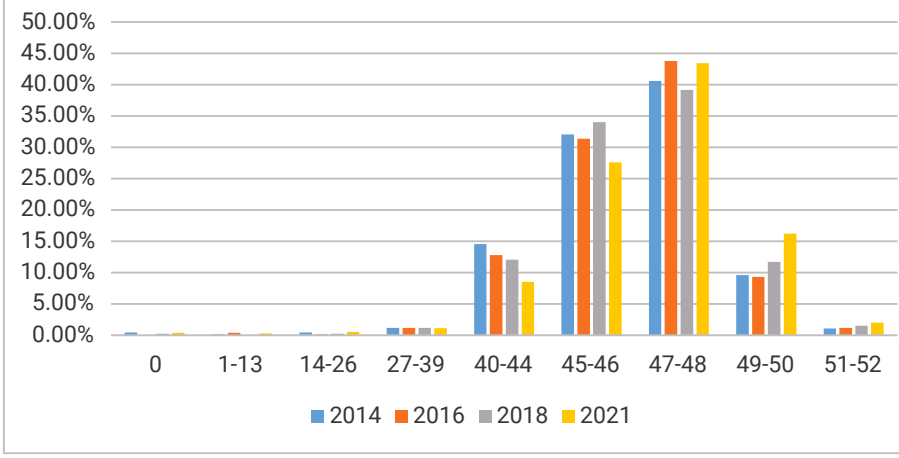
A question asked for the first time in 2021 further explored workload: 13.2% of responders regarded their workload as very light or light, 60.2% as moderate, 24.2% as heavy, and 2.4% as very heavy.

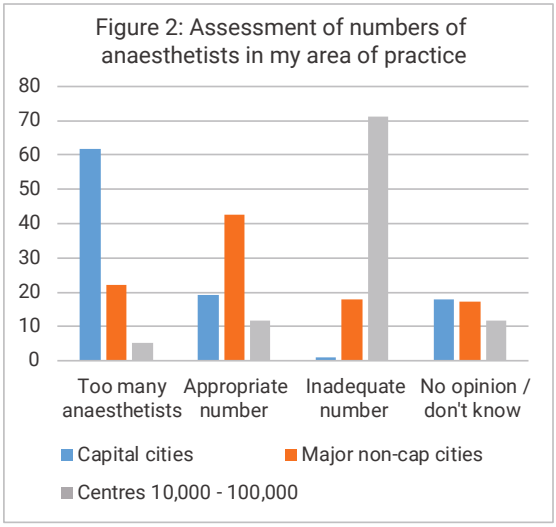
Again, the possibilities of a COVID effect or changes in perceived professional work/life balance arises. (Table 2).

Deeper analysis in the 2016 survey explored for the first time the perceptions of anaesthetists in different geographical locations in regard the adequacy of the anaesthesia workforce in their own areas. Analysis in 2021 shows that 62% of anaesthetists practising in capital cities believe that there are too many anaesthetists in those locations (Figure 2), with 6 responders of 578 having the opposite view.

A sizeable majority (85%) felt that their case-mix and case load was adequate for the purposes of maintaining clinical skills; conversely, 9% had felt obliged to work outside their 'comfort zones' due to economic pressures, and 23% due to workforce shortage or other professional pressures.

Figure 1: Weekly workload in sessions





A new question was asked in relation to 'bullying' during vocational training, with a fifth reporting being bullied

However, only 22% of anaesthetists practising in major non-capital cities believe that there are too many anaesthetists in those locations, and only 5% of those practising in centres with a population of 10,000 to 100,00 believe that there are too many anaesthetists in their locations. A shortage of anaesthetists is identified by 71% of those in these smaller centres (Figure 2).

The most common annual workload in terms of weeks worked was 47-48 weeks, with members in non-metropolitan areas reporting no more difficulty in accessing professional or recreational leave than capital city members.

A sizeable majority (85%) felt that their case-mix and case load was adequate for the purposes of maintaining clinical skills; conversely, 9% had felt obliged to work outside their 'comfort zones' due to economic pressures, and 23% due to workforce shortage or other professional pressures. Only 11 of 795 (1.4%) had moved to, or worked in, a rural region to obtain an adequate workload.

Younger specialists were questioned in all surveys about unemployment or underemployment in the initial years since obtaining Fellowship.

Unemployment was very uncommon, but more than one quarter reported being underemployed for up to 2 years, with limited case numbers and limited case-mix. 50% of all responders believe that public hospitals should increase the availability of work for young specialists, and 75% agree or strongly agree that any increase in public workload should be met by the appointment of specialists rather than an increase in the number of vocational trainees.

Support for vocational training in the private sector is conditional: 32.6% are somewhat supportive and 10.3% strongly supportive. A majority (69.5%) believe that productivity in the private sector would be diminished by vocational training.

In relation to a 'maldistribution' of anaesthetists in non-metropolitan areas, professional and social isolation continues to be identified as the most significant factor affecting recruitment and retention of anaesthetists in these areas

Almost 95% of responders report understanding what is required in obtaining the 'informed consent' of patients. Almost 10% document the attaining of consent with a patient signature, 60% without a patient signature, and 30% without documentation.

Member understanding of the Medical Board of Australia's 'Professional Performance Framework' was canvassed, with one quarter reporting a full or partial understanding; conversely, a large majority reported that they did not understand the requirements. 'Professional Performance Framework' was canvassed, with one quarter reporting a full or partial understanding; conversely, a large majority reported that they did not understand the requirements. Three quarters of responders agreed that anaesthetists will incorporate an increasing component of 'perioperative medicine' into their practices. Conversely, only a third personally wished to incorporate more 'perioperative medicine' into their own practices.

In relation to obstetric anaesthesia practice in private hospitals, just over half report that the facilities with which they are most familiar have no difficulty in covering anaesthesia for epidural analgesia and Caesarean section. Payment is made for participation in obstetric anaesthesia rosters in just under half of private facilities.

New questions were asked in relation to 'bullying' and sexual harassment during vocational training and during specialist practice, whether this was officially reported, and whether the employer response to reporting was adequate. The responses to these questions are being analysed by the Diversity and Equity Subcommittee.

Medical indemnity cover for private practice was provided by AVANT, MDA National, MIGA, MIPS in decreasing order.

Finally, 240 responders expressed some interest in joining a State or Federal ASA committee.

Dr James Bradley

References

[1] Medical Board of Australia: Statistics - accessed 18 June 2018 at http://www.medicalboard.gov.au/News/Statistics.aspx

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MEDICAL SOFTWARE UNDER REVIEW

Communication is important in our work to reduce patient anxiety, conduct pre-operative assessments and obtain consent. In this article, our team reviewed three digital tools that are being used by anaesthetists for communicating with patients.

The way we communicate has changed markedly over the last few decades. We regularly use email, webforms and SMS to convey information and use the internet and social media for 'research'. These modalities are also used in the practice of medicine. The 'traditional' medical model of patients booking appointments, being reviewed in clinics and then billed occurs in other specialties but is not widespread in anaesthetic practice. Communication is important in our work to reduce patient anxiety, conduct pre-operative assessments and obtain consent. In this article, our team reviewed three digital tools that have been used by anaesthetists for communicating with patients.

MEDITRUST

www.meditrust.com.au/mtv4/home

Meditrust markets itself as 'Brilliant Anaesthetic software' and is essentially private practice management software which handles informed financial consent (IFC) and billing with some survey tools added in. It is developed in Melbourne and used by many anaesthetic groups and individual anaesthetists.

There are different modules available to subscribe to: accounts & calendar, pre-op and calendar and the full suite. The accounts module enables invoices to be submitted electronically to Medicare and health funds and has an interactive calendar. The pre-op module includes IFC, patient surveys and the ability to send information. All modules come with an SMS module, which enable messages to be sent for an additional fee per SMS. Discounts are available based on the number of anaesthetists in your group.

On the plus side, it has the ability to import lists in various file formats and the calendar allows you to see your working week, identify when you are not available or on leave and see whether other anaesthetists in the group are available to cover lists. In terms of billing, it can store default information for quoting, has the ability to discount fees for early billing, send reminders for overdue accounts and generate financial reports. There is also a handy chat function for practice members.

	MedConsent	Cast Me	Meditrust
IFC	Yes	No	Yes
Billing	Yes	No	Yes
Consent	Yes	No	
Communication	SMS/email Webportal for patients	SMS/email	EMS/Email Webportal for patients
Cost	$10 per patient	From 50c per survey	$100 – $175 per month. SMS are extra
Support			
Post/op/ COD surveys	Yes	Yes, uses college CPD surveys	Yes, rudimentary
Extra features		CPD surveys	Calendar integration

SECURITY

According to Meditrust 'Information is safe with MediTrust. Our servers are hosted safely in locations across Melbourne ensuring protection under Australia privacy laws. Our highly qualified developers have put in place the highest levels of redundancy, hourly backups of data to remote servers and security similar to your online banking security. Security in the cloud is easy with MediTrust'

In terms of user experience, the setup process is substantial. Every surgeon and procedure needs templates prepared for IFC and preop information. For example, a tonsillectomy template from one surgeon cannot be used by another and the information needs to be copied to the second surgeon's tonsillectomy template.

Some time is required to set up the doctor profile information, pre-op information, questionnaires, IFC data, wording of the billing templates etc. The defaults in the system all need to be reviewed and edited prior to being able to be used. Meditrust can help with the setup and they offer good phone and email support as well as regular staff tutorials.

The IFC, billing and calendar features are well developed. The pre-op surveys and clinical record keeping is a little more rudimentary. It can be used to run a post-op survey, for Continuing Practice Development (CPD) purposes however this cannot be setup to run automatically and patients need to be selected for a batch send out. It is possible to attach pdfs, such as the Patient Information Brochures which have been developed by the ASA for the exclusive use of members, however adding weblinks and videos is challenging or not possible.

CASTME

www.castme.com.au

CAST (Clinical Anaesthetic Survey Tool) is a practice survey and audit tool. It can be used at an institutional level (for example CAST is the backbone of the DayCOR

Registry daycorregistry.com.au) or individual level. It was developed by an anaesthetist and ASA member in NSW.

CAST has a library of surveys and audits which can easily be selected and used in your practice. Many of the published college CPD surveys are already in the system library. Upon completion, the system will process the returned information and generate clinical alerts which are flagged via email to the anaesthetist. It is also possible to use a special patient 'communication' module to send and receive secure and confidential information to/from patients without revealing any personal contact details like mobile phone numbers or email address.

Of the three, CAST is the easiest to set up. New users can sign up for a free account which provides 10 free surveys. Select a survey from the system library, enter the patient details and then press 'create survey' to start sending emails and SMS to your patients. The SMS and/or email messages to patients contain a unique link for them to click which directs them to their survey. CAST will automatically remind patients to complete their survey with a follow up message if they don't complete their survey in the defined timeframe. It enables secure and confidential information to and from patients without revealing any personal contact details. When used at an institutional level, it can be integrated with hospital patient management software so that surveys are automatically sent to patients. It also allows anonymous practice benchmarking against a very large national survey database, making it like the 'Strava for anaesthetists'.

SECURITY

According to CAST, they 'take the protection of health privacy and personal information very seriously. The CAST servers are hosted in an ISO27001 certified facility, use HTTPS encrypted communication and have been independently penetration tested by Triskele Labs triskelelabs.com. CAST only uses Australian based internet assets so no data leaves the country (unlike other internet survey companies e.g. SurveyMonkey). CAST surveys can be configured to automatically have all patient identifiers purged after survey completion. This means in the unlikely event of database compromise only the active survey identifiers will be exposed with the vast majority unidentifiable.

CAST also has extensive reporting and compare features; your reports can be downloaded as a collated PDF file suitable for uploading to your college CPD portfolio as proof of activity completion. You can also download your raw survey data as an excel spreadsheet for your own processing if needed. CAST allows group aggregation benchmark reporting against other users of the same survey stream.

Customer support is friendly and quick as you are liaising directly with the developer who is also an anaesthetist and ASA member.

MEDCONSENT

www.medconsent.com.au

Has been developed by anaesthetists and lawyers to enable a consistent informed consent process that aligns with best practice.

It works by first inviting your patient to register. Once registered, patients add their medical details. Once you have reviewed their medical information, you can send patient and procedure specific risk information. The patient is then asked to review the information and provide consent via an electronic signature. Information is saved and can be accessed at any time. As an optional extra, patients can be surveyed after their procedure for CPD purposes.

The pre-operative questions can be modified by the user, unlike CAST, which requires an email to the developer.

THE VERDICT:

For a robust IFC and billing system with calendar integration ▶ **Meditrust**

For a robust consent process and documentation ▶ **MedConsent**

For an easy and quick pre-op assessment and CPD survey ▶ **Castme**

For all options, please do your own research. We also suggest sending yourself IFC, invoices, pre-operative questionnaires and surveys so that you experience the communication as a patient.

