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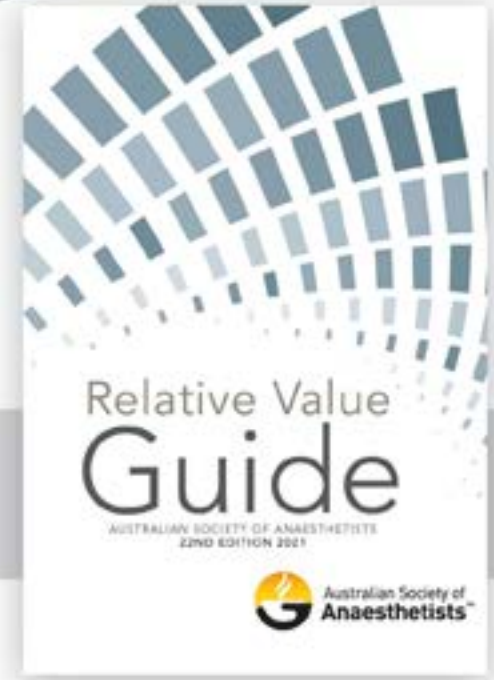

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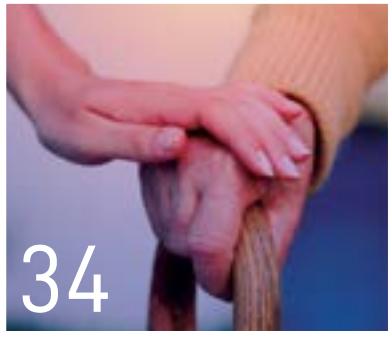


Would you like to contribute to the next issue?

If you would like to contribute with a feature or a lifestyle piece, the following deadlines apply. Intention to contribute must be emailed by 5 October 2021. Final article is due no later than 16 October 2021. All articles must be submitted to editor@asa.org.au. Image and manuscript specifications can be provided upon request.

FROM THE ASA PRESIDENT

DR SUZI NOU
ASA PRESIDENT

No doubt one of the best things about this role is meeting and working with wonderful people along the way. One of my favourite opportunities for this is the National Scientific Congress (NSC). After the disappointment of postponing last year's event (now to be held in conjunction with the New Zealand Society of Anaesthesia in Wellington in 2022) I was delighted to see this year's event proceed. Congratulations to co-Convenor Peta Lorraway and the NSC organising committee who collaborated so well with the Queensland Anaesthesia Continuing Education (ACE) committee in ensuring this meeting was a success. She writes a comprehensive meeting wrap-up in this edition.

One of the things I am most relieved about is delivering my Geoffrey Kaye Oration, affectionately referred to as the GKO. The GKO is an opportunity for the outgoing President to share some of their reflections from this unique perspective. I hope I highlighted historical moments of anaesthesia in Australia that we should be proud of, described our current circumstances and encouraged how we may tackle future challenges.

One of the more controversial moments from my GKO is recounting a small part of the night from the 2018 NSC. I include my reflections on that night in the following pages. I encourage you to consider this piece in the context of the GKO by viewing the full version, available on the ASA website .

Speaking of controversies, a few of the more challenging presentations from the NSC have been shared with you here. Dr Viren Naik, presented the Canadian experience of using intravenous medications in assisted dying and asked what role do we have as anaesthetists? Dr Jo Rotherham shares her insights into medical cannabinoids and Peter Waterhouse delves into the threat of managed care. If you do nothing else today, then I encourage you to look at www.sendtheeaglehome.com.au to learn more about this issue and further action you can take.

One of my favourite talks during the NSC was from Professor Eddie Holmes, an evolutionary biologist who talked about the origins of SARS-CoV-2. A benefit of the meeting moving to a virtual format is that the presentations remain available for registered delegates to view via the conference portal. I encourage you to make use of this opportunity.

This will be my last editorial of Australian Anaesthetist. It has been an honour and a privilege to serve our ASA community. I owe incredible thanks to the Board, Council, committees, and general members of the ASA. I would particularly like to thank the team at ASA HQ who have weathered a pandemic, moving offices whilst working from home and launching a new logo amongst many other novel and unprecedented events. They have handled these challenges with tireless efficiency and buoyant graciousness, particularly our CEO, Mark Carmichael. I hope that we as a profession and as individuals uphold similar compassion and courtesy particularly when communicating about and with each other.

To close, I am pleased to share that we now have some logo inspired jewellery: a necklace, earrings, a lapel or tie pin and some cufflinks will be available following the AGM on the 11th of October. They have been handmade in Hobart, the birthplace of the ASA, and finished with sustainably farmed Tasmanian blackwood. I hope that they will be worn in unity and gifted in friendship during our challenging times and our cherished moments.

Dr Suzi Nou

PRESIDENT'S AWARD

CONGRATULATIONS TO ASSOCIATE PROFESSOR ALICIA DENNIS

The President's award is presented to a member who has made a significant contribution to the affairs of the ASA

Alicia's extraordinary contribution to the Society particularly acknowledge her contribution in undertaking a major role in compiling, developing, researching and documenting the ASA response to the Anaesthesia Clinical Committee (ACC) of the Medicare Benefits Schedule review.

Alicia's invaluable work in documenting the high-quality ASA response to the recommendations was crucial in communicating our deep concerns regarding the recommendations made by the ACC.

Thank you Alicia for being an effective member of advocacy teams who made representations to the MBS review Chair and committee, and the Federal Health Minister.

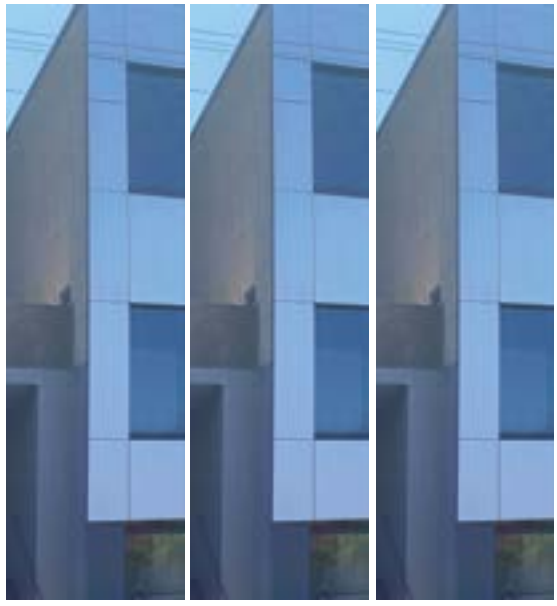
Without her tireless input, keen eye for detail and academic rigour, the favourable result achieved may have been quite different.

A sample of the jewellery handmade in Hobart, the birthplace of the ASA, and finished with sustainably farmed Tasmanian blackwood.

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.

FROM THE CEO



MARK CARMICHAEL, ASA CEO

I am writing this article from Sydney in lockdown, in the days after our 2021 National Scientific Congress (NSC). We had planned to hold the Congress in sunny Brisbane. Indeed, this edition of Australian Anaesthetist was scheduled to be a celebration of the event full of pictures of our members enjoying great collaboration and social interaction. However, that was not to be.

Members may recall that the Congress was originally planned for Cairns in early October, but to mitigate the risk of COVID-19 we decided to bring the Congress forward to July with a compressed two-day program.

As 'bad' luck would have it, in the week leading up to the Congress a serious delta strain of Covid spread through Sydney, Victoria and then Adelaide causing borders to shut and half the population to go into lockdown.

With less than a week to go the organising committee made the decision to pivot to plan B – a totally virtual format. My gratitude goes to co-convenors, Peta Lorraway and Ed Pilling and the organising committee who worked tireless to deliver a great event. While some of the workshops were not possible, I think everyone would agree that it was a high-quality program, covering a wide scope of content from current medicopolitical issues to important clinical updates from experts in the field. Highlights of the Congress remain available on demand via the meeting portal.

Aside from the threat posed by COVID-19 the other pressing issue facing the profession is the push by private health insurance companies to become increasingly involved in the delivery of health care in Australia. Our Professional Issues Advisory Committee Chair, Dr Peter Waterhouse, has prepared an excellent article highlighting the issues at hand and what the possible impact may be. This runs in parallel to the upcoming ACCC determination concerning the proposal by Honeysuckle and nib which Dr Waterhouse covers. It is important to note that the ASA made a submission along with a number of other bodies opposing the proposal, and we thank all our members who joined us in this action. In total some 240 submissions, nearly all opposing the proposal, were made. A determination from the ACCC is expected in September, which all medical organisations are eagerly awaiting.

Planning is an important aspect of everything we do. Recently our Council revised the Strategic Plan of the ASA for the period 2021–2023 – strengthening our Mission to Support, Represent and Educate our members. The plan, supported by five strategic pillars, is included in this edition and should be viewed as the road-map for the immediate future.

Planning is an important aspect of everything we do. Recently the ASA Council revised the Strategic Plan of the ASA for the period 2021– 2023. The plan is included in this edition and should be viewed as the map for the immediate future.

Speaking of the future it is exciting to share with you that the ASA has now moved to new premises. Throughout 2018 there was a considerable amount of commercial development in the North Sydney area. This made for a competitive market, culminating in the sale of the building that housed the ASA in May 2019.

We made the decision to establish a new home for the ASA in a building we would own and independently control. I am delighted to share that on 29 July we took possession of 86 Chandos St Naremburn. This is a free-standing building, in a location convenient to the city and one kilometre from Royal North Shore Hospital. With

three floors, and basement parking, we have wonderful scope for meetings and great spaces for our museum collection and library. If in the area please call in to say hello and visit our much-improved ASA library and museum.

While on the topic of new things, thank you also to those members who have been so complimentary regarding the refreshed ASA logo which was launched recently. It is much appreciated.

In closing I would like very much to acknowledge President Dr Suzi Nou, who steps down as President at the October 11 Annual General Meeting. Due to unforeseen circumstances in 2019 Dr Nou who was then the Vice-President was called upon to assume the role as Acting President and was then elected President at the 2019 AGM serving her two years. It is said that you can be fortunate and have a leader for the times and I believe Dr Nou has been just that leader.

Mark Carmichael

Contact:

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

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Australian Society of Anaesthetists (ASA) STRATEGIC PLAN 2021 – 2023

Welcome

I'm delighted to present the ASA's Strategic Plan 2021–2023 and to share our plans for supporting, representing and educating anaesthetists across Australia.

The Board and Council spent considerable time discussing strategy in a post 2020/COVID world. We started with a strategic planning workshop in December and over another six meetings we considered more than 100 ideas. Our newly defined strategic priorities – Membership Growth, Advocacy, Proactive Wellbeing and Education will help achieve our vision of 'Practitioners functioning at their best in the delivery of anaesthetic and peri-operative care'.

Functioning at 'their best' means different things to different people but we are committed to making you feel supported and that your voice is heard.

We have two new priorities with Membership Growth to help sustain the future of the society – the more members, the more we can do – and a new focus on Proactive Wellbeing. The year that was 2020 showed the importance of supporting anaesthetists because when we feel safe, we perform at our best and provide the best for our patients.

The 2021-2023 plan may look a little different to previous ASA strategic plans but it provides clarity of our role and continuous goal to be responsive to member needs. You will notice that we no longer list governance as a strategic priority. Of course we value governance but we consider that it already underpins all of the work of the ASA – strategic, tactical, operational and day to day – and is fundamental to all of our priorities. I would like to thank the people who have come before me in this role and on Boards and Councils for their hard work in developing the governance of the ASA and the constitutional change in 2016.

In the new Strategic Plan we hope you see elements of your life represented and can see how the ASA will continue to support, represent and educate you.

Suzi Nou

President

Vision

Practitioners functioning at their best in the delivery of anaesthetic and peri-operative care.

Mission

Support, represent and educate our members in the provision of high-quality healthcare that ensures patient safety in anaesthesia, peri-operative and pain medicine.

Strategic Priorities

Priority 1 - Membership Growth

Sustainably grow membership to support and facilitate the vision and mission of the Society

Priority 2 - Advocacy

Promote the needs of the specialty to all relevant stakeholders

Priority 3 - Proactive Wellbeing

Foster the personal health and welfare of members, associates and their families

Priority 4 - Education

Embrace innovation to provide a broad range of high-quality resources and opportunities

MEMBERSHIP GROWTH: Sustainably grow membership to support and facilitate the vision and mission of the Society

Supporting Strategies

1. Proactively communicate with existing and prospective members on membership benefits and the work of the Society.
2. Offer a broad and flexible range of services that provides value to members in line with their career progression and individual needs.
3. Continue to develop and maintain a reliable system for the efficient and effective processing and approval of membership applications and renewals.
4. Develop and implement an appropriate and targeted marketing strategy for the anaesthesia profession to promote awareness of the Society and benefits of membership.
5. Promote the ASA as a value-driven organisation that aligns with member values and provides supports on relevant issues.
6. Empower staff and members to drive membership growth through advocacy on behalf of the ASA across the profession.

Key Outcomes

- Growth in ASA membership in both numbers and share of the anaesthesia specialty in Australia.
- Increased member engagement as demonstrated through survey feedback, event attendance, digital media analytics and officeholder membership.
- Rise in profile and awareness of the Society with members, the specialty of anaesthesia, and the medical and broader community.
- Increase in membership revenue with related re-investment in services and benefits to members.
- A simple and effective system for processing membership applications and renewals that supports membership growth.

