AUSTRALIAN
# Anaesthetist
THE MAGAZINE OF THE AUSTRALIAN SOCIETY OF ANAESTHETISTS • DECEMBER 2020

## THE YEAR IN REVIEW – IMPACT OF COVID-19

- 2020 on 2020: Presidential reflections on the ASA COVID response
- How did 2020 impact ASA membership?
- Nimble and focussed: the keys to advocacy in the pandemic
- Remote representation: How the ASA staff left the office behind in 2020
- The fourth ASA COVID-19 survey
- Experiences during the pandemic: rolling out a comprehensive half-faced powered air purifying respirator program during the 'second wave'

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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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## REGULARS



## FEATURES

# 14 PRESIDENTIAL REFLECTIONS ON THE ASA COVID RESPONSE


## INSIDE YOUR SOCIETY



### 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 8 January 2021.
- Final article is due no later than 18 January 2021.

All articles must be submitted to editor@asa.org.au. Image and manuscript specifications can be provided upon request.

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# EDITORIAL FROM THE ASA PRESIDENT

DR SUZI NOU
ASA PRESIDENT

2020. It used to be an expression of visual clarity. When used in hindsight, it would imply that we had a full and complete understanding of past events. 2020 will now be permanently etched in our memories as the year that the COVID-19 pandemic reared its global head. A year where we faced anything but clarity in our work, health and ways of relating to each other. Coming to the end of 2020, it is a time to reflect on the year that has been. Unfortunately, I am not certain that we can do this with the clarity of 2020 hindsight as the world is still rapidly changing around us (I write this ahead of the US election) and many of this year's behind-the-scenes efforts are yet to see the light of day. Dogma in modes of transmission and PPE guidelines are still being debated and new work processes implemented. One thing is for certain, and that is that SARS-CoV-2 will live amongst us, at least for the foreseeable future.

This edition focuses on the work of the ASA during this 'annus horribilis' as it is probably one area in which we do have some clarity. ASA Policy Manager, Jacintha Victor John highlights some of the advocacy work undertaken by the ASA this year. She reminds us of the sudden change of pace in decision making, scheduling of meetings and preparation of resources for members that occurred in March. Whilst it was hard work and at times difficult and uncomfortable, I am also reminded of the many benefits from our advocacy work this year. For example, we have strengthened relationships with key stakeholders nationally as well as at state level.

In order to best represent our many members, it was important for the ASA to be continuously scanning our environment and trying to best gauge what would be in the interest of members. Another approach is to ask directly, and that is what we did, not once but four times. Thank you to all who responded, particularly the many Victorians who responded to the final survey as they were recovering from the second wave. Thanks to Specialty Affairs Advisor Jim Bradley and Patrick Gifford for preparing the surveys throughout the year and the article in this edition.

Executive Councillor Nicole Fairweather provides insight into some of the changes to our membership processes this year. Recognising that many were joining to access our varied resources, we streamlined approval of new members. What Nicole neglects to mention is her own hard work! Many thanks to Nicole and the ASA membership team for supporting new and current members this year. A common question that I am asked when I first meet with external stakeholders is how many members we represent. I wholeheartedly agree that there is "real safety and power in numbers".

We wouldn't be anaesthetists if we didn't mention patient safety at least once in this 'year in review'. Thanks to Edward Murphy for providing an update on the Australian Standard for electrical safety. It is reassuring to know that we still consider all aspects of patient safety, not just those related to COVID.

It also wouldn't be a proper review of 2020 if we also didn't include mention of PPE. Thanks to Rob Wengritzky, Chris O'Loughlin and Leo Cordova for sharing their experience of implementing the CleanSpace HALO powered air-purifying respirator into their operating theatres at Frankston Hospital in Victoria. What impresses me with their efforts is the speed with which full implementation was achieved and the bringing together of many entities: the Department of Health and Human Services (DHHS), CleanSpace, nurses, CSSD staff, surgeons and even the engineering department. If we are to move quickly and effectively when implementing any new technology and particularly in response to COVID-19, we need to do it together.

Speaking of a team who worked incredibly well during trying circumstances one can't help but consider the staff in the ASA virtual office. Jacintha's hard work was indicative of the hard work from all of the ASA staff this year. We pay particular tribute to IT Manager Paul Singh and Administration and Executive Events Officer Molly Jinta who worked tirelessly behind the scenes as we ramped up our work in response to the pandemic. As we congratulate the ASA staff and delve into their experiences of working from

home, we also share some good news and congratulate ASA Events Coordinator Jade Melville on the birth of baby Ayda!

As we approach the festive season and our end-of-year traditions, we thought we would also continue the December Australian Anaesthetist tradition of sharing highlights from the National or Combined Scientific Congress. Given that we did not host one in 2020, we thought to indulge in some of the highlights from years gone by when we could meet and mingle more freely. I hope you take a moment to reminisce good times and share some optimism that we'll be meeting again soon.

I wish you and your family a wonderful festive season and hope that you still enjoy the best of your traditions in our transformed world. I hope you'll join me in a prayer or dance to the vaccine scientists, Gods or other ethereal beings that a vaccine is forthcoming soon.

Have a safe and wonderful Christmas and New Year.

**CONTACT**

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

# 2021 ASA MEMBERSHIP

Thank you for your ongoing support of the **Australian Society of Anaesthetists (ASA)**.

We continue to implement the ASA's vision of **'supporting, representing and educating'** members to enable the provision of safe anaesthesia to the community.

You would have received your 2021 membership invoice by early December. If you have not received yours, please contact the **Membership Services Team** by email **membership@asa.org.au.**

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# ASA UPDATE FROM THE CEO

MARK CARMICHAEL, ASA CEO

**When preparing this article in mid-October, I took the opportunity to look back at this same time last year, as a way of seeing what had occurred and how that compared to 2020.**

At this time in 2019 we had just finished a hugely successful National Scientific Congress in Sydney, had hosted an equally successful Common Issues Group (CIG) meeting just prior to the Congress and had welcomed Dr Suzi Nou as the 46th President of the Society. We were looking forward to having a presence at the 2020 World Congress in Prague in September, at which our American friends were going to host the 2020 CIG. Following on from that the Combined Scientific Congress with our New Zealand colleagues in Wellington scheduled for October, was shaping up as a first class meeting, and one many members were planning on attending.

Twelve months on the world, due to COVID-19, is as we know a very different place. The World Congress has been rescheduled hopefully to September 2021, as has the CIG, although there have been some Zoom meetings of delegates to keep things moving. The Combined Meeting in Wellington has been placed in 'hibernation' and will be held in October 2022, thus ensuring the great work of the Organising Committee is not lost. Fortunately Dr Nou remains as President, and has, during this unsettled time provided strong leadership to the Society.

During this year a number of things have occurred which under different circumstances may well have resulted in slightly different approaches. A case in point was the awarding to Dr Christine Ball AM and Dr Rodney Westhorpe OAM AM and past ASA President, of the Ben Barry Medal, for their outstanding contribution to the ASA's scientific journal, *Anaesthesia and Intensive Care*. This award was announced in 2019, and it was hoped that it could be presented to both recipients at a suitable occasion. Alas, no such opportunity has been possible, and graciously both Dr Ball and Dr Westhorpe were happy to receive their medals by post, with both writing extremely warm letters of thanks.

A second event, unfortunately a sad one, was the passing of South Australian past president Dr John Richards. Dr Richards was President from 1990-92, and at the 2018 Adelaide Scientific Congress was guest speaker at the Past Presidents Dinner staged as part of the Congress. Dr Richards entertained the gathering with some wonderful anecdotes of past ASA happenings, which brought smiles to the faces of those present. As is common in these COVID-19 times, travel restrictions meant that many friends and colleagues were unable to attend his funeral service in person, and as is the way of COVID, it was live streamed, allowing many friends from interstate to be present. The Society wishes his wife Etelka and his children every comfort during this difficult time.

So where do we go now? At the time of writing, the number of COVID-19 cases in Australia overall appears relatively low, with Victoria appearing to gain some form of control from the July/August outbreaks, although NSW was showing signs of some small outbreaks which would require attention. I dare not predict what things will look like by the time this edition reaches you, other than to say I hope the number of cases remains low.

The ASA, through its advocacy by President Dr Nou in particular, has tried to position the Society on a number of COVID-19 related issues including fit-testing and PPE. This has not been easy, and not everyone has agreed with the position of the ASA, however, it is fair to say that the ASA has been seen as a voice of reason in most debates and as such is invited to contribute.

At a more personal level the Society is very aware of the difficulties experienced by some members during the year. In recognition of this the Board decided that it would keep membership subscriptions at the same level for this year as last. In making this decision the Board is optimistic that members will appreciate this consideration and continue to support the Society.

This year has been a particularly difficult one for trainees. To all the trainees please know you have the support of the Board, Council, the membership at large and all of the ASA staff. A word of encouragement to our colleagues at ANZCA who have worked tirelessly to manage all of the problems associated with trying to deliver the exams, well done.

The secretariat remains working remotely. For how much longer we do not know and are guided by the directives of the NSW Department of Health, and the Chief Medical Officer. Suffice to say a big thank you to all the staff who have made every effort to ensure that services are delivered without interruption or delay.

Like everyone we hope that 2021 will be a positive year. We are looking forward to a face-to-face National Scientific Congress in Cairns in October and we do hope that many of you will take the opportunity to come together after what has been a most unusual year.

**CONTACT**

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*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, 2021.

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 2021.

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 2020. Applicants will be notified of the outcome of their application by mid-January 2021.

Kind regards,

A/Prof John Loadsman

**Chief Editor, Anaesthesia and Intensive Care**

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# LETTERS TO AUSTRALIAN ANAESTHETIST

## WHO GUARDS THE GUARDIANS?

What a good topic to air: ageing, competence, planning and timing. It is worth raising from time to time. These were my thoughts over a decade ago, which the *AMJ* saw fit, and had the grace to publish, and is reproduced below:

> Sed quis custodiet ipsos custodes?
> *(Who guards the guardians?)*
>
> *Adler and Constantinou raised a concern about the ageing doctor[1] that also worried me when I was practising as an anaesthetist. The same concern was raised recently in the* Australian and New Zealand College of Anaesthetists Bulletin.[2] *In anaesthesia, decisions and actions have to be made in seconds and minutes, rather than days and weeks, and maintenance of standards is very important. Doctors practise largely in isolation, and may not be aware of their standard failing against the general standard. Operating theatres offer both an opportunity to observe the practice of others and a conduit for information on colleagues – nursing and medical.*
>
> *I used this opportunity in private and public practice by asking younger colleagues, one in each, to be my 'buddy', as in diving safety. They were asked to keep watch for any rumour of my declining standards and to report it to me. We would then discuss what to do: retrain or retire. The latter became more of an option the older I grew.*
>
> *This strategy opened up pathways. One was that the buddy was given the authority to approach me on the topic. Another was that I was open to the idea that my ability could diminish, while a third was that the hostility, so often seen in this setting, was abolished. I would rather be tapped on the shoulder by a sympathetic colleague than a medical board, a hostile stranger or a vindictive prosecution lawyer.*
>
> *In the end, there was no tap on the shoulder and I went because I had had an enjoyable and rewarding career and could afford to retire. This allowed succession planning in both areas, public and private, and a younger colleague could embark on a similar path.*
>
> 1. Adler RG, Constantinou C. Knowing – or not knowing – when to stop: cognitive decline in ageing doctors. Med J Aust 2008; 189:622-624.
> 2. Carr G. Ageing issues [letters]. ANZCA Bull 2008; 17 (3 Oct):4.

Dr Cammack does not want a tap on the shoulder from a colleague, but if one gives permission, it is welcome.

Also, my sentiments about the ASA echo in the anonymous letter exactly, in the same issue of *Australian Anaesthetist*.

Dave Fenwick
Adelaide, South Australia

## MULTIPLE CHOICE QUESTION BANK

Despite having retired 13 years ago at the age of 70, I found the September issue of *Australian Anaesthetist* a wealth of interesting and well conducted research and historical comment. I was particularly interested in the article by Dr Viliunas about the Final Examination Improvement Clinic and specifically her comments about the Multiple Choice examination.

From 1974 to 1986 I was a member and one time chair of the Panel of Final Examiners of the Faculty of Anaesthetists RACS. During that time and with Dr Arthur Woods FFARACS, I inherited care of the Multiple Choice Question bank. The questions and their history of performance were typed on Hollerith type cards with a series of holes punched around the edge of the card, each open hole or series of open holes identifying a specific question topic or other useful information.

The cards, in a locked metal box which also contained a pointed skewer with a wooden handle and a clipper device to open the edge holes, were handed over to me by Dr Herb Newman, a retiring examiner. To select a particular card or cards they were stacked together, the skewer was passed through the stack at the appropriate hole, lifted up and the selected cards which were left behind could then be checked for question content.

In 1978 the Department of Anaesthetics at the Royal Women's Hospital, Melbourne bought, from departmental funds, a Hewlett Packard 9845S desktop computer and an impact printer together with an eight inch Hewlett Packard disc drive. It was a case of write your own programs! We decided to create an automated anaesthetic reporting system and Dr Craig Morgan and I, with the help of a professional software company achieved this. This program allowed the production of monthly activity reports to be provided for each anaesthetist.

The next task was to write a program to manage the multiple choice question bank. The computer used HPBasic programming language which was relatively easy to master. We needed to purchase two more eight inch disc drives.

After nine months the program was written, tested, the content of the MCQ cards was entered and the first MCQ test paper was successfully printed and delivered to the examination secretary at the Faculty.

After each examination the MCQ answer sheets were sent to a facility at a Sydney university where they were scanned and marks were allocated. Additionally statistics about each question's performance in the examination were provided. For instance questions which every candidate got right or all candidates got wrong were essentially useless. After each examination Dr Arthur Woods and I met, examined the status of each question and where necessary amended, rewrote or deleted the question. We also created a steady stream of new questions.

I have no knowledge of the current management of the College MCQ bank.

One point which I made to every candidate at information sessions prior to the final examination was that if, whilst doing the MCQ you cannot find an answer to a particular question, spend no more than thirty seconds thinking about that question, but go on with the next lot of questions. When you reach the end, go back and look at each of the questions you could not answer and in the majority of cases your subconscious brain will have searched your memory bank and identified the correct answer.

When I retired from the RWH in 1990 I donated a printed copy of the MCQ management software to the College Archive. I hope this is of some interest to you.

John Paull
Lanena, Tasmania

## HAVE YOUR SAY

We would love to hear your feedback on our magazine and its content. All letters are welcomed and will be considered for publication. The Medical Editor reserves the right to change the style, shorten any letter and 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 us at editor@asa.org.au to submit your letter.

# WEBAIRS NEWS


## Cardiovascular incidents during anaesthesia among the first 8,000 reports to webAIRS.

ANZTADC reached an important milestone in May 2020 with 8,000 reports submitted. A breakdown of the main categories is shown live on the webAIRS website and the results for the first 8,000 are shown in the table below.

| Main category | Percent |
|---|---|
| Respiratory/Airway | 29.4% |
| Medication | 16.5% |
| Cardiovascular | 16.1% |
| Medical Device/Equipment | 11.3% |
| Neurological | 5.8% |
| Assessment/Documentation | 4.7% |
| Infrastructure/System | 4.6% |
| Other organ | 2.0% |
| Miscellaneous/Other | 7.5% |
| Not specified | 2.2% |
| **Total** | **100%** |

Interim results of first 8,000 reports shown as a percentage.

The most common category of the incident reported was respiratory and airway (29.4%). A detailed analysis of difficult and failed intubations among the first 4,000 reports has been accepted by the peer reviewed journal *Anaesthesia and Intensive Care (AIC)*, and should be published by December 2020. A further analysis, which includes the respiratory and airway events amongst the first 8,000, is also currently underway. The second most frequent category was Medications (16.5%). The anaesthetic incidents relating to medication amongst the first 4,000 reports have been analysed, and a paper is in the process of being submitted to *AIC* for peer review.

Critical incidents involving the cardiovascular system were the third most common category and are an important cause of anaesthetic morbidity and mortality. A selection of cases to illustrate examples of the above categories have been added to the ANA – Alerts on the webAIRS website. To view the latest ANA-Alerts go to the webAIRS website and login or register at https://www.anztadc.net

A formal systematic analysis of the incidents listed above is currently being planned. This will include a narrative search using key words and an automated database search to return additional reports that may be relevant. The narrative search will augment the original coding by the reporters that is shown in the table on the right. Data cleansing will also be performed to cross check that the reports were correctly coded by the original reporters. These additional checks might result in small changes to the percentages shown.

At present we have a small number of teams analysing the incidents and ANZTADC is looking for more analysers and teams to assist with this analysis. Although the number of reports in each main category is high, each individual subcategory associated with the main categories has a smaller number of reports usually numbering between 100 and 300. All the reports are already codified according to the following parameters, which assists in the analysis. To view the full dataset collected visit https://www.anztadc.net/demo/IncidentTabbed.aspx and select all of the tabs on the web page.

The ANZTADC Publications group is looking for volunteers to assist with the analysis of the data. The volunteers will be formed into teams to analyse the various subcategories. Please contact anztadc@anzca.edu.au to register your interest and indicate the main category that you are interested in analysing.

| Sub-category cardiovascular | Percent |
|---|---|
| Other (including anaphylaxis) | 22.90% |
| Arrhythmia (other than cardiac arrest) | 19.70% |
| Hypotension | 17.90% |
| Cardiac arrest | 16.00% |
| Myocardial Ischaemia/ Infarction | 7.00% |
| Blood loss | 7.40% |
| Embolism | 3.10% |
| Hypertension | 2.80% |
| Cardiac failure | 2.10% |
| CVS trauma (unintentional surgical) | 0.60% |
| Disseminated Intravascular Coagulation | 0.20% |
| Electrolyte/Metabolic disturbance | 0.20% |
| **Total** | **100%** |

Interim results of the subcategories of the cardiovascular reports amongst the first 8,000 reports shown as a percentage. Please note that the figures above are approximate and might change slightly because of data cleansing during the detailed analysis that will be performed by ANZTADC before final publication.

# SPOTLIGHT ON CONSENT

## The challenge of patient consent

**Clinicians do not set out to deliberately cause harm to patients, but occasionally unexpected issues and avoidable deaths do occur. According to Human Factors Specialist and Consumer Representative, Dr Graham Beaumont, the reasons are often reported in the literature to be the result of poor decision making.**

Dr Beaumont has been working in the area of healthcare safety for more than 20 years, as a member of the Clinical Excellence Commission, Collaborating Hospitals Audit of Surgical Mortality (CHASM) and the ANZ Audit of Surgical Mortality Committee.

"Surgeons themselves report that the decision to operate is the most complex and testing aspect of their professional life. If this is the case, then sharing the decision making with other professionals through referral to peers or multi-disciplinary teams should ease the burden and produce more reliable decisions," Dr Beaumont explains.

"Regardless, the consenting of patients is integral to any decision to operate, yet the evidence suggests that patients are often not included in the process to the extent that they should be."

The process of obtaining consent is something that surgeons and anaesthetists learn on the job, rather than being taught formally, Dr Beaumont says. And that can be problematic. "There appears to be no formal approach that is consistent when it comes to teaching clinicians how to consent patients."

"While other high-risk professions have mandated decision making training and the testing of learning, surgeons rely heavily on the apprenticeship model to arm trainees with the required decision-making skills and knowledge."

## Consent relies on clear communication

**Dr Graham Beaumont**
**Human Factors Specialist**

Surgeons and anaesthetists cannot guarantee outcomes, says Dr Beaumont, whose doctoral research concerned human factors in real-time scenarios. "What they can do is establish a reasonable expectation of an outcome, and patients are consenting to that reasonable expectation."

"However, in many cases, the patient does not necessarily understand what is going to happen to them in full, does not really appreciate all the risks that might be applicable, and may feel obliged to give consent in the face of ignorance."

Consent is a shared decision-making process between the surgeon and patient, and surgeons need to ensure that the patient is able to clearly understand the information given to them, Dr Beaumont says.

Obtaining anaesthetic consent from patients immediately prior to surgery in the preoperative area can also be problematic. At this late stage, they are anxious or may already have been given medication that inhibits decision making.

There needs to be more training for surgeons in terms of communication, the words they use, the way they ask questions, and how they listen to the patient's story, Dr Beaumont says, without the pressures of time.

"Surgeons are very busy people, but that doesn't take away the obligation to help the patient understand what is intended, so the consent that's given is meaningful."

## Expanding the role of anaesthetists

When it comes to consent, anaesthetists could be viewed as the last line of defence, but they need closer involvement in the decision-making process, Dr Beaumont says.

"In order for anaesthetists to provide this quality control function, their consenting processes and professional judgement need to function as an integral part of the decision to operate process. That should occur closer to the beginning of the patient journey, rather than outside the theatre doors.

"That would require a full assessment of the patient before they are given any anaesthetic drugs, and a conversation with the surgeon if it is deemed surgery is problematic because of frailty or comorbidities, particularly near end-of-life where improved quality of life is difficult to define.

Anaesthetists would need to be just as informed as the surgeon as to the likelihood of a successful outcome."

Harnessing all available resources is a cornerstone of safe systems, explains Dr Beaumont. There is no doubt that expanding the decision-making team to meaningfully include patients and anaesthetists will help surgeons make consistently better decisions and avoid unfavourable outcomes.

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Australian ASA members can access significant savings with a single SimSTAT module for US$175 (list price $350) or the module 1-5 bundle for US$735 (list price $1,575).

Contact **events@asa.org.au** for the ASA discount code and check **www.asahq.org/simstat** for the modules available.

American Society of Anesthesiologists™

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ASA
Australian Society of Anaesthetists

REGULAR

# DAY CARE ANAESTHESIA OUTCOMES: DAYCOR REGISTRY II

## www.daycorregistry.com.au

DayCOR has now obtained Human Research Ethics Approval from Bellberry Ltd who provide private HREC approvals.

In the present climate and forward into the post COVID-19 era, it is becoming more important to have the best indications of post discharge progress for all our day care cases:

- We have now surveyed almost 90,000 patients, mainly at the Epworth group of hospitals and at Sunshine Coast University Private Hospital.
- We have an 87% response from adult patients.
- 96% response from parents of children (mainly ENT cases).
- Older patients, often with multiple co-morbidities, recover very well with day care management.
- Variance requirements of National Safety and Quality Health Standards are fully met.

## CHANGES IN CARE

Total Joint Arthroplasty is being seriously considered as a day case procedure and orthopaedic surgeons are taking up the cudgel.

Patient Selection. Clearly there are a number of points to be considered and recently some risk assessment and prediction tools have been published.[1,2] They are beyond the scope of this newsletter today, suffice it to say that your surgeons will obviously be discussing it, if they haven't already.

The important point is that we can provide a survey for you to include all the questions required for these cases.

## THE FUTURE

Although the pundits are now predicting a fall in our population, there is no doubt that Australians are living longer and therefore needing more medical care.

Considering the current aged care residential situation:[3]

- Just 15% of Australians trust the aged care industry.
- Significant increase in those between 50 and 70 are considering in-home aged care services.
- More than two in three people using aged care service do not trust it.
- Even higher numbers of family members and people not engaged in the sector.
- 74% of Australians want the government to focus on ensuring people can stay in their homes.
- This reform cannot wait.

Accordingly, there is every likelihood that more elderly patients will be cared for at their home, or with their family. It would follow that a larger percentage of the elderly would be encouraged by carers and their family to seek medical care.

It is a sad fact that patients in aged care facilities appear to often be ignored. The number of deaths in aged care this year has fallen. One could surmise that the care has improved, but this is a side issue when one hears that the elderly are far keener, where possible, to apply for a Home Care Funding package.

At any rate, the issue of frailty becomes most important.

Chan et al in a recent review[4] observed the increasing provision of anaesthesia for elderly patients. The elderly have a more propensity for comorbidity but a decline in physiological reserve and cognitive function which can substantially impact peri-operative outcome and the quality of recovery.

Frail patients frequently attend for skin cancer removal, for diagnostic procedures and for prognosis of gastrointestinal, urological and gynaecological cancers. Quality of life is most important and there needs to be:

- Optimisation of their nutritional and medical status.
- Understanding of their cognitive state.
- Assessment of the home situation and reliability of the family/carers.
- Careful counselling and discussion of the desired outcome.

These cases can be performed if the patient can be managed at home by family and carers, supported by the DayCOR survey 24 hours post discharge.

Dr Ken Sleeman
*Chairman and Clinical Director*
*DayCOR Registry II Ltd*

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3. 'Trust in aged-care system dwindling, say survey', *The Australian* 16/09 p.5.
4. Chan SP, Ip KY, Irwin MG. Peri-operative optimisation of elderly and frail patients: a narrative review. *Anaesthesia* 2019, (Suppl.1), 80-89.

FEATURE


# 2020 ON 2020

## PRESIDENTIAL REFLECTIONS ON THE ASA COVID RESPONSE

The COVID-19 pandemic this year put a new spotlight on the role of anaesthetists at the frontline of critical care. ASA President Suzi Nou spent much of 2020 squarely in that spotlight as she advocated for the health and safety of our members and the healthcare workforce in general.

Anaesthetists are often the most overlooked specialists in the operating theatre and some of our colleagues jokingly refer to it as the 'Cinderella specialty' but this year has heralded a dramatic change. The public and the media have a newfound appreciation of our role and the ASA quickly became one of a handful of go-to medical organisations for comment on the health response to COVID-19 in Australia.

I was made acutely aware that the world was developing a new understanding of anaesthetists when one of our number graced the cover of *Time Magazine* as a frontline hero in April. All the discussion around ventilators and intubation in treating COVID patients put the focus well and truly on anaesthetists very early in the pandemic. This presented a powerful opportunity for the ASA to play a role in raising that profile even further.