All of them have the ability be branded in some way, such as including a photo of yourself (patients greatly appreciate this) or adding a bio or link to your website. None of the software reviewed here link with MyHealth Record (MHR), real-time opioid monitoring services (SafeScript, QSCRIPT etc) or any pathology or radiology providers. Hopefully this will improve in the future. Of course, they are also dependant on patients' ability to use smart phones, the internet and/or email. Many reviewers thought that they do streamline workflow and overall, have helped communication with patients.

Suzi Nou

Do you have experience with any of these tools? Please share your experiences with us on the ASA Open Forum https://asa.org.au/asa-forum/. Listen for future episodes of the Australian Anaesthesia podcast where I will be delving into more depth with the developers or users of these software designed to make our work easier.

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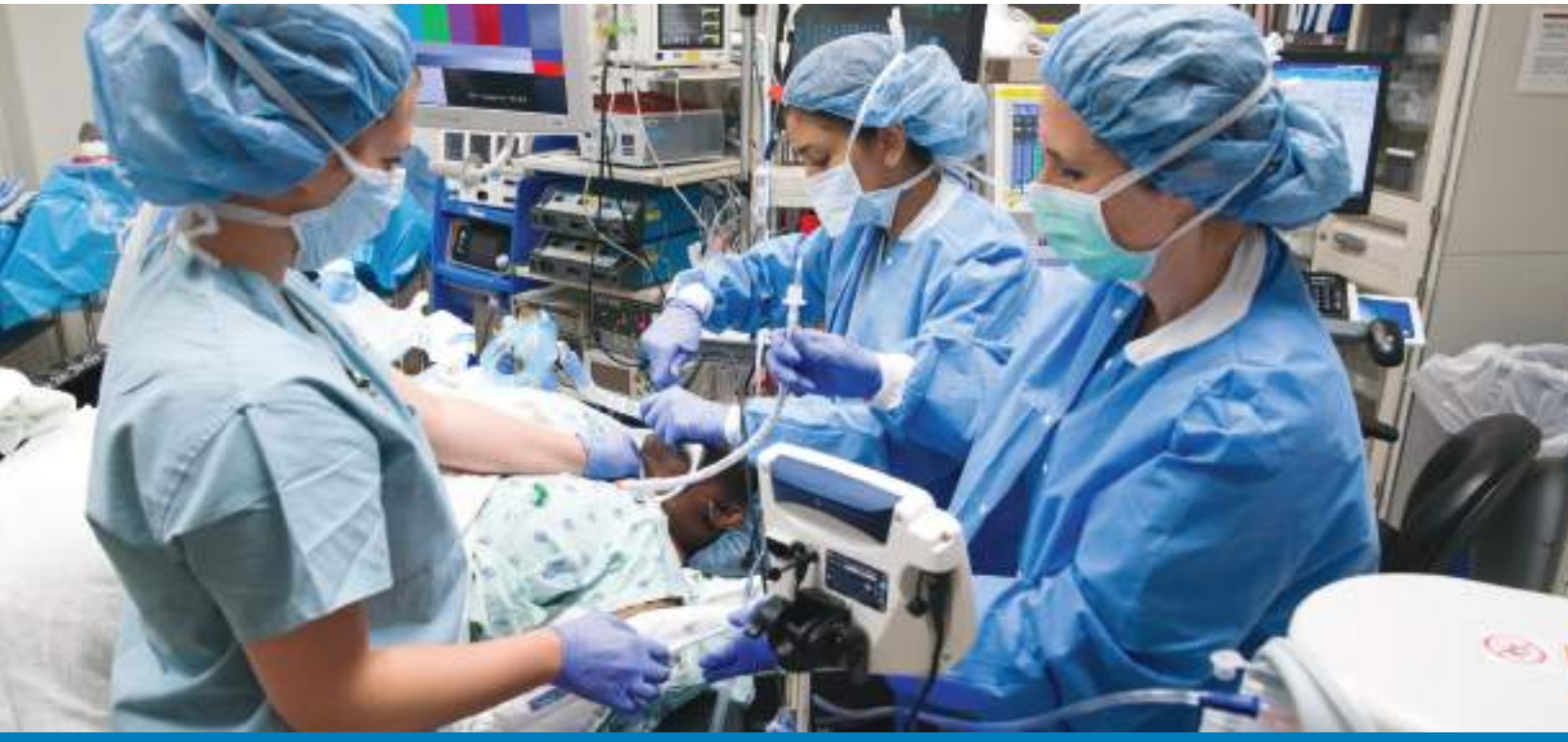

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2021 FINAL EXAM PERFORMANCE IMPROVEMENT CLINIC

during COVID again

Dr Vida Viliunas, ASA Education Officer and EPIC boot camp convenor presented the EPIC weekend in July this year.

Changes to the epic and the final exam

For the second year, EPIC July 2021 was entirely virtual.

Recently, the exam format has changed with the cancellation of the medical vivas for those sitting the up-coming 2021.2 exams. These are difficult times for candidates who have had to adjust to changing conditions and formats for the exam. It is a credit to the final exam subcommittee that it has managed to successfully conduct several exams during this pandemic and allow candidates to get on with their professional lives.

ACT and Victorian candidates for the 2020.1 sitting interviewed after their exams (see ASAEd trainee resources section) sent the message to their colleagues to be flexible during their exam preparation. The learning objectives for the exam have not changed nor have the standards. The substantial changes relate to the format of the exam as well as the potential for regional exams and exams by zoom during this time. As we have learned: anything is possible.

The introduction of evening ASA final exam practice sessions during the year for the written and viva components has created a virtual community of exam candidates. Candidates who were familiar zoom faces during tutorials met again (virtually) over the EPIC weekend to share resources and fellowship in zoom chats.

Preparations and logistics

Candidates and presenters were by now very familiar with the virtual webinar-like format.

As in previous years and live interactions, candidates were encouraged to commit to the weekend as if they were in a lecture: with cameras on and without distractions.

Presenters and other supporters

Thank you to the examiners who participated in the exam panel. Examiners Drs Margaret Buckham, Carmel MacInerney, Sharon Tivey, Linda Weber and Charlotte Wilsey devoted their Saturday morning to answering candidate questions and running through all exam sections.

It was reassuring to hear that although the entire curriculum is examinable, the expectations of examiners were to hear evidence where it exists and sensible, defensible judgement and practice for problems relating to core material.

They wanted to hear from candidates who were confidant, not arrogant, and who could calmly respond to scenarios presented to them in vivas, reflecting adequate experience with actual cases.

Exam sections

Each exam section (MCQs, SAQs and Vivas) was addressed and ingredients for success outlined. The medical viva review – a section which has since been cancelled – was an opportunity to cover the learning objectives should they arise in the SAQs or anaesthesia vivas.

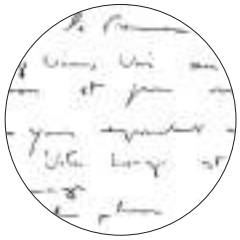
Since there is no negative marking for MCQs, each question should be answered. Strict timing is important to allow review of all responses.

The Short Answer Questions are a test of knowledge, some reasoning and communication skills. This is a demanding section for which strict timing is essential and a construct is helpful. Writing less, writing legibly with all abbreviations explained was stressed. Practising questions to time and having responses assessed is key.

Viva deconstruction, viva creation, developing scripts that work for individual candidates, practising vivas in sections, role-playing as examiners and video review were suggested as techniques to improve viva performance.

Exam Sections SAQ

- Test of knowledge / reasoning / communication
- STRICT TIMING
- Easiest to hardest - if that works for you
- Watch writing and abbreviations
- Write less, write legibly
- Watch spelling



Anaesthesia Vivas

- JUST DO IT - not quickly not briefly
- CONSULT with an aim, when you have exhausted your considerable knowledge
- INVESTIGATE with a purpose
- ACT with an END-POINT
- ACKNOWLEDGE novelty / emergency / out-of area of expertise

What to do if you don't know the answer

- Look interested, not alarmed
- Go back to first principles
- Say you've just forgotten the detail (valve area for example as a marker of severity) ... and know where you can get it
- Approach the situation clinically and sensibly: put yourself IN THE CLINICAL SITUATION
- Let the examiner know **you understand why the question is important** (i.e. send a reassuring signal)

What is it?

- Improves cognitive performance, reasoning, memory, attention, problem solving, abstract thinking
- Improves CVS performance
- Reduces the risk of malignancy
- Has psychological benefits
- Improves lipid profile and diabetes risk
- Improves immunity

Viva Specific Tips

- Answer incidental questions formally (in OR) to practice speaking; OR time is useful
- Write, deliver, video and analyse vivas for content and technique
- Keep a folder of useful 'scripts' and moments of great responses
- Attend to anxiety management if it affects your performance
- Consider a speech coach

It is important to systematically interpret investigations (for the exam as well as professional life). This demonstrates understanding and competence.

How to manage "viva-brain" and recovery techniques for what to do when candidates stall were discussed.

Exam preparation technique

Interviews with present and past examiners reveal that examiners want to be reassured that candidates have the knowledge to safely look after patients. An edited video of these interviews can be viewed under the ASAEd publications tab: "How to give a viva".

Recent exam reports have developed into an extremely valuable resource for candidates and their teachers. They should be studied and analysed for their information about the exam questions and the expectations of examiners.

Where pass rates for questions that relate to core material are poor, it is likely that those questions will be repeated in some form in an upcoming exam in the same or some other section.

Every year, examiner reports repeat the importance of answering the question asked. Techniques to ensure that the precise questions are answered were discussed.

Examiners are active clinicians. Operating theatres, preadmission clinics and pain rounds are where candidates learn about anaesthesia. That is where examiners develop questions to ask candidates to test their knowledge, judgement and reasoning. It is where candidates can reflect on how to apply what they know to patients and where their teachers can guide them in their training.

Under the "Trainee events" tab on the landing page of the ASA website, candidates can register for exam practice and review edited videos of previous practice sessions. All trainee members are invited to join live streams with registrars from all over Australia for written and viva sessions.

Thank you

The weekend would not have been possible without ASA office super-hero senior events coordinator Rhian Foster. She responded personally to all candidate queries in real time, ensuring that issues were sorted and information was followed-up.

Donation to Lifebox

All proceeds from this weekend were donated to Lifebox (lifebox.org)

Lifebox is an international non-profit co-founded by Atul Gawande. The organization works to make surgery and anaesthesia safer on a global scale. The need for hypoxia monitoring has escalated during the COVID-19 pandemic. Thousands of pulse oximeters have been distributed across 43 countries for the monitoring and care of COVID-19 patients.

LIFEBOX pulse oximeters for home and operating theatres enable the rapid treatment of hypoxia and aid in decision-making in the allocation of limited hospital beds and oxygen supplies in the developing world.

Dr Vida Viliunas

Opportunity to donate

BENEVOLENT FUND

LIFEBOX CHARITY

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To make a tax deductible monetary donation

Find out more please visit asa.org.au/donations

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

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

HARRY DALY MUSEUM AND RICHARD BAILEY LIBRARY:
Help preserve our collection for future generations to enjoy

ASAEd

For Anaesthetists

A significant ASA development/achievement for trainee and consultant support this year has been the launch of ASAEd: "a place where ASA Members can find professional resources for all facets of anaesthetic learning".

The shift to offering on-line education sessions for anaesthetists is very timely in the age of COVID. ASAEd offers a convenient opportunity to access continuing education content at your fingertips. The webinar library, National Scientific Congress recordings, New Fellow support, podcasts and ASA publications offer convenient opportunities to learn and achieve CPD points.

For Trainees

Successful anaesthesia departments include candidates who are well-supported for the exam component of their training. One focus of ASA Ed is to support trainees and International Medical Graduate specialists in their exam preparation.

On-line exam preparation sessions for primary and final exam trainees offer a variety of benefits, including:

A national community for trainees going through a shared experience during this difficult time

Real-time practice for written and viva sections

Interactions with current and past examiners and consultants with special interests in candidate preparation

A huge library of edited videos to review

ASA Ed navigation: how to get there

From the asa.org.au landing page, scroll down to "Quick links" and click on "ASA Publications" or simply log-in to the members website and go to asa.org.au/asaeducation/

This leads you to all publications: Australian Anaesthetist, Anaesthesia and Intensive Care, ASA Podcasts, the RVG, The Anaesthetic Crisis Manual, Anaesthesia History publications, and ASAEd learning resources where consultant, New Fellow and trainee resources reside.

Education Committee

Earlier this year, the ASA formalised the Education committee.