ADVOCACY: Promote the needs of the specialty to all relevant stakeholders

Supporting strategies

1. Continue to raise the profile of the ASA and increase awareness of the role of the specialty in ensuring patient safety and quality healthcare
2. Actively engage and build working relationships with Federal and State Governments and all relevant stakeholders on issues that impact the specialty
3. Forge strong relationships with relevant industry stakeholders and work with like organisations to promote areas of common interest.
4. Enhance and expand support provided to active committees representing the ASA
5. Improve engagement with members to ensure we are representing them on key issues
6. Strive to ensure the makeup of committees reflects the diversity of the profession and our membership

Key outcomes

- Expanded opportunities to promote the ASA and the speciality in the broader community
- Develop and distribute position statements to reflect the ASA and the specialty on key issues
- Increased partnerships and collaborations with other bodies
- Increased support provided to state-based committees to ensure capacity for local advocacy
- Enhanced communication opportunities with members

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WEBAIRS NEWS

A Bowtie Analysis of Medical Device and Equipment incidents

ANZTADC Case Report Writing Group

In this edition of Australian Anaesthetist, a Bowtie Analysis has been performed on the incident reports involving Medical Devices and Equipment among the first 8000 incidents reported to webAIRS. This main category of incidents accounted for 959 (12%) of the first 8000 reports in an initial interim analysis.

The left side of a bowtie diagram is designed to prevent a critical incident, which is known as a Top Event. This process involves identifying hazards, which might lead to the critical incident category that is being analysed and methods to trap these hazards.
The right side of the diagram deals with recovery from the event, which involves management methods to rescue from harm, and the final stage is to learn from the outcomes. The shape resembles a bowtie hence the name for the diagram.

Figure 1 shows an overview of the risk factors anticipated and methods to trap these potential hazards, summarised in a qualitative bowtie diagram. It is also possible to have quantitative diagrams with a single pathway from the Hazards to the Top Event, but these are more difficult to construct in complex situations, such as anaesthesia. Using the diagram as an overview, it is possible to expand each section with more detail. The detail can be as complex as required. There are five columns in this version of the diagram under the five headings Avoid Hazards, Trap Anomalies, Rescue from Harm, and Learning from Outcomes. Extra information and more detail for each of the boxes in the diagram can be expanded into paragraphs with more detail for each of the columns.

Avoid Hazards

The hazards are split into four categories as shown in the green boxes. The results of the interim hazard analysis are shown below with the percentages rounded to one decimal place where the percentage is less than 1%.

Patient Factors

- This type of incident might affect patients of all ages, ASA PS, sex and BMI.
- Complex medical history or status

Task Factors

- Device malfunction in 50% of the 959 reports in this main category
- Cognitive overload or distraction with complex procedures or patient

Caregiver Factors

- User error 29%
- Wrong selection of device 5%
- System Factors
- Environment
- Electrical danger 1%
- Electrical harm in two reports 0.2%
- Equipment or device
- Unavailable 4%

Other

- Other or not specified 14%

(Please note that it is possible to have more than one sub-category (x2) of incident per report and so the total of the percentages of the incident subcategories above is 103.2% rather than 100%)

Trap anomalies

Setting up barriers to prevent incidents involving Medical Devices and Equipment needs to address several sets of potential hazards. The first is incidents due to the device itself, whereby the device might fail or malfunction. The second issue is the use of the device where an error might occur due to unfamiliarity, distraction, or the use of the wrong device for the task. Another problem might be the lack of suitable equipment. There are also several other potential hazards that might occur as a result of user and equipment interaction. It was noted that in some cases, the reporter had programmed a syringe pump incorrectly or placed the wrong syringe in the syringe pump. An example of the latter would be to load the propofol syringe in the remifentanil pump and vice versa.

Using the bowtie diagram as a template, the box labelled 'Assessment' will involve patient and task assessment. This should include a check of the equipment before use. For example, checking the

laryngoscope light before induction, or the view on a video laryngoscope or flexible bronchoscope, or checking an ultrasound machine and battery before use. In the Planning phase, the equipment requirements would be decided based upon patient and task requirements (Plan A). If any equipment required is not available, then a decision based on whether it is still safe to proceed would be required. Contingency planning (Plans B, C and D) would need to be considered for dealing with equipment problems should they arise.

In the section 'Escalate' the actions might involve changing to plans B, C or D in response to emerging problems. Mitigate would be the immediate actions taken just prior to an imminent incident.

Rescue from harm

Management will depend on the stage at which the Top Event occurs. If the procedure has not begun, a risk versus benefit decision is still possible. It might be possible to locate alternative equipment if a device fails and it should be possible to correct human error associated with the device. If a procedure is already in progress, then strategies might involve the use of alternative equipment or strategies. For instance, if a TIVA pump fails then a change to inhalational technique might be possible until the pump can be reprogrammed, or an alternative pump is deployed. Alternatively, frequent boluses could be used during the period when infusion was not possible.

In cases of electrical danger, the staff and patient should be removed from the area as soon as possible, and when safe to do so based on other risk factors.

Learning from outcomes

The immediate outcomes and the final outcomes are shown in the tables below. Although, there is a potential for serious harm or death with a failure of a medical device, in most cases harm was mitigated. The immediate outcome was minor or no effects in 87% of the case reports. There was a minority of cases where the procedure was cancelled (0.6%) or prolonged length of stay (1.5%). The levels of harm noted in

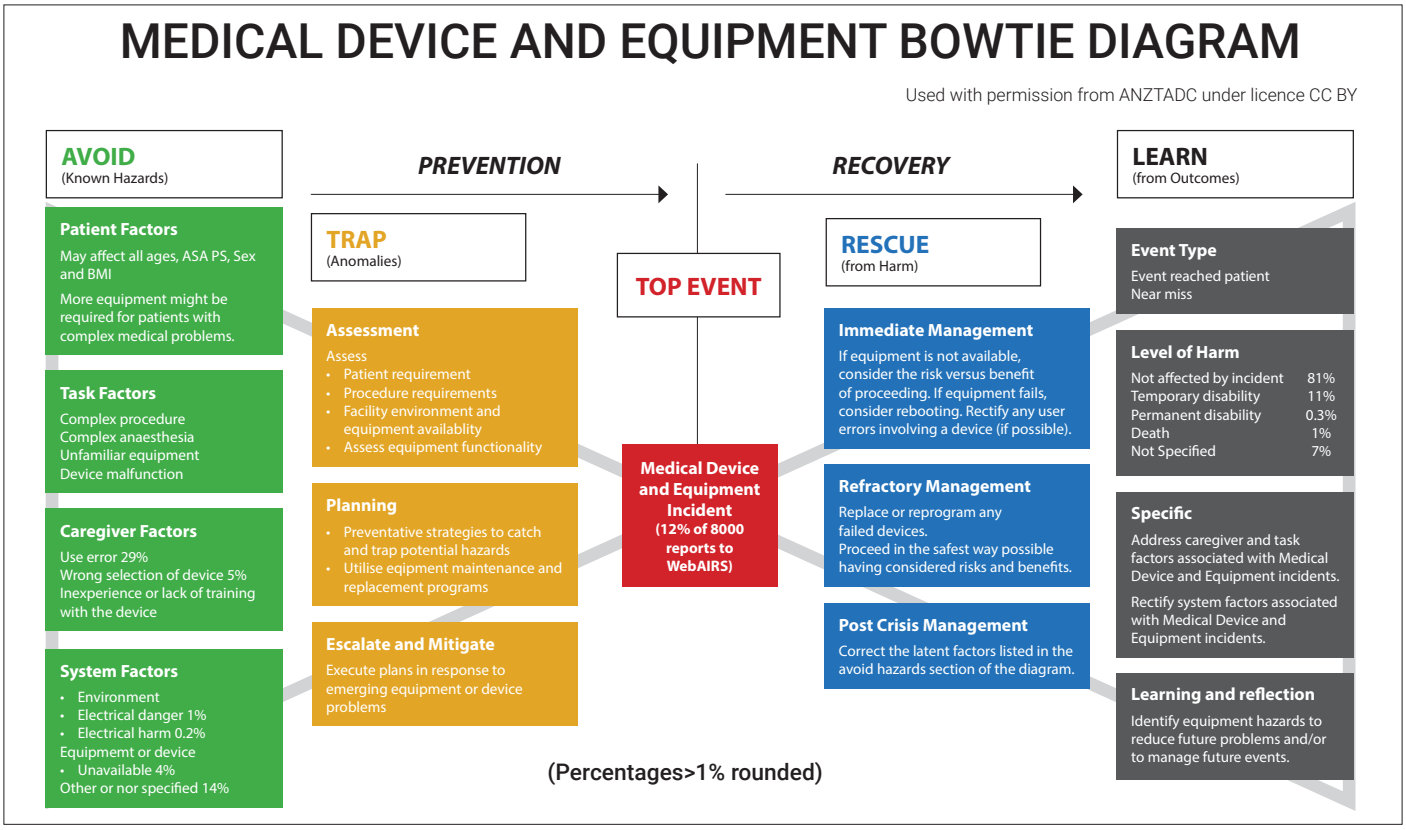
Immediate Outcomes	Percent
No effects	57.8%
Minor Effects	29.4%
Case Cancelled	0.6%
Prolonged length of Stay	1.5%
Unplanned ICU/HDU Admission	2.8%
Death	0.5%
Not Specified	6.7%

(It is possible to have more than one immediate outcome per report. Therefore, the total percentage has not been calculated)

Final Outcomes	Percent
Not affected by incident	81%
Temporary disability	11%
Permanent disability	0.3%
Death	1%
Not Specified	7%
Total	100%

(Percentages >1% rounded)

(Figure 1) Bowtie diagram for anaesthetic incidents involving a Medical Device or Equipment



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the final outcome were also low, with 11% having temporary harm and 0.3% permanent harm. Fortunately, there were no immediate effects recorded in 57.8% of cases. There were 5 deaths (0.5%) in the immediate outcome and 10 deaths (1%) in the final outcome.

Previous analysis of anaesthetic incident reports in Australia and the United Kingdom (UK) have identified problems with medical devices and equipment during anaesthesia [1,2]. Webb et al identified equipment failure in 9% of the first 2000 reports to AIMS [1]. The equipment included anaesthetic equipment, monitors, gas supply, electrical supply, and other theatre equipment. Fifty five percent of these errors were potentially life threatening but fortunately it appears that most of the incidents were detected and corrected before serious harm occurred. In the webAIRS series, medical devices and equipment were involved in 12% of the incidents reported, but harm only occurred in just over 11% of these cases, and death unfortunately occurred in 1% of these cases. No harm was reported in 81% of the cases, and in 7% the outcome was not known or not specified. The degree to which equipment contributed to cases where harm occurred has not been completed at this stage of the analysis.

In the UK study by Cassidy et al [2] identified 1029 reports relating to equipment failure. The most frequent problem was monitoring failure (39.8%) and many of these incidents related to screen failure during anaesthesia. Problems relating to ventilators were noted in 17.9% of the reports. In this study 89% were associated with no patient harm and only 2.9% were associated with moderate to severe harm, which is similar to the outcomes reported to WebAIRS.

A full analysis of the WebAIRS reports relating to failure of medical devices and equipment is currently underway to determine the relationships between the outcomes and the various risk factors in the Hazards section of the bowtie. This will allow a more detailed description of the analysis of each item in the Hazards section and more detailed diagrams depicting each topic in more detail.

ANZTADC thanks all webAIRS users for their contributions to the webAIRS database. www.anztadc.net

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MANAGED CARE, THE ACCC AND THE FUTURE OF AUSTRALIAN MEDICINE

The story so far

A great deal has happened since December 23 last year. On that day, the Australian Competition and Consumer Commission received an application by Honeysuckle Health to create a buying group for healthcare payers.

Honeysuckle Health is a joint venture between Australia's NIB and American giant CIGNA. Both of these publicly traded health insurance companies have a history of assertive behaviour towards other market participants. NIB remains one of the few Australian health insurers to decline rebates to patients whose doctors do not abide by the conditions of it's MediGap scheme[1] CIGNA is an established provider of managed care in the USA, where pre-approval for surgery, value-based payment models and preferred provider networks are entrenched features of the healthcare industry.[2]

Although this is not the first attempt by a health fund to gain market power over hospitals and healthcare providers, it represents a significant escalation.

Previous initiatives to increase health insurer power have included ownership of hospitals by insurers and the introduction of "bundled" payments for joint replacement surgery. Under such schemes, doctors enter a contract with health insurers to provide services to eligible patients, with terms including payment under insurer control.

ACCC draft determination

On May 21 this year the ACCC released a draft determination indicating that it would most likely approve the Honeysuckle application. It imposed a condition that the buying group could not account for more than 40% of health insurance policies in any given state.[3]

The ACCC was created to police the Competition and Consumer Act 2010.

It's website states that "Competitive, informed and (when necessary) well-regulated markets lead to lower prices, better quality products and services, and more choice. This increases the prosperity and welfare of all Australians." [4]

The ASA, along with many other groups within the healthcare industry, believe that the draft determination overlooked significant risks to quality and consumer choice. As the ASA stated in its response to the draft determination, the decision to approve the Honeysuckle application represents a turning point for Australian healthcare.[5]

Mobilisation of Providers and Hospitals

The ASA was not the only organisation to respond to the draft determination. Medical societies were joined by colleges, hospital operators and individuals. The ACCC received well over 200 submissions in response to the Honeysuckle application. With few exceptions, these submissions urged caution, warning of serious damage to Australia's healthcare system if the application was approved.