When the ASA was formed 86 years ago we were one of only four medical organisations in Australia with the founding goals to represent Australian anaesthetists, facilitate the exchange of ideas with overseas organisations, support research in anaesthesia, and to publish the journal.

We continue with those same goals to this day and have distilled them down to the ASA being here to 'Support, Represent and Educate' and our experiences during 2020 have highlighted exactly how the ASA fulfils this role.

The work of the ASA on behalf of our members and our specialty has shown that even during a pandemic, or perhaps especially during one, we have confirmed and enhanced our commitment to support, represent and educate Australian anaesthetists.

### REPRESENT

I can vividly recall the level of concern amongst our colleagues in early March as the number of COVID-19 infections were increasing rapidly around the world. These concerns were not just about how to care for COVID patients but about our own personal physical safety.

Since then the ASA has spoken up for the safety of anaesthetists like never before. We were one of the first voices to call for a postponement to elective surgery so that we could adequately prepare and we have continuously sought improvements in the recommendations for PPE at national, state and hospital level as well as providing practical solutions such as organising fit-testing for members.

The ASA has been incredibly vocal this year in our fight to protect healthcare workers and while there has been slow progress in many states to address issues like fit-testing I think it is a testament to our advocacy efforts that we have been included on the DHHS Healthcare Worker Infection Prevention & Wellbeing Taskforce in the epicentre of the second wave in Victoria. This is just one example of our progression in getting a seat at the table on issues that impact our members.

In hindsight it was fortuitous that I had planned to cut down on my clinical time in 2020 so that I had the capacity to focus on the ASA President role – who would have guessed exactly what that could entail this year! It was also lucky that I had planned something like nine weekends in a row of travel in the early part of the year, which was cancelled of course, as that also gave me the extra time needed at the start of the crisis to really get things in motion for the enormous workload that was about to hit us all.

We gained significant media presence for the Society and indeed for the specialty over this time. It was fortunate we appointed a Media and Communications Advisor late last year. I am not naturally one to court the media, but I am indebted to Cindy Jones for her support and encouragement. For many months her days were shaped by the morning press conferences in every state and the rolling coverage of the pandemic which put us in the position to respond quickly. There were times when the ASA's response to a government announcement was published in the media, quoting yours truly, before the Prime Minister had even wrapped up his presser!

# Anaesthetists call for strong action

Australia's health system is auditing its critical care capacity and ability to cope with the deadly coronavirus pandemic.

Anaesthetists — the medical professionals with respiratory expertise — have voiced concerns for more than a week that the system will not cope with the virus and ramping up of elective surgery at the same time.

"The Australian Society of Anaesthetists continues to call for the postponement of non-urgent elective surgery to ensure anaesthetists have adequate time to prepare for the COVID-19 pandemic in our hospitals," ASA president Suzi Nou said in a statement.

"We are on the front line of critical care as experts in advanced airway management and without time to prepare, we are growing increasingly concerned that our members will be exposed to high-risk procedures."

**Health Minister Greg Hunt.** Picture: AAP

Source: AAP

You can track the ASA media messaging on the COVID-19 updates page of our website.

## SUPPORT

Early on in the pandemic it quickly became apparent that our safety concerns were not just about physical health for anaesthetists. This crisis was having an enormous impact on the mental health and wellbeing of our members. We have made a concerted effort this year to enhance the ways we can support anaesthetists and to build on the work that was already underway in this important area.

At the start of the year we were already well into promoting the development of Wellbeing Advocates on each State Committee and beginning to plan psychological and mental health first aid training. This meant we were perfectly placed to pull together contacts, support services and wellbeing resources for members. This has continued with the development of peer support and other wellbeing initiatives through our state committees. We have also recommitted to the promotion of the Long Lives, Healthy Workplaces toolkit which I encourage you to check out as it will be a great resource for building resilience in your workplaces going forward.

I am only too aware of the emotional impact of this pandemic on anaesthetists in Australia. At first I was contacted by ASA members, then anaesthetists more broadly, then medical, nursing and allied health professionals who were anxious and frustrated that not enough was being done to protect their safety at work. Realising the potential impact of some of our guidelines, I also reached out to managers of health services and directors of anaesthesia departments. Ironically, I felt much safer when case numbers rose and the hospitals where I work in Melbourne moved to widespread airborne

# FEATURE

MEDIA RELEASE

**24 October 2020**

**ASA Welcomes Aerosol Acknowledgement for COVID Transmission**

The Australian Society of Anaesthetists (ASA) has welcomed the acknowledgement of aerosol transmission of COVID-19 by the Victorian Healthcare Worker Infection Prevention and Wellbeing Taskforce

ASA President Dr Suzi Nou said the Society has been advocating for this acknowledgement to help improve the safety measures required to protect healthcare workers including anaesthetists on the frontline of this pandemic.

"The Mode of Transmission Statement issued by the Taskforce outlines how SARS-CoV-2 can also be transmitted via aerosols in specific circumstances and that it is well recognised during aerosol generating procedures in a healthcare setting"," said Dr Nou.

precautions. Being in 'full PPE' gave me a level of autonomy and influence over the hazards that were within my ability to mitigate. I am determined to ensure our members can also have a better understanding of how to speak up around these issues and take action to reduce your own anxiety. Thank you to my colleagues at the Northern Hospital for support and inspiration during the year!

You can see our wellbeing resources on the COVID-19 updates page.

## EDUCATE

As we all remember, the March introduction to a global pandemic on our doorstep happened surprisingly quickly. The controversy over the Grand Prix in Melbourne will remain in my mind as the trigger point that really kicked things off. I am proud to say the ASA was prepared.

We put out a call for members to join the COVID-19 Working Group in the first week of March and our first guidelines were published on our website on March 13, a mere two days after the World Health Organization declared COVID-19 a pandemic. The ASA has recently published our ninth edition of the guidelines thanks to many contributors and collaborators. This has been a valuable tool in sharing knowledge across our specialty and ensuring you all had the most up-to-date information at hand.

Much of 2020 has not just been about educating others but educating ourselves. For example, six months ago I had never heard of occupational hygienists and now we are one of their loudest supporters. My introduction to this invaluable profession came about through an interview for one of my podcasts this year. This communication medium is new to the ASA and new to me and although it has been a steep learning curve I think it has contributed enormously to the information exchange we have all needed in these times. The ASA podcast, called Australian Anaesthesia, can now be found wherever you listen to your podcasts. They highlight the work of the Society and individual members, so please get in contact if there is anything you would like to learn more about. To some extent, just as anaesthetists have been finding our collective voice this year, I have found mine too. Connecting with podcast listeners and those that I interviewed definitely helped me get through the 'longest and toughest' lockdown in the world.

You can see ASA COVID-19 Guidelines and other educational resources on our COVID-19 updates page of the website, including links to podcasts and recorded webinars.

## THANK YOU

I would like to thank the Board, Council, Guests of Council, and Working Group members for your hard work over the last year and particularly since March. You have openly shared opinions, knowledge and experiences from around the country and many of you have gone above and beyond in terms of representing, supporting and educating anaesthetists.

I would particularly like to thank Vice President Andrew Miller for his support throughout the year. He was a great source of inspiration and wonderful sounding board especially as we were dealing with similar issues while both in the media spotlight with Andrew wearing his WA AMA hat.

The staff at the ASA head office deserve an extra special mention. I think we have asked much of them and they have continued to deliver well above my expectations, particularly whilst adapting to the challenges of working from home.

And I especially would like to thank you, our members. It has been a busy time for all of us. I personally appreciate all the feedback, emails, responses to surveys, posts on the ASA Forum and phone calls that you have made to me, the ASA office team or your local State Committee Chair. Knowing what is happening in your world gives us a stronger base from which we can advocate and best serve to represent your interests. Thank you for keeping in touch and engaging with the Society.

While I may have been the public face of the ASA throughout this year, we could not have achieved all that we have without the enormous support I have been given from my ASA colleagues. You have worked tirelessly to help educate me on all things COVID related so that I could appropriately represent you.

Thank you.

# HOW DID 2020 IMPACT ASA MEMBERSHIP?

**ASA Executive Councillor Nicole Fairweather is the Board member responsible for membership so she has her finger on the pulse of trainees and members across the specialty. She has faced the challenges of the year with a unique perspective.**

At the start of 2020, like many other member-based organisations we had grand plans for new ways to promote the benefits of ASA membership and to highlight how we support, represent and educate Australian anaesthetists. Within a matter of weeks all of those plans had to be put on hold but the challenges posed by COVID-19 probably did more to promote ASA membership than any campaign could have achieved.

I'm still impressed by the speed with which we responded. Right from the start with Dr Suzi Nou establishing the Working Group and the ASA staff switching quickly to working from home. We stepped up and I don't think I've been prouder to be part of this organisation.

I'm also proud to be a 'dyed in the wool' member of the ASA and, as most people know, or may soon discover, I'm never short on words around the importance of membership and encouraging new applications. This year would prove challenging even for me given the uncertainty facing anaesthetists.

We really had little idea how the arrival of COVID was going to impact membership numbers and it has been reassuring to see the amazing number of renewals and especially new ordinary members this year. A renewal rate of 90% is pretty encouraging for the year we have faced. In fact, it's pretty good result for any year.

One of the key changes we made quickly was pushing membership approvals through in real-time so that people could access information and resources on the ASA members-only website. This

"I have recently joined the ASA and it was because the ASA as an organisation has worked so hard during this pandemic and I finally got myself into action and joined to ensure the ASA has as much member support as possible. The work done by the very hard working team at the ASA has been superb. It has helped me as an individual enormously but us as a profession immeasurably. Thank you!!!"

Comment from ASA member survey

# FEATURE

temporary process offered something of a provisional membership before formal Board approval and helped take the pressure off many State Chairs who were busy on the ground with so many COVID-related issues.

The guidelines and resources on the ASA COVID-19 updates page became essential reading for many and helped keep members informed on the latest advice around PPE and other safety precautions even as the situation changed over days, weeks and months.

This has been a year where we've all learned so much and our language around personal safety has really changed. Our new appreciation of mask fit-testing may have empowered us but it also highlighted some real frustrations in my own workplace. I still remember the first time – yes there were other times – I was refused fit-testing and when I left the hospital and saw tradies drilling stone with respirators, I asked them if they had been fit-tested and was told they wouldn't be allowed to work otherwise! We still have so far to go in this field but I'm confident a strong membership-base for the ASA will help us progress things.

It has also been interesting to see how quickly the general public and patients have been educated this year, particularly through media coverage around COVID. I deal with a lot of lung cancer patients whom I need to advise will be 'woken up' differently from many other patients with them still being on a ventilator. Normally this required a lot of additional information to help them understand, but this year the standard response about being on a ventilator was "like COVID patients?". Yes, but not for as long. Suddenly my patients had taken a giant leap in their own education and I know this meant they also had a greater appreciation of the risks that their healthcare providers were taking. Even my mother suddenly had a new understanding of my job saying "you do *that*?"

Just as the debate about health versus economy or lives versus livelihoods took hold in the public and political environment so did the conflicting issues in our members. There was an expectation that the ASA would be vocal around personal safety issues, PPE or halting elective surgery in the early days of the pandemic balanced with real concerns about loss of income especially for our members in private practice.

I think we continue to do our best to strike this balance during COVID. A good measure of how we have done

Find out why other ASA members joined by viewing our member video testimonials at www.asa.org.au/asa-membership-benefits

has actually been with the number of financially-strapped members who have put their memberships on hold rather than resigning. We know many of our members are hurting and they've been very upfront about not being able to afford discretionary costs. It was heartening to see that despite the financial duress that a lot of members found themselves under this year, many have chosen to put their membership on hold.

This has also been a really tough year for trainees with the exam disruptions. I'm sure the ramifications of what they have been through will rock the workforce for years to come. In recognition of this, the ASA will retain their current training levels and not change the fees for 2021. It's the least we can do, and again I want to remind trainees that the ASA is an 'ANZCA free zone'. I don't mean that in a negative way, far from it. I simply mean that we are a safe space, a non-work-related support where you can ask the stupid questions and this won't reflect on your career.

One of the silver linings to the grey cloud of 2020 has been our move to more online webinars and training courses. This has been a huge boost to the reach of Vida Viliunas and her courses which bring in a lot of new members to the ASA. Offering the training online has meant we can offer the courses to people right across Australia and especially in the rural and remote locations with overseas trained doctors in small hospitals. We can, as Vida says, really open our arms and foster them.


A very real demonstration of our role to support, represent and educate.

Throughout this year the ASA has conducted several surveys to keep in touch with the concerns of members and to ensure we are continuing to be a responsive organisation. I was particularly pleased to see the results of the final COVID-19 member survey which included questions around the advocacy role of the ASA this year.

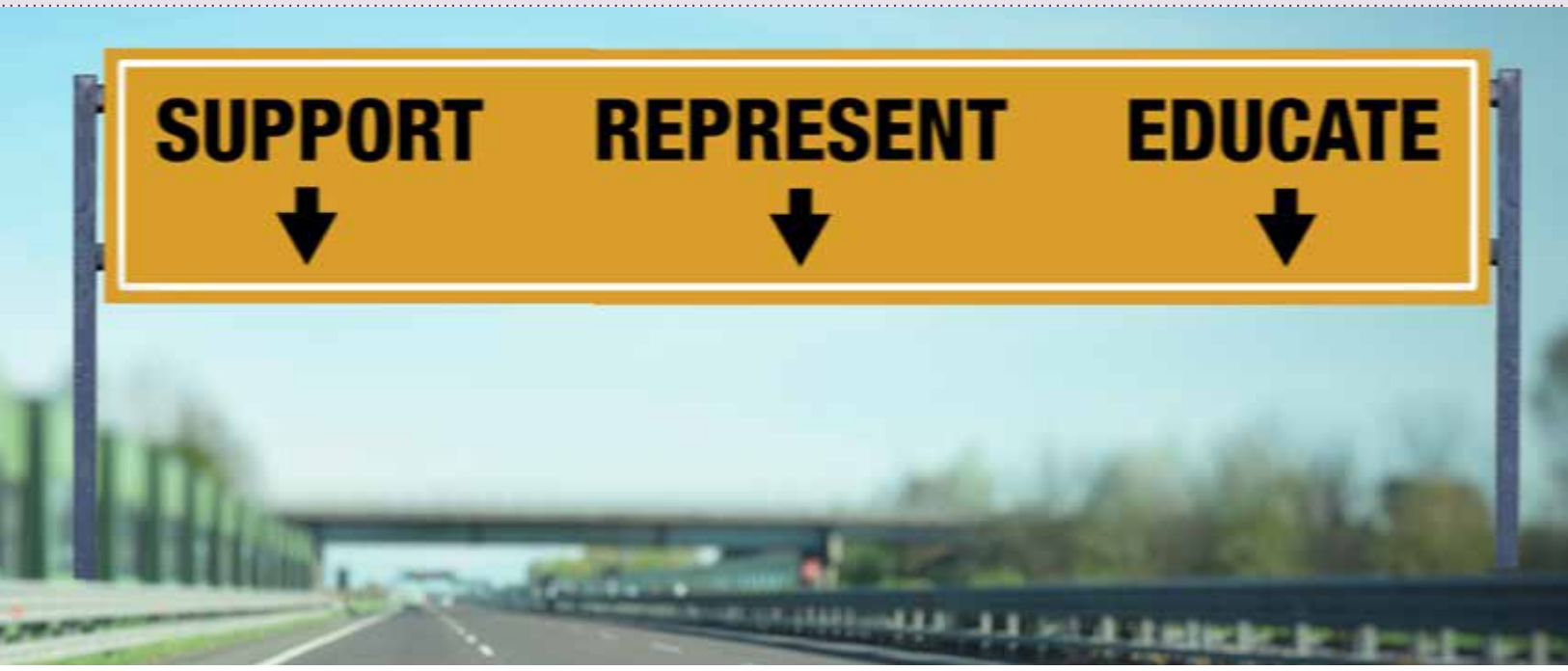
While there was a high level of awareness and indeed support for our advocacy actions, I think the most telling result from the survey were the answers relating to how people had heard about this work. As expected, ASA emails topped the list of the main communication tool but surprisingly, and refreshingly, we discovered that word of mouth was nominated by 38% of respondents as their source of information on the work of the ASA.

Tea room advocacy is so important. The corridor conversions and what we share with our colleagues can often make the biggest impact so it is great to know the work of the ASA was very much at the heart of those conversations. I like to think the tea room advocacy (socially distanced) was behind the extraordinary increase in ordinary membership applications we have received this year.

I am confident that as we head into 2021 the ASA will have an even stronger voice for our members and for our specialty. Everyone should be a member of the ASA because everyone benefits – just look at what we've achieved through EAC around telehealth this year. There is real safety in numbers and power in numbers. Encourage your colleagues to join our number!

We continue to need our members support – look out for the 2021 membership renewals which will be posted in early December. Renewals are due by 28 February 2021.

FEATURE




# NIMBLE AND FOCUSSED:
## THE KEYS TO ADVOCACY IN THE PANDEMIC

**The ASA's increased advocacy activity during COVID-19 has strengthened our profile across key government departments and provided important knowledge and experience that will support our work in other areas. ASA Policy Manager Jacintha Victor John reflects on this busy year.**

I recall the day I walked into the ASA office on Monday 9 March like it was any other work day. That afternoon we all received an email in relation to the ASA Board decision to cancel all ASA events. No one expected everything around us to start changing rapidly at the speed of a rollercoaster, but it did.

A call for members to join the COVID-19 Working Group was sent that week of March and our first guidelines were published on a dedicated COVID webpage on the ASA website on 13 March, just two days after the WHO declared COVID-19 a pandemic.

With a pandemic declared, the ASA strategy, reliant on securing meetings with the relevant individuals and setting meetings with high level politicians during a crisis, appeared near impossible. However, we used existing meetings with the Department of Health we had secured months before on ASA ongoing matters and immediately changed the agenda topics to what was now relevant. There were many who said the ASA would not get in the door with politicians who were too busy dealing with the unknown of the pandemic. However, persistence did not fail us. Our first meeting was with Professor Brendan Murphy to discuss restrictions on mass gatherings and further meetings gave President Dr Suzi Nou the opportunity to start discussions regarding postponement of non-urgent surgery. We continued to secure meetings with the Chief Medical Officer (CMO), Chief Health Minister, Minister of Health, State CMO and CHO. Our agenda quickly grew to discuss other COVID-19 issues ranging from Personal Protective Equipment (PPE), fit-testing, Workcover matters and discussion with Therapeutic Goods Administration (TGA) on the issue of rapid procurement framework.

Building on the new structures and processes that reform put in place, the ASA quickly adopted a more collaborative way of working, accelerating processes and dramatically increasing collaboration between Council, Working Groups and internal departments. We circulated a total of 55 letters to Federal, State Health Departments, non-government stakeholders including private healthcare on matters surrounding the pandemic.

The ASA persuaded decision-makers to adopt practical policy changes to unknown medical circumstances. On 23 March, the ASA joined the National Clinical Evidence Taskforce Executive Group. An early action

# MARCH 2020

| DATE | ASA | ADVOCACY | MEDIA ACTIVITY |
|---|---|---|---|
| Friday 6 March | EOI for members to join COVID-19 WG<br>Decision to cancel all F2F meetings and events for one month. | | |
| Friday 13 March | First guidelines published.<br>ASA volunteer database created. | Contact CMO Prof Brendan Murphy to restrict mass gatherings ahead of the Australian Grand Prix. | ASA President Dr Suzi Nou interview with *The Age* on mass gatherings and anaesthetist concerns.<br>Media release issued: **Anaesthetists issue COVID-19 Warning for Australian hospitals** |
| Sunday 15 March | | Discussion with Brendan Murphy regarding postponement of non-urgent surgery. | Media release issued: **Anaesthetists call for elective surgery to be cancelled**. Story published in *Guardian* online. |
| Monday 16 March | | Confirmed the use of **MBS Telehealth** numbers for anaesthetists.<br>Meeting with Council of Procedural Specialists (COPS) to raise concerns regarding non-urgent surgery. | Radio interviews with President Dr Suzi Nou aired in NSW, VIC, QLD and SA. |
| Wednesday 18 March | Decision to close the ASA office.<br>Initial meeting of the ICU/anaesthesia/ED collaborative (5Cs). | Meeting with Victorian CMO.<br>Request to Brendan Murphy to clarify availability of PPE and medications. | |
| Thursday 19 March | EAC meeting. | Meeting with National Incident Room (NIR) to discuss PPE availability.<br>Correspondence with TGA to discuss rapid procurement framework. | |
| Friday 20 March | Second edition of guidelines published.<br>CIG TC: update of global situation.<br>Meeting with NZSA Executive. | Launch of **notifycovid@asa.org.au** to hear from anaesthetists impacted by work related COVID exposure. | Media statement issued:<br>**ASA response to AAP on PPE issues** |
| Saturday 21 March | | Meeting with NIR to discuss N95 masks. | |
| Monday 23 March | Tips of the week emailed to members.<br>ASA COVID-19 member survey.<br>Joined the National Clinical Evidence Taskforce Executive Group. | NSW AMA and ASA commenced regular meetings to support members during COVID-19 preparedness. Discussions included VMOs and elective surgery, telehealth, workforce, COVID-19 testing and PPE supplies.<br>Letter to CMO requesting extreme population containment measures. | AAP Newswire story runs nationally including ***The Australian*** including 77 syndications across the country.<br>ASA/PPE concerns also covered online on *SMH, The Age,* ***Brisbane Times***. |
| Tuesday 24 March | Joined the COVID-19 Critical Care Coordination Collaborative (5Cs) with ANZCA, ACEM, CICM, NZSA. | Letter to all State Health Ministers, CHOs and CMOs requesting extreme population containment measures. | ABC-TV interview with ASA President Dr Suzi Nou on PPE concerns airs in Sydney, Canberra, Brisbane, Darwin, Melbourne and Adelaide. |
| Wednesday 25 March | | Request for Brendan Murphy to engage with private hospitals regarding non-urgent surgery. | Media release (am) – **ASA calls for Extreme Containment Measures** Story runs online on *Guardian* and **9News**.<br>Media release (pm) – **ASA Welcomes Elective Surgery Cancellation** Story coverage continues – currently AAP and syndications, ***Daily Telegraph***, ***SBS***. |
| Thursday 26 March | | Discussion with Victorian DHHS regarding PPE recommendations. | Media release issued: **ASA concerned about private hospital exemptions.**<br>Coverage in ***SMH***, *Age* and ***Newcastle Herald***. |
| Friday 27 March | Guidelines updated. | Teleconference with Dep CMO to discuss PPE. | Suzi Nou interviewed by ***ABC*** and ***AGE/SMH*** about ventilators. |
| Saturday 28 March | Board and Council meeting. | Working with AMA (WA) regarding PPE suppliers. | |
| Monday 30 March | Tips of the week and HAZMAT podcast with Brian Spain. | VIC: Workcover and SCV discussions. | |
| Tuesday 31 March | | Liaised with Minister Greg Hunt and Dep CMO Nick Coatsworth regarding Aust Govt partnership with private health sector.<br>The NSW Agency of Clinical Innovation (ACI)/ Anaesthetics Community of Practice (COP) invited ASA to support PPE training at private hospitals.<br>The ACI will escalate local concerns and solutions raised with key information reported to MOH. | |

# FEATURE

## APRIL 2020

| DATE | ASA | ADVOCACY | MEDIA ACTIVITY |
|---|---|---|---|
| Wednesday 1 April | Meeting re: CSC e-news.<br>Enquiries re: insurance brokers, fit-testing.<br>D/w AVANT. | Discussion with NASOG President.<br>Webinar with Dep CMO Nick Coatsworth confirmed.<br>Webinar with AVANT confirmed. | |
| Thursday 2 April | | **National COVID-19 Clinical Evidence Taskforce**.<br>Discussion with Tasmania AMA CEO on issues around public patients being treated in private hospitals. | |
| Friday 3 April | Guidelines 4th edition.<br>ANZCA SQC meeting. | Draft Position Statement on PPE circulated to stakeholders. | |
| Saturday 4 April | | Meeting with Burnet Institute re: fit-testing. | |
| Monday 6 April | | Dept of Health Webinar on PPE.<br>Multiple communications with Federal Department of Health in relation to new COVID-19 Telehealth Items rejected. | |
| Tuesday 7 April | | Draft 2 of Position Statement on PPE sent to stakeholders. | |
| Thursday 8 April | | Teleconference with Dep Chief Medical Officer Dr Nick Coatsworth to discuss public-private arrangements. | |
| Tuesday 14 April | | Teleconference with Ramsay Healthcare CEO Danny Sims, CMO Prof John Horvath and Regional Manager Southern Region Greg Hall to discuss private sector COVID-19 Partnership agreements. | |
| Wednesday 15 April | | Meeting with National COVID-19 Clinical Evidence Taskforce. | |
| Friday 17 April | ASA COVID guidelines updated (5th edition). | Teleconference with VIC CMO Andrew Wilson to discuss VIC DHHS Guidelines and establish a VIC anaesthetic advisory group.<br>Draft 2 Position Statement circulated to ICEG. | Media statement issued to ***Guardian Australia*** on **PPE Fit Testing**.<br>Media release issued: **ASA Encourages Safe Return to Elective Surgery**.<br>Story covered in ***The Australian***, *Courier Mail*, ***Daily Telegraph***, ***SBS***, ***9News*** and ***AAP*** story syndicated across several states. |
| Saturday 18 April | | Meeting with industry to discuss local production of N95 PPE. | |
| Sunday 19 April | | Meetings with industry/university innovation collaboration stakeholders. | |
| Monday 20 April | | Teleconference with APHA CEO Michael Roff and Policy Director to discuss private hospital stance on elective surgery introduction by the Government.<br>Teleconference Dep CMO Nick Coatsworth to discuss policy move return to elective surgery.<br>Teleconference with Department of Health to further discuss telehealth items rejected claims.<br>Teleconference with Ramsay Healthcare to further discuss PPE and return to elective surgery. | |
| Tuesday 21 April | Joint media release with Commonwealth.<br>AVANT Webinar – COVID-19 Emerging Risks and Advice ASA/AVANT. | Teleconference with Ramsay Healthcare to further discuss PPE and return to elective surgery.<br>Joint media release with Commonwealth.<br>Invitation to join Burnet Institute knowledge hub. | ASA part of joint media statement from Health Minister Greg Hunt announcing **Elective Surgery Eased.** |
| Wednesday 22 April | | Telehealth: Discussions with Minister Hunt, the Department of Health, AMA. | Media Release issued: **ASA Alarmed at Telehealth Oversight**. |
| Thursday 23 April | My Health Record Agency/ASA/ANZCA meeting (monthly) | Meeting with National COVID-19 Clinical Evidence Taskforce.<br>ASA COVID-19 Working Group meeting.<br>ANZCA COVID Expert Writing Group. | |
| Friday 24 April | ASA COVID guidelines up-dated (6th edition). | | |
| Monday 27 April | Extra Council meeting to discuss public in private contracts. | Meeting with ASOHNS to discuss changes in PPE recommendations, | |
| Tuesday 28 April | Electronic Prescribing update for Dispensers Webinar. | | |
| Wednesday 29 April | Electronic Prescribing update for Prescribers. | | |