From left to right: Chair: Vida Viliunas (ACT), Deputy: Kaylee Jordan (VIC), Basic Trainee representative: Hamish Lanyon (Vic) Advanced Trainee representative: Bridget Bishop (VIC), Rhian Foster is the ASA's Senior Events Coordinator. A big part of her job is facilitating all ASA in-person and virtual event support: ASA exam preparation tutorials, PMET zoom functions, Practice Management seminars, webinars and other ASA events. If you have any suggestions for events, questions or submissions please email: events@asa.org.au

ASA VIVA NIGHTS AND EPIC COURSE TRAINEE PRESPECTIVES

EPIC was a 2 day course first run completely online in 2020 which showcased approaches to all aspects of the exam and included a question and answer session with current Chief Examiner Dr. Sharon Tivey.

The ANZCA final exam is a gauntlet that all trainees must run. Thankfully, the ASA provided a number of excellent resources to help prepare for this epic task which proved particularly useful for those of us in regional centres and in the setting of the pandemic induced reduction in face to face exam preparation. This was not only valuable in terms of the resources that provided exam relevant content, exposure and experience, but also facilitated the development of a community of trainees facing the challenge nationally.

The toolbox provided by the ASA included the Exam Performance Improvement Course (EPIC), frequent 1-2 hour SAQ or viva sessions by videoconference and a series of online videos in the ASAEd portal which allowed for asynchronous learning. EPIC was a 2 day course first run completely online in 2020 which showcased approaches to all aspects of the exam and included a question and answer session with current Chief Examiner Dr. Sharon Tivey. The online viva sessions were held once to twice a month by Dr Vida Viliunas and Rhian Foster with guest appearances. These nights were generally two hours in duration, on Zoom, with several vivas given. The vivas were frequently split between three candidates to spread the experience (and the suffering!) After a viva, an immediate in-depth analysis would occur allowing all present to reflect, both upon the content and the delivery. In addition, the vivas were frequently multipurpose, serving to train both Medical and Anaesthetic Viva techniques, and highlighted difficult decision points for discussion with evidence based resources. The videos presented in the ASA Education Portal were primarily examples of candidates' performance, interspersed with comments and education to guide candidates towards the right path. The asynchronous nature of these videos allowed for more flexibility in learning and covered content that was core to the entire exam.

The main powerhouse behind the ASA educational program was Dr Vida Viliunas, former Chief Examiner

of the Final Exam and Rhian Foster, ASA Senior Events Coordinator. The planning, organisation and incredible time commitment that these two put into these sessions that ran over a series of months was immense and truly appreciated by trainees nationally. And to the guest examiners who generously gave up their time to teach and train us, we are incredibly grateful.

In addition to originating from sources intimately familiar with the ANZCA exam and providing a scheduled prompt to engage with exam-focussed study, the ASA resources had a number of additional unexpected benefits that assisted with our preparation. In particular, we found observing other vivas and discussing them helped develop a sense of the benchmark of trainees from a diverse range of settings. Although there may have been some selection bias in those participating, seeing others' good performance was a powerful motivator and we were reassured to see that nobody had all the answers! Group discussion promoted learning from each other, and cultivated a sense of belonging and camaraderie. As well as the objective learning outcomes examined, there is a cultural and subjective aspect to being an anaesthetist - this time spent discussing clinical situations with senior trainees helped to refine our identities as Anaesthetists in the Australian context.

The final exam is a daunting prospect due to the breadth of the curriculum and its importance as a key measure of the expertise required to be a specialist anaesthetist. Trainees now have instant online access to whole libraries of information to help them study; selecting and prioritising these resources is crucial to success. We believe ASA's educational offerings should be prioritised highly by all upcoming candidates.

Dr Brigit Ilkin, Dr Alistair Park, Dr James Correy and Dr David Hargreaves

TRAINEE MEMBERS

ONLINE EDUCATION FROM A TRAINEES PERSPECTIVE

Dr Bridget Bishop
Anaesthetic Registrar (Advanced Trainee Year 1), North West Training Scheme, Victoria

With nation-wide lockdowns, interstate and international border closures, and the need for social distancing, the pandemic forced both educators and trainees to adapt. In these last two years or so, we have all experienced the range of both advantages and disadvantages of online education.

For years, online education has been an important aspect of learning and developing as an anaesthetic trainee, and it is increasingly essential now more than ever thanks to the COVID-19 pandemic.

Previously, in my experience, online education consisted of storage sites for sharing resources, watching video tutorials, listening to podcasts, and reviewing recordings of past lectures. It was an important element of study, but it was still very much complementary to what were largely in-person education encounters.

In a pre-COVID world, if you were seconded to a rural hospital, you would often miss out on attending study group or tutorials at your home hospital. Most exam preparation courses were with trainees from your state, and you would sometimes have to travel great distances to attend a conference. Times have changed, at least for now.

With nation-wide lockdowns, interstate and international border closures, and the need for social distancing, the pandemic forced both educators and trainees to adapt. In these last two years or so, we have all experienced the range of both advantages and disadvantages of online education.

Online education has many benefits. For a start, it is inherently flexible as it allows you to tune in to a tutorial, lecture, course or conference from anywhere in the world. This means that busy parents can be at home with their children (or in my case, my puppy) to listen to a lecture, rural doctors can join tutorials without having to drive back to the city, and international conferences are more practical to attend, time difference permitting.

This flexibility extends beyond "where" you tune into online education events to "when" as well. Availability of recordings online allows trainees on night shift or annual leave to catch up when it suits them.

In addition, attendance at nation-wide educational events has generally increased due to the accessibility of online platforms, providing trainees with more opportunities to learn from one another.

However, online education is not without its pitfalls. Despite how long we've had to learn to use the platforms, technical challenges are still a common and often frustrating issue. Phrases like "Can you hear me?", "You're on mute!", and "Can everyone see my slides?" have made their way into our lexicon for good reason.

While online education provides flexibility, it can also impair professional and social interaction. So much of the benefit of attending a course or conference in person is the ability to network, and often, the conversations had over lunch are just as valuable as the content delivered in session. These opportunities are frequently lacking when the event is conducted online.

It can also be difficult for trainees to maintain concentration and focus during an online education session. Likewise, I'm sure it's challenging for educators to be engaging via a webcam! Furthermore, the accessibility of online content may weaken some trainees' ability to learn in the moment. Knowing that you can always review the content later can make it hard to get the most out of the session at the time.

Finally, some forms of education and training just don't translate well to the online space, namely simulation and practical skills sessions. This is likely to be the case for some time, at least until virtual reality technology becomes more readily available!

In order to get the most out of online education, I can offer some tried and tested tips. For a start, ensure you block out adequate time to attend the event, allowing yourself a few minutes to turn on your device, login to the platform, sync your ear phones, and get comfortable.

Similarly, it is helpful to attend online events in a dedicated space in the house if possible. This space should be quiet, well-lit, and free from distractions. Try not to check your phone or eat snacks while online – save these for the breaks as you would at an in-person session. That being said, a good cup of tea or coffee never goes astray!

Engagement in the content will increase if you keep your camera on. This also helps the educators feel like they're teaching actual people (rather than a webcam) and also allows you to see if there are any familiar faces at the event. You could even chat to friends or colleagues during the breaks, just as you would in a pre-COVID world.

Now that our vaccination rates are increasing, and there is an end to the lockdowns in sight, we can be optimistic that educational events such as tutorials, lectures, courses, and conferences return to a primarily in-person format. It is my hope, however, that online education continues to play an important role, including the options of virtual attendance and reviewing recorded content post-hoc. This hybrid in-person/online format would allow for a more flexible and inclusive approach to education in future.

Dr Bridget Bishop

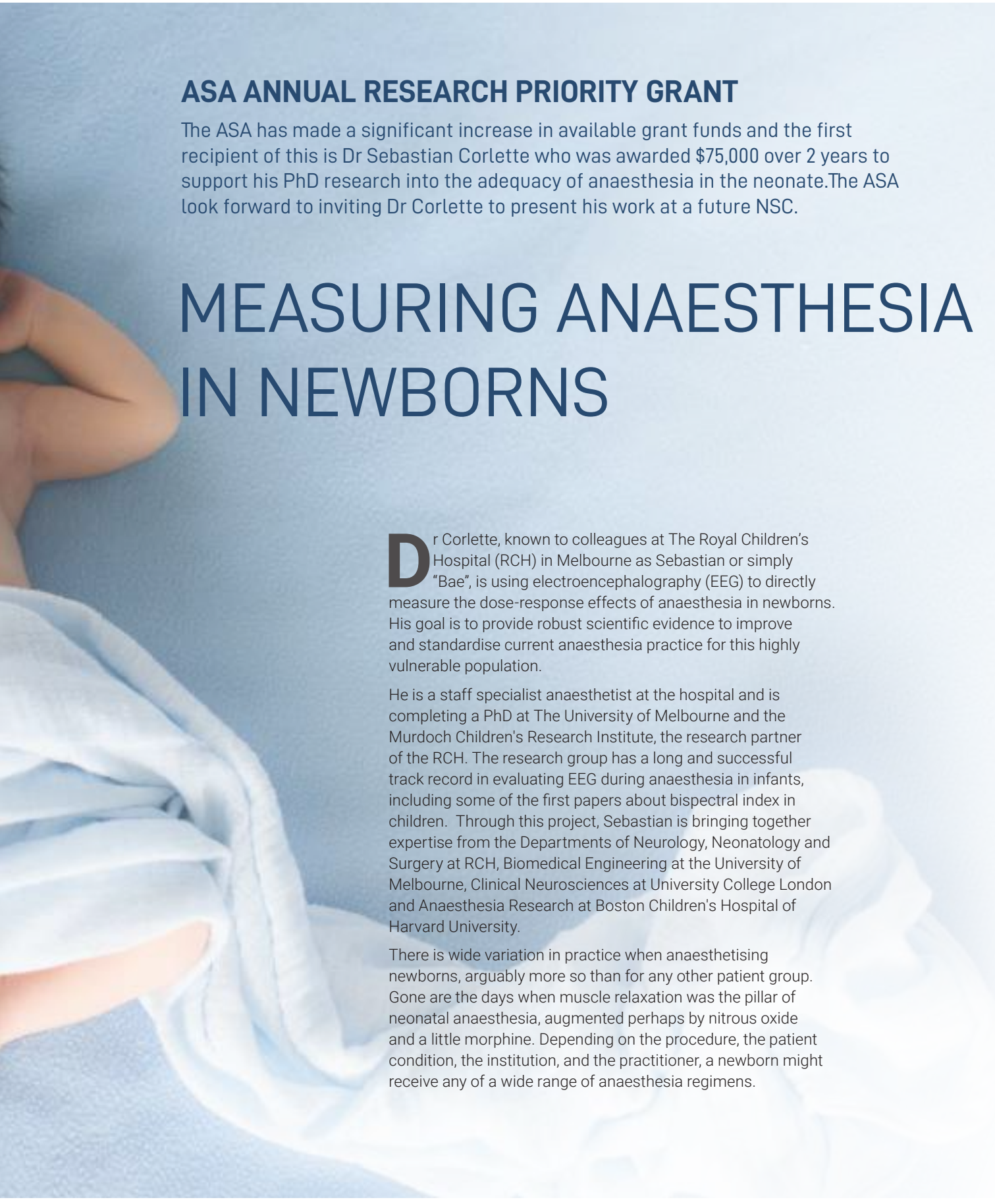
RESEARCH GRANTS & 2021 PRIZE RECIPIENTS

Despite a year without a live Congress, the ASA has still managed to encourage participation from early career anaesthetists in research initiatives. These junior anaesthetists usually receive significant support and supervision from more senior colleagues- in the eyes of a university this is considered a significant contribution to research education, especially for those with or seeking a academic affiliation.

ASA ANNUAL RESEARCH PRIORITY GRANT

The ASA has made a significant increase in available grant funds and the first recipient of this is Dr Sebastian Corlette who was awarded $75,000 over 2 years to support his PhD research into the adequacy of anaesthesia in the neonate.The ASA look forward to inviting Dr Corlette to present his work at a future NSC.

MEASURING ANAESTHESIA IN NEWBORNS



Dr Corlette, known to colleagues at The Royal Children's Hospital (RCH) in Melbourne as Sebastian or simply "Bae", is using electroencephalography (EEG) to directly measure the dose-response effects of anaesthesia in newborns. His goal is to provide robust scientific evidence to improve and standardise current anaesthesia practice for this highly vulnerable population.

He is a staff specialist anaesthetist at the hospital and is completing a PhD at The University of Melbourne and the Murdoch Children's Research Institute, the research partner of the RCH. The research group has a long and successful track record in evaluating EEG during anaesthesia in infants, including some of the first papers about bispectral index in children. Through this project, Sebastian is bringing together expertise from the Departments of Neurology, Neonatology and Surgery at RCH, Biomedical Engineering at the University of Melbourne, Clinical Neurosciences at University College London and Anaesthesia Research at Boston Children's Hospital of Harvard University.