On July 8, the ACCC held a pre-determination conference, allowing

interested parties to discuss their concerns. With 100 participants, this conference was the biggest in the Commission's history.

Objections to the proposal were centred upon common themes, which are explored below.

This is just the start

The term "Managed Care" is variably defined and, in the context of the current debate, somewhat emotive. However, it is commonly accepted to imply the following attributes: [2]

- Contracted (or employed) providers
- Restricted benefits to members using non-contracted providers
- Pre-certification or authorisation for treatment

Simply put, a system in which third party payers influence medical therapy can be considered managed care.

It is the prospect of managed care in Australia that inspired the magnitude of the response to the Honeysuckle submission.

Coercion vs competition

Honeysuckle Health needed to apply to the ACCC because its proposal is potentially anti-competitive. This is acknowledged in the application.

The ACCC has to make a decision based on the balance of likely public benefits and detriments.

From the point of view of providers, there are only detriments. Loss of independence and an increased administrative burden are foremost among them.

The lack of any perceived benefit to providers is the very essence of the motivation for the buying group. The scheme proposed by Honeysuckle will not be taken up unless providers are forced into it. The goal of the buying group is to amass a coercive degree of market share. Providers will then face a stark choice. They can participate, sacrificing independence for the promise of work, or continue with a reduced ability to treat patients insured by the buying group, who would not receive adequate rebates for treatment from out-of-network providers.

The 40% limit imposed by the ACCC acknowledges this reality. Accepting the proposal even with limitations will be viewed as quasi-endorsement by the insurers.

Wendell Potter, a former public relations executive for American insurers Humana and CIGNA, gives a sobering account of the for-profit health insurance industry in his book Deadly Spin.[6]

He concludes that "The health care marketplace has been distorted by insurance companies wielding concentrated power because of their unique role as both sellers of insurance and buyers of health care services. Insurers have run roughshod over weaker health care providers, paying independent doctors and hospitals cut-rate fees. With only a handful of large insurers operating in most local markets, weak doctors and hospitals have no choice but to accept the offered fees, even if it's unprofitable to do so. In self-defence, many hospitals have merged or formed alliances, and many doctors have joined large group practices to have more clout at the bargaining table, contributing to an endless upward spiral in health care costs."

Spiralling healthcare costs

Readers may be familiar with Stephen Duckett's "death spiral" analogy for the Australian private healthcare industry.[7] He points out not enough young, healthy Australians are paying for health insurance to fund treatment for the older, sicker members of our community, who tend to purchase health insurance, often later in life.

The for-profit health insurance sector is promoting an Australian version of managed health care as the solution to this dilemma. We are being encouraged to hand over control to these corporate saviours, allowing them to efficiently fund and provide private healthcare.

There are two major problems with this. The first is the likely increase in healthcare expenditure on complex administration. Currently, independent doctors simply issue an invoice for service provided. Contracts with health insurers will oblige providers to comply with insurer-specific fee schedules, and with conditions, including data collection. There will be as many different sets of conditions as there are insurers. The upward spiral in cost begins.

The second problem is that managed care will not be acceptable to consumers. Private practice in Australia is characterised by choice, access and quality - choice of doctor, treatment and hospital; access to timely treatment at the most appropriate facility; and quality care from senior doctors, with continuity over time. Patients and their doctors make choices about healthcare without external pressure.

Given our excellent free public hospital system, consumers will see little value in paying expensive premiums for managed care. It is conceivable that the very measures proposed to combat the death spiral will actually accelerate it.

Autonomy preserved?

Our publicly listed insurers are attempting to become both payers and providers, establishing networks of contracted health professionals and hospitals. At the same time these companies loudly proclaim that the clinical authority of doctors is unchallenged.

This claim requires close scrutiny. Surely the goal of contracts and networks is to create an asymmetrical relationship between payers and individual providers? Under such a system, doctors, hospitals and other providers of healthcare become dependent upon insurers, who act as rainmakers, directing work to those providers under their control.

Why go to such trouble if not to exert control over providers?

When the fiduciary duty of the company to create value for its shareholders is taken into account, it is reasonable to assume that the companies must use any power at their disposal to improve their financial position.

The needs of the insurer's customers, our patients, take second place in these considerations.

Public detriment

To invoke the lexicon of the ACCC, examination of the motives behind managed care reveals clear public detriments.

Given the underlying theme of market control, patients can expect much greater input to their medical care from health insurers. This starts with primary care. Health insurers have purchased general practices, despite being unable to provide rebates to patients for visits to the GP. [8]

The health insurer network begins with primary care, where referrals to preferred specialists originate. Contracted specialists can then suggest treatment in a facility controlled, and perhaps owned, by the insurer. Rebates for treatment outside the network will be lower, strongly discouraging deviation from the insurer's stable.

Within the network, choice, access and quality are all influenced directly by the insurer, who has become both payer and provider.

Unfortunately for patients, the first, and legally binding responsibility of the insurer is to its owners, the shareholders.

Despite the best of intentions, an irreconcilable conflict of interest arises when a payer becomes a provider.

Health insurance euphemisms

The for-profit health insurance sector has developed its own vernacular. "Data analytics" and "value-based contracts" are specifically mentioned in the Honeysuckle application. Their use by CIGNA is cited as proof of their desirability. The term "pay for performance" is very frequently used in similar settings.

Like the term "managed care", definitions of these industry-coined terms are variable. However, to provide definitions is to give undeserved legitimacy to a nebulous cluster of deceptive euphemisms.

While these terms may defy cogent definition, they are all powerful vehicles for insurer's objectives. They provide a pretext for unilateral control. Control of treatments, control of hospital setting, length of stay, and control of payment for services.

Doctor patient relationship

What is the fate of the doctor-patient relationship? Under managed care, it is superseded by an insurer-patient relationship for the purposes of choice, access and quality.

Three pillars

Given that lopsided market power is the basis for pursuing the managed care agenda, it follows that a market in balance provides the best protection for patients, providers and, ultimately, payers.

Three pillars provide the basic structure of our private healthcare system. Doctors and other providers, hospital operators and insurers. Unless all three are strong and independent, the industry risks being dominated by the commercial interests of the most powerful group.

Our patients need a balanced system to provide them with high-quality care, free from unnecessary constraints and unwieldy administration.

Where is the line in the sand?

What is it that defines our world-leading system, maintaining the primacy of the doctor-patient relationship? The most important attributes are:

- Independent doctors, not contracted to insurers
- Independent hospitals, with genuine power to negotiate with insurers
- Avoidance of preferred provider networks, maintaining the largest possible pool of doctors and providers available to treat individual patients

The next steps

The threat of managed care taking root in Australia is real, but there is no need for fatalistic acceptance.

The unified voice of doctors, hospitals and patients cannot be drowned out by health insurance industry lobbyists.

The coalition against managed care faces an opportunity and a challenge. Mobilisation of the healthcare sector against unchecked insurer power may defeat the Honeysuckle initiative. The greater task, though, is to plot a course for the future of Australia's healthcare system.

A future in which the doctor-patient relationship is the only binding contract. A future which recognises the conflict of interest arising when payers become providers.

This challenge will require engagement of the Australian population and our government. Legislative change may be required.

Our journey has just begun.

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NSC FLASHBACK – A DIFFERENT PERSPECTIVE

During the recent 2021 conjoint ASA NSC and Queensland ACE meeting, I had the pleasure of delivering my Geoffrey Kaye Oration. During the oration, I read an excerpt from this piece that I wrote in 2018. To view the full Oration, please visit https://asa.org.au/asa-presidents-geoffrey-kaye-oration/ (ASA member login required).

It was the Saturday night of the NSC in Adelaide, 2018. Breaking with tradition the Gala Dinner had been moved to this night, rather than the usual Monday night. This change meant that, amongst other things, it would precede the AGM. Thus I could still be incognito, except for a few in the know and a few close friends about the new role I was about to enter.

I chose to wear a red dress. I like this dress. It is incredibly light, doesn't need ironing and thus perfect for travelling. I like that I bought it from an op shop in Cambodia. I also liked that I had worn it the year before to the same event when it was hosted in Perth. A second-hand dress from a developing country worn two years in a row. I wondered if I could wear the same dress at the NSC gala for every year of my Vice Presidency and Presidency, akin to Karl Stefanovic wearing the same suit for a year and wondering whether anyone would notice. One of the advantages of being incognito.

Another advantage was the quiet confidence I had as I kissed my family goodnight and headed to the dinner, alone. That soon I was going to be Vice-President of this organisation. This organisation that was hosting this dinner. That was hosting this conference. I felt trusted. Confident. This male dominated profession, organisation (with two-thirds of members being men) had accepted and recognised me as one of their future leaders. I could quietly enjoy this knowledge, without the wider membership knowing, without having to make any formal speeches or presentations, without having to consider what I said, or wonder if there was a hidden agenda in someone approaching me. No, I could be myself, relax, and also feel a little bit invincible.

The night began really well. I found two other stragglers making their way there through the crowd of returnees from the Monster Trucks show. I quickly jumped into the slipstream and we formed a peloton through the sea of families. I met with good friend, powerhouse and newest recruit to the Executive Council, Brigid Brown, the new State Chair for SANT Committee on the way into the grounds. I made my way to my assigned table, greeted my fellow diners and soon was engaged in fascinating conversation with the partner of an ASA committee member. I was impressed how he had immediately introduced himself as David's* partner, without a hint that this was anything other than normal. I was patting the Society, the membership on the back. Yes, this is the Society I know, a big family, where all are respected and welcomed.

After two courses of entertaining conversation I joined the many others who had left their tables and went roaming in search of friends I hadn't yet seen. Very soon I was chatting amongst friends and acquaintances. The very few that knew congratulated me unofficially on my new role. The great many that didn't know, I enjoyed catching up with from within my cloud of anonymity. I used these moments to talk about all things but I really enjoyed it when we got talking about the ASA. At the back of my mind I wondered if we could have such a frank conversation in a few days' time, after the AGM and once the news became public.

The band had truly warmed up now and people had started filling the dance floor. During a lull in our conversation, I heard the band enticing people to the floor by mentioning that this would be the only slow song for the night and I made some comment about it. One of the men in our group responded that he wouldn't mind taking me for a dance. I chose to ignore him. The conversation and laughs rolled on before I spotted someone I hadn't seen for a while and made the usual end-of-conversation murmuring. Before I left, David* came to me and again expressed his desire to dance with me. This time in a low, deep grumbling voice that came straight from the groin and accompanied by a whack to my bum. The future Vice President's bum.

Just like that, I went from being future Vice President to a woman in a red dress with a bottom. One that could be handled. By another person. Another man who was not my husband. By someone who had once upon a time taught me the craft of anaesthesia. Who I respected. And trusted. Who I regarded as a hard worker, knowledgeable, a good professional citizen. A good guy.

My reaction was conflicted. I was disappointed, sure. If this had been a random stranger I would hope that I would say something,

let him know it was unacceptable, taken him down. I have images of the waitress who throws a customer down after he grabs her bottom while she is doing her job. I secretly dream of having that strength and speed if I'm ever in that moment. But I was just in that moment. And I didn't react that way. Because I knew the person. He was a good guy.

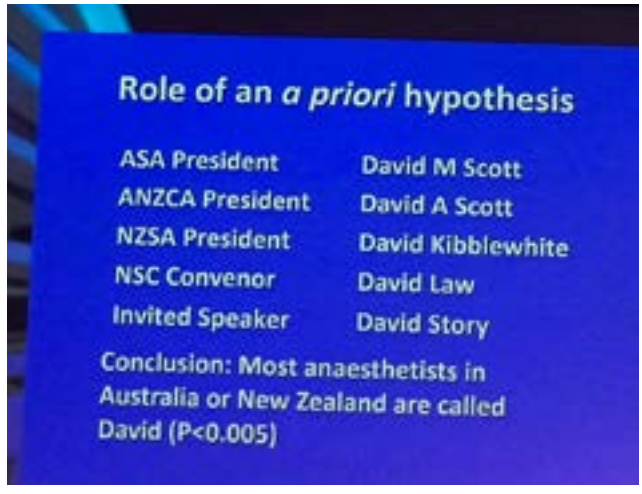
I've said it before. I tire of hearing excuses for good men. "David* has just done something sexist/racist/bigoted but otherwise he is a good guy". "No" I would say, "if they were truly a good guy, they wouldn't do that". I consider myself a bit of an expert because my husband is truly a good guy and I never hear him say or do anything like that.

I also grew up in the 80s. That sort of behaviour was tolerated much more then, compared to nowadays. I also work with men and women who grew up in the 70s and 60s and find myself much more tolerant of their language and attitudes than I do of colleagues younger than me. So although I was disappointed, I was able to acknowledge and even tolerate his behaviour a little. I also questioned my all or nothing definition of a good guy.

My attitude to David* and the many Davids* before and after him probably softened a little. I didn't see him for the rest of the night. I like to think it was because he was ashamed and scared to come near me. I like even more to think that he was running amok and dancing on the dance floor (the NSC does put on a good night and I do like a good party, particularly when I am one of the "hosts" of the night). As it turned out, I bumped into him again at the conference, having lunch with another good friend. The first thing he did was apologise for his behaviour. I could see he meant it. I was left a little speechless. My first instinct was to say "its ok" but my brain stopped my mouth as it screamed "no, it wasn't ok" so what came out was an indecipherable mumble. Had I my time again, I would say "apology accepted".