# MAY–OCTOBER 2020

| DATE | ASA | ADVOCACY | MEDIA ACTIVITY |
|---|---|---|---|
| 1 May | | Meeting with Vic DHHS Clinical Engagement discussion | |
| 4 May | | NSW AMA COVID-19 fortnightly teleconference | |
| 7 May | ASA NSW Forum Pandemic Public / Private Partnership and Elective Surgery | NSW AMA Privacy 2020 Webinar – Changes and updates to Privacy Act | |
| 11 May | | Joined the Medication Shortages Demand Forecasting Group convened by the Commonwealth Medicine Shortage Taskforce | |
| 13 May | PIAC Teleconference | Meeting with National COVID-19 Clinical Evidence Taskforce | |
| 14 May | ASA Telehealth Working Group teleconference | Associations Forum – Influencing Government priorities in a crisis | |
| 15 May | ASA COVID guidelines updated (6th edition) | | |
| 16 May | Psychological First Aid workshop for ASA Wellbeing Representatives and State Chairs | | |
| 18 May | ASA NSW co-hosted webinar with Cutcher & Neale to support financial wellbeing. Latest information on 'Update and Finding Value in a Turbulent Market' included government stimulus and JobKeeper | AMA NSW fortnightly meeting – Private/public contracts | |
| 20 May | | Telehealth services COVID-19 anaesthesia item number amendments to COVID-19 determination | Media release: ASA Telehealth win for anaesthetists |
| 23 May | EAC meeting | | |
| 28 May | My Health Record Agency/ASA/ANZCA meeting (monthly) | | |
| 29 May | | Private Hospital Obstetrics Billing – ASA, Federal and NSW AMA Australian Medical Association and National Association of Specialist Obstetrics NASOG | |
| 1 June | | National COVID-19 Clinical Evidence Taskforce Executive Leads Group (meetings held weekly) | |
| 2 June | | Fit-testing Epworth Hospital, Richmond, Victoria | |
| 3 June | | Fit-testing Epworth Hospital, Richmond, Victoria | *Age/SMH* photographer documents ASA Melbourne fit-testing session |
| 4 June | | Fit-testing Albury-Wodonga Hospital | |
| 17 June | | Victoria DHHS webinar | |
| 20 June | | Council of Procedural Specialists | |
| 23 June | | | Media release: ASA Calls for PPE Fit-Testing |
| 25 June | My Health Record Agency/ASA/ANZCA meeting (monthly. | | |
| 6 July | | National COVID-19 Clinical Evidence Taskforce Executive Leads Group (meetings held weekly) | |
| 19 July | ASA NSW Members Forum | | |
| 20 July | | | ASA calls for masks to be mandated in *AGE/SMH* story |
| 22 July | | Department of Health webinar | |
| 23 July | ASA COVID Working Group | | |
| 24 July | | | Suzi Nou interview on ABC Radio Canberra on COVID testing of patients pre surgery |
| 25 July | | | *Canberra Times* story on ASA ACT call for mandatory testing of elective patients |
| 30 July | My Health Record Agency/ASA/ANZCA meeting (monthly) | | |
| 31 July | | VIC Peri-Operative Presidents and Chairs Meeting (meetings held weekly) BUPA meeting | |
| 1 August | | Council of Procedural Specialists | |
| 2 August | | | AAP story on our call for mandatory fit-testing with nationwide syndication including SBS news and 7 news online |
| 3 August | | National COVID-19 Clinical Evidence Taskforce Executive Leads Group (meetings held weekly) | |
| 7 August | | | Media release: Victorian Hospitals Alarming COVID-19 Risk to Workers |
| 12 August | | | Media release: ASA Call for Risk Assessments of Victorian Hospitals |
| 15 August | | | ASA fit-testing photographs feature in *Age/SMH* story on PPE and masks |
| 19 August | PIAC meeting | | |
| 20 August | | Council of Procedural Specialists | |
| 24 August | | Meeting with David Watters and CMO Andrew Wilson Victoria DHHS Healthcare Worker Wellbeing Subgroup | |
| 25 August | | Medibank Meeting | Media release: ASA Welcomes HCW VIC Changes |
| 27 August | My Health Record Agency/ASA/ANZCA meeting (monthly) | Victoria DHHS Healthcare Worker (HCW) Infection Prevention and Wellbeing Taskforce | |
| 31 August | PPAC meeting | | |
| 1 September | ASA webinar | | |
| 2 September | | APHA Meeting Ramsay Health Care meeting | |
| 3 September | | Victoria DHHS Healthcare Worker (HCW) Infection Prevention and Wellbeing Taskforce (meeting held fortnightly | Media release: ASA Welcomes Progress in PPE Fit-Testing Campaign |
| 7 September | | National COVID-19 Clinical Evidence Taskforce Executive Leads Group (meeting held weekly) | |
| 10 September | | Victoria DHHS Healthcare Worker (HCW) Infection Prevention and Wellbeing Taskforce | |
| 17 September | EAC meeting | | |
| 18 September | | | *Age/SMH* features photos from ASA member fit-testing session |
| 19 September | | | *GP News* reports on the results of ASA member fit-testing session |
| 22 September | | GRADE Evidence to Decision framework – interactive webinar and Q&A Nexus Hospitals Meeting HCF Meeting | |
| 24 September | My Health Record Agency/ASA/ANZCA meeting (monthly) | Council of Procedural Specialists | |
| 30 September | | | Suzi Nou interviewed in *Age/SMH* on mask fit-testing |
| 1 October | | Victoria DHHS Healthcare Worker (HCW) Infection Prevention and Wellbeing Taskforce (meeting held fortnightly | |
| 6 October | | Budget night | |
| 7 October | | Victoria DHHS Healthcare Worker Wellbeing Subgroup (meeting held fortnightly) | |
| 9 October | | Victoria DHHS Healthcare Worker Infection Prevention & Wellbeing Data Insights Group | ASA media statement on Medical Costs Finder website |
| 10 October | | CIG meeting | |
| 11 October | | | ASA quoted in *Age/SMH* article on the Medical Costs Finder 'white elephant' website |
| 15 October | | AMA Managed Care Forum Council of Procedural Specialists | |
| 19 October | | Managed Care | |
| 20 October | | Dr Tim Read, Member for Brunswick (VIC) Little Company of Mary Meeting regarding bundled and managed care | |
| 22 October | ASA webinar | CPR flowcharts | |
| 24 October | | | Media release: ASA Welcomes Aerosol Acknowledgement for COVID Transmission |
| 29 October | My Health Record Agency/ASA/ANZCA meeting (monthly). | | |

# FEATURE

was to join other colleges in pushing for the cancellation of non-urgent elective surgery, other medical and nursing organisations such as the Australian Medical Association (AMA), Australian and New Zealand College of Anaesthetists (ANZCA), College of Intensive Care Medicine (CICM), Australian and New Zealand Intensive Care Society (ANZICS), Australian College of PeriAnaesthesia Nurses (ACPAN) at national and state levels over COVID-19 related issues and we continue to do so. It is clear that we are stronger together and most effective when working in close collaboration. This was demonstrated through some of ASA key wins in 2020 and continues to be essential as we have moved to respond to the unique challenges of the COVID–19 pandemic.

I recall attending a meeting where CMO Dr Andrew Wilson expressed how surprised he was in relation to the number of guidelines the ASA produced and published in such a short timeframe, within the first three weeks of March. He politely asked whether we will be able to provide these resources to him for internal discussion with the Department, we now know the Victorian Department did not take the ASA Guidelines seriously into consideration in the beginning of the pandemic. Regarding guideline development, we continue to liaise with ANZICS, have joined ANZCA's Clinical Expert Advisory Group (CEAG) as well as the National COVID-19 Clinical Evidence Taskforce of the Australian Living Evidence Consortium led by Cochrane Australia.

This time the ASA advocacy reach was different, we had the opportunity to announce our advocacy work through the press. The ASA policy work had a channel to reach an audience outside the Society into the public domain. We sneaked into the mainstream media and exploded like a bomb. The media attention helped establish the ASA as a powerful advocate for our members and the issues of concern to them.

## STRONGER STAKEHOLDER RELATIONS

The ASA's invitation to join the Clinical Taskforce steering committees on COVID-19 was a result of strong advocacy as well as an acknowledgment of the role that anaesthetists have in the prevention, management and treatment of chronic disease. These relationships have been invaluable during the current pandemic and have helped the organisation drive support for the introduction of COVID–19 specific guidelines.

Throughout this crisis, ASA has strengthened existing relationships and built new ones within the Department and Minister's office in all states and territories which will provide important foundations for future advocacy work.

Our proactive and collaborative approach to advocacy work in 2020 has put the ASA and its members in a stronger position to tackle the issues that have arisen, and that will continue to challenge our sector as we move through 2021.

The ASA's key objectives are to:

- deliver effective advocacy that provides value to members;
- enhance our profile with key stakeholders to increase influence;
- support our members to enhance their own knowledge and influence;
- develop a sustainable resource base to achieve our purpose.

A wide range of strategies are employed against these objectives each year to achieve our goals for the membership.

ASA secured representative roles on key steering committees created to support the government's national COVID-19 plan. The ASA continues to work closely with other college and society presidents as well as key government officials including Australian Deputy Chief Medical Officer Dr Nick Coatsworth, an infectious diseases physician.

## YOU PLAYED A PART IN OUR ADVOCACY

This year we had to make the critical decision to not go ahead with the ASA bi-annual workforce survey. Although the ASA workforce survey was postponed, thanks to Specialty Affairs Advisor Dr James Bradley and Policy Administrator Patrick Gifford, the Society engaged members in not one but four surveys to assist and structure our advocacy according to membership needs during a health crisis.

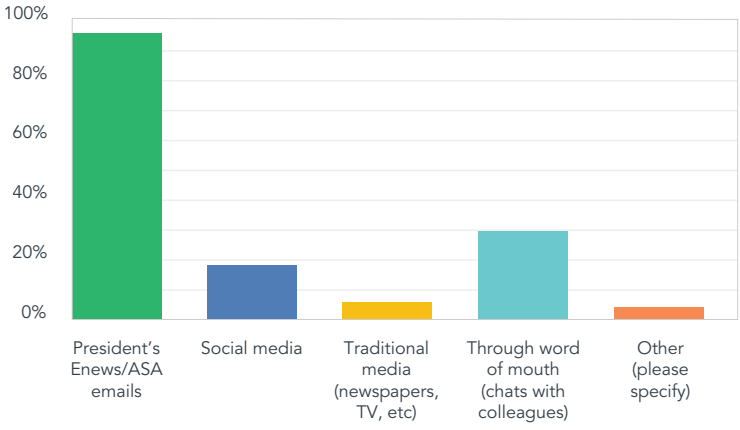
Member participation to influence our policy lobbying was vital. We managed to finalise four surveys on the impacts of COVID-19. The first survey distributed in March was designed to give the ASA an overview of the situation for the specialty in Australia at the start of the pandemic, and alert us to the issues anaesthetists were facing on the ground.

The second survey was released in May as a follow-up to the first, specifically covering the response from the different states and territories, and hospitals within them. With this survey, we attempted to draw out members' views on the efforts to combat COVID-19 from spreading by asking questions about pandemic preparedness and access to adequate PPE. This allowed us to analysis state specific views from the membership.

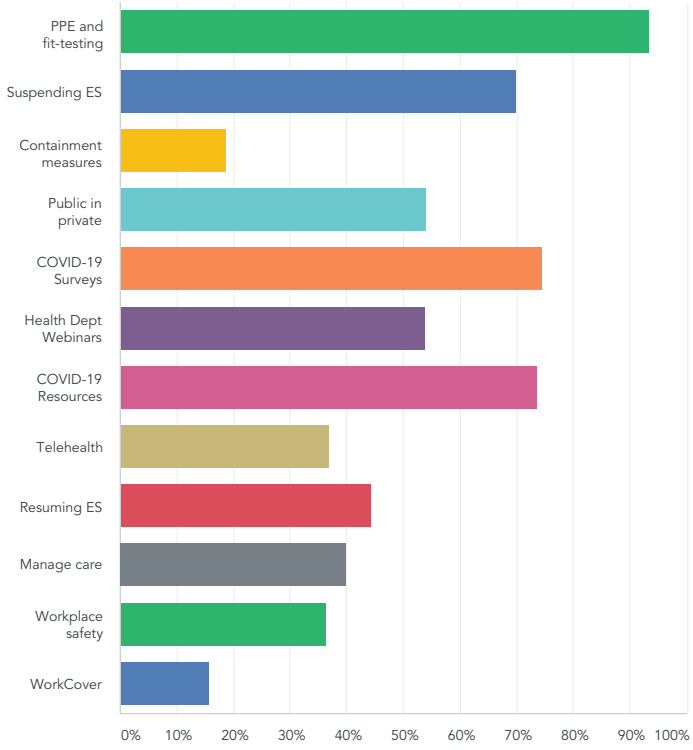
In our third survey in June, several questions were included to give the Society an insight into the welfare and wellbeing of ASA members during the pandemic, specifically looking at both mental health and the personal and financial impacts from the changes to work-life balance and finances many anaesthetists were experiencing. We listened and made it easy for members to seek help by creating a wellbeing resource guideline for anaesthetists looking for support during COVID-19.

Lastly, the fourth survey, launched in September, was designed so the Society could assess how the concerns of our

## ASA Advocacy mode of communication




## ASA Advocacy Policy topics




The ASA ordinarily circulates monthly President e-news to the membership throughout the year (12), but during the pandemic peak period of March 2020 to June 2020, we circulated 58 electronic communications to the membership.

members and their professional situations had changed over the duration of the pandemic through comparing the results with our previous engagements. At this stage we were looking to assess any outstanding concerns from our members around PPE and the effectiveness of our advocacy.

## ADVOCACY MODE OF COMMUNICATION

The ASA ordinarily circulates a monthly President's e-news to the membership throughout the year (12), but during the pandemic peak period of March 2020 to June 2020, we circulated 58 electronic communications to the membership. It was great to know how well these emails were received as 95% of members were aware of our advocacy efforts through the President's e-news.

As presented by the survey results above you continued to speak about the ASA work even after shutting down your laptops with 39% of the membership learning about ASA engagement at work with your colleagues over lunch – wearing a mask of course.

It is great to highlight that 88% of respondents indicated that they were pleased with the ASA's efforts at advocating for members' interests. The top three advocacy campaigns that registered with members included:

- ASA's work for improved PPE access and standards (93%);
- COVID-19 workplace resources and guidelines outside of PPE (73%) including; COVID-19 member surveys (73%); and
- suspending elective surgery (70%).

An overwhelming 91% of members surveyed also indicated they felt the Society was sufficiently vocal in addressing the concerns of its members during the pandemic.

## 2020 A YEAR TO REMEMBER

I am very fortunate to be part of a Society that brought positive results and achievements to influence healthcare policy changes for its membership during a worldwide pandemic. Being part of a team with hard-working anaesthetists who worked around the clock and continued to produce work after hours for the membership has been an extraordinary experience.

It has been a strange and eventful year for all of us. Reflecting back, it seems insane the Secretariat managed to coordinate and deliver to the membership while working from home. Thank you to the office team who worked hard and closely together via the phone to deliver to the membership in a time of crisis.

As we round up a surreal year and approach a new normal in 2021, I wish all of you and your family a wonderful holiday season.

FEATURE

# REMOTE REPRESENTATION:

## HOW THE ASA STAFF LEFT THE OFFICE BEHIND IN 2020

**The concept of 'working from home', while obviously not an option for many working ASA members, quickly became a necessary reality for the Society's head office staff earlier this year and the transition was so seamless you probably didn't notice.**

Throughout 2020, the advocacy work of the ASA staff in policy and media featured prominently in communications with members as we kept you up to date with the Society's response to COVID-19. However, as is true with many organisations there was a great deal more going on 'behind the scenes' to support the Board, Council and members in this challenging year.

"I have very much missed checking in with the team face to face each day and I look forward to seeing everyone soon."

Sue Donovan, Executive Assistant

In mid-March when the pandemic hit Australian shores and it became clear that Sydney was heading into lockdown we needed to act quickly to ensure we could continue to provide the quality of support and services that you all rely on.

Our IT Manager Paul Singh had the unenviable task of setting up more than a dozen people to be able to work from home in a very limited timeframe. Between VPN access and all the IT equipment we needed to work remotely, Paul also had the challenge of inconsistent internet connectivity in some staff homes. He assisted in getting upgrades to connections or new WIFI dongles to ensure we had the fast internet speeds required and to provide us all with a remote IT helpdesk service.

Paul assisted the membership and finance teams with a number of initiatives to ensure important processes could be carried out remotely including invoice approvals and membership receipting. Our membership team transitioned to daily membership application approvals for quicker access to ASA online services and alerts.

The head office team didn't just have to change where and how we worked but the addition of many COVID-related tasks increased our reliance on teamwork and 'working together but apart'. As President Suzi Nou noted at the AGM, not only did we not miss a beat but we developed more resources and communicated more often than has been done previously by the Society in such a short timeframe. For an extended period we were sending members at least three emails a week to keep them updated on the ASA COVID activities. Paul played a vital role in this email communication and managing the website especially the COVID-specific page that broke all records in web traffic for the ASA site.

It was also important for staff to keep each other updated on our work without

the opportunity to chat across cubicles or in the office kitchen. Our regular Tuesday morning staff meetings moved to Zoom where we caught glimpses of pets and balcony views and an added insight into our colleagues at their new workstations. CEO Mark Carmichael's dogs were regular contributors to our conversations.

"I was impressed with the professionalism of our response to COVID and ensuring the ASA was open and it was business as usual under trying times."

Maxine Wade, Committees Assistant

Like most people across Australia we quickly became familiar with the concept of Zoom meetings and our Administration and Executive Events Officer Molly Jinta was a patient guide. As well as the regular staff meetings Molly was responsible for setting up other ASA meetings for the Board, Council and various Committees as well as many webinar links.

The majority of these meetings were held after hours and Molly has managed more than 50 online gatherings since the start of the pandemic. She also helped make the day of many participants when several meetings involved a surprise delivery of coffee and cake with some 60 plus uber deliveries coordinated across the country. This task is the closest Molly has got to her usual role of organising ASA social functions which she hopes will return in 2021.

"The ASA team's passion and enthusiasm transcended the Zoom e-meets and introductions."

Kate Pentecost, Museum Curator, Archivist and Librarian

Working from home has brought many challenges and nowhere is that more apparent than the challenges of onboarding new staff. The ASA has recently welcomed a couple of new staff members and Zoom has been a surprisingly efficient training tool with our e-meetings being just as effective as traditional in-office inductions.

Zoom has also transformed our event offerings this year. While the early part of 2020 was very much an event-free space right across Australia this actually meant more work for the ASA events staff. All the arrangements for events in states and territories were suddenly up in the air and decisions needed to be made quickly to cancel or reschedule even while we were in a period of great uncertainty. The difficult decision by the ASA, NZSA and Congress Convenors to reschedule the Combined Scientific Congress (CSC2020) until 2022 started an enormous process to 'deconstruct' the major event. From venue bookings and sponsorship arrangements to international speaker invitations – everything needed to be cancelled or postponed after many months, sometimes years, of locking these things in.

The ASA managed to quickly pivot to the online event world with webinars growing in popularity and accessibility. Whatever 2021 throws at us it is clear that members are keen to support online activities and we hope to continue in this space so that more people have the opportunity to connect with the ASA and with each other. A world with 'online wine-tasting' doesn't sound too bad.


Paul Singh


Molly Jinta

As challenging, frustrating and sometimes alarming this year has been, the ASA head office team has managed to do a pretty remarkable job even if we do say so ourselves. Thank you to the ASA officer bearers and members who have been so supportive and patient as we have done our best to support you through this time.

Cindy Jones
*Media and Communications Advisor*

"Building work relationships in this time has been easy, everyone made me feel so connected in a short space of time."

Rhian Foster,
Events & Membership Officer

## WELCOME TO THE YOUNGEST TEAM MEMBER

We may have felt like 2020 has been the longest five years of our working lives but one staff member helped us keep a good sense of time over many months. It was at one of our first zoom staff meetings in late March when Jade Melville, ASA Events Coordinator, announced she was pregnant and planned to head off on maternity leave in September. At the time we were all convinced we would be back in the office to celebrate this news in a matter of weeks. Little did we know we would be facing months of remote working and only being able to follow her pregnancy virtually. Jade welcomed baby Ayda on October 19 and we are keeping our fingers crossed that we get to meet her in person, in the ASA office, in the near future. Congratulations Jade!

FEATURE

# THE FOURTH ASA COVID-19 SURVEY

**In directing its COVID-19 advocacy, the ASA has surveyed members four times this year: in late March, early May, late June, and most recently late September.**

While COVID seems to have been with us for an eon, it's only eight months since the pandemic was declared on 11 March 2020, and only six months ago, in May 2020, that the 'curve' of the 'first wave' was 'flattened' across the country – until with hindsight benefit,the trickle of new positive tests in early June in Victoria became the 'second wave', peaking in early August before receding over the following two months.

It's worth recalling that about 45% of cases in the first wave were in NSW and 20% in Victoria, with cases diagnosed in all states and the territories. Deaths occurred in all jurisdictions except the Northern Territory. The contribution of 'returned travellers' to the caseload was well understood. Much less understood at the time was the incidence of 'community transmission'. In the second wave of course, the focus was on community transmission in Victoria.

As reasonably anticipated, almost 70% (31) of anaesthetists who had treated a known COVID-19 patient were from Victoria.

The ASA surveys have sequentially sought member views on what have seemed to be the most immediate issues at the time of survey. The focus throughout has been on the level of preparedness of responders and the facilities, the availability of PPE equipment and training, and satisfaction with COVID-19 screening procedures. Progressively, further questions have explored clinical activity, PPE and drug shortages, quarantining, training issues, the possibility of experiencing discrimination as a health worker, the psychological and financial implications of the pandemic, and finally member satisfaction with the ASA's advocacy.

The responses to the first three surveys reflected known age, gender and public/private demographics. The third survey was conducted as the second wave was beginning in Victoria, and did not capture any significant differences in the responses of Victorian members compared with other members. The fourth survey did have a disproportionately high response from Victorian members.

"A large majority (71%) of responders agreed that 'fit testing' should be mandatory".

When the first survey closed on 23 March 2020, an average 25% daily increase in case numbers over the previous 10 days had been occurring, and a total of 1,716 cases had been diagnosed. In this survey:

- 8% reported being prepared and 70% somewhat prepared to deal with ongoing patient care during the pandemic;
- 59% reported having received training in donning/doffing;
- 23% reported having been fit-tested;
- 61% reported a lack of PPE equipment.

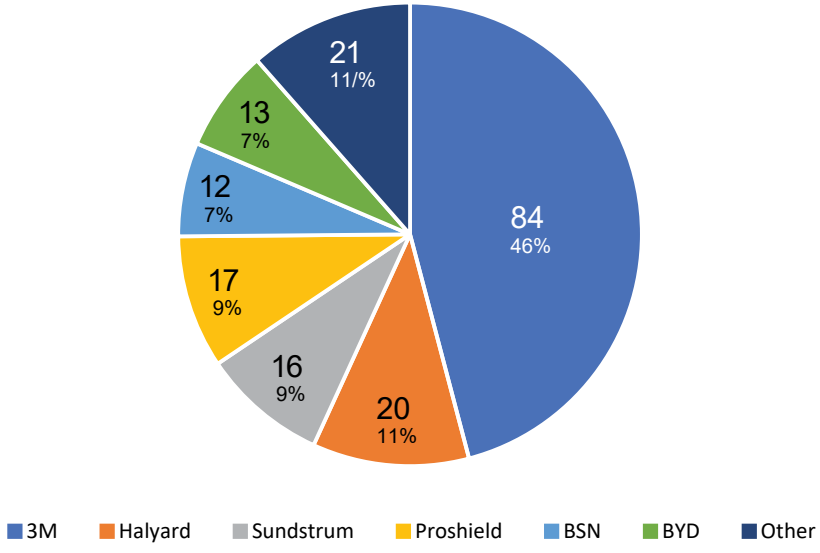
When the second survey closed on 6 May 2020, 6,875 cases had been diagnosed but the curve had been flattened, with an increase of only 129 over the preceding week. In the second survey:

- 39% reported being prepared and 57 % somewhat prepared to deal with ongoing patient care during the pandemic;
- 89% reported having received training in donning/doffing;
- 20% reported having been fit-tested (and of those who had not been fit-tested, 61% wished to be fit-tested, and 59% thought that fit-testing should be mandatory);
- 50% reported a lack of PPE (with surgical and N95 masks most commonly identified, followed by P2 respirators).