There is wide variation in practice when anaesthetising newborns, arguably more so than for any other patient group. Gone are the days when muscle relaxation was the pillar of neonatal anaesthesia, augmented perhaps by nitrous oxide and a little morphine. Depending on the procedure, the patient condition, the institution, and the practitioner, a newborn might receive any of a wide range of anaesthesia regimens.

The goals of anaesthesia in the neonate are in some ways unique. The patients are often unwell with deranged physiology and the surgeries are often technically challenging. We therefore want to achieve immobility, physiological control, and optimised access as early as practicable. The next priority is sufficient analgesia, commensurate with the degree of surgical insult, which has been standard of care since its necessity was demonstrated in the 1980's. Providing hypnosis is also regarded as needed, though surprisingly, very little evidence has emerged to guide the use of hypnotic agents.

The approach to the typical anaesthetic goals of amnesia and loss of consciousness is complex in newborns. Consciousness in this group is difficult to define and even more difficult to measure. While some events may cause distress in one newborn and not in another, perhaps even giving the impression of individualised personal experiences (or consciousness), this is more likely to reflect the simple overlap of primitive reflexes with wide input receptive fields, which provide the scaffold upon which develop neural connections through repeated activation. In other words, a newborn is anatomically primed to receive a flood of new sensory inputs when they meet the world and to gradually develop neural pathways adapted to their environmental exposures as they grow. This is also known as implicit memory. However, newborns do not yet form explicit memories and so amnesia is unnecessary as a goal of anaesthesia. By logical extension, this implies an absence of conscious awareness of self or of the environment. This can only possibly develop once the underlying architecture for explicit memory formation has developed, which in turn relies on the accumulation of implicit memories from ongoing immersion in the environment of life. In other words consciousness, as we adults experience it, develops gradually.

In fact, the goals of anaesthesia for a newborn may be seen as an inversion of the anaesthesia priorities for older patients, where ensuring amnesia and loss of consciousness reign supreme. As a result, in adults, measuring the adequacy of anaesthesia is often considered synonymous with measuring the 'depth of anaesthesia', a relatively recent and somewhat intangible concept where an index is derived to reflect the inverse likelihood of an anaesthetised patient being awake.

One standard technique to monitor anaesthesia depth is to measure end-tidal minimum alveolar concentration (MAC) of a volatile anaesthetic. The MACs of all volatile anaesthetics are well validated with extensive population studies. What is more, the relationship between MAC and MAC-awake, the concentration of volatile at which a patient will make a voluntary response (such as eye opening) to a verbal command, is hugely consistent. There are few MAC studies in newborns, with small subject numbers. There are no MAC-awake studies in newborns.

Various indices derived from adult EEG have more recently become commonplace. These indices

The neonatal brain is different to the adult brain. It is small, functionally immature, and rapidly growing. Structure-activity relationships are dynamic and ill-defined. The vast day-by-day developmental changes along with the immaturity of body systems, make the pharmacology of drugs highly variable in neonates.

fundamentally describe changes in the the frequency composition of frontal EEG under anaesthesia to infer a predicted change in the brain state. While they do directly measure the end organ being acted on by anaesthesia (the brain), they do not measure the actual clinical effect of the anaesthesia. As such, they are at best indirect surrogate measures of probability, outside the causal path, that are highly vulnerable to confounding and bias. We know these indices perform poorly in newborns.

The neonatal brain is different to the adult brain. It is small, functionally immature, and rapidly growing. Structure-activity relationships are dynamic and ill-defined. The vast day-by-day developmental changes along with the immaturity of body systems, make the pharmacology of drugs highly variable in neonates. The huge body of literature from older brains therefore cannot be directly applied to the neonatal brain, nor can MAC or EEG derived indices. Thus, in the context of such unique goals of anaesthesia, we are effectively left with no meaningful measure of anaesthesia adequacy at all in the neonate.

However, too little, or too much anaesthesia each pose a risk of harm to newborns. With inadequate anaesthesia, babies mount a profound stress response to surgery that can lead to end organ injury. Untreated pain has long-term effects when the exposure occurs during sensitive periods of neurodevelopment while the brain is highly plastic, including long-term behavioural changes and altered pain sensitivity that persists for decades. Excess opioid may lead to post-operative apnoea or even mechanical ventilation requirements, with the associated non-trivial risks. Excess hypnotic anaesthesia may be associated with hypotension which may have a significant impact on the vulnerable brain. Excess anaesthetic drug exposure may also be toxic for a developing brain, however the impact of this is unclear at typical clinical doses.

Given the paucity of obvious end points to measure, meaningfully assessing the adequacy of anaesthesia in newborns is a challenging task. In the absence of any other target, our research makes the bold assertion that a primary goal of neonatal anaesthesia is to attenuate unique neural responses to surgical incision. The underlying assumption is that these responses represent cortical integration of the afferent noxious signals, and that such cortical integration can reasonably be expected to be sensed as unpleasant, without undertaking to define exactly what that unpleasantness might be or mean. Based on this premise, we are now measuring high-quality high-density continuous EEG data across the whole scalp before, during and after anaesthesia during routine surgeries, time-locked with noxious stimuli such as venepuncture and surgical incision. In addition, we deliver precisely timed noxious stimuli whilst under anaesthesia using quantified somatosensory testing devices as control conditions. We then analyse the data using multivariate statistical methods looking for patterns of brain activity before and after noxious stimuli and examine how these patterns change with different amounts of anaesthesia. Our study, approved by the RCH Human Research and Ethics Committee, is an opportunistic observational cohort study in which each patient provides their own control condition because we acquire baseline data prior to anaesthesia. Clinical anaesthesia management is completely independent from the study team and at the discretion of the treating team, who are blinded to the study data.

Its early days, but we already have some very interesting results. Newborn patients exhibit prolonged and profound changes in their EEG with very low doses of anaesthesia. These changes differ from burst suppression and from EEG patterns uniquely found during prematurity. What is more, these changes appear to vary in proportion to anaesthetic dose.

We hope that through this research we will as a field better understand how newborns' brains respond to anaesthesia. Given the wide variety of anaesthetic regimens in clinical practice today, we aim to create a method to formally evaluate different anaesthesia strategies. In the future, and built on the success of this study, we will hopefully develop controlled clinical trials to evaluate different anaesthesia regimens and answer some of the large gaps in our knowledge about neonatal anaesthesia.

Dr Mark O'DonnelL
Winner 2021
Kevin McCaul Prize

The Kevin McCaul Prize

Instituted in 1978, this prize commemorates the late Dr Kevin McCaul who was, for many years, the Director of Obstetric Anaesthesia at the Royal Women's Hospital, Melbourne. He had a major and lasting influence on obstetric anaesthesia throughout Australia.

The prize is open to ASA members who are trainees or specialists within two years of obtaining a higher qualification in anaesthesia. The prize is awarded for a research proposal, critical review or essay suitable for publication (as determined by AIC or Australian Anaesthetist editors) on any aspect of anaesthesia, pain relief, physiology or pharmacology, with particular reference to the female reproductive system.

The 2021 Kevin McCaul Prize of $11,000 and a certificate was awarded to Dr Mark O'Donnell for his research proposal "Maternal anaemia and postoperative outcomes after Caesarean Section- the MAPOC study". The ASA congratulate Mark and look forward to his presentation at an upcoming NSC.

Dr Jeremy Sin
Winner 2021
Trainee Poster Prize

Trainee Member Group Best Poster Prize

The Trainee Member Group (TMG) Best Poster Prize was introduced in 2011 and is only open to TMG members who present a poster at the National Scientific Congress. The objective of this annual prize is to encourage registrars to present scientific research in a clear, concise, and visually attractive manner.

Despite the abbreviated and online form of the CSC, the ASA held the trainee poster prize as part of the Queensland Tess Crammond prize session. The winner for 2021 was Dr Jeremy Sin for his systematic review and meta-analysis titled "Dexmedetomidine on PACU discharge and recovery".

The ASA congratulates Jeremy and looks forward to meeting at a future NSC where he will receive a free registration.

2020 TMG poster prize winner Dr Sneha Neppalli reflects on the experience of entering the prize and speaking to the NSC.

Having not had much prior formal research or audit experience, I embarked upon a quality improvement project entitled 'Audit of Labour Epidural Response Times (ALERT)' as part of my ANZCA Scholar Role Activity.

Being invited to speak at the ASA NSC in the Trainee Audit/Survey Prize category provided me with an excellent opportunity to present my work in front of a panel of esteemed colleagues and allowed me to expand my audit activity to beyond a mere 'tick boxing' training exercise . Designing a creative, visually appealing, clear and concise e-poster was easier said than done but well worth the effort!

Overall the whole experience provided me with an insight into the 'world of research' that I would not have otherwise been exposed to. The encouraging words of feedback I received during my oral presentation fueled my interest in undertaking further quality improvement activities in the departments I have subsequently worked in.

I am grateful that the ASA is dedicated to promoting the pursuit of research and audit amongst trainees by providing them a platform to present their work.

ASA RESEARCH GRANTS & SCHOLARSHIPS

Start planning now! Applications open early 2022

2022

The ASA has over $120,000 is available each year to support members (including Trainee Members), who are currently engaged in research related to anaesthesia, intensive care or pain management.

A trainee applicant must have a suitable supervisor who is also full member of the ASA.

Preference will be given to applicants enrolled in a higher degree or post doctorial early career researchers, although all members are eligible to apply.

Projects addressing the ASA research priority areas will be preferred:

ENVIRONMENT & ANAESTHESIA

INNOVATION & ANAESTHESIA

SAFETY IN ANAESTHESIA

Non-priority research proposals will still be considered.

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

FOR FURTHER INFORMATION APPLICATION & FORMS LOG IN TO

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

Thank you to our adjudicators and grant assessors

The ASA and SPARC wish to formally acknowledge the valuable contribution of the following anaesthetists who have assisted with adjudication and grant assessment over the last 15 years.

Dr Michael Barrington
Dr Brigid Brown
Dr Jim Bradley
Dr Christopher Breen
Dr Penny Briscoe
Professor Thomas Bruessel
Dr Michael Bennett
Dr Anthony Coorey
Dr Allan Cyna
Associate Professor Alwin Chuan
Dr Guy Christie-Taylor
Dr Martin Culwick
Dr Peter Cox
Dr Richard Clarke
Dr Stuart Day
Dr David Elliott
Dr Robert Edeson
Professor Lars Eriksson
Dr Nicole Fairweather
Associate Professor Stephen Gatt
Dr Genevieve Goulding
Professor Mike Grocott
Dr Neville Gibbs
Dr Richard Grutzner
A/P Roger Goucke
Dr Alec Harris
Dr Alexander Harris
Dr Peter Kam
Dr Ross Kerridge
Dr Steven Katz
Dr John Loadsman
Professor Guy Ludbrook
Professor Kate Leslie
Dr Andrew Messmer
Dr Andrew Mulcahy
Professor Colin McKenzie
Professor Lorimer Moseley
Dr Tom Mohler
Professor Paul Myles
Dr Pam MacIntyre
Dr Simon Macklin
Dr Andrew Ottaway
Dr Tim Pavy
Dr Michael Paech
Professor Freidrich Peuhringer
Dr Phil Peyton
Professor Colin Forbes Royse
Professor Keith Ruskin
Dr Lindy Roberts
Dr A Ross
Dr Peter Roessler
Professor Robert Sanders
Professor David Scott
Professor David Story
Clinical Associate Professor David M Scott
Dr Martin Smith
Dr Scott Simmons
Dr Jim Troup
Dr Walter Thompson
Dr Vida Viliunas
Professor A Van Zundet
Dr Elizabeth Ward
Associate Professor Glenn Woodworth
Dr Joyce Wahr
Dr Linda Weber

ECONOMICS ADVISORY COMMITTEE

Dr MARK SINCLAIR

Medicare Benefits Schedule (MBS)

As mentioned in the last issue of Australian Anaesthetist, the ASA is involved in ongoing discussions and meetings with the Compliance Assessment Branch (CAB) of the Department of Health, regarding correct claiming of Medicare items.

The incorrect use of item 20170 (anaesthesia for intra-oral procedures) for dental extraction procedures has essentially been settled. Hopefully, now that members are aware of the issue, all future claims will involve the correct item, 22900 (anaesthesia for dental extractions) rather than 20170. However, there are several other claim patterns which have been noted by CAB, and which were discussed at an October meeting involving CAB personnel, and representatives of the ASA and ANZCA.

There have been instances of simultaneous claims for both an anaesthesia service and a procedure. Members should note MBS Explanatory Note TN.10.7, which states in part:

"Except in special circumstances, benefit is not payable for the administration of anaesthesia …. unless the anaesthesia is administered by a medical practitioner other than the medical practitioner who renders the medical service in connection with which anaesthesia is administered."