*Every man in this story has been named David. Real names may or may not have been used. No harm to any Davids has been intended. There are more David CEOs of ASX 100 companies than there are women and this night was in the twilight era of Davids in anaesthesia: David M Scott, ASA President for two more days, David A Scott, ANZCA Immediate Past President, David Kibblewhite, NZSA President and David Law, Convenor of the 2017 Perth ASA NSC, amongst many other Davids. I have the highest respect for all of these David's whose company, intellect and humour I have greatly valued and can vouch that they have never touched my bum.

Dr Suzi Nou



FROM NEVILLE GIBBS, OUTGOING EDITOR OF AIC. NSC PERTH, 2017.

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CONJOINT ASA NSC QLD ACE MEETING WRAP UP

DR PETA LORRAWAY

October 2018

Convene a meeting they said.

It'll be fun they said!

If you had suggested we would progress through one pandemic, two cities, two dates, two committees, three formats, multiple lockdowns and finally into the virtual world, I'd never have believed it.

November 2019

We have a date, a venue, a committee, confirmed international and local invited speakers, and ideas are being generated for academic and social content.

January 2020

COVID-19 arrives in Australia following horror reports of international outbreaks.

October 2020

We've seen a halt to elective surgery, travel, and all major events including educational meetings have been cancelled and postponed. We're now unfortunately very familiar with the concept and reality of lockdown.

Longer game COVID-19 was a dawning reality.

November 2020

Ongoing uncertainty meant a dramatic change in plans for the NSC had to be considered. With the anticipated commencement of vaccination, and a growing sense of a need to return to some face to face education, which allowed for safe social interaction, the reimagined Conjoint ASA NSC QLD ACE Meeting was born. This was achieved via a much appreciated collaborative effort with the Queensland ACE committee. Not wanting to be left without a contingency plan, a hybrid event with a limited virtual component ensured we could still deliver a meeting in the worst possible scenario.

April 2021

No local cases, Australians are moving freely across the country, and the New Zealand travel bubble is commencing.

Meeting registrations open and the initial response is positive with a large number of registrations over the opening weekend. We just might be able to give people what they seem to want, a return to an event with opportunities to meet face-to-face again.

June 2021

Sydney Covid outbreak begins, with new variant Delta identified as the culprit, bringing even more uncertainty as it rewrites the rules of transmission.

Southeast Queensland also enters a snap lockdown as mystery cases appear locally.

The committee meets regularly, with enacting backup plans constantly on the agenda.

July 2021

Restrictions are easing locally, life in South East Queensland is back to 'new normal' with large events still proceeding under Covid safe plans. But lockdowns and border restrictions are still affecting almost every state and New Zealand. The threat of a pending local outbreak is omnipresent. Safety concerns have to take priority, not only for participants, but for the communities we serve as health care providers.

We're a resourceful group so most can now navigate a Zoom meeting, a pre-record, or presenting to a screen when needed, even if the thought of returning to a live audience was preferred.

So after much deliberation, progression to a completely virtual meeting was deemed the most appropriate path and enacted, beginning a busy week of finalising plans to make this a reality. I hope that the end result was worth it for the 600 plus delegates who attended.

We were able to retain the vast majority of scientific content, and huge thanks must go to all our presenters and facilitators for enabling this. An advantage of being in the second year of a pandemic is that the world of virtual meetings is no longer such a strange beast to us. We're a resourceful group so most can now navigate a Zoom meeting, a pre-record, or presenting to a screen when needed, even if the thought of returning to a live audience was preferred.

Australian Society of Anaesthetists
80th NATIONAL SCIENTIFIC CONGRESS
Collaboration in challenging times

ACE ANAESTHESIA CONTINUING EDUCATION

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The meeting commenced on a high note with an interactive webinar style day for trainees. Learning how to perform under pressure, a block masterclass, an exam boot camp. Discussions on career choices, private and public practice, working regionally, and training with children were amongst the topics discussed. Our top five trainee research presentations were delivered and the awarding of the Tess Cramond Prize for excellence in trainee led research to Dr Harry Marsh rounded out day one.

Day two began with the Kester Brown lecture and we heard evolutionary virologist Professor Edward Holmes discussing the origins and future of pandemics, which was at times chilling, but an outstanding insight into this disease we are battling, and his thoughts about those we might need to deal with in the future.

We continued looking forwards with the ACE Future session, where Dr John Loadsman discussed the outlook for medical journals, and Mr Sean Lowry took us through Australian healthcare trends. Dr William Lindores was awarded the ePoster prize for trainee research.

The final day highlights included one of the best Geoffrey Kaye orations ever delivered from our current ASA president Dr Suzi Nou, a masterclass in engaging your audience and delivering an empowering message on how we are all part of the solution when it comes to inclusion and supporting gender equity.

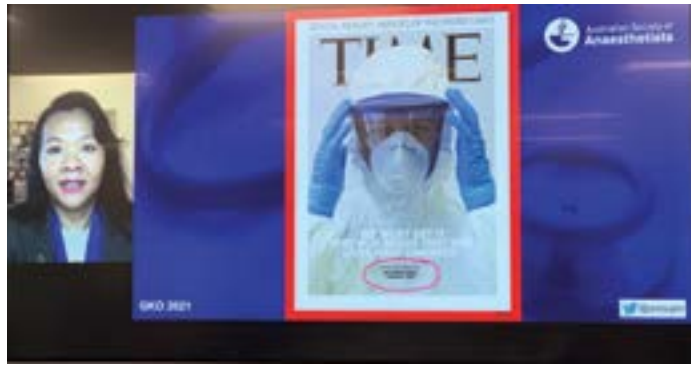
Assoc. Prof. Viren Naik discussed the very topical Medically Assisted Dying experience in Canada, which was confronting, but delivered in a manner that encouraged sensitive and open discussion. Our international neighbours are walking a similar path which we might make easier for all if we continue learning from each other's experiences.

Assoc. Prof.Kerstin Wyssusek reminded us of our responsibilities to focus on sustainability, as did our trainee research collaboration during the AIC editors session. Assoc. Prof. Laurence Weinberg updated us on advanced brain monitoring during our neuroanaesthesia session, Dr Nick John gave us some recipes on how to age well, and Dr Jo Rotherham helped us navigate managing the increasing number of our patients who are taking medical marijuana.

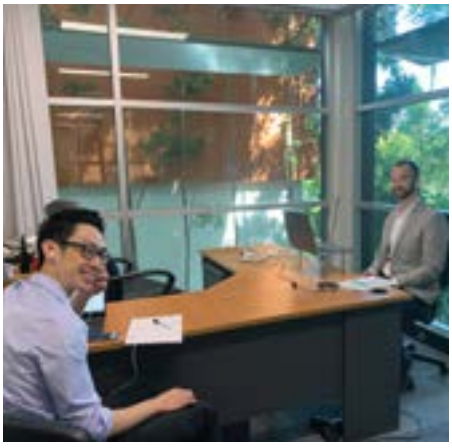
Our concurrent and SIG sessions continued throughout the entire meeting, with numerous high quality lectures on a wide range of topics, I'd love to highlight them all. The virtual format brings an added advantage of being able to watch everything on offer after the meeting, not just attend single competing sessions, and a number of delegates have appreciated this opportunity, which still exists for anyone interested. There were a number of wellbeing activities over the weekend, something we were keen to include as it has never been more important to look after ourselves and others.

Virtual workshops, the new addition of case conferences and the larger interactive ACE morbidity and mortality meeting meant quality assurance activities were accessible for a large number of delegates.

We were disappointed that despite a lot contingency planning, the emergency



I'm very conscious that yet again, Covid has disrupted our ability to bring people together for some much needed, more traditional social interaction. I hope that at some point soon we are able to balance the need for this with safety concerns.



response workshops and our social program were beyond the scope of a virtual program. This disappointment obviously extends to our industry sponsors, who have been incredibly supportive throughout, we were looking forward to engaging with you at the exhibition.

I'm very conscious that yet again, Covid has disrupted our ability to bring people together for some much needed, more traditional social interaction. I hope that at some point soon we are able to balance the need for this with safety concerns.

By combining two existing meetings, it allowed us to retain and enhance the excellent content of both, whilst ensuring each proceeded successfully; something not always easily achieved as we have seen an explosion of virtual & hybrid educational events.

A final shout out to Ed Pilling and Steven Bruce, the entire organising committee including Denyse Robertson (ASA) and Julie Donavan (Qld ACE), and Amy Buttery from Arinex, who all worked incredibly hard behind the scenes, often fitting this in amongst already busy lives. I hope we've shown you can collaborate in challenging times with great success!

Thanks,

Dr Peta Lorraway

CURRENT AND EMERGING TRENDS IN THE AUSTRALIAN HEALTHCARE MARKET

Sean Lowry FACHSM is the Principal of Green Cup Consulting specialising in health system reform, hospital performance improvement and efficiency. He has worked in the private and public health sectors for over 25 years across Australia, UK and in the Middle East in policy, advisory, operational and health service leaderships roles.

Sean was a key note speaker at our recent Conjoint ASA NSC and ACE Meeting. Here is an extract from his presentation.

Around the world, aging populations, increased prevalence of chronic diseases, growth in emerging markets and shifting reimbursement models are causing the healthcare sector to be reimaged.

We are moving from the reactive treatment of disease to proactive prevention. Health services are rethinking patient engagement strategies, care delivery models, and funding models.

The financial burden is shifting toward providers and patients. As health costs continue to rise, it will be critical for doctors to engage their patients in making evidence-based healthcare decisions, through education and better disease management.

Drive to contain costs

In the past ten years health spending in Australia has risen by more than $40 billion. The cause is not just the ageing population nor the tsunami of chronic disease; we are seeing rising rates of intervention and service utilisation.

11% of our overall economic activity is spent on health or around $7700 per person per year.

While middle of the pack in terms of OECD spending, Australia is top ranking in terms of health outcomes.

People are seeing doctors more often, undergoing more screening, diagnostics, procedures and taking more prescription drugs. The challenge being - how to maintain these great health outcomes while reining in spending?

Drastic solutions are being considered by funders, government, private insurers and indeed individuals. Efficiencies need to be found to reduce both the operational and capital costs associated with building and running health assets. This includes achieving more efficient working environments, increasing the productivity of the system and ensuring the most appropriate party undertakes the service delivery.

The complexity of the flow of funding and the lack of clarity or confusion this can cause amongst the voting public, on where their health care dollars are spent, makes stakeholders accountability for value very difficult.

Patient driven change

We're spending more on health care because it's increasingly valuable to us, both as a society and as individuals. More effective treatments are increasing the length and quality of our lives.

Patients are transforming from passive recipients of healthcare services to active participants in their own health, with superior customer service expectations.

The days of making an appointment to see the family doctor and waiting days or sometimes weeks for care will soon be over. Consumers now expect to engage with healthcare providers on their smart phones, tablets, or computers. Patients who don't feel well, want care right away, and as close to home or the office as possible and they want to know up front what it will cost – if anything at all.

New Models of Care

Technology empowers patients, real-time analytics improves care and enables a mind shift towards prevention

— but also opens the door to new non-traditional competitors.

Tech-focused primary care startups and retail outlets offering patients on-demand access to healthcare providers via mobile apps and convenient locations, will draw patients away from incumbent health systems.

In order to remain competitive traditional health providers must transform their services with an emphasis on transparency, access, and ongoing engagement outside of the clinic.

Any strategies health specialists, systems and hospitals can implement to create a consumer-centric patient experience which fosters satisfaction, loyalty, and patient volumes will be beneficial.

Virtual health gains could be a silver lining of the pandemic. During the early phases of the COVID-19 crisis many health systems and clinicians rapidly implemented processes around virtual health. As a result, the sector is probably closer than ever to a digital enabled future.

The pandemic has disrupted traditional care models and we should all work to meaningfully scale up our new learnings to transition to a longer-term, enterprise-wide approach.

A wide range of companies—from inside and outside of the health care sector — are already making strategic investments that could form the foundation for a future of health, defined by radically interoperable data, open and secure platforms, and consumer-driven care.

While disease will never be eliminated; through science, data, and technology, we will be able to identify it earlier, intervene proactively, and understand its progression to help consumers effectively and actively sustain their well-being.

The future will be focused on wellness and managed by companies that assume new roles to drive value in a transformed health ecosystem. If this vision for the future of health is realised, we could see healthier populations and dramatic decreases in health care spending. By 2040, we might not recognise the industry at all.

Sean Lowry

HOW CAN ANAESTHETISTS RESPOND TO THE CHANGING HEALTH LANDSCAPE?

Continue to seek opportunities to demonstrate greater value and relevance in the health sector – maintain your distinction as an invaluable part of the health system

Think extensively about your customer offering and how best to delight your range of customers– consider whom your customers are – not just patients - they are also surgeons, private health insurers, private and public hospital leadership teams, surgical team members.

Collect feedback – from surgeons, from patients (PREMS and PROMS) and private health insurers and hospitals.

Try and add a differentiator in your particular offering.

Become increasingly digital savvy or at least partner with digitally savvy organisations and individuals. (e.g., improve your "webside manner" on virtual health care interactions)

Encourage your Society and College to have a greater voice and role in influencing and steering the health reform agenda.

Form companies and partnerships and alliances of your own which are agile and adaptable.

WEEDING OUT THE ANAESTHETIC ISSUES WITH CANNABINOIDS

DR JO ROTHERHAM

Legalisation of medicinal cannabinoids in 2016 has seen the emergence of a new user cohort: middle aged people, living with chronic pain or psychological distress.