In the third survey, which closed on 22 June 2020, emerging and ongoing member concerns were explored in detail

- 57% reported concerns about future PPE supply;
- 48% reported insufficient access to PPE;
- 45% reported lack of information about PPE stocks;
- 44% reported a lack of access to fit-testing;

## Number of responders passing 'fit-testing' according to brand of respirator




- 43% reported confusion about when and what PPE to use;
- 37% reported disagreement with institutional, state or national PPE recommendations;
- 30% reported concerns about colleagues overusing PPE.

In the fourth survey, existing PPE related concerns identified in the first three surveys were pursued. Responses revealed that:

- a sizeable minority of anaesthetists continued to report shortages of one or more items of PPE with surgical masks (46%) and N95 masks (40%) identified most often;
- 91% had had training in donning and doffing of PPE;
- 81% had had simulation training for intubation of suspected or known COVID-19 patients;
- 79% were satisfied with the patient screening procedures conducted by the hospital or facilities where they mainly practised;
- 45 responders (10% of the survey) had treated a known COVID-19 patient.

As reasonably anticipated, almost 70% (31) of anaesthetists who had treated a known COVID-19 patient were from Victoria and 11 from NSW, but there were two from South Australia and one from the ACT.

Fit-testing was a focus of the first three surveys, and was further addressed through five questions in the fourth survey. Members were asked if they had been fit-tested by a trained fit-tester, after reminding them that fit-testing was not the same as fit-checking. Nationally, 41% reported having been fit-tested and 58% not. Of those 261 responders, 45% expressed a wish to be fit-tested, 16% did not wish to be fit-tested, and 40% did not offer an opinion. A large majority (71%) of responders agreed that fit-testing should be mandatory, with 17% disagreeing and 12% undecided.

Further, responders were asked if they had achieved an 'effective fit' with an N95/P2 respirator, and if so, what type or types of devices were effective for them. With 115 individual responses, some indicated that more than one brand of mask was

# FEATURE

"…hospitals should stock multiple types of N95 masks as it is unlikely for a single type and size to provide for the entirety of their frontline staff".

effective, and accordingly the total individual responses were less than the summed indicated 'effective fits'. There were several brands of respirator that had obtained a pass on less than 10 occasions with lower than 10 effective fits, and these were then combined into a single category.

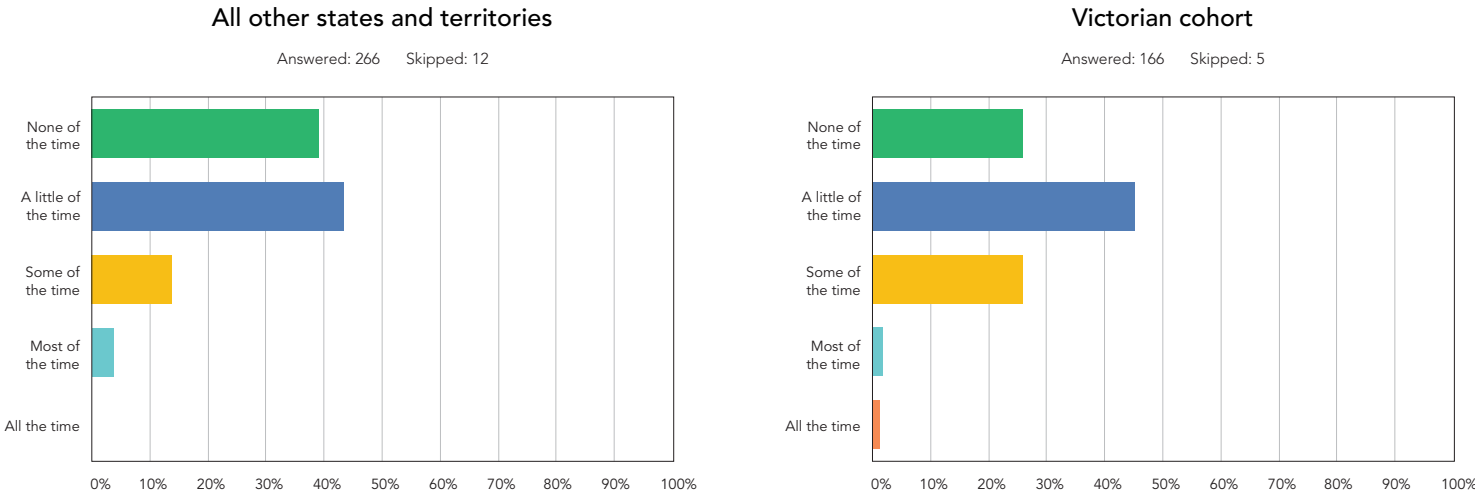
It can be seen that successfully passing fit-testing was achieved with 3M products by 73% of responders. Given that it was anticipated that the likelihood of being required to treat COVID-19 positive patients was more likely in Victoria than elsewhere in Australia, and that fit-testing would have achieved an immediacy not seen elsewhere, the Victorian responses were then further analysed. This showed that a lower 44% achieved an effective fit with 3M products, but also that a lower percentage achieved the effectiveness with other products. This does not prove that the 3M products confer a higher likelihood of passing a fit-test. It is the actual range of masks and respirators offered to responders that uncovers effectiveness, and the range offered is unknown, as are the other factors associated with 'fit' – age, gender and ethnicity. These findings can be compared with those of Cheung, Low and Nou in the September 2020 *Australian Anaesthetist*, which reported on the fit-testing of 60 anaesthetists from metropolitan and regional Victoria arranged by the ASA. An overall pass rate for disposable N95 respirators of 57% was seen with the 3M products achieving 81%. We summarised that hospitals should stock multiple types of N95 masks as it is unlikely for a single type and size to provide for the entirety of their frontline staff.

"It was anticipated that Victorian anaesthetists might reasonably report higher levels of distress given their immediate proximity and exposure to COVID-19 cases, and this was the case".

Almost half (47%) of responders perceived having received conflicting advice about fit-testing from government and healthcare worker advocacy groups, 42% were undecided, and 12% perceived that the advice received was not conflicting.

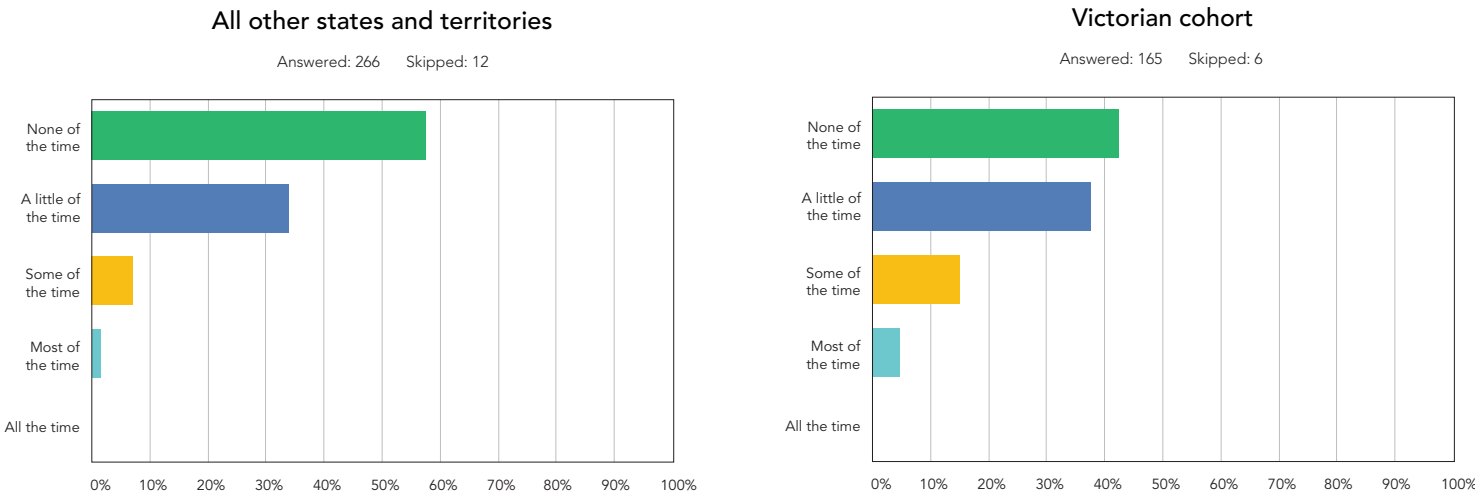
The potential for the pandemic to influence the wellbeing of anaesthetists was explored in the third and fourth surveys. Some specific questions were asked, accompanied by 10 questions from the Kessler Psychological Distress Scale. These findings were reported by Peta Lorraway in the September 2020 *Australian Anaesthetist*, and showed that the majority of responders reported some impact on wellbeing, and that a small percentage had experienced high levels of distress. When the Kessler questions were repeated in the fourth survey, it was anticipated that Victorian anaesthetists might report higher levels of distress given their immediate proximity and exposure to COVID-19 cases, and this was the case. The Victorian responses to two of the Kessler questions compared to those from the other states and territories were:

## About how often did you feel nervous?




In respect to 'feeling nervous', almost 74% of Victorians compared with 60% of others experienced varying degrees of nervousness.

## About how often did you feel restless or fidgety?




In respect to being 'restless or fidgety', 57% of Victorians compared with 42% of others experienced varying degrees of distress.

As noted earlier, Victorians were over-represented (38%) in the fourth survey (from a mean 31% in the three earlier surveys), a possible measure of local concern. It could be postulated (given the second wave was seen to be receding when the fourth survey was circulated) that the response rate might have been higher and the responses more adverse if the Victorian members had been surveyed six to eight weeks earlier.

"Most members (89%) were moderately or very pleased with the ASA's advocacy".

Finally, unique to the fourth survey were questions intended to gauge member responses to the ASA's advocacy during the pandemic. The large majority (95%) were made aware of the advocacy campaigns through the President's e-news or other emails, with lower percentages through 'word of mouth' or social media. Most members (89%) were moderately or very pleased with the ASA's advocacy, with only 4% mildly or very displeased. Responders were most aware of ASA's position on PPE (93%), COVID-19 resources (74%), the suspension of elective surgery (70%) and 'public in private care arrangements' (54%).

James Bradley
*Specialty Affairs Adviser*

FEATURE


# EXPERIENCES DURING THE PANDEMIC:

## ROLLING OUT A COMPREHENSIVE HALF-FACED POWERED AIR PURIFYING RESPIRATOR PROGRAM DURING THE 'SECOND WAVE'

**For many anaesthetists prior to the Coronavirus pandemic, giving second thought to face masks was fairly uncommon, perhaps only occurring during bronchoscopy lists for example. It was quite the surprise to learn about all of the complexities of masks including levels of protection, filtration capabilities, fit-checking, fit-testing and finally the more novel devices such as reusable masks.**

Our journey to implementation of a novel medical device began during Victoria's first wave of COVID-19, when it became clear that sustainability of N95/P2 mask use was a significant worldwide issue. As we watched news stories of novel solutions to disrupted mask supply in other countries, our thought processes turned to how we could deal with a situation where our own mask supply was severely disrupted.

The CleanSpace® HALO™ powered air purifying respirator (PAPR) became a device of interest. The device is a half-faced respirator, made in Australia. It is designed with user comfort and protection in mind and has seen use in many countries during the pandemic and in industry since 2018. The primary advantages of the device over disposable masks include wearer comfort, the ability to disinfect and reuse the mask, environmental benefits (including decreased landfill), supporting local innovation with supply chain reliability and a higher level of respiratory protection.

In mid-August 2020, Victoria experienced a 'second wave' of COVID-19. Peninsula Health was allocated 50 HALO PAPR units from Health Procurement Victoria (HPV) as part of a pilot program conducted by the Victorian Department of Health and Human Services (DHHS), in order to guide development of a policy statement for the use of PAPRs in the operating theatre and intensive care units.

With staff infections in our institution rising alongside general case numbers in Victoria, and some of those infections having being traced back to the operating theatre environment, we set about implementing a shared-usage HALO Program that required consideration of infection control procedures to a level not addressed in other institutions to our knowledge.

## WEEK 0

The Peninsula Health Department of Anaesthesia and Acute Pain Medicine was informed mid-week in early August ('Week 0') of the DHHS pilot program. Due to significant restrictions on elective operating in Victoria at the time, two staff anaesthetists (the project leads) were able to be removed from clinical duties to focus on implementing the HALO PAPR project.

After investigation into the experiences of other institutions in rolling out similar programs and identification of key hospital stakeholders, a goal time-frame of clinical roll-out at the start of Week 4 was established.

Relevant regulatory bodies in our institution provided oversight. These included Infection Prevention and Control (IPAC), New Technologies, the COVID Taskforce and the Executive Director of Medical Services. Additionally, a Safer Care Victoria representative was kept informed of progress throughout the project.

It was planned that after 'going live', the project would undergo an evaluation period consisting of process mapping and user evaluation and feedback for approximately 10 cases over a two week period.

## WEEK 1

The first 30 of our units arrived in Week 1 and were tagged and checked by our Biomedical Engineering Department. These units were safely stored in a locked location in the Anaesthetic Department until they were ready to be used.

After meeting with our DHHS Liaison and Clinical Lead (Director of Anaesthesia), a steering committee was formed with significant overlap with the 'super-user' group – the initial group trained in the devices, with ongoing responsibility for coordinating further training. This committee was carefully chosen to include staff that could continue the project on a long-term basis after the initial evaluation period by coordinating ongoing support, training and evaluation. Included were a mixture of consultant staff anaesthetists, consultant staff surgeons, the Central Sterile Services Department (CSSD) manager, the procurement and supply manager, and three senior theatre nursing staff (clinical nurse educator, COVID-theatre supervisor, and an additional assistant nurse unit manager). All displayed enthusiasm towards establishing the PAPR program in a rapid yet safe manner.

Device check and donning of the HALO

At the suggestion of the surgical lead, a surgical registrar was recruited to assist with the data collection for process mapping and project evaluation, and a surgical research co-ordinator to assist with quality assurance and any further ethics committee applications.

Ensuring that the CSSD manager had a chance to undergo device orientation and education with a CleanSpace representative and trainer gave them a chance to voice any concerns about processing and infection control in the early stages of the implementation. The cleaning protocols were designed in conjunction with CSSD and addressed not just the issues surrounding sterilisation of units in a pandemic, but also the logistics of having CSSD manage all cleaning processes. The full cleaning protocol can be found online in the ASA Forum in the Clinical Practice Guideline (CPG), or can be obtained on request to the authors.

The super-users spent the remainder of Week 1 reviewing the device. This was important to facilitate device familiarity prior to commencement of 'train the trainer' education. The project leads commenced the task of writing a comprehensive Clinical Practice Guideline (CPG) that would be used by our institution but also shared with the DHHS to help guide their PAPR policy. The following key headings were identified to be researched and addressed:

# FEATURE

Project leads Dr Chris O'Loughlin (left) and Dr Rob Wengritzky (right) setting up COVID theatre

COVID theatre HALO trolley

- Device background.
- Training and credentialing processes.
- Donning and doffing protocols with full COVID operating theatre PPE.
- Device failure protocols.
- Handling, transport, disinfection and storage processes.
- Feedback and evaluation.

## WEEK 2

Week 2 saw the completion of training for the nine super-users, followed subsequently by an additional 19 regular users (six anaesthetists, one surgeon, ten theatre nursing staff and two theatre technicians). At the time of training, all our staff had been required to have two negative COVID-19 swabs spaced several days apart.

Using two rooms in our simulation centre, we had a group of three users and one super-user (there to help facilitate and to ensure appropriate social distancing and disinfection occurred throughout) undertake the official 45 minute CleanSpace online training session via the Zoom application. On completion of this session, each user was directed to another room where two super-users would spend a further 45 minutes running through our hospital specific protocols giving users time to practise donning and doffing the device and full theatre COVID PPE. This approach was maintained for the first three weeks, to the point at which a subset of super-users was comfortable assuming the role of training new users.

Some of the challenges that presented themselves during Week 2 included logistical issues surrounding storage of units, and handling and transport to and from CSSD. Sealed tubs were used to allow users to doff the device and safely transport to CSSD for cleaning and disinfection. A previously unused cupboard near the COVID theatre was able to be adapted by the engineering department to add power points, a lock, adequate ventilation and a fire alarm. Custom trolleys were ordered to allow storage of the masks, neck supports and head harnesses by size, allowing users to easily select the appropriately sized components for a case. The top of the trolley was fitted with a CleanSpace charging box which was retrofitted with a padlock, to be stored outside the COVID theatre and contain eight charged units ready to go in case of an emergency COVID case.

The CleanSpace HALO design lacks a filter of any sort on the exhalation valve, an issue addressed by wearing a Level 3 surgical mask over the top of the valve. Worn low enough, this allows visualisation of the user's face (given the HALO uses a clear mask). The 'sterile' users (surgeon and scrub team) were given the option to use an after-market filter attachment (available from CleanSpace) should they wish, however this option was not taken up by many as the filter is bulky and not compatible with full COVID theatre PPE, particularly the disposable face shield.

To conclude Week 2, formal quantitative fit-testing was undertaken with an

independent external occupational hygienist using the PortaCount system. This ensured adequate fit of the masks could be achieved in the unlikely event of the units losing power, in which case the units convert to an N99 passive respirator unit. One issue not considered prior to fit testing was the fact that wearing the units in the off-mode (passive mode) could allow back-flow of the user's breath, potentially contaminating the inside of the power unit and the clean side of the filter in the event a staff member was an asymptomatic or pre-symptomatic carrier of SARS-COV-2. It was decided all the filters would be replaced after this fit-test session as a precaution. Subsequently it was discovered that one-way valve inserts specifically designed for fit-testing of the units in the passive mode were available and these were provided by CleanSpace for use in all future fit-testing sessions.

## WEEK 3

Our formal credentialing system was finalised in Week 3. The process is described in detail in our CPG and consists of a three-stage process:

- An initial device orientation and mask selection and fit in-person training session.
- A quiz that required 100% correct answers to pass, primarily multi-choice and focusing on safety and infection control principles. The quiz answers could be found in our CPG which was made available on a training portal and via our intranet document library. A set of training videos (available on request to the authors) was also created for users to watch prior to attempting the quiz.
- Observation by a super-user of adequate device check, donning and doffing following a formal checklist evaluation. This could be completed during 'cold case' sessions described below.

A further 34 users were trained in Week 3 with a focus on training more surgeons who were on the Week 3 and 4 on-call roster and could potentially be asked to bring a case into the COVID theatre.

Surgeon Mr Senthilkumar Sundaramurthy performs the first operation in a HALO PAPR unit

The super-user team also organised to perform mock scenarios in an unused operating theatre. These involved general theatre activities such as simulation of initiation of anaesthesia and surgery and also involved mock surgical and anaesthetic emergencies (such as massive surgical bleeding and anaphylaxis on induction of anaesthesia). The purpose of the simulation was to identify any final issues that required resolution prior to our set 'go-live' date and to test out our biggest concern about the devices – the potential communication issues, given that the HALO unit muffles a user's voice slightly more than an N95 mask but also has the added complication of the unit noise which is near the user's ear. While communication was more difficult, the issue was not insurmountable. Communication principles that were helpful are now taught as part of the HALO credentialing process and include:

- Limit conversation to essential clinical communication only.
- Enunciate and vocalise 30% louder.
- Use staff names (which are written on staff role stickers for each case).
- Make eye contact if possible.
- Use closed loop communication.

# FEATURE

After receiving approval for the CPG and theatre processes from the oversight committees, the HALO PAPRs were able to be used in theatre for the first time late in Week 3 for a non-COVID case – 17 days after commencement of the project. These 'cold cases', as they would become known, allowed all members of the surgical and anaesthetic team to practise using the devices, practise communication and get comfortable with the donning and doffing process of the HALO unit with our full COVID PPE. Our evaluation process could also commence and this allowed us to continue to discover and solve any logistical issues that might arise. For example, the initial time required to fully don eight staff members was 45 minutes (as the donning 'clean room' is also used to house anaesthetic and surgical support staff, trollies and equipment, creating a cramped environment not conducive to multiple staff donning at once). By moving the donning process for the anaesthetic team into theatre, the initial receiving team were able to don in under 10 minutes, allowing them to commence patient assessment and anaesthesia whilst the surgical and scrub teams donned in the clean room.

## WEEK 4

To provide adequate support during the first four weeks of the device implementation, it was communicated to staff that the PAPRs would only be deployed during business hours, until the staff became comfortable and processes had been evaluated. Subsequent expansion to use during non-business hours is planned in a graded manner and this approach has been viewed positively by staff.

Mid-Week 4, and marginally behind our scheduled 'go-live' date, we were able to perform our first suspected COVID case in theatre with all staff wearing HALOs. From this date forth, the COVID theatre would see at least one case per day in it with staff wearing HALOs – these were either COVID cases or more 'cold cases' taken from the emergency parking list. Each case was attended by the project evaluation surgical registrar who documented progress and any issues that required addressing, whilst collecting evaluation data.

Some refinements to our processes that resulted from these sessions included:

- The installation of a mirror inside the COVID theatre that aided with final PPE checks, and allowed users to see the battery indicator lights on the side of their unit.
- Adjustments to microphones used to communicate with the support staff in the clean room.
- The practice whereby the doffing buddy took responsibility for undoing the release clip of the unit to aid users who requested assistance (as the clip can be stiff and difficult to undo for some).
- Documentation of user fit settings into a printed spreadsheet that was available in the donning room so that users need not remember all their sizing settings.

Preliminary analysis of evaluation forms showed a strongly positive response from staff in all assessed domains (device check, donning, comfort, safety, communication, and doffing), with the vast majority of staff stating that they preferred a HALO unit to an N95 mask in the COVID theatre.

At the time of writing, due to the reduction in case numbers in Victoria and resultant reduction in COVID patients requiring surgery, the focus has shifted to training the remainder of theatre staff for HALO use. Close to 200 staff have been formally trained and credentialed for HALO use. A strategy to maintain staff proficiency and confidence in device use, and preparedness for any future outbreaks, is also being considered. For example, a donning/doffing station was set up recently near our COVID theatre. Staff who wished to use a HALO for a case or session could attend this station and don/doff the device there prior to attending their own theatre.

Evaluation and regular review also remain ongoing.

## Acknowledgements

We would like to acknowledge the hard work and support of the super-users and steering committee staff whom this project could not be accomplished without: Katherine Temme, Rosemary Bush, Glenn Matthews, Dr Chris Bowden, Dr David Hunter-Smith, Louise Niggemeyer, Vicky Tobin and Dieanne Corbyn.

We would like to thank all theatre staff for their support and enthusiasm during the project roll-out which continues as we navigate our entry towards 'COVID-normal'.

In addition, we would like to thank Dr Patricia Ferguson (Westmead Health), Dr Cate McIntosh (John Hunter Health), Dr Jonathan Barrett and Dr Michael Patterson (Epworth Healthcare), Dr Justin Burke (Alfred Health), Dr Isaac Cheung (Monash Health) and Dr Lachlan Miles (Austin Health) for their advice and assistance during the initial design phase.

Dr Robert Wengritzky
Dr Chris O'Loughlin
Dr Leo Cordova
*Peninsula Health*

## DECLARATION OF INTEREST

CleanSpace HALO PAPR units were provided to Peninsula Health by Health Procurement Victoria (Department of Health and Human Services). CleanSpace provided support and donated replacement damaged parts and some consumables during early phases of the program. The authors declare no other financial interests or conflicts.


# ELECTRICAL SAFETY FOR STAFF AND PATIENTS – WHAT'S THE STANDARD?

**Most of us take the supply of electricity in a hospital for granted, as it generally just works.**

It may therefore be a surprise to know that we as clinicians are part of the electrical safety system, and have a role to play in protecting both patients and other staff from electrical hazards.

If you haven't considered this before, just think about what our work in an operating theatre includes: we work with immobilised and unconscious patients and tether them by conductive wires to electrical equipment plugged into the mains (power company supplied 230 volt). We insert invasive monitoring and conductive tubes of fluids into their body which can also leak onto the electrical powered operating table and run down into the mechanism. The same goes for the bag of electrically conductive IV fluids you have hanging above the mains powered syringe driver on a drip stand.

To add to this risk we have surgical diathermy being used to purposefully direct electrical current into a patient's body without accidentally affecting staff.

Occasionally the hospital power supply fails and we have the opposite problem of no electricity.

When we factor in major procedures with frail or critically unwell patients, it is clear that there needs to be a robust set of requirements to minimise the chance of electric shock and electrical supply failure.

## SOME OF THE SPECIFIC QUESTIONS ANAESTHETISTS MAY NEED TO ADDRESS

1. Can a central line or pacing lead be safely inserted in a hospital ward area or is there a risk of microshock to the heart?
2. Do you need a 'body protected' or 'cardiac protected' room to use an anaesthetic machine within a specific hospital location?
3. Why is the 'Line Isolation Monitor' alarm sounding in the operating room and how do you stop it?
4. Is it safe to start a new procedure during a power failure because the hospital has a generator?