This means that in general, an interventional or procedural item, and an anaesthesia administration item, cannot be claimed at the same time, even if the anaesthetist does perform a procedure. There is of course no problem with claims for items from MBS Relative Value Guide (RVG) Subgroup 19, which contains numerous items for diagnostic and therapeutic procedures performed in association with anaesthesia. Examples include certain local anaesthetic nerve blocks performed for post-operative analgesia, and invasive cardiovascular monitoring where indicated. We believe that in some cases which have been noted by CAB, an error was made and a procedural item was claimed rather than a Subgroup 19 item.

As can be seen from TN.10.7, the Department of Health accepts that there are occasional situations where such co-claiming is acceptable, and does not raise compliance concerns. Members should contact the ASA via policy@asa.org.au if they have any queries.

CAB is also considering anaesthesia time claim patterns. In some cases there has clearly been some form of clerical error made, with total anaesthesia time claims of well beyond 24 hours on the same calendar day. However, CAB is also interested in claim patterns for individual practitioners where large numbers of hours are repeatedly claimed. Naturally, CAB is aware that some doctors do indeed work long hours, but they may ask questions of "outlier" anaesthetists. The key factors for a good outcome in the case of an audit, are keeping detailed

clinical records, and recording anaesthesia start and finish times carefully.

Any member who receives a request from CAB for an explanation of billing patterns should immediately contact their medical indemnity organisation (MDO), and the ASA, before making any contact with the Department of Health.

Members are reminded that correct Medicare claims, and errors, are ultimately the responsibility of the doctor involved, regardless of who lodges the actual claims.

CAB has a firm focus on education of doctors, in order to avoid errors in claiming in the first place. The ASA supports this of course, and will continue to liaise with and assist CAB in this area.

Private Health Insurance

By the time of publication of this edition of *Australian Anaesthetist,* Bupa will have changed its rebate schedules. No doubt members are aware that, since the inception of "no gap" and "known gap" billing schemes, Bupa and the Australian Health Service Alliance (AHSA) funds have had different rebate schedules in each state.

During October, Bupa announced its intention to change this, with new rebate schedules to be in place from 1 December 2021.

Firstly, the Bupa rebate schedule is now the same across all states. The effects on the RVG unit value, and the most common pre-anaesthesia assessment item (17610) are shown in table 1 and table 2. There have been significant cuts to rebates in SA and Victoria.

Secondly, as is also shown in table 1 and table 2, there are now different Bupa rebate schedules for "no gap" and "known gap" billing. Bupa aimed to encourage "no gap" billing by providing higher rebates than those in the "known gap" schedule.

It is important to note that anaesthetists can vary their approach from hospital to hospital. Should an anaesthetist wish to adopt "no gap" billing for Bupa customers at a specific facility, this will need to be registered with Bupa. The anaesthetist will then be obliged to use the "no gap" schedule, with no out-of-pocket (OOP) expenses charged to any Bupa patient at that facility. Registration for the "no gap" schedule is available on the Bupa website (bupa.com.au/for-providers). The terms and conditions applying to the new schedules, and the complete lists of rebates for all MBS items, are also available

Should an anaesthetist already utilising "known gap" billing for Bupa patients wish to continue to do so, he or she need do nothing; simply continue to bill as in the past. Importantly, as has always been the case, informed financial consent (IFC) by the patient is required in order to obtain above-MBS rebates under "known gap" billing.

Anaesthetists may change their Bupa billing preferences at any location, at any time. Again this can be done on the Bupa website.

Before considering their responses to these changes, the ASA advises members to consider the following:

- The Bupa RVG unit value under the "no gap" schedule is only 1.7% higher than the "known gap" unit value
- No doctor is obliged to take part in "no gap", "known gap" , or any other funding scheme put in place by any health insurer.
- Doctors have every right to maintain their independence, and not agree to the restrictions in insurers' terms and conditions.

- Doctors may bill for their services in any way they see fit, for a fair and reasonable financial return. This may however result in a higher OOP expense to the patient, so best possible IFC is essential.
- Handing control of one's billing and income to a health insurer, which has a vested interest in spending as little as possible on rebates for medical services, will result, relatively speaking, in a gradual erosion of income. The repeated inadequate indexation of rebates over many years, and the 7-year MBS freeze (which was followed by most insurers), is definitive evidence of this.
- The ASA maintains its general advice – "charge what you are worth, and be worth what you charge".

Dr Mark Sinclair

Bupa Rebate Schedules from 1 December 2021

TABLE 1 Bupa State-by State Changes – RVG Unit Value

State	RVG Unit	Dec 2021 "Known Gap"	Change	Dec 2021 "No Gap"	Change
NSW/ACT	$34.30	$34.40	+ 0.3%	$35.00	+ 2.0%
Vic	$36.40	$34.40	- 5.5%	$35.00	- 3.8%
Qld	$34.35	$34.40	+ 0.1%	$35.00	+ 1.9%
WA	$34.40	$34.40	Zero	$35.00	+ 1.7%
SA	$37.15	$34.40	- 7.4%	$35.00	- 5.8%
Tas	$34.30	$34.40	+ 0.3%	$35.00	+ 2.0%
NT	$34.40	$34.40	Zero	$35.00	+ 1.7%

TABLE 2 Bupa State-by-State Changes – Item 17610 (Pre-anaesthesia Attendance, up to 15 minutes)

State	17610	Dec 2021 "Known Gap"	Change	Dec 2021 "No Gap"	Change
NSW/ACT	$76.15	$76.15	Zero	$77.20	+ 1.4%
Vic	$79.65	$76.15	- 4.4%	$77.20	- 3.1%
Qld	$76.05	$76.15	+ 0.1%	$77.20	+ 1.5%
WA	$76.40	$76.15	- 0.3%	$77.20	+ 1.0%
SA	$79.25	$76.15	- 3.9%	$77.20	- 2.6%
Tas	$75.80	$76.15	+ 0.5%	$77.20	+ 1.8%
NT	$75.65	$76.15	+ 0.7%	$77.20	+ 2.0%

As we approach the end of another eventful year, the ASA remains occupied by many of the same themes that we faced in 2020.

PROFESSIONAL ISSUES ADVISORY COMMITTEE REPORT

Dr PETER WATERHOUSE
CHAIR PIAC

Change of leadership

New ASA President Andrew Miller inherits a society in good shape. Immediate past president Suzi Nou has deftly navigated the many challenges facing our profession, while somehow also finding time to record dozens of stimulating and educational podcasts! My thanks to Suzi and congratulations to Andrew.

Public in Private

It is likely that this issue will become increasingly prominent as the COVID pandemic creates a backlog of public elective surgery.

The clinical challenges of public in private surgery (PIP) have been addressed in these pages before. They include patient selection, access to hospital records, assembly of an appropriate peri-operative team and planning for escalation of care. Although the ASA has met with major private hospital operators, systems for ensuring safe care of PIP patients are still evolving. ASA Position Statement 23 addresses these challenges and is available to members and the public to provide guidance.

The funding of PIP has become increasingly problematic.

For funding purposes, PIP can be considered to fall into two categories:

1. Elective 'overflow' from the public hospital system undertaken by private hospitals operating as normal.
2. Public work undertaken by private facilities during periods of restricted elective surgery as a result of high community prevalence of COVID-19. Private hospitals are often supported by 'viability agreements' with state governments under such conditions.

Funding for the 'overflow' type of work is relatively straight-forward. State health departments enter agreements with private hospitals to undertake a certain amount of work for an agreed price. Finer details including doctors' fees are determined by the hospital. Anaesthesia remuneration varies depending on several factors including the type of procedures being performed. Currently the RVG unit value for most PIP of this type falls between $34.10 (Department of Veterans Affairs rate) and $60.

Funding arrangements for the second, 'COVID' type of PIP are far from clear.

Private hospitals enter viability agreements with state health departments. These agreements are in turn supported by the Commonwealth government. Payment of medical specialists is via either sessional payments or fee-for-service billing. Considerable uncertainty surrounds each method.

Hospitals in viability agreements are offering an RVG unit of 125% of the Medical Benefits Schedule rate, which works out to about $25.50. This fee is said to be stipulated by the state governments. The state governments claim that this fee is set by the Commonwealth government. The ASA has contacted the federal department of health for clarification on this point.

125% MBS has the apparent advantage of simplicity if applied across all specialties. However in practice this rate is much more acceptable in some specialties than others. In the case of anaesthesia it falls well below even the modest rates offered by DVA or private insurers.

Furthermore, clinical work performed in hospitals bound by viability agreements is likely to be characterised by slow theatre turnover due to COVID precautions. This compounds the effect of the low unit value.

The alternative to this problematic funding model is a sessional rate.The viability agreement allows for the payment of specialists using a sessional rate analogous to the payment of Visiting Medical Officers in public hospitals.

Payment of a sessional rate overcomes the problem of slow turnover, and would also be suitable for anaesthetists employed on COVID wards, intensive care units or in other unconventional roles.

The actual rate of remuneration under this model is the subject of negotiation. Hourly rates in public hospitals do not translate directly to the sum paid per session. Allowances for leave, overtime, workers' compensation insurance and other entitlements need to be made if a truly comparable payment is to be offered. To this end the ASA has sought exemption from the Australian Competition and Consumer Commission to facilitate collective negotiation with hospitals on behalf of members in Victoria. Other jurisdictions may benefit from this approach.

Managed Care

The ACCC have conditionally approved the application of nib/CIGNA joint venture Honeysuckle Health to form a buying group for medical services.

This development represents another step towards domination of our healthcare system by insurers, who may in time wield much greater bargaining power than doctors or hospital operators. US Style managed care is the end result of such an imbalance of power.

The ASA is working with other medical organisations to prevent further steps towards managed care. To this end an ASA position statement has been developed to articulate the characteristics essential to the high-quality system Australians currently enjoy. At the heart of this system is the freedom of patients to see any doctor without regard to affiliations with particular health insurance companies. Medicare underwrites this system of independent doctors and patient choice.

Our position statement allows the ASA to work with lawyers to identify elements of legislation and regulation of the greatest importance to protecting our system from domination by insurers. By understanding the legal issues we may better resist the slide towards managed care which seems irretrievably advanced in the United States. I encourage readers to familiarise themselves with our position statement so that all anaesthetists can recognise and resist insurer initiatives likely to undermine our system.

ANZCA PS09

The College is currently revising PS09, Guidance on procedural sedation. This document is intended to apply not just to anaesthetists but all who undertake procedural sedation. I would like to recognise the efforts of ANZCA Director of Professional Affairs – Professional Documents, Dr Peter Roessler, who has worked tirelessly to oversee this challenging project. Following stakeholder consultation, currently underway, the document will be released as a pilot for six months.

Consent for anaesthesia

Members are reminded to take advantage of the ASA Patient Information Pamphlets. These are available as PDF files and are a valuable resource for ensuring that patients are well informed to give consent for anaesthesia. They can be conveniently emailed to patients along with fee estimates and fasting instructions.

Suggestions for new pamphlets addressing procedures not covered by our existing documents are welcome.

Happy Holidays!

As we look forward to a new year I wish all a safe and happy festive season. I look forward to joining you as we face the challenges of 2022.

Peter Waterhouse

POLICY MATTERS

Welcome to our incoming president, Dr Andrew Miller, while acknowledging the significant contributions and leadership of Dr Suzi Nou. Suzi has led the ASA through a very challenging time, and we thank her greatly for her efforts.

Public in Private Hospitals in Victoria

The ASA Policy Team has been recently been directly involved in developments in Victoria including elective surgery, public in private hospitals, renumeration and collective bargaining and has met directly with the Department of Health this week.

The ASA is aware of the need to also have greater availability of public records for Public in Private patients. We continue to meet and foster greater working relationships with Hospitals to develop a list of appropriate documentation that should unreservedly be made available perioperatively.

To that effect, the ASA also discussed with the Department having broader access to Hospital electronic/medical records for VMO's in private hospitals.

The ASA believes in equitable, accessible, quality and safe healthcare for all Victorians, and sees the "health" of hospitals in benchmarking our national healthcare standards and therefore believe that these measures will strengthen these core values.

ACCC Collective Bargaining

The Policy team has in the week gone, submitted the ACCC Collective Bargaining Exemption form, both the ACCC and several major Hospital groups respectively.

Having taken this step-in advocacy, we believe this will enable us to have an ongoing conversation about Public in Private Hospital work and will strengthen our position moving forward.

Renumeration

Given the important role that Anaesthetists play in the health care system in Australia, it is our belief that Anaesthetists should be recognised by way of pay grade or renumeration.

With that in mind, the ASA met with the Victorian Department of Health this week, requesting a review of the hourly rate, penalties and recalls that apply for VMO's in Public and Private Hospitals.