Patients are not waiting for solid scientific evidence to be convinced of the benefits the use of cannabinoids.

The AIHW National Drug Strategy Household Survey 2019 found cannabis use had increased, with 11.6% of Australians using it in the past 12 months. 6.8% of these people only used cannabis for medical reasons.

Legalisation of medicinal cannabinoids in 2016 has seen the emergence of a new user cohort: middle aged people, living with chronic pain or psychological distress.

Dr Jo Rotherham is an Anaesthetist and Pain Specialist working at the Princess Alexandra Hospital in Brisbane. Speaking at the recent Conjoint ASA NSC and ACE Meeting, she shared her experience of managing patients who are cannabinoid users.

A large systematic review of RCT published July 2021 in Pain, found insufficient evidence to support or oppose use of medical cannabis for treating pain, "however, the real-life experience of patients is quite different," Dr Rotherham said.

"If you have a patient suffering from chronic pain or in palliative care, it is advisable to ask some probing questions about what medical and non-medical substances they may be using, Dr Rotherham said.

Approximately 14,000 Australian doctors are prescribing medical cannabinoids for about 300,000 patients. Stereotypes of pot smoking delinquents are outdated. The typical medicinal cannabis user today is a middle-aged woman in a relationship with a steady job.

Cannabis use presents a lot of issues for anaesthetists to consider. Will it interact with anaesthetic agents; will it affect their pain regime post-operatively; should we ask them to stop taking it; will this cause withdrawal symptoms? What will we do if we are asked to prescribe?

While research is emerging about the benefits of cannabinoids, the science is lagging behind the practise. A 2020 meta-analysis of 43 randomised controlled trials found a 'statistically' significant reduction in pain. The majority of these trials involved patients with neuropathic pain. While not 'clinically' significant, the results were noteworthy with a 1.7 point reduction in the visual analogue scale.

In addition, a large Israeli study, involving a questionnaire of 551 patients conducted over 12 months, showed cannabinoid use to be associated with a reduction in opiate dependence, anxiety, depression, sleep disorders and an increase in quality of life, Dr Rotherham said.

What are medicinal cannabinoids?

There are three TGA approved cannabinoid products

- Nabiximol for MS induced spasms and neuropathic pain
- Nabilone for chemo induced nausea and vomiting
- Dronabiol for paediatric epilepsy

In addition, there are 100 or more unregistered agents that are available through the TGA's Special Access Scheme (SAS).

If a patient you are treating says they are using a medicinal cannabinoid, it is important to check with the prescribing doctor, or the dispensing pharmacist, to ensure the product is legally available.

Within a hospital these products are treated like S8 substances so

it would be advisable to inform the Director of Pharmacy of the patient's needs, ahead of time.

Is the patient is using a non-TGA approved cannabinoid? If it is <0.2% THC, the patient will be able to continue this on the ward like any other complementary medicinal supplement. If the substance is >0.2% THC (or unknown content), then - if taken daily – a slow wean and cease prior to elective surgery would be advisable and charting of clonidine for potential withdrawal phenomena if that is not possible. Prescribing of non-TGA approved substances with > 0.2% THC is clearly to be avoided."

Composition and dosage

"Tetrahydrocannabinol (THC) is the principal psychoactive constituent of cannabis and appears to be responsible for both the psychoactive and analgesic affects.

Cannabidiol (CBD) is also found in most of the products but it has few side effects and psychoactive properties. A purely CBD product has little potential harm associated with it.

However, with THC – the prescriber must be mindful of dosage. While a young fit adult could have a maximum dose of 10mg per day, 2.5mg would be a daily maximum dose for a frail elderly person. Any daily dose over 20mg will produce psychoactive symptoms. Regardless of dosage, patients taking THC are not allowed to drive.

For more information on the safe use of cannabanoids, the TGA has a helpful range of guidelines covering general use, palliative care, nausea and vomiting, epilepsy, MS, and in chronic non-cancer pain," Dr Rotherham said.

Pharmacokinetics and pharmacodynamics

"In addition to dosage it is important to understand the bioavailability of each product which is impacted by the mode of administration. Vaporising creates higher bioavailability than smoking. Even less viability is achieved via oral administration. Topical oils that go on the skin are not likely to reach any meaningful concentration at the effect site," Dr Rotherham said.

"Pharmacodynamically, it is worth remembering tolerance, dependence and addiction can be an issue, and patients can experience a withdrawal phenomenon especially if using more than 20mg a day."

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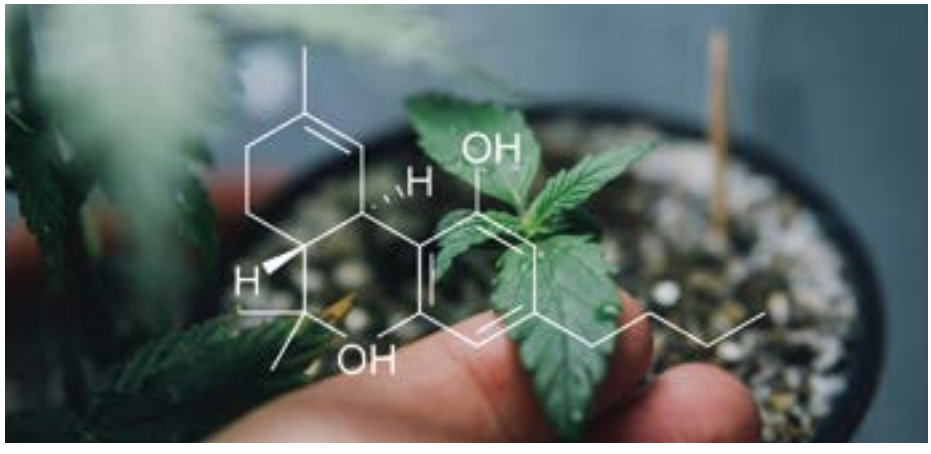
Kathy Scott



MINDFULNESS ON THE RUN

DR SHAHINA BRAGANZA
EMERGENCY PHYSICIAN GOLD COAST HEALTH

A busy Emergency Department would seem an unlikely place for people to be practicing mindfulness but that is exactly what is happening at Gold Coast Health.

Speaking at the recent Conjoint ASA NSC and ACE, Dr Shahina Braganza, an Emergency Physician at Gold Coast Health in SE Queensland, explained the wellbeing benefits of incorporating mindfulness into a high-pressure workplace.

With over 20 years' experience working in emergency medicine, Dr Braganza says it was the much-anticipated move to a new, tertiary hospital which triggered the shift in mindset.

"In 2016 we moved from the old Gold Coast Hospital to the new Gold Coast University Hospital. While we were thrilled to have a new facility with an expansion of services, the size and scale of the new operation also meant we lost the sense of community that came with working in a smaller hospital. That led us to consider: what can we do to retain the old dynamics and nurture the interpersonal relationships that are so important to a strong team? A few of us attended a mindfulness course and recognised that some of the principles and learnings could be applied to a busy emergency department," Dr Braganza said.

While the program started under a slightly different guise, Dr Braganza says this wellness program was ultimately successful because it is home-grown.

"Over four years ago we developed a program called oneED. Incorporating many principles of mindfulness, we initially promoted it as a tool to enhance performance rather than creating wellbeing but over time we can now be more overt over our wellness agenda," Dr Braganza said.

"I think the success of oneED is largely due to the fact that it is a program created by us for us. We continue to find new ways to introduce the practice of mindfulness into our busy schedules and support each other through stressful times.

"The organic nature of the oneED program has created a safe environment where colleagues can share and support each other. While many different elements have been introduced over the years the one enduring feature is our Mindfulness Session at Handover every Thursday morning. We dedicate four minutes of this time to a mindfulness exercise. It might be a guided meditation or a Consultant sharing the strategies they use to get through a stressful shift.

"One of my colleagues talked about how he uses the technique of square breathing - inhaling for four seconds, hold for four seconds, exhale for four seconds, hold for four seconds - at intervals during his shift, for example before the arrival of a resus patient. There is a significant evidence

> There is an increasing evidence base for the benefits of mindfulness. Mindfulness is about being able to recognise and regulate your stress response. Techniques that focus on your breathing and help you reset your thoughts, short circuit the sympathic drive that causes hyper arousal.

base behind why this square breathing is so physiologically beneficial.

"We have sustained these mindfulness activities for 4-5 years which shows it is an activity we place value in. When senior emergency clinicians share stories of vulnerability and talk about how they deal with hardship, it can give others permission to talk about how they are feeling," she said.

A range of oneED strategies have been embedded in the Department to encourage team members to use mindfulness every day.

"While work in an ED can be relentless, there are times when we are forced to stop and at these moments we try and direct thoughts to mindfulness activities. For example, at the blood gas machine or near the sink when scrubbing for procedures, we strategically place poster messages describing breathing techniques, so people can use this time to pause and reboot. In the tearoom we have a mindfulness poster asking people to be in the moment and focus on every, nourishing bite of their meal," Dr Branganza said.

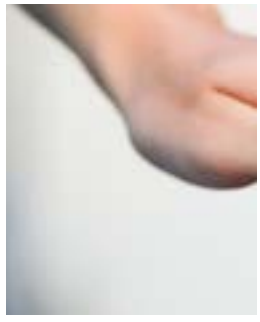
Over time the oneED banner has hosted a range of activities such as fun runs and charity fundraising events, even the occasional flash mob dance. Dr Braganza says the core objective is strengthening the sense of the ED community which has never been more important than during the Covid outbreak.

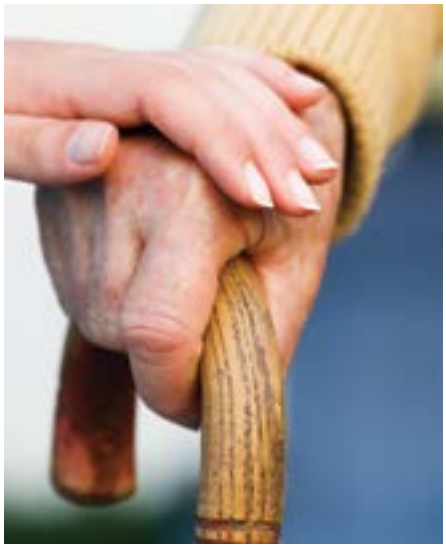
"On Mondays we were in the habit of holding 'gatherings', whereby people who have time, join us for some journaling or to engage in a discussion about wellbeing. Since COVID-19 we have had less face-to-face time. Instead, I will email out a reflection and people will share their reactions and experiences. Although remote, the virtual connection is valuable," she said.

"Part of the success of our oneED program is the sense that we care for one another and no one is alone. From time to time, we set up a staff 'Resus Trolley' offering snacks and fruit. This is done by staff for staff. It gives our team members an opportunity to take a break and recharge, but even more significantly, it generates a powerful feeling when you know your colleagues are doing this because they value and care for you," Dr Braganza said.

Kathy Scott

WHAT ROLE FOR THE ANAESTHETIST IN ASSISTED DYING?





While many of the pharmaceutical agents used in voluntary assisted dying are the remit of anaesthetists, in other countries GPs and nurse practitioners are upskilling to perform the procedures.

The push for voluntary assisted dying legislation is gaining momentum in Australia. VAD has been legal in Victoria since 2019 and similar laws came into effect in Western Australia on 1 July 2021.

In Tasmania and South Australia legislation is scheduled to come into effect within the next 18 months. At the time of going to press a Euthanasia Bill was due to be debated by the Queensland Parliament.

In New South Wales, MPs from across the political divide have confirmed they will support a Voluntary Assisted Dying Bill when it is introduced to Parliament in August.

In the Territories, the Federal Euthanasia Laws Act 1997, commonly known as the Andrews Bill, has blocked attempts to legislate on euthanasia.

In New Zealand assisted dying will be legal from November 2021.

While many of the pharmaceutical agents used in VAD are the remit of anaesthetists, in other countries GPs and nurse practitioners are upskilling to use these agents. With euthanasia being legalised in many states across Australia it is timely to consider the role anaesthetists will play.

While the Voluntary Assisted Dying Act 2017 (Victoria) provides for conscientious objection, the Act encourages open discussion of death and dying and the promotion of a patient's wishes. The legislation, which is forming the template for other states to follow, allows for life-ending substances to be both self-administered and practitioner administered.

Many of the proponents of euthanasia in Australia have drawn on overseas experience where brave individuals have taken their fight for self-determination to their highest courts. One such example is the Carter vs Canada Supreme Court Challenge in 2015 which paved the way for the Medical Assistance in Dying (MAiD) Act made effective in Canada in June 2016.

DR VIREN NAIK

Canadian Clinician and Administrator, Dr Viren Naik, shared the Canadian experience at the recent Conjoint ASA NSC and ACE Meeting. He is a former Clinician Advisory Council Member for Dying with Dignity, Canada and sits on the Board of the MAiD Assessors and Providers Group in Canada. As the Medical lead for the MAiD program across eastern Ontario province (including Ottawa Hospital), Dr Naik was charged with making this newly minted law available to people in his region.

Dr Naik says Canada had only one year to implement the legislation from the court decision and credits the operational success with the detail embedded in the legislation.

"There has been a steady rise in the number of people seeking MAiD. Not surprisingly, they are predominantly the elderly, with cancer the leading condition, followed by cardiovascular, respiratory and neurological diseases. Five years down the track MAiD has accounted for 21,000 deaths in Canada, with 2.5% of all deaths in 2020 attributable to MAiD", Dr Naik said.