# FEATURE

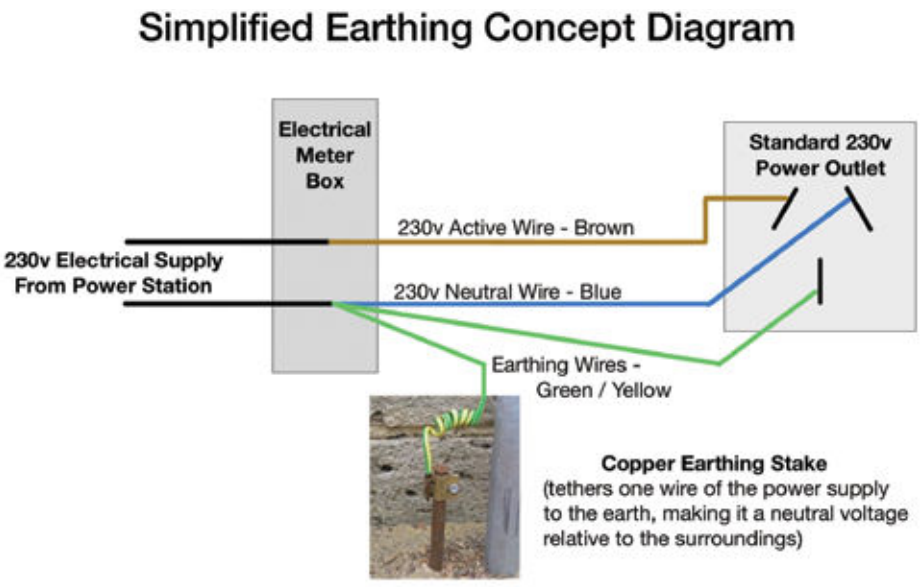



Diagram 1: Simplified earthing concept diagram – 230v AC supply

Information on these topics may be provided in part by textbooks or local hospital protocols addressing aspects of electrical safety, however there is a specific standard titled: 'AS/NZS 2500:2020 – Safe use of medical electrical equipment in health care' which is a useful generic resource for Australian and New Zealand clinicians and covers a wide range of relevant topics.

This standard received a major overhaul in 2020 to ensure it is relevant to modern technologies. The review included substantial clinician input to improve readability from a clinician perspective as opposed to the more typical engineering language used in medical equipment standards.

Unlike the majority of medical equipment standards which are normative for equipment design, this one is intended to provide a resource to support clinicians in understanding what is best practice for electrical safety when using diagnostic and therapeutic equipment. It also indicates which features the hospital environment are meant to include and can be used as a resource to justify inclusion of appropriate equipment or location safety features if they are not already provided.

Whilst the standard can be consulted for greater detail, some of the more frequent electrical safety questions encountered by the author are discussed below.

## SOME ELECTRICITY BASICS AND WHY WE HAVE AN ELECTRICAL 'EARTH'

If we make an analogy between the blood circulation and an electrical circuit then blood pressure is akin to voltage, blood vessels are the wires and blood flow is like an electric current. Unlike blood flow, electric current will usually stop immediately if you break the wires: you therefore need two electric wires connected to anything conductive (including people) for current to flow: a supply source of electricity *and* a return pathway for that electricity.

In a typical home or hospital mains electrical supply, the 230 volt supply changes direction at a frequency of 50 times per second (50Hz) and results in delivery of an alternating current (AC). The alternating part allows transformers to step voltages up and down during power transmission. The 50Hz frequency was originally chosen for efficient use of electric motors, however this is unfortunately an ideal frequency to trigger ventricular fibrillation if sufficient current travels through the heart.

In the early days of mains electrical supply distribution, electrocution due to faulty connections was not uncommon. A loose wire inside a metal-encased appliance could make the whole appliance into a 'live' electrical connection and current could flow through anyone or anything which came in contact – provided there was a return pathway. This return pathway could take the form of other faulty appliances or metal objects accidentally connected to the electricity supply. To minimise this risk, we use the concept of 'earthing' or 'grounding' the electricity supply. Whilst the theory of earthing can fill a thesis, the underlying principle is that exposed and uninsulated metal parts of appliances within a building are all connected to each other by wire (the earth wire in each plug and socket of a 230v electrical system), so there should not be a voltage difference between exposed metal surfaces in the event of an electrical fault inside any appliance. Some older installations have other metal surfaces (like plumbing pipes) connected to the earth wiring.

To further enhance this system, one of the two alternating current wires from the power station to the building is connected to the earth wire at a point just outside the building (see diagram 1), which makes this lead 'neutral' (the other lead is 'active'). So you have two supply leads (active and neutral) plus one earth wire going into the house. This means that if the active wire inside an appliance contacts the earthed case, then excessive current flow will ultimately flow back via the neutral power supply wire (a so called 'short' circuit) which will overheat and break a fuse incorporated in the circuit.

For additional safety, the earth connection is also joined onto a copper stake driven into the actual earth so that

everything around your house should be at a similar functionally neutral voltage (even if underground electrical cables are damaged). This also has a beneficial effect to prevent substantial voltage differences across a building in the event of a lightning strike. To provide additional protection against electric shock, residential buildings are now required to have a residual current device (explained later in the text).

## MICROSHOCK AND CENTRAL LINES OR PACING LEADS

You might recall from anaesthesia training that there is a risk of microshock if you are working with conductive wires or catheters being inserted near the patient's heart and that you need a 'cardiac protected' location to do these sorts of procedures.

The concept of microshock refers to electric leakage currents from medical equipment which are of such low intensity that you can't feel them if you touch the outer case, but which are still strong enough to cause ventricular fibrillation if you somehow link them to a conductor touching the heart. This has certainly been confirmed scientifically with older studies which looked at fibrillation thresholds and found that under specific circumstances as little as 10 micro-amps of alternating current fed into the right ventricle was enough to induce VF.

Our human threshold of perception to detect an alternating electrical current through our skin is about one milliamp (mA), or 100 times the VF threshold. Despite this, there is little objective evidence that harm from microshock happens commonly in the clinical environment and this may be in part due to the many safety standards which are enforced.

According to AS/NZS2500, inserting a central line does *not* invoke the requirements to protect against microshock. This sounds counter-intuitive,


Diagram 2: Cardiac protected electrical area sign – the body protected area sign is similar, but with a human stick figure image inside the box

but reflects the fact that the guidewire is not insulated through the majority of its course in the body, and any current transmitted is likely to be dissipated across a large volume of blood and tissue compared with the final wire tip which will usually not even enter the right ventricle but may impinge on the right atrial wall. Mechanical stimulation of atrial ectopic beats is not uncommon in this circumstance.

The procedures where microshock is thought to be a significant risk are those where insulated pacing (or ECG sensing) leads are being inserted into or against ventricular tissue, and also pulmonary artery catheter use (because electrolytic fluid provides a conducting pathway inside the insulating wall of the catheter between an external fluid connection and ventricular tissue).

Having a safe location to perform procedures at risk of microshock requires both an appropriate mains electrical supply ('cardiac protected' – see diagram 2) *and* safe medical devices which are cardiac protected (with a 'CF' sign on the back of the equipment) for any patient applied parts which could contact the relevant lead or catheter. It is not sufficient to have only the power supply *or* the device cardiac protected, as they are both protecting against different things. A cardiac protected electrical supply has heavy duty earthing


Diagram 3: Cardiac protected electrical area earthing test point

connections (see diagram 3) in addition to other safety features so that microshock level electrical current should not be present in external cases of equipment or metallic building fixtures which you or a patient may contact. A cardiac protected medical device may still have dangerous current levels internally but ensures that the 'applied parts', which are connected to a patient, are sufficiently insulated to avoid transmitting more than 10 micro-amps of current flow.

## BODY PROTECTED HOSPITAL LOCATIONS VS YOUR HOME?

We have already considered earthing and microshock. If we contact an earthed device (easy enough to do) and also an active electrical wire (e.g. putting a knife in the toaster), then earthing doesn't protect against this problem because we become the circuit. At higher current levels (easy to achieve with 230v) we start to approach the traditional concept of electrocution, where involuntary muscle contraction happens somewhere around 7mA, and above 10-15mA the muscular effects are so powerful that if your hand is grasping the current source, you cannot voluntarily let go (the so called 'let-go' threshold). This is one of the worst

# FEATURE


Diagram 4: Operating Room RCD outlets from a generator power supply (red colour outlet)


Diagram 5: Operating Room line isolation monitor (LIM) protected outlets from an uninterruptible power (blue outlet)

scenarios as far as electrocution risk goes: aside from potential burns from the energy involved, sufficient current may flow across the thorax and into the heart to cause ventricular fibrillation. Clearly this is best avoided and this is where a device called a Residual Current Device (RCD) protects us: this monitors current flowing through the active supply to your house and automatically cut the power supply if more than 30mA is leaking somewhere and not coming back through the neutral wiring. This is below the threshold for current to trigger VF based on the resistance in most people's skin. It also takes into account the fact that you reflexively move away from a brief electric shock before sufficient energy has been transferred to cause serious harm. For operating theatres, the choice was made to enforce RCD activation at 10mA, due to the fact that we have potentially unconscious patients connected to electrical systems and who can't respond to protect themselves (see diagram 4).

Line isolation monitors (LIM) perform a similar function to RCDs but use a different method: without going into full details, the concept is that a special type of transformer is used to produce a 'floating' power supply for the operating room, which is only supplying current to and from the power outlet, and not connected electrically to any other object in the room (see diagram 5). Touching any of the 230v mains supply wires individually whilst touching an earth, will not therefore have any return pathway and you (or the patient) remain safe. The line isolation monitor is continually checking if this system works properly, and the alarm will sound if there is a failure of the system (some LIMs display the potential leakage current which would occur in an electrocution situation). This is effectively two level protection: preventing a hazard from occurring in the first place, and alerting if the system is not working properly. This system has advantages over RCDs where life support equipment is being used: it still protects against a specific level of electric shock under normal conditions but connected equipment will not be immediately shut down in the event of an incomplete failure of the system (e.g. potential leakage goes from 2mA up to 13mA). The appropriate initial response is to disconnect potentially faulty or non-essential equipment from the room supply where this is safe from a clinical perspective (often the last thing you plugged in before the alarm triggered). The power supply will still function if the alarm persists but there is a 'potential' hazard from one or more devices connected to the system so further action needs to take this into account. All modern homes should have 30mA RCDs whereas hospital operating theatres may have a combination of both RCD and LIM outlets depending on the intended use. The combination of a LIM and the necessary transformer system is expensive and not normally used in homes.

## ELECTRICAL SUPPLY BACKUP OPTIONS

Most hospitals will have a variety of power supply sources including:

1. Electricity from the mains electrical grid (sometimes more than one feed into the hospital) for routine power supply.
2. An on-site backup generator supply which should start automatically in

the event of a power failure (most hospitals).

3. An uninterruptible power supply (UPS) which, as the name suggests, will continue uninterrupted should the mains supply fall. This is not a long term supply. Some hospitals will have UPS power outlets for plug in equipment, but in many cases these supplies are only connected to operating theatre (surgical) lights.
4. Inbuilt battery backup for some medical devices.

Many Australian states have seen their hospitals depending on their backup systems in recent years with a statewide blackout in South Australia in 2016 being perhaps the most striking example.

Each hospital should develop their own contingency plan to include an understanding of the available power supply options as the duration will vary.

Generators are often diesel powered and depend on an ongoing fuel supply and may be unreliable under high demand. UPS outlets have a battery sourced supply system which is continuously charged from mains electricity and therefore has a finite duration of action – most likely only a few hours at most unless the generator system is able to recharge them in use. These are intended to prevent sudden and complete loss of power but are only a short term solution. There are also separate power outlets intended for use by cleaning staff. These have a standard mains supply and should not be used routinely for medical devices unless you would like the cleaners to unplug them.

Operating theatre pendant with both generator and UPS electrical outlets

Each power outlet is colour coded by standard as per the table below (see also diagrams 4 and 5 which show optional supply and protection method combinations).

Each hospital anaesthesia department should ideally have a strategy to ensure that equipment is connected to the appropriate outlet to minimise the risk of patient harm in the event of a power failure.

The AS/NZS2500 standard is available free of charge through many medical libraries (licensed for viewing by a single user), and may also be available to view in hospital biomedical engineering departments. Given this is one of the few medical equipment standards directed at a clinical audience, obtaining a copy for reference within the anaesthesia department is likely to be useful.

Table 1
Colour coding for Australian hospital power outlets

| Power source | Outlet colour | Suggested uses |
|---|---|---|
| Mains (power station) supply | White | Non-critical medical devices with high current draw, eg: forced air warming devices |
| Generator backup | Red | Medical device which can function briefly on battery backup |
| UPS | Blue | Critical medical devices and those which do not tolerate loss of power without data loss (eg: heart lung machine, anaesthetic machine with monitors or computing systems dependant on mains power |
| Cleaning only | Beige | Electrically powered cleaning equipment |

Edward Murphy
*Senior Staff Specialist Anaesthetist*
*Anaesthesia Department Equipment/ Standards Coordinator*
*Royal Adelaide Hospital*

# CONGRESS FLASHBACK

This year proved a frustrating period for many of us who were looking forward to getting together at the Combined Scientific Congress in Wellington in October. In fact, it was a frustrating year for anyone who enjoyed catching up with friends and colleagues at any event, especially those amongst us who like to get a little dressed up.

If you spent time this year reminiscing about conferences and gala dinners you were not alone. This would ordinarily be an issue which featured some glamour shots from the CSC or NSC.
We missed seeing photos of your congress highlights, so what better time than to revisit the past and fun times of old. We hope you enjoy the following flashback pages and look out for any familiar faces you can spot!

## NSC 2005 – BROADBEACH

Greg Deacon with the NSC 2005 Organising Committee. Convenor Anthony Coorey holds the Certificate of Appreciation

Dave Fenwick is presented with the President's Medal by President Greg Deacon and Vice President Richard Clarke

ASA members of the Australian Defence Force

Entertainment at the gala dinner

Andrew Mulcahy receives the President's Medal for his contribution to and leadership of EAC

Millie and Michael Fanshawe (Scientific Convenor) with John Lauritz

Jeanette Thirlwell is honoured with Life Membership of the ASA

Greg Deacon, Peter Fenner, Tanya Brycker, Richard Waldron and NSC Convenor Anthony Coorey

Back: Charlie Collins, Greg Deacon, Peter Lawrence, David Pescod, Chris Bowden, Daniel Jolley, Brian Spain
Front: Pedro Ibarra, Steve Kinnear, Kester Brown and Rob McDougall

Past Presidents Jim Bradley, John Hains, Greg Deacon, Greg Wotherspoon, Don Maxwell, John Richards and David McConnel

# NSC 2006 – COOLUM

NSC 2006 Organising Committee

Welcome Reception

Desmond Sweeney, Greg Deacon and Chris Meadows

Alan Stern, Kerry Warner, Rosemary Camuglia and Michael Tuch

David and Roslyn Gibb and John Hains

Greg Deacon, Anna Granger and Jim Bradley

Helen Hains, Don and Jan Maxwell

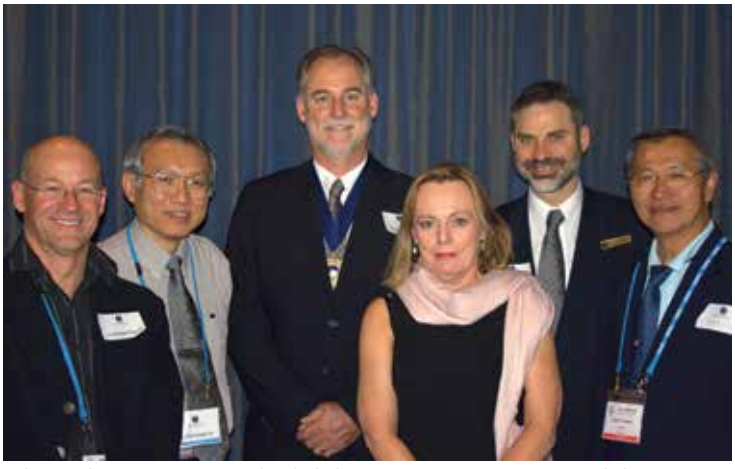
Wally Thompson and Gai Thompson

# AUSTRALIAN ANAESTHETIC IDOL


# NSC 2007 – PERTH

2007 Organising Committee

Andrew Mulcahy, Piers Robertson, Cassandra Hargreaves, John Laurtiz and Jim Bradley



Mike Paech, Tat-Leang Lee, Richard Clarke, Liz Feeney, Greg Deacon and Thara Tritrakarn

Andrew Mulcahy with Richard and Vera Riley

Mike Farr and Vida Viliunas

Nigel Symons, Mike Hodgson and Greg Deacon

# BATTLE OF THE BANDS








# CSC 2008 – WELLINGTON, NZ


ASA Booth

Piers Robertson, John Lauritz, Andrew Schneider and Jim Bradley

Back row: David McConnell, Richard Clarke, Gregory Wotherspoon, Greg Deacon, Rod Westhorpe, John Gibbs, Mark Bukofzer, Annette Turley, David Jones, Graham Sharpe, David Sage and Jim Bradley
Front row: John Hains, Trevor Dobbinson, V.B. Cook, Elizabeth Feeney and Andrew Warmington


Graham Sharpe and Philippa Bascand


Rob McDougall and Puakena Boreham


Richard Clarke, David McConnell, John Hains and Greg Deacon


Richard Clarke receiving a traditional Maori welcome.


Keith Ruskin and Steve Yentis and Daniel Sokol


Greg Deacon, Steve Yentis, Leona Wilson and Stephen Gatt


Andrew Mulcahy, Kerry Pendergast and Greg Deacon

# NSC 2009 – DARWIN

Linda Weber, Elizabeth Feeney, Michael Paech, Neville Gibbs, Jeanette Thirwell and John Loadsman

Gerry Turner

Notoriously Bad

Tap Chatterjee

Mark and Anita Sinclair

2009 NSC Organising Committee
Back: Piers Robertson, Attila Nagy, Linda Partridge, Carolyn Wood, Chris Purser, Peter Harbison, Simon Macklin
Front: Waleed Alkhazrajy, Brian Spain, Derrick Selby, Mark Sinclair, Paul Herreen, Libby Freihaut

Delegates at the gala dinner

Opening ceremony

Hanging out with friends

Andrew Warmington, President of the New Zealand Society of Anaesthetists, Elizabeth Feeney and Richard Birks, President of the Association of Anaesthetists of Great Britain and Ireland

# NSC 2010 – MELBOURNE

Catching up with friends at the cocktail party

Delegates arriving at the gala dinner

Retired Anaesthetists Group lunch

Council lunch

David M. Scott

The 2010 Organising Committee: Antonio Grossi, David A. Scott, Andrew Wyss, Andrew Mulcahy, Renald Portelli, Richard Grutzner, Jenny King, Simon Reilly, Peter Seal, Mark Sandford and Jean Allison
Front Row: Andrew Schneider and Michael Boquest.

Delegates hit the dance floor

2010 Anaesthesia Continuing Education Co-ordinating Committee: Peter Lawrence, Greg Deacon, Elizabeth Feeney, Kate Leslie, Jeanette Thirwell, David Elliot, Nicole Phillips, Ted Hughes, Carolyn Handley, Peter Maclean, Alex Terry and Michael Tuch

Entertainment at the gala dinner

Gala dinner

# NSC 2011 – SYDNEY

Andrew Patrick, Mark Colson, Mark Sinclair and Elizabeth Barker

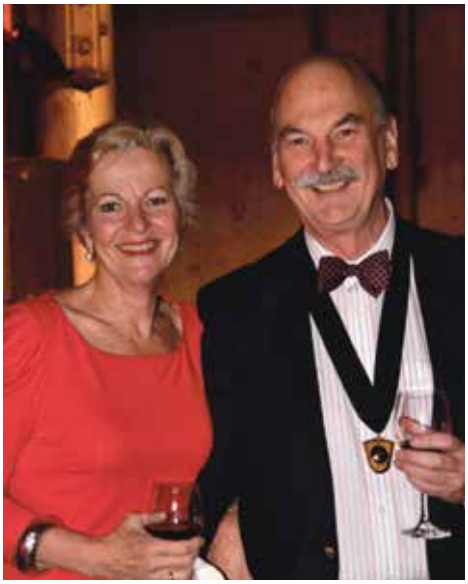
Michael Levitt and David Elliott


Delegates at the gala dinner

Catching up with friends at the gala dinner

Interesting choice of canapes

Andrew Mulcahy and Ross Holland



Margot and Rod Westhorpe


David McConnel, John Hains and Staffan Ahlstroem

Renald Portelli, Karen Kharasch and Andrew Schneider

Rob and Fiona Sneyd, Mark Skacel and Piers Robertson

Children enjoying the petting zoo at the Family 'Aussie Bush Dance'

# NSC 2012 – HOBART

GAS/ACT lunch

Cocktail reception at the Museum of Old and New Art (MONA)

Gala dinner at Princes Wharf

Don Chalmers, convenor Cameron Gourlay, Peter Underwood (former Governor of Tasmania) and Andrew Mulcahy

Welcome drinks

Delegates take to the dance floor

# NSC 2013 – CANBERRA

Ice cream is always popular


GAS/ACT trainees


AFL Grand Final screening


Testing out the sporting equipment at the Australian Institute of Sport

2013 NSC Organising Committee

Conga line in the Grand Hall

Delegates hit the dance floor

President's cocktail party

Gala dinner at Parliament House

# NSC 2014 – GOLD COAST

Guy and Sue Christie-Taylor

Andrew Schnieder, Nikki Barnes, Andrew and Leonie Mulcahy

Stephen Bruce, Kim McLennon, Anthony and Millie Coorey

Genevieve Goulding and Vida Viliunas

Gerald Turner, Linda Weber and Mark Sinclair

Ted Hughes and Margaret Blakely

Families enjoy 'A Night at the Movies'

Sylvester welcomes families on the red carpet

Photo op with Tweety Bird

Jane and Richard Grutzner with David M. and Rachel Scott


2014 NSC Organising Committee: Cameron Hastie, Anthony Coorey, Stephen Bruce, Cameron McAndrew, Peta Lorraway, Philip Melksham, Patrick See, Chris Richardson, Mitchell Morse, Guy Christie-Taylor

Delegates hit the dancefloor

Ted Hughes, Margaret Blakely, Renu Borst, Genevieve Goulding, Guy Christie-Taylor, Jane Harrop-Griffiths, Sue Christie-Taylor and William Harrop-Griffiths

RAG lunch


Delegates enjoy the entertainment

# CSC 2015 – DARWIN

Delegates hit the dancefloor

Penelope and John West, Guy and Sue Christie-Taylor

GASACT at the CSC, Darwin. Back: Dennis Millard, Greg Bulman, Ben Piper, Christopher Mumme, Adam Hill, James Anderson, Scott Popham.
Front: Brigid Brown, Nichole Diakomichalis, Debra Leung, Jennifer Hartley, Karla Pungsornruk

Workshop Coordinator Brian Spain congratulated by Guy Christie-Taylor

Dinner guests in the loud and colourful dress code


Members of the CSC Organising Committee celebrate a successful Congress with Guy Christie-Taylor

The band entertains attendees at the gala dinner

Cameron Hastie, Brett Chaseling and Graham Mapp dressed to impress

Congress delegates at Crocosaurus Cove

RAG lunch: David M Scott, John Gibbs, Don Maxwell, Don Stewart, Diana Khursandi and Rod Westhorpe

# 2020 IN REVIEW

## POLICY UPDATE

**Submissions:**

- **8** submissions to relevant fields of inquiry

**Government consultation:**

- **128** Stakeholder Engagement meetings

**Surveys:**

- **8** surveys sent to members

**239** policy queries

**89%** completion rate

**55** letters written to healthcare stakeholders in government, non-government, and private healthcare

## EVENTS UPDATE

**UNIQUE OPPORTUNITY FOR MEMBERS**

**November-December**

Pilot project with CleanSpace HALO

**64**

members attended fit-testing workshop

**1,200+**

**members attended Webinars**

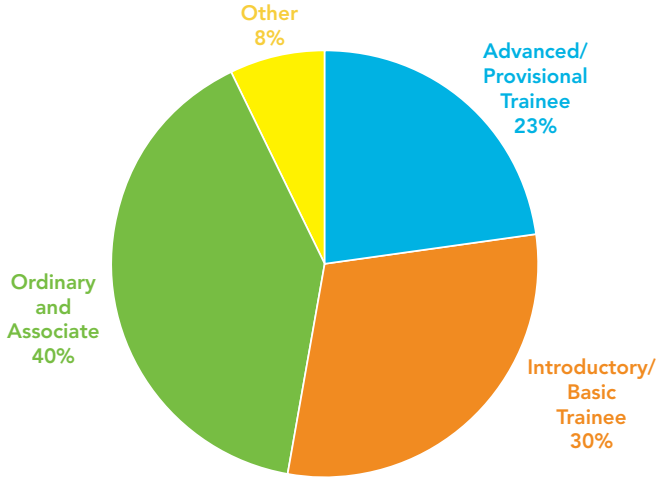
**212**

**Face-to-face events held**

**275** attended **VIVAS**

# MEMBERSHIP UPDATE

## New member statistics




**398** new members

# MARKETING & COMMUNICATIONS

## Harry Daly Museum


**4,200** visits to online collection

## ASA enews


**40** COVID-19 updates

**26** enews

**18** media releases

**148** media articles

**3.8m** potential audience reach

**$5.7m** advertising equivalent

## ASA website

- **82%** increase in sessions
- **99.95%** increase in new users
- **58%** increase in page views

**5.7k** followers
up by **1k**

**2.4k** followers
**5.5k** engagement
up by **3.4k**

**21** podcasts


*Note: All information and statistics for the period of November 2019 to November 2020.*

INSIDE YOUR SOCIETY

# ECONOMICS ADVISORY COMMITTEE

DR MARK SINCLAIR
EAC CHAIR

## MEDICARE BENEFITS SCHEDULE (MBS)

As members will by now be aware, the telehealth items introduced into the MBS during the COVID pandemic were originally to expire on 30 September 2020. The Federal Government has extended this expiry date to 31 March 2021. **The ASA will now work on the introduction of permanent telehealth items.** There is widespread agreement among medical bodies that telehealth services are an important aspect of medical practice, and that they should not be limited to just rural and remote areas. A podcast led by President Dr Suzi Nou, discussing telehealth issues with me, can be found on the ASA members website.