The ASA also discussed opportunities with the Department to increase the unit rate being offered. As we know, it has largely been recognised as inadequate and it is an area of discussion that the ASA is keen to facilitate ongoing discussion in.

QSCRIPT

The Policy Team has recently been quite involved in developments out of Queensland pertaining to QScript. Under the Medicines and Poisons Act 2019 (the Act) and the Therapeutic Goods Act 2019 (QLD), it is mandatory to check QScript prior to prescribing, dispensing, and giving a treatment dose of monitored medicines.

While the ASA is highly supportive in principle of the intent of this legislation as providing a method for identifying the misuse of medications by at risk members of the community.

The ASA does however have a number of concerns regarding the unintended application of QScript in day-to-day clinical practice. As so, the Policy team has reached out to the Queensland Premier, and the Chief Medical Officer respectively to provide our contention for potential harm of the day to day functioning of QScript as well as the workflow issues that may arise for Anaesthetists in both the public and private systems.

My Health Record

As last year, a primary focus of the Policy Team is to continue to support the Federal Governments direction in implementing My Health Record. We are happy to announce that we will be continuing that work heading into the new year with a greater focus on practical use and implementation.

This will allow us to provide further opportunities to meet with our members, practice managers, and our overall contingent through webinars and other channels.

Final Comments

Many exciting things happening in the Policy space, and as always, we will continue to update you as they unfold.

As we move into the end of the year, the Policy Team wants to take this opportunity to wish everyone a safe and enjoyable holiday period.

Jason Alam

PODCASTING WITH A PASSION

Past President Suzi Nou speaks to Australian Anaesthetist about how connecting with people during the pandemic lead her to a love of podcasting.

AA: What made you decide you wanted to start recording a podcast?

I was first inspired to write a blog by the Past President of the NZSA, David Kibblewhite. I was lamenting that the ASA was doing so much work and reporting it all in the monthly President's e-news meant I was only able to describe most things in a few sentences. David had been writing a blog for NZSA members to explore some of the work of their society in more detail. When I sat down to write the first blog I had significant writer's block. I was pressuring myself to write something intelligent, profound and funny that would connect with people. I was speaking with Paul Singh, our ICT Manager about building the webpage for the blog and explained to him my predicament. His suggestion was to record a podcast. A few weeks later, he further encouraged me to 'just press record', so I did.

AA: What have you enjoyed about podcasting?

I've enjoyed being able to meet people and chat with them in some detail. I think podcasting is a great medium for exploring and conveying information, emotion and opinion. I've also enjoyed the creative process. Being able to connect with someone and regularly produce an episode certainly kept me going, particularly during our lockdowns in Melbourne. I've also joined an international community of podcasters which has been very supportive.

AA: Has it been a lot of work?

At the start, yes. There is an estimate that there is a 4:1 ratio of editing time to finished podcast and certainly at the start it took a lot longer than that. That also doesn't include recording time and organising the logistics. A few people thought I was crazy to start podcasting during a pandemic when there were so many other things to do as ASA President, but as I mentioned, the connection, creative process and satisfaction of regularly producing an episode really helped to keep me motivated and focussed to do all the other work. Also, I am grateful for the support from the ASA office team in sharing the work: Michelene Stomann and Kathy O'Grady for producing the cover art, Paul Singh and Hayley Yan for the web support and Kathy Scott for the editorial input.

AA: What have been your favourite episodes?

I have a soft spot for Episode 1 on the RVG which I recorded with EAC Chair Mark Sinclair. It was done without any special equipment, minimal editing and the sound quality has improved a lot since then. It reminds me of how far we have come. I still recommend the episode because the content is relevant to so many anaesthetists, particularly when they first emerge from training and ask

"What is the Relative Value Guide?". I also like the episode I recorded with Communications Committee Chair David Borshoff on the Anaesthesia Crisis Manual. I had been working on my interviewing skills at the time and the beautiful back story of what inspired David to write the Manual unfolded before me. And of course, there have been the big hitting episodes.

AA: Which ones were they?

I did an episode with Kate Cole, an occupational hygienist which I still chuckle about because in the introduction I double check that I am pronouncing her job title correctly! It was on respiratory protection and fit testing and at the time these were such new concepts to health professionals. We made it publicly available on our website and I remember 4 days after it was published, Paul rang me and asked what I had done with the podcast as it had been downloaded nearly 4000 times in 4 days! On a different level, my conversation with Colin Baird, an anaesthetist recovering from substance use disorder seems to have made a significant impact on some people, not just anaesthetists. I'm of the mindset that if one person listens and has found some benefit, then that is good enough for me!

AA: How does that make you feel there's been close to 100,000 downloads in the last year alone?

To be honest, I don't track the numbers of the podcast. My goal for this year was to commit to publishing an episode every fortnight, and I'm delighted that I've managed to achieve that so far. Granted, some of the episodes in the 'Talking Money' series have been only a few minutes, but they seem to be the ones I get the most positive feedback about.

AA: So where to next with the podcast?

When I was podcasting as the President, I very much wanted it to be about the work of the ASA from my perspective as well as my areas of interest: women in leadership and wellbeing. I'm very mindful to give Andrew plenty of space to speak as President and will instead be focussing on the work of the ASA as well as that of our members. During my time as President and before, I've been impressed with how many anaesthetists have an entrepreneurial side to them and run related projects outside of clinical anaesthesia. Those who might have already listened will have also heard the new theme music. Many thanks to fellow Victorian and Communications Committee member Mark Suss for composing and producing the music. It's another example of the many talents outside of anaesthesia that exist within our community.

Suzi hosts the podcast 'Australian Anaesthesia' which can be found on any of the major podcasting platforms or via the QR code. Members can access full versions of the podcast by logging onto https://asa.org.au/podcasts-for-asa-members

ANESTHESIA SIMSTAT

Practice Perioperative Crisis Scenarios with Online Simulation Program

Staying up to date on the latest approaches to anesthesia emergencies has been simplified with the release of five training modules in ASA's Anesthesia SimSTAT program.

SimSTAT allows anesthesiologists at all levels of experience to improve their management of anesthesia emergencies using a computer at the office or at home, at any time. The program uses a virtual interface to put the user in an O.R., post-anesthesia care unit (PACU) or labor and delivery unit.

"I am impressed with the fidelity of the environment and the capabilities of these autonomous screen-based simulation products," said Adam I. Levine, M.D., editor in chief of the ASA Interactive Computer-Based Education Editorial Board (ICBE) who was involved in the development of SimSTAT. "Having been an adamant critic of screen-based simulation in the past, I can see its virtue in reaching more anesthesiologists so they can practice high-risk scenarios in an O.R. setting. I am very excited about the future of SimSTAT."

The SimSTAT project was developed over more than four years and its first education module was released in July 2017. It was designed as an option for anesthesiologists needing to attend full-day sessions at a conference or simulation center to earn American Board of Anesthesiology Maintenance of Certification in Anesthesiology™ program (MOCA®) Quality Improvement activity points, said Steven Houg, ASA simulation education manager. It is an online, screen-based virtual simulation for anesthesiologists to practice high-risk, rare or critical crisis scenarios on their own time.

In addition, many anesthesiologists find live simulation intimidating because they have to "perform" in front of their peers, Dr. Levine said. SimSTAT provides a less stressful option while still providing challenging opportunities to learn.

"Despite the fact that many of the members of the ASA Editorial Board for Interactive Computer-based Education are leaders in, and strong supporters of, live, mannequin-based simulations, we appreciate the unique opportunities provided by this kind of screen-based interaction," said Dr. Levine, professor of anesthesiology, perioperative and pain medicine, otolaryngology and pharmacological sciences at Icahn School of Medicine at Mount Sinai, New York.

"There are a number of advantages," he said. "Having played the simulation once, the ability to play again immediately, or at any time, to practice the management of a critical event is enormously advantageous. My guess is that every anesthesiologist, no matter the level of training or competency, can use this type of immersive education to identify knowledge and performance gaps while improving their knowledge and management through repetitive play."

SimSTAT allows users to navigate a fully functioning O.R., PACU or labor and delivery unit, work with a responsive patient, interact with medical equipment, work with an inter-professional team to manage a complex anesthesia emergency, and receive performance feedback.

Anesthesiologists can work through the SimSTAT scenarios as many times as they wish to improve their work. After scenarios conclude, users receive feedback on their performances. To claim credit, users must complete a minimum threshold of key interventions, but they do not have to pass a test, Houg said.

"Getting comfortable with SimSTAT's environment is critical, and it does admittedly take time and practice, but once you learn to use it, it becomes less of an obstacle," Dr. Levine said. "We expect the program to react autonomously. While we wanted the cases to be challenging for practicing anesthesiologists, we didn't want the scenarios to be so difficult or happen too quickly that they would ultimately frustrate the users.

"The members of the ICBE Editorial Board have spent countless hours improving the user experience by improving the interface, developing an orientation module, and attempting to perfect the timing of events in the virtual environment."

SimSTAT's five education modules are:

- **Trauma**, which focuses on the management of a patient with multiple injuries and peri-arrest hypotension, requiring the use of advanced cardiac life support skills.

- **Appendectomy**, in which an unstable patient undergoes laparoscopic surgery requiring the user to explore a differential diagnosis and use crisis management skills to manage patient care successfully.
- **Robotic Surgery**, where an obese patient in steep Trendelenburg has elevated airway pressures and experiences complications associated with the use of a surgical robot.
- **PACU**, where a patient develops altered mental status and a post-operative crisis ensues.
- **Labor & Delivery**, in which effective communication among an interprofessional team is needed during an intrapartum emergency.

The modules can be purchased individually, but if all five are purchased at once, the user receives a 10 percent discount. SimSTAT is available online at asahq.org/simulation. Before purchase, a free demonstration module is available so potential users can experience the interactive environment.

"I'd like to eventually see SimSTAT made available in a virtual reality mode," Dr. Levine said.

"The platform has been built so that it could be upgraded and adjusted to support virtual reality simulations. That would be exciting, and I'd like to see that as the future of SimSTAT."

Also contributing to this article were John Rask, M.D., and Rebecca D. Minehart, M.D., MSHP-Ed, members of the ASA Interactive Computer-Based Education Editorial Board. Dr. Rask is a professor and director of Simulation Education Programs at the Department of Anesthesiology and Critical Care Medicine at the University of New Mexico School of Medicine. Dr. Minehart is an assistant professor at Harvard Medical School and Massachusetts General Hospital, Department of Anesthesia, Critical Care and Pain Medicine, and is MGH O.R. Simulation officer and Learning Laboratory director.

SPECIAL OFFER

ASA members can now access discounts of up to 50% off single SimSTAT modules and 1-5 bundles for the American Society of Anesthesiologists SimSTAT series.

Contact membership@asa.org.au for the discount code and check asahq.org/simstat for the modules available.

HOW TO MOVE A MUSEUM AND LIBRARY DURING LOCKDOWN

Moving presented the perfect chance to deep clean the majority of the collection. This helps preserve the items for longer and readies them for display at Chandos Street.

Kate Pentecost (second from left), ASA staff and HALMA committee members cleaning and packing objects from the Harry Daly Museum, ahead of the move to Chandos Street. Photo: Rhian Foster.

"Could you describe your experience with the process of moving a museum collection?" It's early July 2020 and I'm being interviewed for the position of curator, librarian and archivist at the Harry Daly Museum. Sydney is in the midst of its first lockdown and the initial experiment of work from home orders.

I was anticipating the question. I knew about the impending move when I applied for the role. That the move happening was certain. It's exact date floated in the future, undefined but looming.

My answer was more questions:
We would need to assess how delicate the objects were. How would the items be moved? And by whom? By staff? Removalists? Specialists? How many items were already housed securely? Did we have a trolley to move the items from their display cases to the packing area? And where would the packing area be?

The chance to move a museum, library and archive is rare. Museums and libraries, by nature and design, do not tend to move buildings too often. The last time the Harry Daly Museum and Richard Bailey Library moved was in 2012. In 2020, the move included 250 archive boxes, 80 crates worth of books and some 2000 collection items, ranging from delicate needles to palm-sized 1930s anaesthetic masks through to anaesthetic machines that are as tall as myself. Oh and there's a blow pipe too, and a model tall ship. Plus the historical drugs in ampoules and glass bottles.

The first step to packing up a museum or library is not ordering a tonne of boxes. It's counting. Reviewing what you have and updating the collection database so you can figure out how many boxes you need to order.

The initial audit of the collection took three months and included updating the locations of all items in the collection database. Much easier to pack when you know what you have and where it is, and even how large and heavy an item is.

Auditing also helps with the shopping list of supplies. It soon became apparent we needed a mix of different sized archival grade boxes, several grades of acid free tissue paper, bubble wrap and foam. In fact, quite a bit of ethafoam, in depths ranging from 1cm to 5cm. Hot glue guns and box cutters too, plus a new special vacuum to gently clean the nooks and crannies of the objects.