"In Belgium assisted Dying has been the norm for decades, with the rate sitting at 4%, but I wouldn't be surprised if the rate in Canada exceeds this as acceptance of MAiD continues to grow", Dr Naik said.

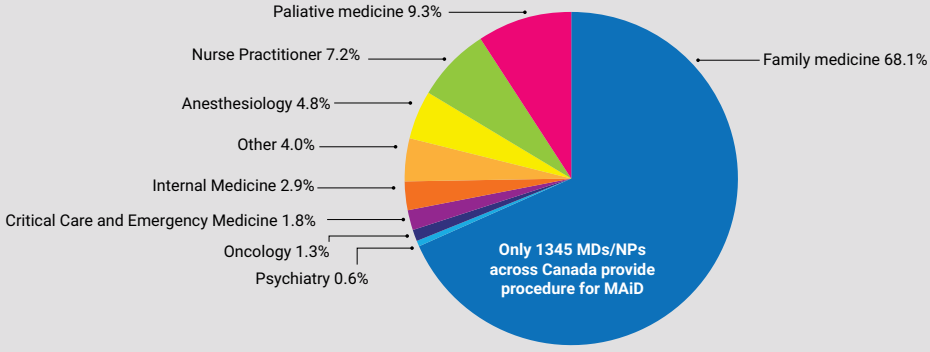
Legislation in Canada allows for both physicians and nurse practitioners to provide clinical assisted dying. The legislation is clear about conscientious objection. No clinician is obligated to perform medically assisted dying. However, every healthcare professional needs to respond to a patient's request and facilitate access to this service.

The legislation provides for both self-assisted and clinician assisted modes of death, however in five years there has only been two self-assisted deaths. Dr Naik says this is because Canada is focused on quality of care.

"Self-administered drugs are not the favoured means of dying. The process involves large amounts of pharmaceuticals which are unpalatable and requires the patient to have the ability to swallow and digest substances. It can take up to 22 hours to die, which is difficult for everyone involved, and even then, the medication is only 90% effective. This is not a quality end of life option", he said

"There is an emerging preference for MAiD to be delivered in the comfort of your home, or in a palliative care / residential aged care setting, but in some cases the patient is hospitalised and cannot be moved," Dr Naik said.

"The vast majority of patients favour clinician administration, however, only 1300 practitioners provide the procedure for MAiD which is a limiting factor. GPs are the leading group administering MAiD, followed by Palliative Care Clinicians and Nurse Practitioners. 4.8% of procedures are conducted by Anaesthetists."



Recently the Canadian Medical Assistance in Dying legislation was amended, removing the requirement for 'reasonably foreseeable natural death' as a prerequisite. With the exception of mental illness as a reason, any patient who considers their suffering to be intolerable can now seek MAiD in Canada.

Dr Naik says this shift has been challenging for his colleagues.

"This new cohort of patients seeking MAiD is very different from the person suffering from a terminal disease and three-months down the track we are having difficulty finding doctors willing to perform the procedure", Dr Naik said.

Dr Viren Naik was a key note speaker at the Conjoint ASA NSC and ACE Meeting in July 2021.

Kathy Scott

ECONOMICS ADVISORY COMMITTEE

Dr MARK SINCLAIR

Medicare Benefits Schedule (MBS) Audits

The ASA has provided assistance to Members who were approached by the Department of Health (DoH) for incorrect use of Medicare item numbers. These cases related to MBS item 20170 (anaesthesia for intraoral procedures) and items 22900/22905 (anaesthesia for dental extractions and dental restorations, respectively).

The Department accepted our arguments that the Anaesthetists concerned used item 20170 in good faith and that the administrative error was at no additional cost to Medicare, as all three items attract exactly the same Medicare funding. Our members have been informed that DoH will not ask for refunds.

Our members were working with fully qualified oral and maxillofacial surgeons, and genuinely believed that MBS items covering anaesthesia for "dental" services were inappropriate. However, there is a requirement that MBS anaesthesia initiation items are only claimed in conjunction with an "eligible" surgical/procedural service – generally, this means a service with the term "(Anaes)" at the end of the item descriptor. The only procedural services excluded from this requirement are in fact items 22900 and 22905, given dental procedures virtually never have an eligible Medicare item. Therefore, the use of item 20170 was technically incorrect. This resulted in an "outlier" statistical pattern for some anaesthetists, from the point of view of anaesthesia services, with no "matching" surgical Medicare claim. Statistical outliers will attract the attention of the Medicare compliance section.

Again, we thank our Immediate Past President, A/Prof David M Scott for his assistance to these members, via discussions with senior DoH officials, with whom he developed good working relationships during his excellent work on the MBS Review.

The ASA has developed a good working relationship with DoH on this particular issue. The Department is supportive of ASA's desire to educate our Members on the correct use of Medicare items, and we are pleased to have the opportunity to contextualise the work of the anaesthetist and ensure the DoH understands the valid reasons why unusual claim patterns may occur e.g. a special interest in a specific clinical field. To this end, another meeting with the relevant DoH officials has been arranged, and will have been held by the time this edition of the magazine is published. Members are advised to watch for their regular ASA President's E-news releases, and the ASA website, for any updates.

Meanwhile, we re-emphasise that all claims for anaesthesia for dental extraction/restoration services must be claimed under items 22900 and 22905, regardless of the qualifications of the surgeon.

As can be expected, this unfortunate experience has been stressful,

inconvenient and time-consuming for the anaesthetists involved. If you should receive any communication from DoH regarding incorrrect use of MBS items please seek the advice of your medical indemnity provider, and the ASA (policy@asa.org.au) immediately. Both organisations are experienced in dealing with these matters, and will be able to provide you with the appropriate support to resolve the issue.

We also thank our legal advisors at HWL Ebsworth for their invaluable assistance

Medicare Benefits Schedule (MBS) – Other

A small number of the MBS Review recommendations have not yet been implemented into the MBS Relative Value Guide (RVG). There are likely to be several changes to the MBS RVG in November 2021, but these will generally only involve minor changes to wording. The ASA will advise Members as soon as the exact nature of the changes have been finalised.

Arguably, the most important recommendation will be the requirement to have anaesthesia start and finish times recorded for every patient. Again, this should not have a major impact. It is already very common practice, as it is a feature of most billing software products.

However, anaesthesia time items are a common source of queries from both DoH and private health insurance (PHI) companies, and in the future, it is likely that even more attention will be paid to these items by payers. Recently we were called upon to support Members with queries from one PHI provider, where the anaesthesia times claimed were substantially longer than the operation/theatre times. The letters even asked for a repayment of incorrectly claimed funds. As expected, we found that all claims were entirely correct. One case, for example, involved an unwell patient requiring the immediate presence of the anaesthetist, for quite some time after leaving theatre and arriving in the recovery room. Another involved a significant amount of time spent in the anaesthesia room prior to GA induction, placing invasive monitoring lines and a local anaesthetic nerve block.

Anaesthesia time starts when the anaesthetist commences exclusive attendance on a patient, and ends only when the anaesthetist is satisfied that he or she can leave the patient in the care of another person – usually a recovery nurse. There are no clock times recorded by the theatre and recovery team which directly reflect anaesthesia start and finish times. We have repeatedly tried to educate payers that anaesthesia start time is not necessarily the same as theatre arrival time, and the anaesthesia time does not end with departure from theatre or arrival in recovery. We will continue to emphasise this in our dealings with DoH and PHI. However, in the meantime we again advise any members receiving such queries to approach their MDO and the ASA immediately. And of course, to ensure that accurate start and finish times are always recorded.

Another important aspect of our ongoing work with DoH is to ensure the MBS remains up to date. We regularly receive queries from Members as to what RVG item is appropriate for anaesthesia for novel surgical procedures. Unfortunately, the process of obtaining appropriate anaesthesia items is very slow. Concern regarding MBS expenditure features highly in discussions, even where such changes would merely provide clarity rather than extra funding. We will certainly continue our efforts in this regard.

July 1 Rebate Indexations

The MBS Fee for the RVG unit was indexed by 1.0% on 1 July 2021, and is now $20.60.

Private health insurance rebate indexations were, as always, variable. It is worth noting that Bupa has failed to index

its rebate schedule in Victoria and SA for the second year running. This results in a lower payment by Bupa for each and every claim in these states, given the slight increases in Medicare rebates in July of 2020 and 2021. This has generated millions of extra dollars in profits for Bupa.

Unfortunately, it is nowadays the case that most insurers do not pay a consistent unit value. They apply a specific indexation to each MBS item, and round off the figure, typically to the nearest 5c. Medicare, the Department of Veterans' Affairs (DVA) and the Australian Health Service Alliance (AHSA) funds now appear to be the only payers with a consistent unit value. The EAC has repeatedly highlighted this issue to insurers, and will continue to advocate for a consistent unit value.

Private Health Insurers – "Managed Care"

It should be noted that there are numerous implications involved in the push by health insurers to gain more control over the healthcare system, not just implications for medical fees. These issues continue to be highlighted and publicised by Dr Peter Waterhouse and PIAC, and by ASA President Dr Suzi Nou.

However, from the EAC point of view it is again worth highlighting that while initial offers by health insurers may look attractive to doctors, there is no guarantee this will continue into the future. The for-profit health insurers leading the charge have a vested interest in cutting costs. Signing their one-sided contracts could have significant ramifications for doctors' ability to charge fair and reasonable fees and practice medicine independently.

Dr Mark Sinclair

RVG Unit Values and Indexation	Fund	RVG Unit Value	July 2021 Indexation
	MBS	$20.60	1.0%
	DVA	$34.10	1.0%
	AMA	$89.00	2.2%[1]
	CPI		1.0%[2]
	Known Gap		
	Medibank Private	$34.02	0.9%
	AHSA[3]	$36.42	0.9%
	HBF[5]	$30.80	0.7%
	St Luke's	$35.70	1.0%
	HCF	$34.00	1.5%
	Bupa[3]	$34.39	0.5[4]%
	No Gap		
	HCF	$35.00	0.9%
	NIB	$34.00	1.0%
	HBF[4]	$39.40	0.5%

1. AMA RVG unit value was indexed on 1 November 2020
2. The CPI figure is for the 12 months to March 2021
3. Average value - varies from state to state.
4. Average value. Bupa rebates were not indexed in Victoria or SA
5. HBF "no gap" and "known gap" schedules apply only in WA. For all other states, see the relevant AHSA table

COMPLIANCE AND THE MBS

Recent compliance activity by the Commonwealth Department of Health (Department) is a timely reminder for Anaesthetists to ensure they are aware of, and complying with, the requirements of the Medicare Benefits Schedule (MBS) prior to submitting claims to Medicare.

Background

The purpose of the Department's compliance activities is 'early intervention and prevention', that is, to inform practitioners regarding the requirements of certain Item Numbers and ensure they are complying with same. The Department says it recognises that most non-compliance is inadvertent and seeks to work with practitioners to resolve any issues.

Compliance activities are also often an attempt to reduce the likelihood of Anaesthetists (or any other specialities) being subject to more intensive compliance action at a future point in time.

Regardless of the purpose of the compliance activities, it is understandably never a pleasant experience for practitioners to receive such correspondence from the Department.

Correspondence

Even if you have not as yet received any correspondence from Medicare, it is important you are aware of the compliance activity which is regularly undertaken by Medicare and what you can do to reduce concerns being raised with respect to your practice.

What Can You Do?

The recent compliance activity undertaken by the Department is a timely reminder to ensure that you are:

1. Familiar with the Item Number requirements (and the associated notes) for the Item Numbers you are submitting to Medicare. These can be located on MBS Online;
2. Regularly reviewing the Item Numbers you claim to determine whether there have been any updates to the requirements for those Item Numbers and / or whether another Item Number might be more appropriate to claim;
3. If you are not sure which Item Number should be claimed for a particular service, contact Medicare directly. It is preferable to ensure that all correspondence with Medicare is in writing so you have a record for future reference;
4. If your staff are submitting claims to Medicare under your provider number on your behalf, make sure you identify the Item Number which is to be billed by your staff and review the claims either before or after they have been submitted to ensure they are correct; and
5. If billings are submitted on your behalf by your employer, you may wish to ask your employer to send you a list of the claims which have been submitted under your provider number on a regular basis for your review.

If you identify that you have not met the requirements for an Item Number which has already been billed under your provider number or, for example, an administrative error has been made regarding your billing, you may be required to submit a Voluntary Acknowledgment of Incorrect Payments Form to Medicare which will require you to repay the amount which was incorrectly claimed.

It is also very important that your record keeping is thorough, contemporaneous and reflects that you have met all the Item Number requirements to be able to claim the service and that the service is clinically indicated. If any queries are raised regarding the Item Number/s you have claimed, your records will be the first port of call to be able to substantiate the claims.

Your Provider Number, Your Responsibility

Ultimately, Medicare is of the view that you as the practitioner are responsible for the services claimed under your provider number. It is therefore very important that you are aware of the Item Number requirements and ensure that all services claimed under your provider number meet the Item Number requirements, are clinically indicated and are reflected in your record keeping.