Members will recall that the Anaesthesia Implementation Liaison Group (AILG) was formed in 2018, to finalise the implementation of changes to anaesthesia MBS items as a result of the MBS Review. The AILG agreed that the deletion of item 22070 (administration of cardioplegia solution during cardiopulmonary bypass, 10 units) should be reviewed. As a result, the Federal Government will increase item 22060 (whole body perfusion/cardiac bypass by a medical perfusionist) from 20 units to 30. This change will occur on 1 March 2021.

The ASA expresses its gratitude to the Taskforce and Department of Health (DoH) for this step, and also thanks the AILG for its work. In particular, the others on the team of anaesthetists on the group who informed the decision of the AILG deserve mention. These include Dr Andrew Mulcahy (ASA), Dr Michael Jones (ANZCA), Dr Charles Nadin (GP Anaesthetist, College of Rural and Remote Medicine), Dr Joe Power (Australian Society of Medical Perfusion), and Dr Matthew Doane and Prof David A. Scott (acting as independent academic anaesthetists).

Further work is required on the deletion of item 21981 (anaesthesia allergy testing). This item was allocated four RVG units, plus the appropriate anaesthesia time item. Item 21981 was deleted by the Dermatology, Allergy and Immunology Clinical Committee (DAIC) of the MBS Review, without consultation with the ASA. Item 12005 was introduced into the MBS at the same time, for allergy testing for "agents used in the perioperative period", and had the same MBS Fee as did item 21981 at the time. However, the DAIC appeared unaware the loss of an anaesthesia time item drastically reduced the total rebate, to the point of the service being unviable in the private sector without a substantial out-of-pocket expense to the patient.

Item 22001 (autologous collection/transfusion of blood in association with the administration of anaesthesia) was also deleted. Members may recall that the Anaesthesia Clinical Committee (ACC) recommended deletion of 22001, believing it covered pre-admission donation of autologous blood for later re-transfusion. This service was not covered by 22001, nor by any MBS item, and the ASA never believed such an item was

The MBS Review Taskforce notification to stakeholders stated in part:

### Why is this change being made?

This change is a Government response to stakeholder concerns of the impact removing item 22070 (cardioplegia – stopping the heart) has had on providers of this service and consumers requiring the service. Increasing the schedule fee for item 22060 (whole body perfusion – heart bypass) by 50% compensates for the deletion of item 22070 on 1 November 2019.

### What does this change mean for providers/consumers?

From 1 March 2021, the schedule fee for item 22060 will increase by 50% ($408 to $612) to compensate for the deletion of item 22070 for patients undergoing heart surgery and requiring whole body perfusion. This change addresses both provider and consumer concerns by ensuring appropriate remuneration for whole body perfusion and reduced out-of-pocket costs to consumers.

needed. This was a clear example of the flaws inherent in the MBS Review process. The descriptor for 22001 clearly stated "in association with the administration of anaesthesia".

The ASA will also continue to work on correcting this situation, although the wording of the original descriptor may need changing. Procedures such as intraoperative cell salvage and intraoperative normovolaemic haemodilution (NVH) are worth considering. Of note, the Blood Products Implementation Liaison Group (ASA representative Dr Greg Deacon) supports the inclusion of NVH in the MBS. Also of note, the 22001-equivalent item 13709, in the Haematology subgroup of group T.1 (Miscellaneous Therapeutic Procedures) (MBS Fee $49.25) remains, although this has been subject to review and may change.

## MEDICARE ITEM AUDITS

The ASA has dealt regularly with the Compliance Operations Branch (COB) of DoH over the years. The COB is part of the Provider Integrity Benefits Division of DoH, and is responsible for investigating possible inappropriate or incorrect Medicare claims.

Naturally, it is essential that MBS items are appropriately utilised, and that taxpayers' money is not spent inappropriately. The ASA has assisted COB in understanding the workings of the RVG as it pertains to clinical anaesthesia practice, and this has often overcome any concerns they have expressed about billing patterns. We have also assisted a large number of individual ASA members facing audits of their Medicare claiming patterns.

The most recent meeting with COB and other relevant DoH officials was held in March this year. They again raised concerns about the number of anaesthesia claims which were not matched with an 'eligible' surgical claim.

MBS Explanatory Note TN.10.2 states:

*Generally, a Medicare benefit is only payable for anaesthesia which is performed in connection with an 'eligible' service. An 'eligible' service is defined as a clinically relevant professional service which is listed in the Schedule and which has been identified as attracting an anaesthetic fee.*

In practical terms, this means the surgical/procedural MBS item should have the term '(Anaes)' included at the end of its descriptor. A quick review of the MBS will reveal that hundreds and hundreds of such surgical items exist, across all surgical and procedural specialties.

There are of course several reasons why an anaesthesia claim may not be matched by a surgical claim. It may be due to clerical errors or delays in surgical account processing. On some occasions we have been informed that a surgeon did not bill for a second or subsequent operation for a surgical complication. Sometimes a 'public patient in private' may be operated on by a surgical registrar or salaried surgeon, with no Medicare claim lodged. COB accepts that these situations may arise, and is not concerned, as such cases are small in number.

However, at the March meeting it was revealed that some individual anaesthetists have many hundreds of claims not matched by a surgical claim. No ready explanation could be found, and DoH expressed its intention to investigate this further.

The COVID situation clearly delayed matters, but in September, notifications were sent to a number of anaesthetists, requiring proof that the anaesthesia and surgical services actually occurred. As we have always advised, members should contact the ASA and their medical defence organisation immediately, should they receive such correspondence from DoH.

We strongly advise against speaking to the DoH official who sends the letter, as in our experience this only serves to confuse matters and cause even more stress to the anaesthetist involved. Generally speaking, DoH officials do not have a clear understanding of clinical medical practice, and simply follow a set of guidelines as to how to progress these matters. This can be seen in the wording of the "requests" for proof of the correctness or otherwise of the claims, which border on being threatening, and are certainly very confronting to the individual practitioners concerned. We have discussed this with DoH in the past. COB officials reassure us that they are fully aware that most inconsistencies in claims are innocent. They are the result of simple errors or misunderstandings, and truly fraudulent claiming is extremely rare. Unfortunately, the tone of the written correspondence offers no such reassurance to anaesthetists on the receiving end.

In almost all of the cases brought to the attention of the ASA by these members, the issue was the use of item 20170 (anaesthesia for intra-oral procedures, not otherwise specified). The MBS Fee for 20170 is currently $120.60 (six RVG units). The anaesthetists concerned were working with fully qualified oral maxillofacial (OMF) surgeons, and in fact OMF lists accounted for almost their entire private practice workload – hence the large number of claims. They believed 20170 to be the correct item, rather than item 22900 (anaesthesia for dental extractions) as 22900/22905 are classed in the MBS book as "anaesthesia in connection with a dental service". As several of the members involved have told me – they rightly felt that OMF surgeons should definitely not be classed as 'dentists', so they used an 'oral surgery' anaesthesia item.

However, quite unknown to the anaesthetists, the OMF surgeons were billing dental items for procedures such as wisdom teeth extractions (which has no MBS item). Hence there were many

# INSIDE YOUR SOCIETY

hundreds of anaesthesia claims for 20170, with no matching surgical MBS claims.

**The ASA strongly advises members to use items 22900 and 22905 for anaesthesia for dental extractions and restorative dental work, respectively, regardless of which surgeon is operating.** This should not be seen as belittling the extensive qualifications of our OMF colleagues, as the RVG does not specify the qualifications of the surgeon involved. It simply refers to the anatomical nature of the surgery.

The ASA has liaised extensively with DoH and COB officials on this matter, but at the time of writing the matter is not finalised.

Items 22900 and 22905 are excluded from the 'eligible surgical service' requirement, under Explanatory Note TN.10.14 :

*Items 22900 and 22905 cover the administration of anaesthesia in connection with a dental service that is not a service covered by an item in the Medicare Benefits Schedule i.e removal of teeth and restorative dental work. Therefore, the requirement that anaesthesia be performed in association with an 'eligible' service (as defined in point T10.2) does not apply to dental anaesthesia items 22900 and 22905.*

Our legal team at HWL Ebsworth, experienced at dealing with the legal aspects of MBS matters, has also written an extensive submission.

Of note, the MBS Fees for items 22900 and 22905 are exactly the same as for 20170, so there has been no financial loss to Medicare.

ASA President Dr Suzi Nou and I have discussed the issue of Medicare audits on a podcast available to members on our website.

## PRIVATE HEALTH INSURANCE

Members are by now no doubt aware of several initiatives created by private health insurance(PHI) companies, aimed at reducing out-of-pocket expenses for certain orthopaedic and obstetric procedures. A number of ASA members have approached us with concerns about the terms and conditions in the proposed contracts.

At the same time, some insurers are clearly aiming to gain more control over the provision of care in the private sector. The most well-known example is the purchase of a 49% interest in a NSW private hospital. But this is not the only step being taken, by any means.

Typically, the offers from PHI involve the promise of an 'uplift fee' in addition to the usual combined Medicare/PHI rebate for the anaesthesia service. This fee is fixed by the insurer. There is no mention of indexation in the future. The ASA recommends all billing be based on the RVG, not an arbitrarily fixed sum, in order to take into account all relevant factors such as the age and medical condition of the patient, and the total anaesthesia time.

Some of the contracts also contain very firm confidentiality requirements, with discussing of the arrangements totally banned. This would include discussing anything about the fees on offer with the ASA. There are also, in one draft we have seen, totally open ended requirements to follow 'all directives' of the insurer.

The offers may at first appear to be attractive, but members should be very wary of what may or may not happen once they have signed up and handed certain powers to insurers.

**The EAC maintains its position that the only 'contract' an anaesthetist should enter into is to provide best possible care to his or her patient.** Your fee for your professional services, and any out-of-pocket which might result, is of course an essential component of your discussions with patients, in order to fulfil this duty.

Further information can be found on the ASA website with general advice about reading contracts, our concerns around managed care as well as Medicare audit information.

# PROFESSIONAL ISSUES ADVISORY COMMITTEE

DR PETER WATERHOUSE
PIAC CHAIR

As 2020 draws to a conclusion, two main issues have dominated the professional issues advocacy of the ASA.

## SLOW RELEASE OPIOIDS

The use of slow release opioids in peri-operative practice has been the object of considerable scrutiny. Earlier in the year, the Therapeutic Goods Administration (TGA) and Pharmaceutical Benefits Scheme (PBS) sent a strong message to prescribers, withdrawing support for these agents for all uses other than the management of moderate to severe chronic pain unresponsive to nonnarcotic analgesia.

The recent ASA survey addressing this issue was undertaken to provide a snapshot of anaesthetists' use of SR opioids and their feelings about them.

The results will hopefully assist the profession as it attempts to strike the balance between post-operative analgesia and opioid-related harm.

Thanks to all who took the time to respond to this survey.

## MANAGED OR CORPORATISED MEDICAL CARE

This has been a fast-moving area. Australian health insurance companies have been actively redefining their role in the healthcare economy.

Traditionally, health insurers have existed to fund care provided by the other two pillars of our system: hospitals and providers including doctors.

Recently there have been several examples of health funds extending well beyond their traditional role. Examples include:

- Purchasing hospitals.
- Direct provision of previously hospital-based care including rehabilitation.
- Exploration of 'bundled' care models under which care is provided by contracted doctors who accept health fund terms and payment.

Medibank Private even states on its website: *Medibank began as a health insurer and is transitioning into a broader healthcare company.*

There are risks associated with health insurers dominating the private health economy. Many stem from the fiduciary duty of the insurer to act in the best interests of its shareholders. Inevitably the interests of policyholders and shareholders will not always align.

### Bundled care and transfer of risk

Health fund attempts to pay a predetermined fee for an episode of care are becoming more common. The attraction for the fund is easy to understand. Financial risk for patients' treatment is transferred to hospitals and providers.

This system is most problematic where patients suffer complications, require long admission to hospital and multidisciplinary care. Once funding via the 'bundle' has been exhausted, cost for ongoing care is presumably met by the hospital, healthcare providers and the patient. This arrangement is a stark departure from the conventional understanding of insurance.

Furthermore, it is uncertain that this arrangement would generate savings at a health system level. In order to allow for cost blowouts from complicated patients, bundle payments would need to be far greater than required for the majority of uncomplicated episodes of care.

### Doctor patient relationship and quality of care

From a clinical perspective, the biggest threat from growing health insurer power is to the central place of the doctor-patient relationship in healthcare.

The patient's choice of doctor is restricted under preferred provider agreements, as is the freedom of doctors to refer to each other. It is increasingly possible that the treatment provided and the venue for this treatment would be decided by the insurer. Insurers will direct the patient to treatments which they can provide for the lowest cost.

### Administrative complexity

If doctors sign contracts with health multiple health insurers to obtain 'preferred provider' status, the burden of practice administration must increase. This is clearly demonstrated by the American experience. Multiple fee schedules and

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differing compliance regimens amongst insurers increase the cost of running a practice and overall health expenditure.

### Standing up for quality and choice

Australia's healthcare system provides world class care for patients. Our hybrid public-private model delivers truly universal healthcare, leaving no one behind.

The Australian private health system is attractive to patients because it provides access, quality and choice. The doctor-patient relationship is at the centre of healthcare provision. Doctors are truly independent and make decisions based on the best interests of patients.

Concentration of power in the hands of health insurance companies is a threat to the best attributes of our system.

The ASA is part of a coalition of medical representative groups opposed to health insurer dominance. Acting in concert with other specialty groups and the Australian Medical Association (AMA) we hope to raise awareness in the community and the government about this issue.

I encourage members to be alert to health insurer attempts to gain increased control of the system. Be cautious when approached about bundled care packages. Read contacts carefully and be wary of payments generated outside of the Relative Value Guide (RVG). Our professional autonomy is at risk under these arrangements.

### HAPPY HOLIDAYS!

Finally, I would like to wish everybody a peaceful and safe holiday season after this unusual and somewhat unsettling year. I look forward to working with you again in 2021.

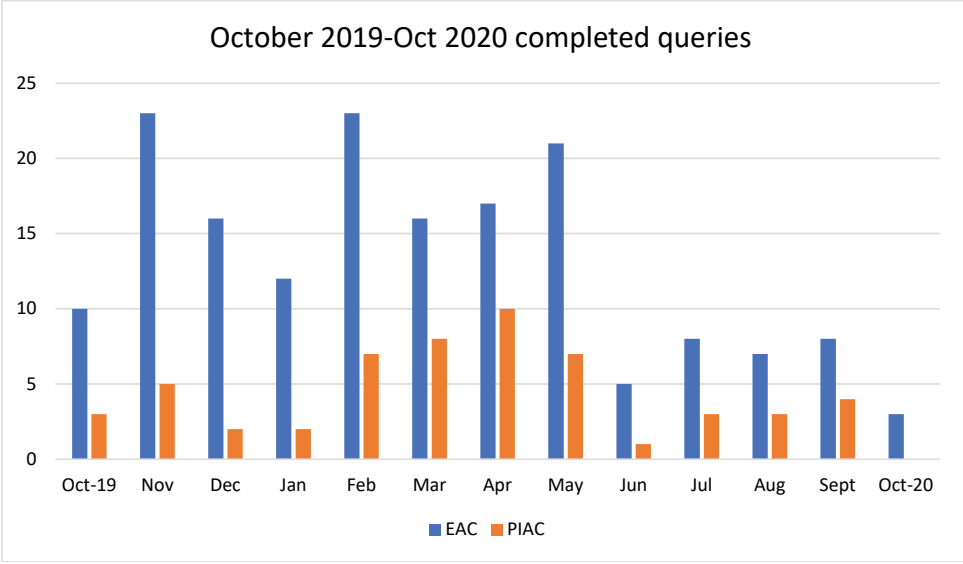
# POLICY UPDATE

**ASA relies on the specific expertise that our members can contribute to ASA policy development and advocacy activities. Our Committees and Working Groups are an important mechanism for interacting with subject matter experts across our membership and for connecting through to the individual working and interest groups of our members.**

The ASA Federal Committees, Economics Advisory Committee (EAC), Professional Issues Advisory Committees (PIAC) and Public Practice Advisory Committee (PPAC) meet regularly to discuss development of submissions, position statements and advocacy campaigns.

In 2020, our three key Federal Committees provided advice in the following areas:

- Department of Health regarding the ongoing Medicare Benefits Schedule (MBS) Review;
- Ramsay Healthcare in NSW regarding the pay cuts for on-call anaesthetists, State and Federal Health Departments regarding COVID-19 pandemic;
- Australian Healthcare and Private Health Insurers regarding rebates and out-of-pocket expenses;
- Submissions relating to a wide range of medical-related topics including anaesthesia workforce issues, the National Medical Code of Conduct and changes to the MBS;
- Representing members at various stakeholder meetings with the Department of Health, Australian Digital Health Agency (ADHA), Federal Department of Health, BUPA, NIB, Medibank and MIGA; and
- Survey on impacts of COVID-19.




For the period October 2019–October 2020, PIAC and EAC responded to a total of 239 member queries with a completion rate of 89%.

## FACE SHIELD

ASA coordinated with SmartAID to facilitate face shield donations for member and non-member anaesthetists in Victoria during the second wave. Dr Mukesh Haikerwal of Circle Health Clinic assisted in the distribution of more than 180 face shields donated by SmartAID. We thank SmartAID for their work and generosity.

## DIGITAL HEALTH

The Australian Government has invested substantial public funding into development and training for digital health platforms such as My Health Record and secure messaging. However, there has been limited funding allocated to engage and support anaesthetists with these technologies. Without significant government support, the ASA and those it supports will not receive the benefits that come from having a digitally connected healthcare team.

ASA continues to work with the Australian Digital Health Agency (ADHA) and Australian and New Zealand College of Anaesthetists (ANZCA), participating in digital health initiatives and representing

# INSIDE YOUR SOCIETY

ASA views on advisory committees. We have strongly advocated for improved health access to digital platforms via conformant software. Other work has focused on practical activities to address some of the key barriers to digital health for ASA professionals. ASA secured grants from ADHA in 2020 for projects supporting ASA practitioners to engage with digital health platforms. These projects focused on research and education workshops with members to better understand how they currently use digital health platforms and how their engagement with digital health could be improved. This is an ongoing collaboration which will continue in 2021 with the vision to engage more members.

## POLICY AND ADVOCACY WEBPAGE

ASA identified the need to build its online and social media presence to support more effective engagement with our membership. A range of new and expanded communications activities were undertaken in 2020, focused on expanding information sharing via our website, forum and on stronger use of Twitter. The Policy and Advocacy section shares ASA submissions and policy updates with the aim of increasing the understanding of issues and opportunities for members in relation to government policy. Members are encouraged to visit the Policy and Advocacy page at https://asa.org.au/policy-and-advocacy/.

## ASA FORUM

Our considerable work on COVID-19 related issues helped highlight the true value of the newly developed ASA Forum for policy discussion. During the Pandemic, we encouraged members to start discussion topics on the website through the forum. There has been active engagement in the forum by the membership on a wide range of policy topics and we continue to encourage all of you to subscribe to the forum https://asa.org.au/asa-forum/forum/open-forum/. It is a great platform for members to connect over shared experiences. Don't wait – visit the forum on our website and start a dialogue with your colleagues.

## PODCAST

This year President Dr Suzi Nou has been actively involved in trying to educate the membership on matters concerning the profession. Dr Nou launched her public podcast on Apple, Spotify and Google Play. Visit https://asa.org.au/podcasts-for-asa-members/ and join the ASA as we chat with experts and friends about issues that impact Australian anaesthesia. If you'd like a particular topic discussed just drop us an email.

The COVID-19 pandemic has caused a seismic shift in the way our world operates and we all had to adapt to a new work norm. We would like to thank President Dr Suzi Nou, Dr Mark Sinclair, Dr Antonio Grossi, Dr Peter Waterhouse, Dr Julie Lee and the Federal Committees for their continued patience and understanding with the policy team throughout this somewhat crazy year.

It has been a bizarre and exciting year for all of us and we wish you all happy holidays and a wonderful 2021 ahead.

Jacintha Victor John
*Policy Manager*

## CONTACT US

If you have any questions about the ASA Policy Team or any of the work they and their committees do, please do not hesitate to get in touch.

**Email:** policy@asa.org.au

**Phone:** 1800 806 654.

# TRAINEE MEMBERS GROUP UPDATE

As I write this, it's late October and I am in Melbourne, waiting to see whether our latest COVID-19 outbreak will be contained. I'm very aware that by the time you are all reading this, the situation is likely to be very different. This year has been a year of uncertainty. It's been a year of plans on hold, plans reimagined, and plans dismantled. I know a lot of you are probably feeling emotionally exhausted, and your resilience has been sorely tested. The recent discovery that for a large number of you, there lies ahead a long break between exams I am sure has come as a hard blow.

This year has come with its own set of unique challenges for all of us. I have been frequently impressed and in awe of the ability of those of you hit hardest by the circumstances of this year to rise above and band together, and to maintain your integrity and compassion in the face of what has been an extremely challenging year. The way you've all supported and looked out for each other, while still managing to compassionately care for your patients in what is at the best of times a challenging and intense training program, is seriously impressive.

This will be my last trainee update as Chair of the ASA Trainee Members Group (TMG) Committee. Whilst I'm sure I'm not alone in saying this wasn't the provisional fellowship year I expected, I can honestly say I'm extremely grateful to have had the opportunity to be part of an organisation such as the ASA, which has done so much to Support, Represent, and Educate us throughout this challenging year, and I'm very proud of what we've managed to achieve despite the trying circumstances!

In *supporting* you, we have run a Mental Health First Aid for Trainees course via Zoom. We're currently processing the feedback from this event but hope to be able to offer this course more widely in 2021. We hosted an online wine tasting social event, complete with wine packages shipped to your door nation-wide! We've arranged a corporate hotel discount that can be used for exam-related travel at Accor-branded hotels nationwide (contact us for the code if you haven't seen this yet), and we've made becoming a prevocational member of the ASA TMG easier, to help support and foster the interests of the next generation of anaesthesia trainees.

In *representing* you, we have advocated on your behalf regarding exam issues to the college, we have participated in forums representing anaesthesia trainees, such as the AMA Council of Doctors in Training forums. We have provided access to representation opportunities such as the Lifebox ANZ trainee position, and we have tirelessly advocated on your behalf on various state-based and national committees across a wide range of trainee issues, from COVID-19, to exams, to research prizes.

In *educating* you, we have provided regular Zoom practise vivas with experienced examiners – a massive thank you to Vida Viliunas for her tireless efforts in the realm of trainee education, and to Frank (mak95) Sun and Natalie Marshall for their time and expertise! We're in the process of overhauling the ASA website's education resources, and are planning plenty of trainee-specific content. We've recorded podcasts on trainee specific issues, and have more planned so watch this space. And of course, our *Trainee Members Handbook* was updated and released at the start of this year – if you haven't seen it yet, check it out today!

In summary, while 2020 has been an extraordinarily tough year, it's been a year with its own rewards and opportunities. We hope that some of the support processes we have established this year will help make your lives as anaesthetic trainees that little bit easier into the future. By the time this article is published, the new ASA TMG Chair for 2021 will have been announced. I wish them all the best for the coming year. Chairing this committee has been a great privilege, and I'm very proud of how far we've come this year, though I'm confident the best is yet to come!

Dr Emily Munday
*Chair, ASA Trainee Members Group*

# ASA TRAINEE MEMBERS

## APPLY FOR OUR 2021 INTERNATIONAL SCHOLARSHIPS

**$4K***

**If travel is not possible due to COVID-19 restrictions, you will be able to defer your scholarship**

Canadian Anesthesiologists' Society

**QUEBEC CITY, CANADA**

**11-14 June 2021**

Association of Anaesthetists

**NEWCASTLE, UK**

**7-9 July 2021**

American Society of Anesthesiologists

**SAN DIEGO, USA**

**3-7 October 2021**

**APPLICATIONS OPEN 11 JAN 2021 AND CLOSE COB MONDAY 1 MARCH 2021**

Download a copy of the application guidelines
**https://asa.org.au/trainee-members-group-tmg/**

If you are not already a member, please contact:
membership@asa.org.au or 1800 806 654

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

**Available exclusively to ASA Trainee Members. Each scholarship is valued at $4,000 to cover cost of airfares and accommodation.*

ASA
Australian Society of Anaesthetists

INSIDE YOUR SOCIETY

# OVERSEAS DEVELOPMENT AND EDUCATION COMMITTEE

## RETIREMENT OF DR SEREIMA DIQAMU BALE

As ODEC Chair, it is with mixed emotions that I write about the recent retirement of a close personal friend, mentor and colleague, Dr Sereima Bale.

William May, Dean of the College of Medicine, Nursing and Health Sciences, Sereima Bale and Chris Bowden, ODEC Chair

Sereima is well known to many anaesthetists in Australia, New Zealand, the Pacific and indeed around the world. She has been a stalwart of anaesthesia development in the Pacific region for the last 30 years, having been directly involved in the postgraduate training of every Diploma and Masters in Anaesthesia Graduate at the former Fiji School of Medicine (FSM), now Fiji National University (FNU).