During the four month packing process you develop some strange and unique skills: How to cut thick ethafoam into odd divots and shapes with a box cutter, the right way to jiggle and swirl the end of the hot glue gun so the glue doesn't develop long stringy hairs, judging exactly how much bubble wrap it will take to cover a doctor's bag (there are several in the

Dr Reginald Cammack, Chair of HALMA, carefully cleans an object, surrounded by boxes and creates. Photo: Rhian Foster.

wipes and paint brushes to clean the objects before packing.

Moving presented the perfect chance to deep clean the majority of the collection. This helps preserve the items for longer and readies them for display at Chandos Street. It's a gentle process aiming to remove the grime and dirt, but not the history of the object. Cleaning with water is avoided. Similarly, common cleaning products for the home are not to be used on collection items as you don't know exactly what is in the formulation nor the strength of it. Acetone and methylated spirits, diluted to various strengths, were the main cleaners of choice for the glass and metal objects. Glass and metal being the most common materials in the collection.

So those who helped packup the museum got a crash course in how to clean museum objects. The HALMA committee members all had a good time removing grime from vaporizers, glass syringes and dusting down gauges. ASA staff lent a helping hand too. Plus if you need a gauge returned to its former dazzling-self, Rhian Foster is very good with a wooden toothpick.

There was training for the volunteers too, with tips from object handling basics to work health and safety for medical collections. Never pick an item up by it's handle (handles are the weakest part of an object), support the base and never place an item near the edge of the table. Please be aware of sharp edges, needls, blades and the drugs. The first aid kit is located over there.

The volunteers and helpers asked "How do you know if an object is packed properly into a box?". The answer is simply "Do the shake test". Gently shuffle the box, and if the item moves, more foam packing is required. Remember too, that while the boxes should not be tipped over, pack it out as if it will happen. An object which doesn't move in it's box is extremely unlikely to break.

Each box or bubble wrapped item was labelled with a crate number and more importantly, at least two bright lime-yellow THIS WAY UP stickers. Most items also had red 'Fragile' labels.

The reality of the move came in stages. The removalists packing up the library books into 80 crates. Suddenly bare cabinets greeted me on my way to clean objects. Then the cabinets were moved to Chandos Street several weeks ahead of the rest of the office furniture. The museum display cabinets moved at this time too.

Finally the boxes overflowing in the boardroom and covering the table could be stacked neatly, ready for their journey. The former North Sydney museum space was now a depot for blue-grey archival boxes. The bubble wrapped items flowed across the floor, a strange take on presents waiting under the Christmas tree.

Each time I visited Chandos Street, the new museum and library slowly emerged from the shell from the building. A few walls, then recesses were filled with the library cabinets and museum display cases. A lick of white paint to the walls and a bold black ceiling gave the space dimension. Then suddenly, there was a large gently curving white wave for

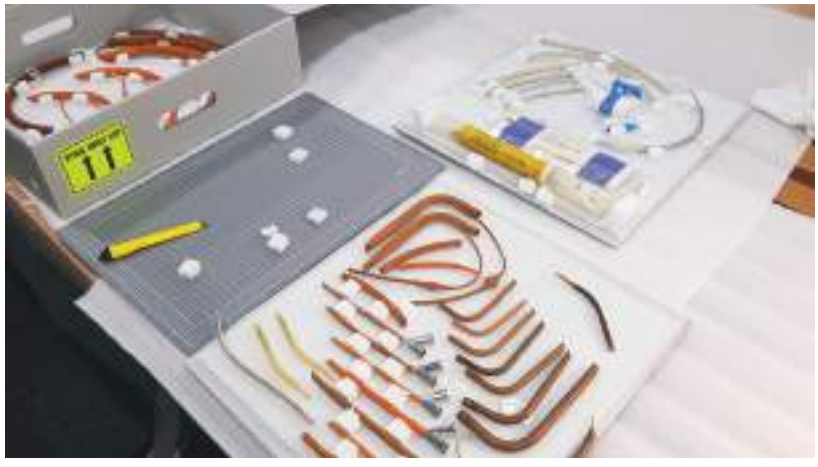
Below (left to right):
Packed and wrapped. A sea of boxes and bubbled wrapped items ready for the removalists.

A typology of mouth gags, cleaned and ready to be packed.

Items are packed by type with archival grade materials. Here squares of tyvek covered ethaform are used inbetween objects to safely space the items out.

Photos: Kate Pentecost.

Perry Hutchings uses a soft hake brush to clean gauge. Photo: Rhian Foster.



The new premesis ready to receive the collection.

open object displays greeting you as you entered. It was coming together, ready for the books and objects to arrive in mere weeks.

One Wednesday in mid-June, I asked Dr Reginald Cammack and Dr Michael Copper if I should be concerned about the emerging Bondi COVID outbreak. The news reports told me the case numbers were rising, but I didn't want to panic. We were heading into the final countdown to the move, just a few weeks to go.

The next week, Sydney was in it's second city wide lockdown.

I was extremely grateful for the help I had received from the staff members and HALMA committee in the previous months.

I was fortunate that moving a business qualified as a legitimate reason to come into the office under the lockdown rules. It is a bit challenging to pack up a museum from home. I stopped taking the train to work, and returned to driving, as I had done when I started at ASA the previous year, in the previous lockdown. The offices across the street were ghostly at dusk, lights on but no-one at their desks. There was less traffic noise and no one was in the lift. The radio helped keep the eerie vibes at bay.

The move itself was - considering the rapid lockdown changes and challenges - easier than expected. The removalists were a wonderful team, getting 80 crates of books, 70 boxes of museum objects plus the bubble wrapped items into level 1 Chandos Street without the aid of a lift (that would be installed a few weeks later).

With Sydney reopening, I'm looking forward to unpacking and in 2022, welcoming you to the new permanent exhibition. The library, archives and the museum are a great asset to the Society and hopefully will see many visitors, along with the new event and lecture space at Chandos Street. The new archive space is brighter and has precise climate control. Shortly, we'll be rephotographing the freshly cleaned museum objects to update the online collection and website.

But my final observation from this project is to always buy the good packing tape. It saves a lot of time and frustration.

Kate Pentecost

Curator

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GETINGE

INSIDE YOUR SOCIETY

AROUND AUSTRALIA

New South Wales

Dr Lan-Hoa Le
Chair of the New South Wales Committee of Management
NSWchair@asa.org.au

SUPPORT

WELLBEING FIRST

Peer support

Research tells us that peer support is an effective pre-clinical mental health intervention. We have NSW Committee representatives trained as peer supporters. We can also connect you with other peer support networks.

'Wellness on-the-fly' program

Research also has shown mindfulness incorporated into self-care strategies can reduce burnout syndrome, stress and anxiety. A valuable Wellness open forum in September has led to a series of 'Wellness on-the-fly' self-care strategy talks for busy people. To listen to the recordings, visit https://asa.org.au/wellness-resources/

SUPPORTING ANAESTHETIC DEPARTMENT LEADERS

Directors of Department Development Day (4D)

The NSW AMA Senior Doctor Pulse Check survey results have shown greater than two thirds of senior doctors do not feel valued by their hospital and only about 14% agreed that senior management at their hospital/LHD can be trusted to tell things the way they are. The survey also indicated that under-resourcing is the top driver of workplace stress. Hence, I believed that it was timely when ASA Public Practice Advisory Committee (ASA PPAC) *Online Directors' Discussion Forum* was initiated for our Anaesthetic Department leaders to network.

https://asa.org.au/asa-forum/forum/ppac-directors-forum/

The *4D* lunchtime workshop held on 26 October with Professor Guy Ludbrook gave a pitch on *Advanced Recovery Room Care and Economics for Leaders*, and Dr Donald Mackie presented on Managing Up from his experience as an Executive Director of Medical Services (EDMS) and Specialist Anaesthetist. Similarly on 29 November, the 4D workshop presenters included Dr Michael Cleary for his experience as EDMS and former president of the Royal College of Medical Administration, and Dr Tracey Tay for her pitch on the Implementation of Health Pathways program including from Wellbeing to Health Pathways.

SUPPORTING PROVISIONAL FELLOWS TRANSITION TOWARDS FELLOWSHIP

Part 3 Education & Networking Event

The combined NSW, ACT and Victoria Part 3 program on 27 November aimed to provide orientation and practical tips from senior consultants acting as mentors with new fellows walking alongside their peers as supports. Collegiality is a positive way to wrap up the year and congratulations to our provisional fellows!

REPRESENT

NSW Safe-Script

Previously known as 'real-time prescription monitoring' has commenced at two pilot regions in NSW. I encourage you to identify and share any concerns during the pilot period so we can advocate for improvement in its application since Safe-Script will roll out across NSW next year.

To listen to our short recorded webinar visit https://asa.org.au/webinar-library/

Public Patients in Private Hospitals (PIP)

There has been an increase success in remuneration negotiations but with minimal changes in work conditions. Members are encouraged to share with their peers and executives our ASA PIP Guideline : ASA+PS+23+Anaesthetists+and+Public-in-Private+Surgery+(PIP).pdf (amazonaws.com)

on safe model of care such as pre-op. assessment and pre- admission clinic from the LHD, separating the operating list to PIP only and an agreed after-hours cover or roster prior to accepting the service.

Remember that private hospital contracts vary and depending on the agreement, the remuneration can be less than working at a public hospital. We have sought legal advice which confirmed that groups of doctors could legally negotiate collectively with suppliers and customers. The

$10M aggregate turnover limit is applied per business. Furthermore a person or organisation outside the collective bargaining entity could act as a negotiator.

**The ASA Professional Issues Advisory Committee (PIAC) is providing a pathway for members:*

1. *For ASA to meet with members and outline the issues (patient safety in terms of referral, pre-op assessment, access to notes, after hours support and*

follow up, escalation and transfer back to the public hospital and remuneration);

2. *Attempt to meet with hospital Executive(s) to discuss and resolve the issues; and*
3. *If unsuccessful, ASA to apply for ACCC exemption for collective negotiation.*

There have been concerns from trainees regarding loss of anaesthetic training time. NSW AMA is advocating for reduction of elective surgery waitlists to be performed at the LHD so Registrars *do not further lose training experience*. Also they support PIP contracts to be temporary and from LHD rather than private hospitals.

Managed Care

Whilst medical specialists have been working hard to continue to deliver healthcare safely during the pandemic, some health insurers have been working to undermine the quality of the Australian Health System.This is based on a number of myths, used to justify increasing health insurance premiums.

The US has the highest GDP and Australia has the second lowest GDP. Despite spending the second lowest, we rank highest in terms of equity and health outcomes and 3rd best in the world overall. So shouldn't it be Australia that is to model the States rather than bring a Managed Care US-style to a country that believes in a fair-go culture?

ASA PIAC has for members a 'Myth-Busters Fact-Sheet' https://asa.org.au/managed-care/

The ACCC has approved the Honeysuckle/ NIB application to form a buying group. However, it was reduced from 12 months to 6 months before revision is required.

The ACCC has approved the formation of the buying group saying it is likely to have a public benefit by increasing competition - resulting in better service and pricing provided by buying groups to smaller private health insurers, who will then be in a better position to provide reduced premiums and improved services to consumers.

Major insurers have been excluded from the buying group, so Honeysuckle plans to target non-private health insurance providers such as transport accident compensation schemes, WorkCover and other government insurance agencies.

It is likely this will be an election issue with federal members of parliament.

COVID-19

ASA is advocating for PPE resources, rapid antigen testing (to assist with a quick return of workforce for vaccinated staff) and vaccine boosters for members to be consistent throughout NSW.

A letter and return correspondence from the Minister For Health and Medical Research was received upon our call for a workplace safe environment https://asa.org.au/workplace-safety-in-nsw-hospitals-updates/

SIRA Value-Based Healthcare

The State Insurance Regulatory Authority (SIRA) is working towards achieving value-based healthcare in NSW workers compensation (WC) and Compulsory Third Party (CTP) schemes. ASA and multiple peak bodies, medical and allied-health representatives have been involved with SIRA's workshops. We strongly advise SIRA to maintain consultation with healthcare providers as they develop the implementation plan for value-based healthcare in NSW WC and CTP schemes. I will continue to monitor their progress.

EDUCATE

2022 Education & Networking Events Calendar

A glimpse of what's coming includes NSW COM hosted *New Fellows forums, PPAC 4D, Approaching Retirement workshop* and '*Wellness on-the-fly*' events. Trainees education includes *exams preparation* and *NSW Members' forums* are on our standing agenda items!

The NSW Committee is interested in hearing your views on how we can further support our members. You're invited to express your interest in joining our Committee activities or just contact us for a chat and drop an email note.