Scott Chapman
Partner, HWL Ebsworth Lawyers

Patricia Marinovic
Senior Associate, HWL Ebsworth Lawyers

INVESTMENT

FINANCIAL MARKETS IN A PANDEMIC

DIRECTOR AND
PORTFOLIO MANAGER,
PRIVATE BANK AUSTRALIA
JASMIN ARGYROU

CREDIT SUISSE GROUP

It is almost exactly 18 months since news of the pandemic first made ripples through financial markets, and it is still the number one theme for financial markets today.

As a portfolio manager I avidly pursue knowledge of the matters of the day that shape financial markets. I then put all my analytical tools to work in order to link that knowledge to the behavior of financial asset prices. When I have the time to look back, I sometimes give myself a hypothetical mental exercise: would perfect foresight about some particular important economic development, on its own, have helped me predict the performance of financial markets? The answer can be surprising.

It is almost exactly18 months since news of the pandemic first made ripples through financial markets, and it is still the number one theme for financial markets today. If we had the benefit of hindsight to see how the COVID-19 virus would unravel - in terms of its longevity, global breadth and severity - as far back as March 2020 or earlier, would that alone have helped us make wiser investment decisions? I actually think the answer is no. As someone who takes great pride in deep knowledge it is somewhat startling to me to come to this conclusion.

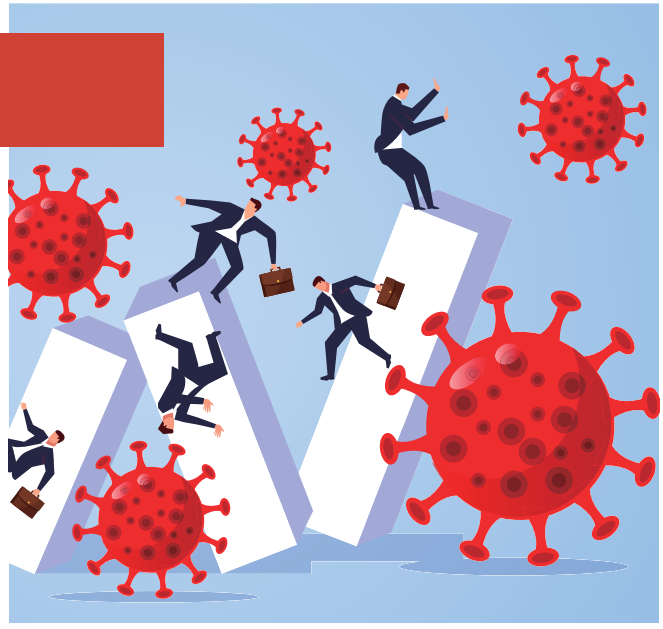
The pandemic has undoubtedly been the main event for the global economy and financial markets for more than a year. In terms of predicting the development of the virus alone, the more pessimistic you were relative to the consensus, the better your predictions would probably have been. However, when predicting financial markets – and in particular equity markets – this pessimism would have cost you dearly.

There are two good reasons for this. The first relates to policy. The slump in global demand growth in 2020 - the largest in peacetime history - was not actually caused by the pandemic. It was the result of the implementation of government policies, designed to prevent a health crisis. It was therefore incumbent on policymakers from the start to counteract the economic consequences of their measures. This is not true of every economic downturn. Most downturns will be the result of private sector excesses, seen often in increased debt and stretched balance sheets, speculative investing, and so on. In such episodes, policymakers need to balance fiscal and monetary stimulus with the moral hazard that comes from propping up and bailing out bad economic decisions. There was no moral hazard to think about in 2020 so policy makers went all-in. Understanding this - more than any detailed knowledge of the pandemic - was the key to making the wisest investment decisions last year.

The second reason relates to our own shortcomings. Armed with superior knowledge about something but not everything may lead us to underappreciate the 'known unknowns', such as the policy response and the reaction of the private sector in the midst of a pandemic. As fund managers and market economists, we are navigating systems, which refuse to conform to mathematical models, with incomplete knowledge.

These lessons give us a good dose of humility, which – unlike pessimism or optimism – is always a good ally to have when making investment decisions. With that, I will recap recent market activity and provide a perspective on the likely future path of asset prices.

The decision in late March 2020 by the Credit Suisse Global Chief Investment Office, to tactically increase risk asset exposure – and in particular equities - in portfolios, was informed by the recognition that policy makers were beginning to combat the economic shock with every tool in their toolkit, and then some more. Equity markets took their cue from the Fed's historic announcement on 23 March 2020 to purchase corporate bonds and never looked back. From the trough, global equities rallied 41% to end October 2020, led by stocks that are most sensitive to the economic cycle, including the closely watched tech stocks. This ended stage one of the current economic



cycle. But, lurking beneath the surface of the stellar returns lay evidence of fear and uncertainty. The five top stocks in the S&P 500, all tech-heavy, were entirely responsible for the positive 3% year-to-date equity returns of the index (meaning that the S&P 500 minus those five stocks was actually still in the red at that point). Investors consider tech stocks to be defensive stocks because their earnings are relatively immune to negative economic shocks. The fact that 495 stocks in the S&P 500 were still down year to date by the beginning of November last year reflected an unwillingness on the part of equity investors to wholeheartedly embrace risk. More good news was badly needed.

And it arrived. November marked stage two of the recovery, which has lasted until now, and looks set to endure a while longer. Policymakers doubled-down on their early efforts in late 2020 and early 2021. So much so, that the chatter among market participants turned to whether too much stimulus was being injected into the economy. We are talking of course of the US, starting with the overhaul of the Fed's policy framework to make it tolerant of higher inflation in December, followed soon after by the COVID-relief plan worth $1.9 trillion, about 8.5% of GDP. Turbo-charging these measures and making them more potent was the November announcement and rollout of highly efficacious COVID-19 vaccines. Equity market performance did not quite match what was delivered in the first stage of the recovery cycle but it came very close, with global equities another 34% higher based on today's numbers. The narrative that seduced financial markets over this period was inflation, and so this time bond markets buckled and long dated yields surged. Government bonds posted small negative returns, but thanks to an ample spread cushion (the additional yield corporate bonds earn over the risk-free rate) corporate bonds continued to rally as credit spreads tightened. Within equities, banks posted returns well ahead of the overall indices, up to 15 percentage points more, as it is an industry that profits from higher and steeper bond yield curves.

> The pandemic was a black swan event that sent financial markets on a rollercoaster ride. Losses and gains occurred at record speed.

In order to navigate financial markets we need to figure out whether or not we will soon progress to the mature stage of the cycle or remain in the more vibrant mid-stage. The hallmark of a mature-stage cycle is high inflation. This occurs when there is little time left for further economic expansion, before the economy absorbs all unemployed workers and before companies max out their production capacity. There are pockets of this happening, the most notable being the manufacturers of semiconductor chips, which have been unable to keep up with strong demand. However, this experience is not widespread or likely to be long lived. At Credit Suisse, we think the global economy is still in the vibrant mid stage of the cyclical recovery. Nevertheless, it is not the time to skew portfolios towards equities but instead to stay close to your long-term allocation to equities. Equity market behavior suggests all the good news is now in the price and so any negative surprise will elicit a disproportionate reaction, by way of equity market correction. Over the medium-term we expect equities to deliver positive returns, driven by earnings growth. Within equities, there are opportunities to profit from the re-opening of European economies, and we continue to expect that cyclical sectors

Companies advancing the sustainability cause can be compared to companies in the tech and health care industries. These are entities that, perhaps more than many others, create structural change ...

such as banks will continue to beat the overall market. Additionally, for the first time in a while, we don't mind holding a bit more cash, keeping it at the ready to deploy if and when there is a correction in equity markets.

The pandemic was a black swan event that sent financial markets on a rollercoaster ride. Losses and gains occurred at record speed. Staying invested was quickly rewarded. We didn't have to wait long to see the positive results from vaccine development and deployment and from fiscal stimulus. This contrasts with climate change, which has occurred over several decades, with even US President Lyndon Johnson warning about it in the 1960s. Similarly, the positive impact from our efforts to limit the threats facing the natural world will not be evident overnight. This includes sustainable investing. Here lies an obstacle for many investors who seek to see short-term financial benefit from their sustainable-oriented investments. My advice is to take a long lens when evaluating the financial and non-financial rewards from such an investment approach. Unlike many of the narratives and themes that captivate financial markets, this one is not going away. Companies advancing the sustainability cause can be compared to companies in the tech and health care industries. These are entities that, perhaps more than many others, create structural change – in the form of digitalization and the internet age - or respond to it – in terms of the ageing populations and the attendant demand for health care. Over the past twenty-five years, these two industries beat the overall world index by an annualized rate of between 2 and 3.5 per cent. That seems small but that additional return, accrued over 25 years, adds up, and you would find yourself with twice the sum of money had you invested in those two industries instead of the aggregate world equity index. I am not promising that sustainable investing will beat the overall equity market over the next few decades. My only point is to emphasize the wisdom in long-term focused, thematic investing, an art that can be underappreciated in times like these, full of fast moving asset prices.

Jasmin Argyroul

PALEXIA® IR

tapentadol immediate release

For the short-term management of severe pain for which other treatment options have failed, are contraindicated, not tolerated or are otherwise inappropriate to provide sufficient management of pain.[1]

When indicated, consider PALEXIA®, an atypical* opioid[2,3]

*Analgesia not solely derived from opioid agonism.

Strong pain relief as effective as oxycodone IR with significantly less constipation, nausea and vomiting[1,4†]

†Non-inferior efficacy (5-day Sum of Pain Intensity Difference); secondary endpoint, primary endpoint was met. Nominal p<0.001 for constipation, nausea and vomiting. PALEXIA® IR 50mg vs. oxycodone IR 10mg.

Responsible opioid prescribing and PALEXIA® IR

Seqirus is committed to the quality use of medicines and the responsible use of opioids where clinically indicated. **For more information please scan the QR code.**

PBS Information: This product is not listed on the PBS.

BOXED WARNING: PALEXIA® IR should be limited to patients for whom other treatment options are ineffective, not tolerated or otherwise inadequate. There are risks of hazardous and harmful use leading to overdose and death; life-threatening respiratory depression; and profound sedation, respiratory depression, coma and death resulting from concomitant use with benzodiazepines, alcohol and other CNS depressants. See Boxed Warning in full Product Information for further details.

Before prescribing, please review Product Information available at www.seqirus.com.au/products

MINIMUM PRODUCT INFORMATION: PALEXIA® IR (tapentadol hydrochloride) INDICATION: For the short-term management of severe pain for which other treatment options have failed, are contraindicated, not tolerated or are otherwise inappropriate to provide sufficient management of pain. **CONTRAINDICATIONS:** Known hypersensitivity to tapentadol or any component of PALEXIA® IR (contains lactose); severe or acute respiratory disease or respiratory depression; confirmed or suspected paralytic ileus; acute intoxication with alcohol, hypnotics, centrally acting analgesics or psychotropic drugs; patients who are receiving MAO inhibitors or who have taken them within the last 14 days. **PRECAUTIONS:** Risk of abuse, misuse, addiction, tolerance, dependence and withdrawal – monitor for signs/symptoms, taper gradually to avoid abrupt cessation; risk of life-threatening respiratory depression, accidental ingestion/exposure and hyperalgesia; risks from concomitant use with benzodiazepines, alcohol and other CNS depressants; not recommended in chronic non-cancer pain, in patients with increased intracranial pressure, impaired consciousness, coma or severe renal or severe hepatic impairment; caution in patients with sleep-related breathing disorders, head injury, brain tumours, a history of seizures or any condition that increases risk of seizures, moderate hepatic impairment or biliary tract disease, including acute pancreatitis. May impair ability to drive or operate machinery. Use in pregnancy (Category C). Should not be used during breastfeeding. Not recommended for children < 18 years old. **INTERACTIONS:** Take care when combining with other opioid agents; additive CNS depression with concomitant administration of other mu-opioid receptor agonist analgesics, general anaesthetics, phenothiazines, other tranquilisers, sedatives, hypnotics or other CNS depressants (including alcohol and illicit drugs); isolated case reports of serotonin syndrome when used in combination with serotoninergic drugs. **ADVERSE EFFECTS:** *Very common (≥1/10):* dizziness, somnolence, headache, nausea, vomiting; *Common (≥1/100 to <1/10):* Decreased appetite, anxiety, confusional state, hallucination, sleep disorder, abnormal dreams, tremor, flushing, constipation, diarrhoea, dyspepsia, dry mouth, pruritus, hyperhidrosis, rash, muscle spasms, asthenia, fatigue, feeling of body temperature change. **DOSAGE AND ADMINISTRATION**: Take whole tablet, orally, approximately every 4 to 6 hours, with or without food. Usual recommended dose 50 to 100 mg every 4 to 6 hours and should be adjusted to maintain adequate analgesia with acceptable tolerability. Total daily doses >600 mg not recommended. *Discontinuation:* taper dose gradually to prevent symptoms of withdrawal. *Special populations:* Not recommended in severe renal or severe hepatic impairment. Initiate at 50mg every 8 hours (maximum three doses in 24 hours) in moderate hepatic impairment. Use care in dose selection for elderly patients (likely decreased renal and hepatic function). Based on approved Product Information.