She has also taught most undergraduates at FNU in the same time period, and there are very few FNU medical graduates in the Pacific who do not know and remember 'Dr Bale' with great fondness.

Sereima herself graduated with a Diploma in Surgery and Medicine from FSM in 1969, and then trained in anaesthesia in the Philippines in 1975, obtaining a Diploma in Anaesthesiology. She then worked as an Anaesthetic Registrar at the Colonial War Memorial Hospital in Suva before obtaining a consultant post in 1988 and becoming Head of Department. In 1998 she was offered a senior lecturer position at FSM, a post she retained with great pride until her recent retirement in 2020.

Sereima has worked very closely and collaboratively with the ASA on projects for a number of decades. She was instrumental in developing the Diploma and Masters in Anaesthesia with Steve Kinnear and Haydn Perndt at the Fiji School of Medicine, she was the founding President of the Pacific Society of Anaesthetists in 1989, and hosted the first ASA Pacific Fellowship in 2003. The Fellowship was renamed the ASA Sereima Bale Fellowship in 2019 to honour her longstanding commitment to, and support for, the program.

Sereima has been a steadfast Pacific advocate and clinical leader for a number of prominent international courses, including Primary Trauma Care, EPM, and the SAFE series. PTC and EPM are now embedded in the FNU Undergraduate Course curriculum, meaning that all medical graduates speak the same PTC and EPM language.

Her service to anaesthesia was formally recognised by the WFSA in 2019 and, as a recipient of the WFSA Distinguished Service Award, she will receive this in Prague in 2021. This is a fitting way to honour such a remarkable career as a clinician, teacher and mentor to so many.

Away from work, Sereima is a proud mother and grandmother, and a passionate supporter of Fijian rugby. She represented Fiji in golf and was a national team member between 1991 and 1998.

Her retirement will allow her to dedicate more time to her true passion – her family first and foremost, and perhaps a round of golf or two.

On behalf of ODEC and the ASA – we wish you all the very best.

Chris Bowden
*Chair ODEC*

# INSIDE YOUR SOCIETY

# AROUND AUSTRALIA

## NEW SOUTH WALES

### Dr Lan-Hoa Le, Chair

On 19 August, the ASA NSW Committee of Management (COM) held their AGM, followed by the second NSW Members' Forum for this year.

I'd like to express my thanks to the NSW COM representatives and in particular Dr Simon Martel (Vice-Chair) for their dedication, ASA President Dr Suzi Nou and Federal ASA for their guidance, CEO Mark Carmichael, office bearers, and to you, our members, for your support during this extraordinary year. Also I'd like to wish you all a well-rested and safe festive season.

The ASA NSW Wellbeing Working Group supported the World Federation Societies of Anaesthesiologists (WFSA) in marking World Anaesthesia Day on 16 October with the focus on Occupational Wellbeing.

NSW COM also hosted a Wellbeing Forum for ASA and NZSA members as part of our spring activities. The webinar was interactive with practical tools to cultivate wellness hygiene .

On 4 November, ASA Public Practice Advisory Committee hosted an inaugural educational and networking event '4D' for directors and deputy directors at public and private hospitals across the nation where COVID-19 leadership experiences were shared.

Part 3 Course hosted by NSW COM will be held on 15 December.

### COVID-19

NSW COM continues engagement with the ACI Community of Practice Anaesthesia. We attended the NSW MOH Bendelta speak up sessions (models of care, workforce, low-value care, virtual care, collaboration across the health system moving forward) to represent our members' best interests.

NSW Health Local Health Districts (LHDs) are rolling out the Respiratory Protection Program and fit-testing. The ASA hosted a respiratory protection webinar encouraging members to get involved with the COVID-19 working group at their public/private hospital(s).

### Reduction of elective surgery waiting lists and VMO contracts at private hospitals

NSW AMA has an ACCC grant to negotiate on behalf of VMOs working at private hospitals.

However, the NSW AMA position is for contracts to be supplied from LHDs. They are concerned of the consequences of further loss of work experience for Doctors-in-Training.

A general guideline is to seek legal advice (such as from the AMA) before entering a contract, understand principles such as sunset clauses with an agreeable timeframe for both parties and to look for a show or no show of cause(s) when exiting a contract. The MOH have confirmed that TMF will also cover all anaesthetists accredited at a private hospital, who have a signed contract at the private hospital (service agreement and TMF cover form), as long as the remuneration was not negotiated i.e. remuneration accepted as 100% MBS or LHD sessional rate.

ASA has currently an official legal counsel available for members to seek advice as individuals at your own expense.

NSW COM advocates for early involvement with an anaesthetic representative at private hospitals with executives and stakeholders to optimise pre-admissions for screening and selecting patients with low-risk co-morbidities, create a separate on-call roster for anaesthetists who have entered a contract to be on-call for public patients, and have a separate list for public patients only rather than mixed with privately-insured patients since not all anaesthetists enter a contract.

### Managed care/bundled care (no gap) obstetrics and orthopaedics services

Medibank Private met with NSW COM and Council of Proceduralists Chairs to discuss issues and ideas around patient gaps and products that may be developed to the mutual advantage of patients, Medibank and providers (doctors). It is obvious that health insurance companies are expanding their roles.

NSW COM urges members to consider the loss of clinical autonomy, financial risk and poorer outcomes for patients from corporatisation of medicine. The imbalance of control between private health insurers, hospitals and providers results have been shown in the US. The Professional Issues Advisory Committee hosted a webinar in November to explore the concerns and examine the US experience.

NSW COM advocates for freedom from arbitrary and non-indexed inventions such as 'uplift fees'.

## QUEENSLAND

### Dr James Hosking, Chair

Fit-testing: ASA QCOM continues in its advocacy for quality of PPE in Queensland. This includes communication with the Chief Health Officer as well as public and private hospitals recommending an upgrade to guidelines for P2/N95 masks including mandatory fit-testing for all as per AS/NZ1715:2009.

## VICTORIA

### Dr Michelle Horne, Chair

Well, who thought I'd be writing about doughnuts in an ASA publication? As I write this we're into the second week of 'double doughnuts' of zero cases here in Victoria, and I think Vic as well as the rest of the country are pretty pleased. As community cases went down, healthcare workers' infections decreased as well.

Reflecting on our efforts to protect healthcare workers in our hospitals, a lot of lessons have been learned for those who choose to listen. I feel like the biggest determinant of numbers of healthcare worker infections here is community prevalence in the first place. In August, when Europe was on summer vacation and doing well and we were locked down, it was natural that people were growing weary of restrictions. Jump to November and we are open again, the weather is warm, people are outside again and with very low infections here in Australia. This is due to the hard decisions we as a nation (and here in Victoria, as a state) have made – when France is having >50,000 cases a day, the UK many tens of thousands of cases too, and lots and lots of stories of prolonged COVID-related impairment – especially among those who are young, previously fit and active and only had 'mild' infection – and I'm so grateful to be where we are now.

We have not absorbed all the potential lessons mind you and challenges remain. This is the time to sort out some of those aspects, whilst the immediate COVID pressure is off, because it might well return. Respiratory protection programs, further consideration of the impact of aerosol spread, review of ventilation systems (in our current spaces as well as those being planned/built) and further attention to the role of elastomeric/reusable respirators. Speaking of reusable respirators or APR (Air Purifying Respirators), DHHS recommended against them apparently based on lack of TGA approval. However, within just a few days of that announcement, Sundstrom received ARTG approval for its APR. So I expect a more nuanced response from DHHS. They have recommended tapes for treatment and prevention of pressure areas related to disposable masks, however, I would like to draw members' attention to the fact that this is *not* recommended by mask manufacturers and fit-testers due to the probability of interfering with mask seal, and the inevitable lack of consistency in application. For those with pressure issues needing ongoing use of respiratory protection, PAPRs and APRs are likely to provide a more comfortable and sustainable option.

Thank you to Suzi Nou, Phillipa Hore, David Scott, David Story, Ben Slater and others representing us in DHHS taskforces and committees – and advocating for the health and safety of both the medical workforce and the good governance of our health system now and moving forward. Together we seek the best care for patients with, and without, COVID in the odd time given to us and as we return to more elective surgery.

### Educate

Many young anaesthetists have had their interstate or overseas Fellowship plans changed, and the current workforce scenario presents challenges some of our established members would not have faced when they finished their training. Earlier in the year we held a forum for New Fellows and in December will be holding our Part 3 Course for senior trainees virtually. There will be some material made available to peruse at any time via the ASA website. We have held and participated in so many events over the last few months, including our own Managed Care Victorian Members Forum and several respiratory protection webinars. I have joined departmental meetings, attended the first Department Directors Open Forum supporting directors across Australia in these unprecedented times for medical leaders and have been liaising with other college/society leaders and chairs, at times weekly.

### Private in public

There is currently quite a need for increased numbers of cases to be performed and it is in our interest and that of our patients and the health system, if we can work together to achieve optimal care for our patients. Some of this is being done in the private system, although from some points of view it is unsatisfactory that this is still being asked of VMOs under the pandemic agreement, with unilaterally set and non-negotiable remuneration terms. In Victoria this is currently set at 125% of MBS rates or $260/hr. For many lists, members are finding that the per hour amount is superior to the 125% of MBS, which is really sub-optimally low given lack of indexation and freezing for many years. We anticipated this would be a short-term arrangement, yet it carries on. The ASA would advise members to bear in mind, with their discussions with hospitals, that this should be a short-term arrangement and is not an appropriate benchmark moving forward. In addition, we have sought to have Workcover and VMIA automatically apply to all care of public patients including in private hospitals, however, we are yet to hear an announcement on this. Please note that there is contract negotiation advice now available on the ASA website. A discount will also be given to members from HWL Ebsworth Lawyers for individual contract legal advice.

### Corporatised/managed care

In recent times we have seen a number of advances from more than one health insurer towards managed care or bundled care (or as a colleague puts it "profit-driven decision-making"). In order to maintain our high standards of care, hospitals, health insurers and providers including doctors need to remain independent from each other. This is

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the key danger from managed care: that insurers become so powerful that clinical and financial autonomy of the other groups is lost. Discussions are occurring at St Vincent's Private, Mitcham Private, Waverley Private and Northpark Private Hospitals as well as Nexus-run day centres about managed care for orthopaedic, obstetric and ophthalmic services. These arrangements threaten the independence of clinician decision-making and increase control by health insurers or institutions. In the agreements we have seen so far, an independently set, non-indexed fee is also proposed for anaesthetic services which would be more appropriate if expressed as a proportion of an existing, independently set and indexed fee structure such as ASA/AMA RVG. Individuals should seek appropriate advice if requested to sign such agreements and not feel pressured to sign, especially given strict confidentiality and secrecy clauses.

In the coming weeks and months, we will continue to talk to many stakeholders including health insurers, hospitals, other clinical groups, our legal teams and the AMA. The ASA will also engage with other medical representative groups to focus the message about the potential risks of and implications of corporatised care.

A national ASA webinar was held to discuss the corporatisation of medicine. Specific recent advances in Victoria have included small groups of non-anaesthetists attempting to control the delivery of anaesthetic services for pain procedures (including a 25% service fee!) and Nexus attempting to bring in bundled care for cataracts. All of these types of proposals have quite serious implications for the way our private health system looks in the future, and who holds the control of clinical decision making: will it continue to be clinicians or will we give it to health insurers and corporate groups?

The ASA remains concerned about moves that would result in loss of patient choice or clinical autonomy or fundamentally change the structure of our healthcare system which is currently one of the world's best. We encourage broad discussion amongst members and proceduralists about these moves.

The ASA supports the principles of independence of health insurer, hospital and providers. No anaesthetist should feel pressured into signing proposals without appropriate consideration and advice: what we as clinicians agree to now will have implications for many years to come.

## WESTERN AUSTRALIA

### Dr Mike Soares, Chair

The WA Committee's reaction to COVID-19 requires context for the size of what was asked. Western Australia is the second largest country subdivision in the world and is slightly smaller than Argentina, itself the eighth largest country globally.

As national and state borders were closing the government of Western Australia also stopped movement to regions within the state. This perpetuated any existing labour and resource shortages.

In comparative terms, at the height of the pandemic estimates in the United States of ventilator shortfall were between 1.4 and 31 patients needing ventilation per available ventilator. In regional parts of Western Australia with populations >10,000 this estimate was as high as 150 patients needing ventilation per ventilator with a median of three trained airway doctors working in the town.

Trained airway doctors and ventilators were needed in both Perth and regional areas.

In response, the WA Committee created a database of specialist anaesthetists willing to be allocated across Perth and those who were prepared to travel to assist regional areas. The committee liaised regularly with the Heads of Department of the four large private hospitals ensuring at any given time an anaesthetist was available to provide cover for a COVID-19 patient in these hospitals. My thanks to all who committed their services but especially to those anaesthetists who volunteered to support colleagues in regional areas knowing they would themselves become isolated providing airway management in areas with limited equipment including limited PPE with potentially no way of restocking.

The WA Committee also supported work on a negative pressure ventilator (NPV) that could be built regionally on site and applied with limited or no airway experience.

Thankfully the 150:1 ventilator apocalypse did not arrive; resources were not overwhelmed in regional areas and the NPV was reduced to an academic curiosity.

As statewide restrictions eased, COVID returned to a national rather than local issue. Nationally, the ASA alongside the AMA, lobbied for fit-testing and the WA state government announced on 11 October funding for fit-testing across WA Health.

Prior to the state government announcement, the WA Committee through it's PIAC representative had commenced a fit-testing project which has been indefinitely suspended whilst there are no COVID positive patients in WA private hospitals.

In non-COVID news I would like to thank the following members for taking on extra responsibilities within the committee. Dr Ian Forsyth, Wellbeing Representative; Dr Celine Baber, PIAC; Dr James Miller, Vice Chair and Dr Archie Shrivathsa, Secretary and CME. Thanks also to Dr Chris Cokis for his contribution to the committee for the past five years.

Upcoming meetings include the Autumn Scientific Meeting on 27 March, 2021 at the University Club, UWA. Convened by Dr Archie Shrivathsa and Dr Charlie Ho, program to follow.

The Perth Children's Hospital will convene the Country Conference Bunker Bay Meeting from 22-24 October 2021.

# HISTORY OF ANAESTHESIA LIBRARY, MUSEUM AND ARCHIVES NEWS

Many of the events and activities planned by the HALMA committee this year were placed on hold due to the COVID situation and the museum and library remain closed. We hope to bring you more web-based and/or small in-person events in 2021.

Our doors may be closed but the collection is just a click away at https://ehive.com/collections/4493/harry-daly-museum. As would be expected, digital visitation to our collection doubled from March to October compared to the same period last year. Twitter and Instagram, with hashtags like #MuseumFromHome, #MuseumsUnlocked and #CURATORBATTLE have helped buoy the spirits of many museum-goers in 2020 and encouraged people to search out collections online.

In July we farewelled Belinda McMartin from her role as Curator, Librarian and Archivist. She has moved onto the Museum of Fire as CEO. Belinda oversaw the audit of the Harry Daly Museum's S4 and S8 drugs, a large and technically involved project vital to maintaining the collection. She also mentored two museum students to assist with cataloguing the Gwen Wilson Archives in late 2019. We're sure Belinda is lighting a fire on the public programs schedule and adding some spark to the collections at the Museum of Fire.

By August, easing restrictions in NSW meant the ASA was able to fill the Curator, Librarian and Archivist role and I began working in the office two days a week and working from home the rest of the week. With the closure of the museum, and the impending move, it is the perfect time to conduct a collection audit. Close to 50% of the collection has been surveyed so far and I've gotten to know many items up close. It has been a lovely introduction to the stories and objects held in the Harry Daly.

## MUSEUM – OBJECTS OF THE QUARTER

September 17 marked the tenth anniversary of #AskACuratorDay, a day to ask museum, archivist or librarian workers everything and anything you've ever wanted to know about what goes on at collection institutions. Dr Kristy Kokegei from the History Trust of South Australia, kicked off the Australian tweets, with the prompt "What object best encapsulates 2020?"

Well, clearly the accessory of 2020 is *the* face mask! Some of the most eye-catching items in our collection are face masks. In fact, we have some 80 masks, dating from the mid-19th century through to 2015. However, some of the earlier items have their gauzes and covers removed or stored elsewhere and what is left is an empty cage of metal, that still reminds you of the mask's purpose.

Our collection represents the ongoing quest to master the ability to administer the right amount of anaesthetic to patients.

One of the more striking masks in the collection is the portable and improvise-friendly Skinner's chloroform mask. Among the first of the wire masks, it was developed in 1862 by obstetrician Thomas Skinner, who believed chloroform was a more favourable drug to administer to women in labour. The simple, foldup wire frame supports a woollen or cotton domette cover (Harry Daly Museum 1998.094).

We also have the closer fitting and more sanitary Schimmelbusch mask which was first described in 1890. Schimmelbusch designed a mask with sterilisation in mind, thanks to the growing interest in aseptic surgery and acceptance of germ theory. Finally, the practice of sharing inhalers wholly between patients was recognised as not exactly hygienic! The metal mask was easier to clean and the trough-like rim prevented excess chloroform or ether from dripping onto the patient's face (Harry Daly Museum 1997.066).

## LIBRARY – BOOKS OF THE QUARTER

The Richard Bailey Library is our research library, which traces the development of anaesthesia but did you know it also contains over 200 works about mesmerism and hypnotism?

First theorised by Franz Mesmer, 'mesmerism' proposes the existence of energy fields between living things and even inanimate objects. Techniques such as hypnosis and trance-like states are used to alter these fields. It grew in popularity around Europe between 1780 and 1850. The popular phrase 'animal magnetism' comes from Mesmer's work.

The field of hypnosis developed alongside mesmerism at this time. Some

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books during this period treat the two as interchangeable subjects, whereas others argue that the two fields are wholly separate practices. Certainly, by the late 1800s there were emerging differences between the animal magnetism and the hypnotism school.

But what does this have to do with anaesthesia? Mesmerism and hypnosis techniques were used in experiments to reduce pain and alter consciousness, both with or without drugs. As the Scottish doctor, William Neilson, noted in his 1855 volume *Mesmerism in its Relation to Health and Disease*: "The Mesmeric process has a revealing power, which is denied to the dissecting knife; and what could not be discovered in the dead body, has been made plain by experiments on the living".

There was always debate over the validity of the 'science' behind Mesmer's theory and work, which explains the number of books in the library from the latter half of the 19th century that explore the practice from every angle – scientific, medical, religious and philosophical.
With questions ranging from:

- if the practice was safe;
- how best to hypnotise a patient (or more likely a dinner guest) safely;
- what did the observation of animal magnetism in the animal kingdom mean to the modern man?
- how best to use your animal magnetism to your own advantage.

What does emerge from the volumes is a back-and-forth, to-and-fro, of whether mesmerism is a medical act, a legitimate command and alignment of the mind to treat a range of woes, or a mere parlour trick.

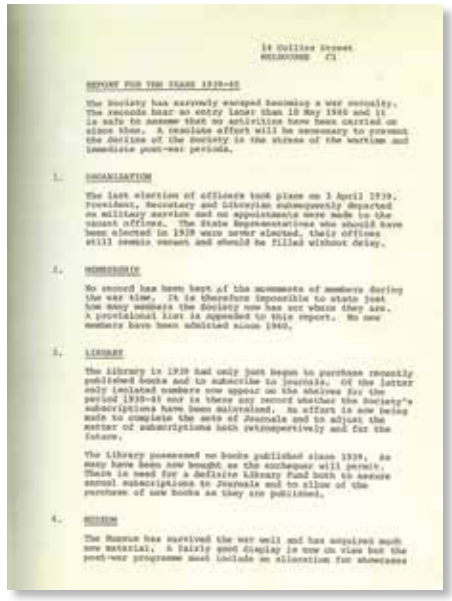
More recently published books in the collection cast a critical eye over the shenanigans and experiments carried out by famous mesmerists and hypnotists. Catherine Jinks' *Charlatan* (2017), explores the scandal of Thomas Guthrie Carr, a self-promoting charlatan whose court case was as dramatic as his shows and supposed legendary personal animal magnetism. Wendy Moore's *The Mesmerist* (2017) notes "mesmerism seemed to be precisely the kind of absurdity they [the medical establishment of London] wanted to distance themselves from…" (p.14).

## ARCHIVE – THE ASA IN 1945

The *Report for the years 1939-1945* by Secretary Geoffrey Kaye gives us a glimpse of the Society during World War II and the uncertainty of how many members were left, but ready to restart their mission to support the profession.

Here are selected excerpts from the first newsletter published by the ASA at the time:

*The Society has narrowly escaped becoming a war casualty. The records bear no entry later than 10 May 1940 and it is safe to assume that no activities have been carried on since then. A resolute effort will be necessary to prevent the decline of the Society in the stress of the wartime and immediate post-war periods.*



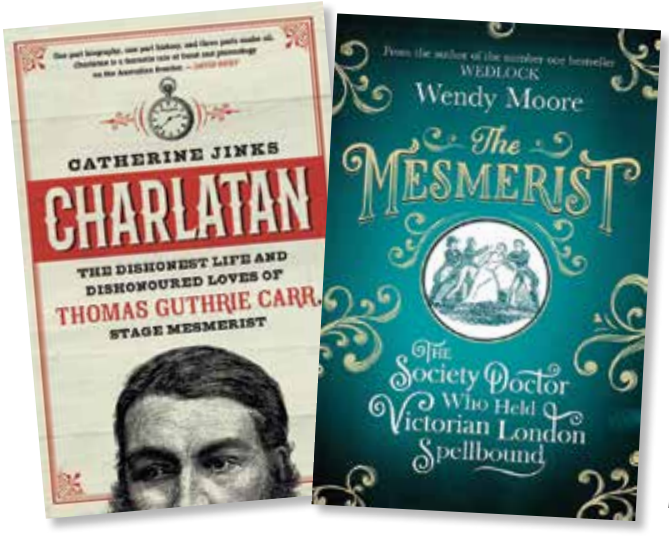
On the topic of elected positions in the organisation, owing to the sudden change in the pace of life:

*The last election of officers took place on 3 April 1939. President, Secretary and Librarian subsequently departed on military service and no appointments were made to the vacant offices. The State Representatives who should have been elected in 1939 were never elected, their offices still remain vacant and should be filled without delay.*

*No record has been kept of the movements of members during the war time. It is therefore impossible to state just how many members the Society now has nor where they are… No new members have been admitted since 1940.*

Members are listed as 'On service' (seven), 'Returned from service' (five), 'In practice' (20), 'No recent tidings' (20) and a single deceased. The next report, from January 1946, noted that the Society was still to hear from 10 members, with whom they hadn't communicated since 1939.

Kate Pentecost
*Curator, Librarian and Archivist*
*Harry Daly Museum, Richard Bailey Library and Gwen Wilson Archives*



# NEW AND PASSING MEMBERS

The ASA would like to welcome all new members from August to November 2020.

## TRAINEE MEMBERS

| | |
|---|---|
| Dr Adeel Aftab | QLD |
| Dr Ahmad Al Helwani | VIC |
| Dr Andrew Allan | NSW |
| Dr Catherine Jane Bella | QLD |
| Dr Jason Robert Bishop | VIC |
| Dr Anthony David Brown | WA |
| Dr Brian Chee | VIC |
| Dr Lindon Collins | QLD |
| Dr James Correy | TAS |
| Dr Laetitia Deknudt | SA |
| Dr Emmanuel Dhoss | QLD |
| Dr Emily Anne Hamilton | WA |
| Dr Tyson Byrne Kevin Jones | QLD |
| Dr Sharna Kulhavy | NSW |
| Dr Sara Letafat | NSW |
| Dr Amy Chien-Ho Lin | QLD |
| Dr Patryck Julian Lloyd-Donald | VIC |
| Dr Alexander John Morris | VIC |
| Mr James Richard Murtagh | SA |
| Dr Rajesh Pachchigar | QLD |
| Dr Christopher William Sadler | NSW |
| Dr Bernard Shan | VIC |
| Dr Tarun Sharma | ACT |
| Dr Benjamin Robert Verstandig | WA |
| Dr David Graham Walker | QLD |

## ORDINARY MEMBERS

| | |
|---|---|
| Dr Lynda Glenys Veronica Allchurch | QLD |
| Dr Simon Bradbeer | VIC |
| Dr Anna Jane Carter | NSW |
| Dr Emily Dickson | VIC |
| Dr Peter Julian Flynn | ACT |
| Dr Mary-Ann Louise Fox | SA |
| Dr Rahul Garg | NSW |
| Dr Emma Suzanne Goodyear | VIC |
| Dr Martin William Arthur Graves | NSW |
| Dr Richard Michael Halliwell | NSW |
| Dr Jeremy Daniel Hickey | WA |
| Dr Nicholas Hughes | QLD |
| Dr Azlan Ismail | SA |
| Dr Michael David Kerr | QLD |
| Dr Rupali Rajesh Kini | NSW |
| Dr Babitha Kudakandira Basappa | QLD |
| Dr David Andrew Lacquiere | SA |
| Dr Nicholas James Litzow | VIC |
| Professor Alan Forbes Merry | |
| Dr Adam Phillip Michael | QLD |
| Dr Patricia Anne Newell | VIC |
| Dr Irene Ng | VIC |
| Dr Gene Anthony Palmer | WA |
| Dr Simon William Patrick Roberts | VIC |
| Dr Sharanjeet Kaur Sidhu | VIC |
| Dr Sarah Wallis | VIC |
| Dr Janette Carolyne Wright | VIC |

## IN MEMORIAM

The ASA regrets to announce the passing of ASA members Dr Nickel Crombie, NSW; Dr Geraldine Hill, NSW; Dr Lyndall Majorie Landsey, NSW; Dr John Phillip Madden, TAS; Dr Desmond O'Brien, NSW; Dr Anthony Edmund Williams, NSW; and former ASA member Dr Neil Eastwood Street, NSW.