Best wishes and stay safe in the coming summer break,

South Australia

Dr Tim Donaldson

Acting chair of the South Australian & Northern Territory Committee of Management

REPRESENT

Since the last publication we have farewelled Dr Brigid Brown from the chair position of the committee. She has been an innovative, energetic, and supportive leader for SA & NT. Thankfully she will continue on the committee as immediate past chair and we thank her for her excellent and on-going service. Unfortunately, due to COVID the AGM was unable to be held and as such I will serve as the acting chair.

We are also so proud and excited to acknowledge Dr Mark Sinclair being nominated and accepted as Vice-President for the Society. A very well-deserved accolade for the wealth of knowledge and incredible work he has done with the EAC members.

We also would like to thank Dr Ruth Barbour for her service as the Northern Territory representative on the committee, we welcome Dr James Corcoran in her place as she takes on more roles within the territory.

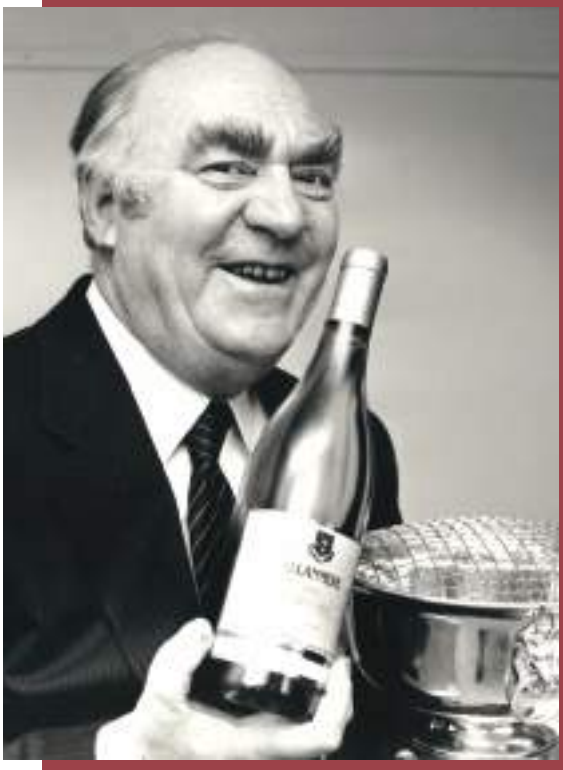
EDUCATE

Dr Sophia Bermingham has been instrumental in growing the state-wide SA Anaesthesia Wellbeing Network and will be holding and face to face wellness event for participants sometime this month.

Julia Rouse and the trainee committee held a very successful Part 0 course, which saw lots of interest from trainees in the work of the ASA and information/ resources available.

SUPPORT

We continue to support local members who are being approached for managed care contracts and we remain aware of national developments and the need for ongoing support and solidarity against the issues posed by our members.



NEWTON POTTER 1930–2021

Newton Potter died on September 1st, 2021 at the age of 91. He was well know in the anaesthetic world in the 1960s, 70s and 80s, as the director of Anaesthetics at the Women's Hospital, Crown St. Sydney and at Sydney Hospital.

He was born on 27 March 1930 near Newcastle upon Tyne, UK, and grew up in a small village called Highfield. Both his grandfathers were coal miners who encouraged his education, advising Newton to "Stick to school son, you don't want to have to go down pit like me". This advice he took and never forgot. However, he had a minor setback beginning grammar school (high school) and ended up in the bottom class, where to his great delight, wood working was taught, a skill he learned and never forgot and was still doing up until he died.

His academic skills very quickly improved and continued until he became dux of his school and received a university scholarship, a very significant achievement. Entry into university was delayed by National Service with two years spent in the Royal Army Medical Corps as a radiographer. This enabled him to skip 1st year and enter medical school at Durham University in 2nd year, graduating in 1955.

He represented both his army and medical school in hockey and rugby, although his great love was cricket. In later years, he and his wife Ginny never missed the January test at the Sydney Cricket Ground.

Friendship with a number of Australian Doctors at the Newcastle Royal Infirmary (NRI) convinced him to further his career in Australia, which meant a senior house officer job at the NRI where he worked with Dr Philip Ayre of T-piece fame. Newton said he was great to work with but spoke very little as he had a severe speech impediment due to a cleft lip and palate.

After arriving in Australia in 1957 as a ships doctor, he worked as a GP locum in Adelaide and country NSW and ended up in Newcastle 'on Hunter' on the suggestion of his friend John Marcus an obstetrician. He was appointed an Anaesthetic Registrar in the department under the then director, Dr Ivan Shallit. He soon passed his parts 1 and 2 in minimum time and became a full-time staff specialist in 1961.

Whilst at the Royal Newcastle Hospital (RNH) he became very involved in the early days of prolonged ventilation in Polio and Tetanus patients and in blood

He published a paper in the Lancet in 1970 with Rod MacDonald an obstetrician; 'The obstetrical consequences of epidural anaesthesia in nulliparous patients'. This paper debunked a lot of the myths associated with epidurals, and had significant impact, world wide.

gas measurements, the only hospital doing such measurements outside of the Sydney University Medical School. He then moved from RNH to Sydney Hospital as the Deputy Director in the department under Fred Berry. Soon afterwards, following the sudden death of Tony Paton, then Director of Anaesthetics at Crown St Women's Hospital, Newton was asked to supervise the anaesthetic registrars there and this resulted in the hospital board asking him to take over the position as director.

Crown St became an important part of Newton's future. He met his wife Virginia (Ginny) there and had a significant influence in the training of registrars from Sydney hospital and also St. Vincents, in the skills of obstetrical anaesthesia and the early days of epidurals for pain relief and for caesarean sections.

He published a paper in the Lancet in 1970 with Rod MacDonald an obstetrician; '*The obstetrical consequences of epidural anaesthesia in nulliparous patients*'. This paper debunked a lot of the myths associated with epidurals, and had significant impact, world wide.

Besides being very busy with his clinical duties, and his family, Newton became involved in the NSW section of the ASA and became State Chairman in 1975–76. This was a particularly political time as Medicare had just been introduced and the society was fortunate to have such a capable leader.

However, by the late 70s, now with two children with Virginia and two from a previous marriage, the family decided to move to the country. A chance meeting with an old friend, Owen James who was the director of anaesthetics at the RNI, saw Newton offered three days a week in the department, which would include both theatre and teaching. The latter, in particular to improve the exam success of the registrars, which happened almost immediately under Newton's influence.

So with 140 acres in the Lower Hunter, a new episode in the Potter family's life began. He ran cattle, planted grapes and within a few years, in 1986, as a self taught wine maker "Allanmere" as the winery was known, was the most successful exhibitor in the small vineyard class at the Hunter Valley Wine show, with four gold medals.

Newton then moved from Anaesthetics into medical administration and was successful at that also, with his great ability to sit down and negotiate problems as though they were mathematical and always find a solution. In 2003, with the family grown up, he moved with Ginny to Nulkaba, near Cessnock and helped build their retirement home. This enabled him to build the ultimate 'Men's Shed' and reignite his passion for woodwork. He joined a group called 'Wood Turners of the Hunter' and spent many hours making professional quality furniture and in later years beautiful small boxes which many of his friends cherish dearly,

The ultimate box he made was his coffin, which he called a 'burial box' and he even included a set of instructions with glue and screws for the undertaker.

He was very close to his family and very proud of his daughters Victoria and Katey.

Newton was truly a man for all seasons. He was a great story teller and with his 'geordie' accent, he could discuss and debate on any subject.

Often he would hold his tutorials to students and registrars in a back room at the Dolphin Hotel opposite the hospital in Crown St.

He said his great loves outside his family, were the 3 Ms: Medicine, Music and Mathematics and he had a well-thumbed copy of Isaac Newton's '*Philosophiæ Naturalis Principia Mathematica*' (Mathematical Principles of Natural Philosophy), in his extensive library.

Our thoughts go to Ginny, Victoria who is in London, Katey and Barbara.

In particular I would like to acknowledge the help both Ginny and Katey have been, with providing information for this brief biography of the life of Newton Potter.

Dr John McGuinness ■

NEW AND PASSING MEMBERS

The ASA would like to welcome all new members from 26 July to 21 October 2021.

ADVANCED/PROVISIONAL FELLOW TRAINEE

Dr Fabio Longordo	ACT
Dr Saman Ali	ACT
Dr Brendon Jonathan So	NSW
Dr Jing Wang	NSW
Dr Timothy Webb	NSW
Dr Rebecca Anne Martin	QLD
Dr Rosie Herrmann	QLD
Dr Sean Morrow	QLD
Dr Heidi Helene Graham Thies	VIC
Dr James Edward Roth	VIC
Dr Megha Kohli Kohli Mehrotra	VIC
Dr Sophia Grobler	VIC
Dr Victoria Ward	NSW
Dr Chantelle Willard	NSW
Dr Tessa Louise Jessica Finney-Brown	QLD
Dr Brendan Goodwin	QLD
Dr Robyn Julie Ison	QLD
Dr Catherine Mason	QLD
Dr Sean Morrow	QLD
Dr Munro Brett-Robertson	SA
Dr Shaun Campbell	SA
Dr Christopher Edwards	SA
Dr Ravindran Samuel Nathan	SA
Dr Rawaf Albarakati	VIC
Dr Grace Andrews	VIC
Dr Mark Gerard O'Donnell	VIC

ASSOCIATE INTERNATIONAL MEDICAL GRADUATE

Dr Amirhossein Dehghanian	VIC

INTRODUCTORY/BASIC TRAINEE

Dr Jared Ellsmore	NSW
Dr Laura Jayne Noble	NSW
Dr Mariam Habib Awad	NSW
Dr Andy Ngoi	QLD
Dr Joanna Hui Li Yu	QLD
Dr Cassandra Driscoll	SA
Dr Matthew Bolt	SA
Dr Matthew Douglas Fischer	SA
Dr Richard Sexton	SA
Dr Lauren De Koning	VIC
Dr Ryan Adams	VIC
Dr Yannick Leon Roosje	VIC
Dr Annica Bester	WA
Dr Daniel Gillespie	QLD
Dr Abir Guha	QLD
Dr Robert Thomson	QLD
Dr Hannah Marie Woodcock	QLD
Dr Terence Guan Hui Kwok	TAS
Dr Abram George Boules Botros	VIC
Dr Lauren De Koning	VIC
Dr Christie Farag	VIC
Dr Mason Ross Habel	VIC
Dr Hamish Westcott Lanyon	VIC
Dr Andrew McNiece	VIC
Dr Christine Shanahan	VIC
Dr Marcus Jia-Sheng Yip	VIC
Dr Elizabeth May Carr	WA
Dr Emily Catherine Scott	WA

ORDINARY MEMBER

Dr Andrew Peter Lindberg	NSW
Dr Catherine A. Hawke	NSW
Dr David Aladar Milder	NSW
Dr Karishma Maharaj	NSW
Dr Nikitha Vootakuru	NSW
Dr Ram Mohan Nallamankalvva Reddy	NSW
Dr Sophie Joy Klaassen	NSW
Dr David Thomas Highton	QLD
Dr Julia McCallum	QLD
Dr Leanne Kerry Ryan	QLD
Dr Sarah Bowman	QLD
Associate Professor Laurence Weinberg	VIC
Dr Irfan Ul Hassan	VIC
Dr Jane Christy Carter	VIC
Dr Jayakumar Rangaswami	VIC
Dr Peter Joseph Bainbridge	VIC
Dr Sam Walsh	VIC
Dr Shashikanth Manikappa	VIC
Dr Kiara van Mourik	WA

PMET

Dr Jacob F. Corlis	NSW
Dr Pooja Shayna Sharma	NSW
Dr Calum Watson	QLD
Dr Alasdair Vu	VIC
Dr Bobby Ou Yang	VIC
Dr Nathan Hanegbi	VIC
Dr Phoebe Ulrick	VIC
Dr Tom John Leslie Neal-Williams	VIC
Dr Jacob F. Corlis	NSW
Dr Pooja Shayna Sharma	NSW
Dr Calum Watson	QLD
Dr Alasdair Vu	VIC
Dr Bobby Ou Yang	VIC
Dr Nathan Hanegbi	VIC
Dr Phoebe Ulrick	VIC
Dr Tom John Leslie Neal-Williams	VIC

IN MEMORIAM

The ASA regrets to announce the passing of ASA members

Dr Newton Potter	NSW
Dr Dorothy Flora Moody	VIC
Dr John Joseph O'Leary	WA
Dr Nicholas Keely	WA

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

SAVE THE DATE

21-24 October 2022

WELLINGTON, NEW ZEALAND

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COMBINED SCIENTIFIC CONGRESS
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21-24 OCTOBER 2022

INTERNATIONAL INVITED SPEAKERS


Prof. Denny Levett


Prof. Steven Shafer


Prof. P.J. Devereaux

INVITED SPEAKERS


Dr Tony Fernando


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