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

INSIDE YOUR SOCIETY

# JOHN DAVID RICHARDS 1945-2020

John Richards was a highly energetic, generous, hardworking and caring man and a very skilled anaesthetist in Adelaide. For the best part of 40 years he devoted a considerable portion of his working life to the advancement of anaesthesia as a profession. He rose to the position of Federal President of the ASA as well as serving the profession on many other committees for many years. After retirement he dealt stoically and uncomplainingly with increasing health issues. It would be rare for most of us to have put more into embracing and enthusiastically living life to the extent that he so did.

John's father, Clarence Richards, was originally a country general practitioner who had worked in rural South Australia at both Lameroo and Pinnaroo in the Murray Mallee. His first wife died and Clarence moved to Broken Hill where he met and worked with a nurse who became his second wife and subsequently gave birth to John on Remembrance Day 1945. When John was just a very young boy the family moved to Adelaide where Clarence set up his practice in Unley in Oxford House and John was enrolled at Pulteney Grammar School where he was to receive his primary and secondary education. He was the only child of his father's second marriage.

John very much pleased his parents by deciding to follow in his father's footsteps in studying medicine at Adelaide University where he graduated MBBS in 1969. He was an Intern at the Royal Adelaide Hospital (RAH) in 1970 and then a Senior RMO at The Queen Elizabeth Hospital (QEH) in 1971. Following this he entered the FFARACS (now FANZCA) Anaesthesia Training Program as an anaesthetic registrar at the QEH. Completing his training in Adelaide he joined a private anaesthetic group Adelaide Anaesthetic Services (AAS) in Adelaide in late 1975.

In his fourth year of medical school John was introduced by a non-medical friend to his future wife, Etelka, who was a nurse at The Adelaide Children's Hospital (ACH). Falling very much in love, John and Etelka were engaged within six months but waited for another 11 months until the end of his fifth medical school year before getting married. John's father had died and his mother insisted that the newly married couple live with her while he completed his medical studies and while Etelka was very busy with her nursing career at the ACH. Etelka says the arrangement suited both of them ideally. After a busy day's work she would come home to a house where his mother had prepared excellent food for them as well as doing all the laundry. Their marriage was a great success and they had 52 wonderful years together. Their first son, Andrew, arrived in 1971, followed by Jamie in 1975.

John was one of the first purely private practice anaesthetists to devote a considerable amount of his time to the ASA when he took on the role as Federal President in 1990 for the full two-year term. He was previously the Secretary of the SA Branch of the ASA and later Chairman. During his term as Chairman he was a member of the organising committee for the ASA's National Scientific Conference (NSC) held in Adelaide and celebrating the ASA's 50th year. He was very involved in many aspects of the ASA's activities and went on to be a part of the SA State Committee of Management. In 1988 he was elected Federal Vice President of the ASA and in 1990 was elected unopposed as Federal President. John served for 14 years (1982-1996) as the ASA SA representative on the State Regional Committee of the Faculty of Anaesthetists RACS which later became the College of Anaesthetists

From 1993-1995 he served as the anaesthesia representative on the Federal Council of the Australian Medical Association (the AMA). This position was important to all anaesthetists as it involved difficult negotiations with the Federal Government on MBS rebates. At the time the government saw the AMA as the body representing all medical practitioners and they did not wish to negotiate with individual specialist medical societies. Department of Health negotiations were always more focused on rebates for GPs who formed the bulk of the AMA membership.

Following his term as Federal President John became Secretary of the Australian-

Asian Regional Section of the World Federation of Societies of Anaesthesia (WFSA). Duties in this position involved visits to eight member countries namely Thailand, Burma, Taiwan, Pakistan, India, Sri Lanka, the Philippines and Malaysia. He was actively involved in helping form the Pacific Society of Anaesthetists and was awarded life membership for his services to this Society.

Etelka accompanied him to all of the above countries and the couple were renowned as excellent company and wonderful hosts. His duties involved a great deal of entertaining overseas and interstate fellow office holders and dignitaries and he became well known for his enjoyment of a glass or two of fine red wine.

For over 35 years John worked in an ever-expanding private anaesthetic group (AAS) where he was a loyal, hardworking member of the practice, generous with his time and always willing to help out with any extra emergency cases if no-one else was available. He made all new members of the practice very welcome and was a mentor to many. The office staff, patients, surgeons and peri-operative theatre staff all loved him and had great respect for his skilled and knowledgeable anaesthetic ability. He was known for his unflustered manner when coping with challenging anaesthetic situations and for his excellence with difficult intubations. In the early 1980s one remembers him actively encouraging the early take up of pulse oximetry monitoring in private hospitals which he saw as a very great advance in making anaesthesia much safer. At this time he was serving as the ASA/Faculty liaison Officer to the Australian Council on Hospital Standards. In his earlier years in private practice, one was often aware of his presence somewhere in the operating suite by virtue of the aroma of fine pipe tobacco in the change rooms – not something that modern day anaesthetists would ever now experience!

There's a lot more than anaesthesia to the life that John enjoyed. He had enormous energy, rose early (5am) most days and was always doing something late into the evening. In his younger days he played football (Australian Rules) and squash for the Public Schools Club in Adelaide. Boating and sailing were also favourite pastimes and he sailed many and various small boats as well as wind surfing and water skiing. John spent countless hours driving speedboats in helping teach his family and friends how to ski.

While studying medicine, he voluntarily enlisted in the University of Adelaide Regiment and rose to the rank of Corporal. John was heavily involved in organising all of the medical school reunion events and these were very thoughtfully and meticulously planned, outstandingly successful and enjoyable.

John had an enduring thirst for knowledge and was an avid reader. He took a particular interest in Winston Churchill and the history of the two World Wars. This resulted in him accumulating one of the best private library collections of books on Churchill and even in his final months he was subscribing to a highly respected UK science journal and purchasing many new books on history which he continued to assiduously read. Note that one of his grandchildren is named Winston. His love and interest in history is evidenced by his donation to the ASA's Gwen Wilson Archives of his large collection of correspondence and papers accumulated when holding office on the State and Federal ASA Committees. In his retirement years he was also actively involved with an authors' group who are writing a book on the first 150 years of anaesthesia in South Australia.

Special mention must be made of his passion for building beautifully and painstakingly faithful replica models of boats. There are many of them that he had crafted with the most intricate and finest attention to detail – they are superb. His skilled craftsmanship is also seen in the woodcarvings of figureheads, busts and people. Some of his works, including one of Victor Trumper, were on display at the ASA NSC in Adelaide in 2018.

John was a natural build for a perfect Father Christmas and loved playing the part which he carried out perfectly, not only at the annual AAS office Christmas family parties with members' young children but also at the Queen Adelaide Club's Christmas parties for children. A big person, he wore the uniform well and was ever friendly and warm. Raucous and rambunctious – yes he indeed was!

John's last few years were complicated by several serious medical conditions, however, he never complained as he underwent various operations and treatments including chemotherapy. Knowing he had a terminal illness that one day would take him, following his final admission to hospital, he expressed a wish that there would be no heroics to try and save him when he knew the end could be near. Complications arose from a traumatic fall at home with fractured ribs masking a kidney trauma which ultimately caused sepsis and his demise. Etelka says that because of his underlying medical problems, this unexpected and rather rapid turn of events may have been a timely blessing.

John lived a very busy, energetic and caring life. He deeply cared for his family, the ASA, his patients, colleagues and staff. He actively sought to improve anaesthetic practice in South Australia, in Australia, in our Pacific neighbours and in South East Asia. He continued his pursuit of knowledge until his final days. A friend so fittingly summed him up to Etelka as "a man of great stature in every sense of the word who always gave more than he took".

John is survived by Etelka, Andrew and daughter-in-law Michelle, Jamie, and his five grandchildren, Poppy, Ruby, Sidney, Winston and Isla.

Vale JDR.

Don Barrie MBBS FANZCA
*Adelaide Anaesthetic Services*

INSIDE YOUR SOCIETY

# HUBERT DESMOND O'BRIEN 1927-2020

Hubert Desmond O'Brien MBBS (Melb) DA (Melb) FFARACS FANZCA, universally known as 'Des' to his colleagues and friends, was an anaesthetist of great stature. His early publications in the *British Medical Journal* on 'Fluothane', a new (in 1956) non-flammable, volatile anaesthetic agent, had a profound impact on the practice of anaesthesia.[1] For the first time, the anaesthetist had a liquid agent which was non-combustible, relatively non-toxic and allowed rapid and clear-headed recovery. It changed the practice of anaesthesia at the time and enabled significant advances in neurosurgery and much other surgery, particularly where diathermy was required.

Des was also at the forefront of anaesthesia for cardiac surgery, first at St Vincent's in Melbourne and later at Prince Henry and St George Hospitals in Sydney. He was a fine teacher. He held leadership positions in the Australian Society of Anaesthetists and Faculty of Anaesthetists of the Royal Australasian College of Surgeons. He served with the Royal Australian Air Force and rose to the rank of Wing Commander.

Des was born in St Kilda, Melbourne in 1927, the eldest of five children. His father was a third generation Irish-Australian and his mother was born in Dublin. He was educated at De La Salle College, Malvern in Melbourne, where he excelled at school and was captain of swimming and a member of the first AFL football team.

He entered Medicine at Melbourne University in 1945 and graduated MBBS in 1950. He was a Resident Medical Officer at Launceston General Hospital in Tasmania from 1951 to 1952.

He started his anaesthetic training as a registrar in 1953 at the Royal Women's Hospital in Melbourne where the Director of Anaesthesia was Dr Kevin McCaul, a renowned teacher and expert in his field. Des then went on to be a registrar at the Royal Melbourne Hospital in 1954 to 1955. The Director of Anaesthesia there was Dr Norman James who was a major figure in Australian anaesthesia, an excellent teacher and a pioneer of high-quality anaesthesia. He was a great organiser and well known both in Australia and overseas. Importantly for Des O'Brien's future, Dr James had worked in England as an anaesthetist through World War II, particularly in Oxford, and established a fine reputation. He was a good friend of Professor Sir Robert Macintosh, the first Professor of Anaesthetics in Oxford at the Nuffield Department of Anaesthetics.

While at Royal Melbourne Hospital in 1955 Des obtained his DA (Diploma of Anaesthetics). At the end of his training at Royal Melbourne, prompted by Norman James, he successfully applied to become a Nuffield Dominion Scholar at the Nuffield Department of Anaesthetics, University of Oxford. He travelled to England where he joined the Oxford department from 1956 to 1957. In 1957 he became First Assistant to Professor Sir Robert McIntosh.

This was a game changer for H.D. O'Brien. Macintosh was a legend in the world of anaesthesia and his department in Oxford was the most prestigious in England and one of the world's best. Many of the world's leading anaesthetists and heads of departments had gained experience and training at the Nuffield Department. While there Des worked with and exchanged ideas with the world's best. He made contacts that would last a lifetime.

In his role as First Assistant to Professor Macintosh Des gained valuable research experience. He, with Roger Bryce-Smith, investigated the new non-flammable liquid Fluothane which had been developed by the British company, Imperial Chemical Industries (ICI) in Manchester. They first experimented on dogs to learn its behaviour and then used it on themselves in turn to determine effective concentrations and safety. All this before using it on patients! Their paper in 1956, together with parallel work by Michael Johnstone[2] in Manchester, changed anaesthesia at the time.

Des prospered in Oxford and gained valuable experience in a wide range of

anaesthetic areas. He and his wife Esma enjoyed the Oxford experience but it was not always easy. While a Nuffield Dominion Scholarship was prestigious it was not overly generous. The O'Briens had married in Australia in 1954 and arrived in England in 1956 with an infant daughter and soon had a second to care for. They did, however, enjoy life and made many friends. It was a wonderful experience for both.

Des returned to Australia in 1958 and joined the staff of St Vincent's Hospital in Melbourne as Assistant Director of Anaesthesia. The Director was Dr Ralph Clark who had himself been trained in Oxford so Des was right at home. Des remained at St Vincent's until 1966. He became a lecturer in anaesthetics at Melbourne University and was also able to practice some private anaesthesia.

At St Vincent's Des participated in the development of cardiac surgery at the hospital. Surgeon John Clareborough had performed the first mitral valvotomy in 1956 with Ralph Clark as anaesthetist. The team in 1960 moved to develop cardiopulmonary bypass techniques and Harry Bray, with Des O'Brien and John Clareborough, began animal experimental surgery and then moved to human surgery.

Des also began a busy private practice during these years and joined the well-regarded Albert Street Anaesthetic Group. He practiced successfully in Melbourne for eight years.

However, in 1966 there was a complete change of direction. Des's wife Esma was desperately homesick so they moved back to Sydney where they took up residence in Manly.

The move was made easier because Des had established a reputation not only in Melbourne but in the Australian anaesthetic community as a whole. He had been active in his professional societies as Victorian State Chair of the ASA and had joined the State Committee of the Faculty of Anaesthetists of the Royal Australasian College of Surgeons. These organisations brought him into contact with anaesthetists from across Australia and he was well known and well regarded.

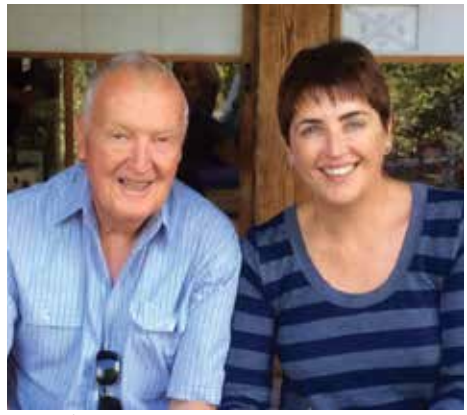
He was invited to join the prestigious General Anaesthetic Services (GAS) group and became a Visiting Anaesthetist to St Vincent's Hospital, Sydney, and later the Prince Henry and Prince of Wales Hospitals and to St George Hospital. He remained an anaesthetist to the Cardiac Surgery Unit at Prince Henry Hospital from 1966 to 1992. His practice in Sydney prospered and he continued until he retired in 1998 – a total of 32 years.

As in Melbourne, he became heavily involved in teaching and chaired the NSW section of the ASA from 1970-1971. Uniquely, he was at different times Chair of both the Victorian and NSW sections of the ASA. He was a member of the Organising Committee of the third Australasian Congress of Anaesthesia in Canberra in 1970 and very proudly of the 11th World Congress in Sydney in 1996. Des was a member of the many working groups of the ASA and in retirement founded the Retired Anaesthetists Group and was its first Chair. His contributions were immense.

In recognition of his many contributions Des O'Brien was awarded the ASA President's Medal in 2005.

Des was a great traveller. He returned frequently to the Nuffield Department and his old friends in Oxford, particularly Tony and Marlene Fisher and John Lloyd, all consultants in Oxford. In 1988 he was made a Fellow of the Senior Common Room at Pembroke College, Oxford, an honour that pleased him greatly.

On several occasions he took working holidays to hospitals in Sweden and did volunteer work in Nepal, Tonga and Taiwan and with the Royal Flying Doctor Service.



Des and Victoria

I personally came to know Des well when we travelled together to Hong Kong, Vienna, Israel and Germany, and Spain on the way to the 1968 World Congress in London. He was a great companion, always good company. We became very close friends. We travelled again together to the World Congress in 1984 in Manila and The Hague in 1988. Sadly, his marriage to Esma did not survive and they separated and divorced in the 1970s. They had five children together – Louise, Christine, Stephen, Annette and Luke.

In later years Des married Victoria Gilsenan, whom he met as a theatre nurse at St Vincent's Private Hospital. They had a long and loving relationship over 37 years and travelled widely, often to Oxford but also to Europe, North America and the East. She cared for him to the end when he died peacefully aged 93.

Des O'Brien had an interesting and full life.

Donald C. Maxwell
MBBS FFARACS FANZCA FFARCS FRCA.
Past President
Australian Society of Anaesthetists
Past Chairman, NSW State Committee,
Faculty of Anaesthetists RACS

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1. Bryce-Smith R, O'Brien HD. Fluothane; A non-explosive volatile anaesthetic agent. *Br Med J* 1956; 50:15.
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INSIDE YOUR SOCIETY

# KERRY MICHAEL GARSKE 1943-2020

**Kerry Garske was the first specialist in anaesthesia and intensive care on the Redcliffe Peninsula, north of Brisbane. He founded the Anaesthetic Department at the Redcliffe Hospital in 1977 and ran it on a sessional basis for several years. He will be remembered for his deep love of his family, his humility and his incredible work ethic. Kerry retired in 2012 and sadly succumbed to Alzheimer's. He died on March 2, 2020, surrounded by his family.**

Kerry was born on February 27, 1943, the second of four children. The family lived at Camp Hill and then Coorparoo on Brisbane's southside. He commenced his schooling at St James Primary School, Coorparoo, before moving to St Laurence's College, South Brisbane, for years 4-12. He was academically gifted and shared being the Dux of Year 12 with his good friend, John Corcoran. Both went on to study medicine at the University of Queensland.

Kerry was awarded a State Fellowship to study medicine at the University of Queensland. In return for the fees and textbooks, Kerry was required to work for six years at country hospitals in Queensland once he completed his first year residency at Princess Alexandra Hospital in 1967. This began a country adventure for both Kerry and his wife Jan, and was the start of Kerry's love affair with the Australian bush.

His first posting in 1968/69 was as Medical Superintendent, with the right of private practice, at Quilpie in far western Queensland. Then followed postings as Medical Superintendent, again with the right of private practice, in Collinsville in 1970, Senior RMO at Nambour in 1971 and then as Acting Medical Superintendent in 1972. He returned to Coorparoo with his growing family in 1973.

One of the real benefits of the Queensland State Fellowship system was that after completing your rural obligations you were offered automatic entry into the training scheme in the specialty of your choice. Kerry chose anaesthesia and began his training at Princess Alexandra Hospital under the guidance of Dr John O'Donnell, the founding Director of Anaesthesia and ICW at Princess Alexandra Hospital. Kerry completed his registrar years at Royal Brisbane, gaining his Anaesthetic Fellowship in 1976.

I first met Kerry at the Princess Alexandra Hospital where I was a Staff Anaesthetist at the time. The Power and Garske families have been lifelong friends since then.

Kerry, Jan and their four children moved to Redcliffe in 1977 and Kerry became the first specialist anaesthetist on the Peninsula. When Redcliffe became a training hospital in anaesthesia, he founded the Anaesthetic Department and ran it as a VMO on his own for four years. This commitment and a growing private practice became too much for one person, thus the Redcliffe Anaesthetic Group came into being.

The story of the service he gave as an anaesthetist is best told by Dr Ross Boulton, an orthopaedic surgeon, who worked with Kerry extensively over a long period of time and was clearly very dependent on the skill and dedication of his good friend Kerry Garske. Many other surgeons also had great respect for his skill and caring.

"Kerry joined the Redcliffe Hospital in 1977, and I started there as a VMO (Orthopaedic Surgery) in 1980 and commencing a long professional and personal association and friendship.

"Kerry was a standard setter at Redcliffe. Not only were anaesthetists encouraged to practice at the highest standard possible, his influence spread to other specialities. His work ethic encouraged others to try to be just as good. But his main influence was on the standard of anaesthetic practice.

"Kerry also provided an anaesthetic service to those of us performing surgery at various private hospitals. Once again he made certain that, from an anaesthetic standpoint, conditions were as safe and efficient as possible.

"He administered the first anaesthetic at the local private hospital, after insisting with quiet but firm determination that

no anaesthetic could or would be given without the full range of safety measures, which for budgetary reasons, the administration was resisting."

"I am particularly grateful to Kerry for his professionalism and sense of duty, as I performed surgery on a large number of children, both relatively minor procedures such as manipulating and immobilising fractures, and more risky procedures to assist with defects caused by accidents of birth and genetics, and conditions in which our young patients suffered from multiple co-morbidities and were receiving numerous drugs to assist them with their lives. It is a tribute to Kerry that there was not one serious anaesthetic complication. Even one death would have been hard to bear, but Kerry paid great attention to preparation and took such care that there were no accidents.

"The satisfaction that I feel in reflecting on my professional life is in reality due largely to the partnership I had with Kerry. The Garske family and the Boulton family were friends. My children often wore Garske hand-me-downs, as Kerry and Jan's children were older than mine and Pat's. Kerry gave us a professional lifetime of excellent service, and he was a great family man. I miss him as a colleague and as a friend."

Besides his academic prowess, Kerry was an excellent athlete, excelling in hurdles and was a member of St Laurence's First XV Rugby Team. One of the humorous 'highlights' of his rugby days was missing the decisive conversion in the dying minute of the grand final in his final year at school. He didn't consider it funny at the time, nor did his coach.

Kerry had many interests outside anaesthesia. One of these was golf, often remarking "hopeless", with a smile on his face when asked how he went in a round. He always loved horse racing and during his university years he worked for a bookmaker at the races at Doomben and Eagle Farm. It was this love of horse racing

Jan and Kerry married in December, 1967

that was the catalyst for Kerry and Jan to enter the horse racing game when they were offered a horse to buy. The horse, *El Laurena*, was to go on to a very successful career the highlight of which was coming second to *Just A Dash* in the 1981 Melbourne Cup. In later years, even while enduring the debilitations of dementia, Kerry would still find himself drawn to the racecourse to have a flutter.

Travel became very much a passion for Kerry and Jan after the children finished their schooling. They embarked on countless trips to various parts of the world, often combining the trips with visits to London where their son Paul and his family were living. Kerry was an avid reader with a great curiosity for the world and the people he met on his travels.

Kerry enjoyed his working life, with the friendships and camaraderie amongst colleagues meaning as much to him as the work and his patients. When he retired in 2012, the thing he really missed most was the camaraderie in theatre. This was most evident by those wonderful medical colleagues who spent time with him during his final months with dementia.

Nothing but the best anaesthetic service that could be provided with the available facilities was good enough for Kerry. He gave a lifetime of excellent service, and was a great family man and friend, and is sorely missed.

Kerry is survived his wife Jan, his four children Paul, Melanie, Michael and Danielle and his 11 grandchildren.

Special thanks to the Garske family for their assistance in preparing this obituary.

Dr Ross Boulton FRACS FA Ortho A

Dr Michael Power FANZCA

INSIDE YOUR SOCIETY

# GAVAN JOHN CARROLL 1930-2020


**These few lines are to celebrate the life and to honour the memory of Gavan John Carroll who died on 6 March 2020. He was one of the distinguished anaesthetists who pioneered the academic and scientific approach to the practice of anaesthesia in the state of Queensland.**

Gavan Carroll was educated at Marist Brothers College at Ashgrove, Brisbane. He graduated MBBS Q'land 1952 and took up resident and registrar positions at the Mater Hospital, South Brisbane from 1953 to 1955. Having decided on a specialty course in anaesthesia he went to England and sat and passed the Primary FFARCS 1956. For his efforts he was awarded the Nuffield Prize, obtaining first place in the examination, a not inconsiderable feat. He obtained the second part FFARCS in 1957. In England he worked at the Queen Charlotte Hospital in London and the Royal Infirmary at Newcastle-on-Tyne with Professor Pask. He returned to Australia in 1958 and obtained the FFARACS in 1961 and the ANZCA 1992.

He was a senior consultant anaesthetist at the Mater Hospital from 1959 to 2002 specialising in ENT and paediatric orthopaedic anaesthesia. As well he was a senior consultant at the Royal Brisbane Hospital from 1959 to 1978.

Gavan was appointed a Primary Examiner in Pharmacology from 1974 to 1986. He was President of the Queensland branch of the ASA in 1971 and organised the Annual Meeting of the Society held in Brisbane that year – this was always done in an honorary capacity. He was President of the Mater Staff Association and a member of the hospital board. As well, he gave numerous lectures and tutorials at local and national level.

On Gavan's return from England he went into private practice with Sadie and Hugh Glynn-Connolly. That practice expanded into Wickham Terrace Anaesthesia, which currently has over 50 members. He worked with all the leading surgeons of the day including Sir Clarence Leggett, Alex Splatt, Ron Aitken, Laurie Parker, Ferg Wilson and the Gallaghers. Administration of anaesthesia in the 1950s-60s in Brisbane was often in the hands of general practitioners who filled a void or were self-taught enthusiasts. Along with Tess Brophy, Danny Hogg, John O'Donnell and Ruth Molphy, he laid the foundations for art and science to be incorporated into the practice of the specialty. What it meant was that any candidate wishing to be an anaesthetist had to do a prescribed course of four years and pass two examinations along the way.

Gavan Carroll had enormous enthusiasm for the specialty coupled with a commanding presence in the operating theatre. He was a natural leader and excellent teacher. He was obsessive about meticulous preparation for anaesthesia: "Good routines have good outcomes". He was responsible for many people being stimulated to enter the specialty.

While in England Gavan married Rita Grogan. Upon returning to Australia they adopted three children. They were a very strong couple and very generous with their time. Many a visiting identity was entertained at their home.

He was a sporting enthusiast – one could almost say a cricket tragic. The inter-hospital games he organised were great days – he was an opening batsman but never made many runs. Depending on the venue we played at, he became known as the 'St Lucia slug' or the 'Tingalpa tortoise'. He was also an ardent fan of the Brisbane Broncos.

We remember Gavan for his integrity, determination, passion for excellence, leadership and compassion. He will live long in our memory.

Dr Phelim Reilly

Rita and Gavan Carroll

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