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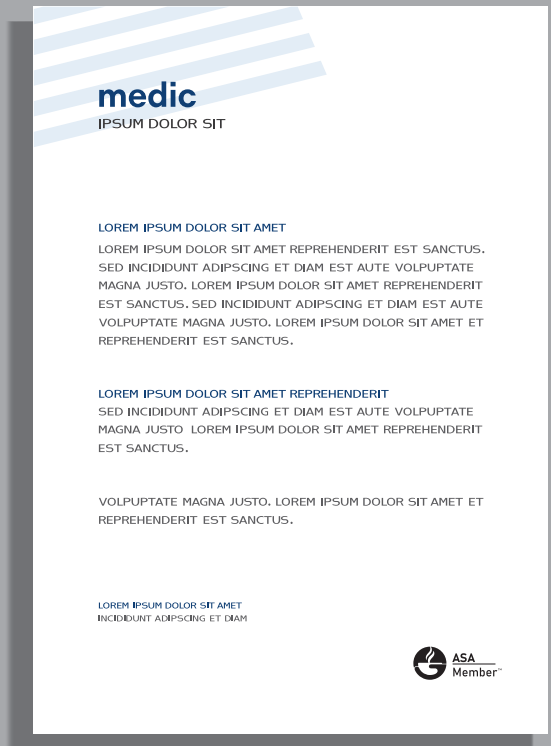
Seqirus™ A CSL COMPANY

ASA MEMBER LOGO

The ASA acts exclusively for the benefit of Australian anaesthetists and the ASA logo is now widely recognised and highly regarded as a mark of respect and excellence.

The ASA has developed a logo specifically for members to use on personal documentation to show their membership of the organisation. If you are a financial member and would like to include this logo on your stationery or presentations please contact asa@asa.org.au for access to the logo and guidelines for use.



ASA Member™

PIAC REPORT

Dr PETER WATERHOUSE
CHAIR PIAC

Like 2020, this year has been an eventful one so far. The Society has been busy on a number of fronts in a rapidly changing medical and political landscape.

Voluntary assisted dying

The governments of Victoria and Western Australia have recently enacted legislation dealing with this issue. Tasmanian and South Australian laws will come into effect in coming months, and the Queensland government is currently considering its legislative options.

With this in mind it is not surprising that around 500 delegates at the recent ASA NSC attended the lecture given by Dr Viren Naik of Ottawa. Dr Naik spoke about his experience of Medical Assistance in Dying (MAiD) which has been established in Canada for five years.

Australian anaesthetists are unlikely to be at the forefront of medically assisted dying. However any doctor receiving a request for this service will need to refer the patient to those who provide such assistance.

Handling of scheduled drugs in the operating theatre

Members have reported wide variations in practice regarding the handling of non-S8 drugs. In some hospitals there is restricted access to ephedrine, clonidine, tramadol, propofol and other agents commonly used in anaesthetic practice.

These variations occur between hospitals in the same geographical location.

Safe and accountable use of anaesthetic drugs is clearly an important goal. However, easy and timely access to drugs in the theatre environment is essential for patient safety. Excessively restrictive practices may lead to unintended adverse consequences.

Reasons for the observed variation in practice are diverse. Local experiences of drug theft and overdose are certainly influential, as are the comments of hospital accreditors. In contrast, legislation concerning drug storage and access is not excessively prescriptive.

Members are encouraged to get in touch with the ASA if the storage of anaesthetic drugs is problematic. A professional document could be produced if there is perceived to be a need for guidance.

Public in private surgery

The practice of treating public patients in private hospitals seems likely to continue. Some areas have well established programmes to facilitate this, while in other locations there is little structure supporting this work.

As previously noted, the commonest challenges relate to patient selection and workup, access to medical records and contingency planning for complications. Funding is also problematic in some areas.

The ASA has created a guide to assist members negotiating the challenges of this work. The Society is also willing to help with local negotiations if needed. Members are reminded that following a recent exemption from the Australian Competition and Consumer Commission, doctors are now permitted to undertake collective bargaining after informing the Commission of their intention to do so. I am not aware of any attempts to test this exemption yet.

Uncertain times continue

As I write this report from home quarantine I am reminded that the uncertainty and disruption of the past 18 months is far from over.

I extend my gratitude to those who contribute to the work of the ASA. Your efforts on behalf of patients and colleagues are greatly appreciated.

Wishing all a safe and enjoyable end to the year.

Dr Peter Waterhouse

DR JOHN PAULL

MB BS, DIP ED, FANZCA, OAM

OAM RECIPIENT IN THE QUEEN'S BIRTHDAY HONOURS 2021
FOR SERVICE TO MEDICINE, AND TO HISTORY

REFECTS ON A LONG AND REWARDING CAREER

I was born on 18 May 1937 in London, my Australian parents having travelled there for medical experience. Fearing war in Europe my father signed on as a ship's doctor, on the *Port Fairy* and we headed for Melbourne on 18 June 1938. I was raised in a busy wartime medical practice.

After Fairfield State School I moved to Northcote High School. The next step was Melbourne University. Completely baffled by Zoology I managed to fail my first attempt at the pre-med year but was successful the following year. Surprisingly I was awarded the Baldwin Spencer prize in Zoology for dissecting the portal venous systems of the toad!

Holiday employment as a cycle builder funded that second attempt. Alfred Hospital provided the clinical experience in years 4 to 6 with 6 month periods at Royal Women's and Royal Children's in year five. Graduation in 1961 lead to a lifetime career of three parts. The first part comprised three years' experience at Alfred Hospital.

Part two was four years as Senior Medical Officer for the British Phosphate Commissioners on Nauru Island. It was here that my daughter was born in 1966. I had to give my wife a general anaesthetic while the Government doctor did a forceps delivery. In November 1968 we returned to Melbourne.

Part three was joining the anaesthetic training program at Alfred Hospital. In 1971 I gained the FFARACS. I moved to the Royal Women's Hospital, Melbourne, mentored by Dr Kevin McCaul, and became Director in 1979 on his retirement.

In 1974 – 75. I gained a Dip Ed in postgraduate education at Monash University. I had multiple roles on the Board of the Faculty, including Education Officer for Australasia and Chair of the Final Examination Committee. At the Women's, I established an active Pharmacological & Physiological Research Laboratory and close links with pharmacological staff in other Departments of Pharmacology. A lot of time was spent travelling and speaking at international meetings and tutoring and examining at universities around the world. I authored or collaborated in more than 70 peer-reviewed scientific papers and book chapters.

From 1983 to 1990 I chaired the Victorian Consultative Council on Anaesthetic Mortality and Morbidity which was established in 1983 by Dr Kevin McCaul but did not function because of a disagreement with the Minister for Health over confidentiality of submissions to the Committee.

From 1984 -1991, I was also a Member of the Maternal Mortality Sub-Committee of the Victorian Consultative Council on Obstetric and Paediatric Mortality and Morbidity. In 1991, I took up private practice retiring in September 2007. In 2000 I had moved to Tasmania, married Denise Kent, and became a part-time senior deckhand on the square rigged *Lady Nelson*.

In 2013 I published "Not Just an Anaesthetist: the remarkable life of Dr William Russ Pugh MD" who gave the first GA for a surgical operation in Australia in Launceston. His statue, was erected in Prince's Square on the 150th anniversary of his first use of ether as a general anaesthetic, 7 July 1997.

Pugh's handwritten diary of his 4-month voyage to Hobart was thought to be lost but a search extending over eight years led to finding the lost hand written diary of his 1835 voyage to Hobart in Bristol, England. The diary was donated by the descendants of Pugh's sister to the Tasmanian Archives and Heritage Office. I was able to transcribe, edit and illustrate the diary and publishing a beautifully printed copy of it was the culmination of my historical activities.

The award of an Order of Australia Medal on the recent Queen's Birthday was a surprising but very gratifying event.

Name	Dr John David Paull	
Date of Birth	18-5-1937	
Place of Birth	London, England	
Citizenship	Australian	
Schooling	Fairfield Primary School, Victoria	
	Northcote High School, Victoria	
Medical Education	University of Melbourne, Alfred Hospital Clinical School.	
Qualifications	1961	MB BS
	1971	FFA RACS
	1973	Dip Ed (Monash)
	1992	FANZCA
Awards.	1961	Alfred Hospital Residents and Graduates Prize,
	1970	Gilbert Troup Prize. Australian Society of Anaesthetists
	1977	Travers Professor, Faculty of Anaesthetists Royal Australasian College of Surgeons, (FARACS)
	1988	Australasian Visitor, Faculty of Anaesthetists, RACS
	2021	Award of an Order of Australia for service to medicine and history
Positions	1972 – 1979	Staff Anaesthetist RWH Melbourne
	1979 – 1990	Director of Anaesthetics and Operating Theatres RWH
	1990 – 1999	Director of Anaesthetics and Anaesthetists' Return to Work Program, Box Hill Hospital, Melbourne
	1999 – 2007	Consultant Sessional Anaesthetist, Launceston General Hospital, Melbourne.

Present Appointments

	2007	Retired Consultant Anaesthetist LGH
	2007	Anaesthesia Historian at Large
	2009	Member, Royal Society of Tasmania
	2012 – 2013	President, Royal Society of Tasmania, Northern Chapter

Special Interests

2013	Published "*Not Just an Anaesthetist.* The remarkable life of Dr William Russ Pugh MD, Pioneer Launceston Anaesthetist in 1847."
2017	Published "Persistence Pays. The discovery of Dr William Russ Pugh's log and journal of his 1835 voyage from England to New Holland."

My most satisfying moments

Teaching trainee anaesthetists the Art And Science of Safe Anaesthesia and conducting basic pharmacological research. Having had more than 70 peer-reviewed papers published.

Another great moment was saving the life of a colleague's wife, near death from obstetric haemorrhage in a Melbourne hospital, by applying abdominal aortic compression to the bleeding woman and calming the panicking obstetrician. Directing the Return to Work Program for Anaesthetists recovering from substance abuse at Box Hill Hospital in Melbourne.

POLICY MATTERS

It is a privilege to introduce myself to our readership as the new Policy Manager here at the ASA. I have joined this wonderful organisation at a truly unique and exciting time.

The health landscape in Australia is changing every day. In many aspects, it is developing in ways we have not seen or faced before. This brings with it a myriad of challenges and yet, also provides opportunities, as we move through the second half of 2021.

The ASA has been actively involved in formulating the National COVID-19 Clinical Evidence Taskforce's infection prevention control guidelines on face masks and eye protection PPE.

COVID-19

From the outset the ASA advocated on behalf of health care workers in urging state and territory health ministers to prioritise and seek vaccination of 1A personnel including doctors involved in intensive care medicine.

Particularly in regional centres, specialist anaesthetists and anaesthesia providers are often responsible for ICU work, after-hours ICU work and after-hours support of Emergency Departments. We also advocated on behalf of all 1B personnel who are all other health care workers on the front-line, including anaesthetists working clinically.

To this end, as demonstrated through the ASA 2021 Member Workforce Survey, data showed that over 58% of our members had received two injections of Pfizer BioNTech Vaccination and more than 31% received one injection of the Oxford AstraZeneca Vaccination, respectively. This number would no doubt be higher if the survey was done today.

The ASA has also been actively involved in formulating the National COVID-19 Clinical Evidence Taskforce's infection prevention control guidelines on face masks and eye protection PPE.

These guidelines are now with the Australian Health Protection Principal Committee. We look forward to new standards being rolled out to better protect health care workers across Australia.

Review of NSW Poisons and Therapeutic Goods Act 1966 and Poisons Therapeutic Goods Regulation 2008.

The NSW Ministry of Health is currently reviewing both the Poisons and Therapeutic Goods Act 1966 and the Poisons and Therapeutic Goods Regulation 2008. The public consultation process will include publication of a Consultation Draft of the proposed new Bill and Regulation via the NSW Government website 'Have Your Say'. This is currently expected to occur in the fourth quarter of 2021. There will be a three-month public consultation process.

The ASA is listed as a key contact for this work, and therefore in addition to publication of the consultation materials on Have Your Say, we will also be receiving the consultation materials directly. As such, the ASA is well aware that many

of our members would like to have input to support this improvement to the legislation and will have the opportunity to do so in Q4 when the consultation opens.

Closing Remarks

Managed Care, Public in Private Partnerships, Informed Consent, and Collective Bargaining, are all current issues affecting the profession. In particular we are expecting a decision from the ACCC regards the Honeysuckle/nib proposal in September. The ASA will continue to advocate on behalf of our members and keep you up to date as these matters unfold.

I wish to thank you all on my first entry to this esteemed magazine, and look forward to providing you further updates in the next edition.

Jason Alam

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WELCOME TO THE SECOND HALF OF THE YEAR!

Sadly, we seem to have hit a rather large speed bump in the road to recovery. Melbourne has just started a fifth lockdown and Sydney is still locked down. WA, NT and SA all have cases and New Zealand just popped our bubble. Only Tas and the ACT seem to be escaping unscathed! While our resilience is certainly being tested, I do hope as you read this article, restrictions have been relaxed a bit, the sun is shining and you can go outside for a (COVID-safe) walk!

DR ALEX COURTNEY
CHAIR TRAINEE
MEMBERS GROUP

Educate

Dr Suzi Nou and I hosted a follow up session for our newest Prevocational Medical Education and Training members. We were graciously joined by a wide selection of experienced trainees from across the country to answer the questions thrown to them. Initially hosting an open forum then breaking out into state-based groups to discuss the peculiarities of the states. The feedback has been positive from those who attended. It really did highlight that despite a (multi) national college, each state handles their application process for the training program remarkably differently. These two events have certainly demonstrated that there are a large bunch of future anaesthetists out there who are hungry for information and knowledge on how best to succeed at joining the program so we plan to hold more of these in the future. Please, take the opportunity to engage with the eager junior medical staff you encounter and encourage them to join ASA.

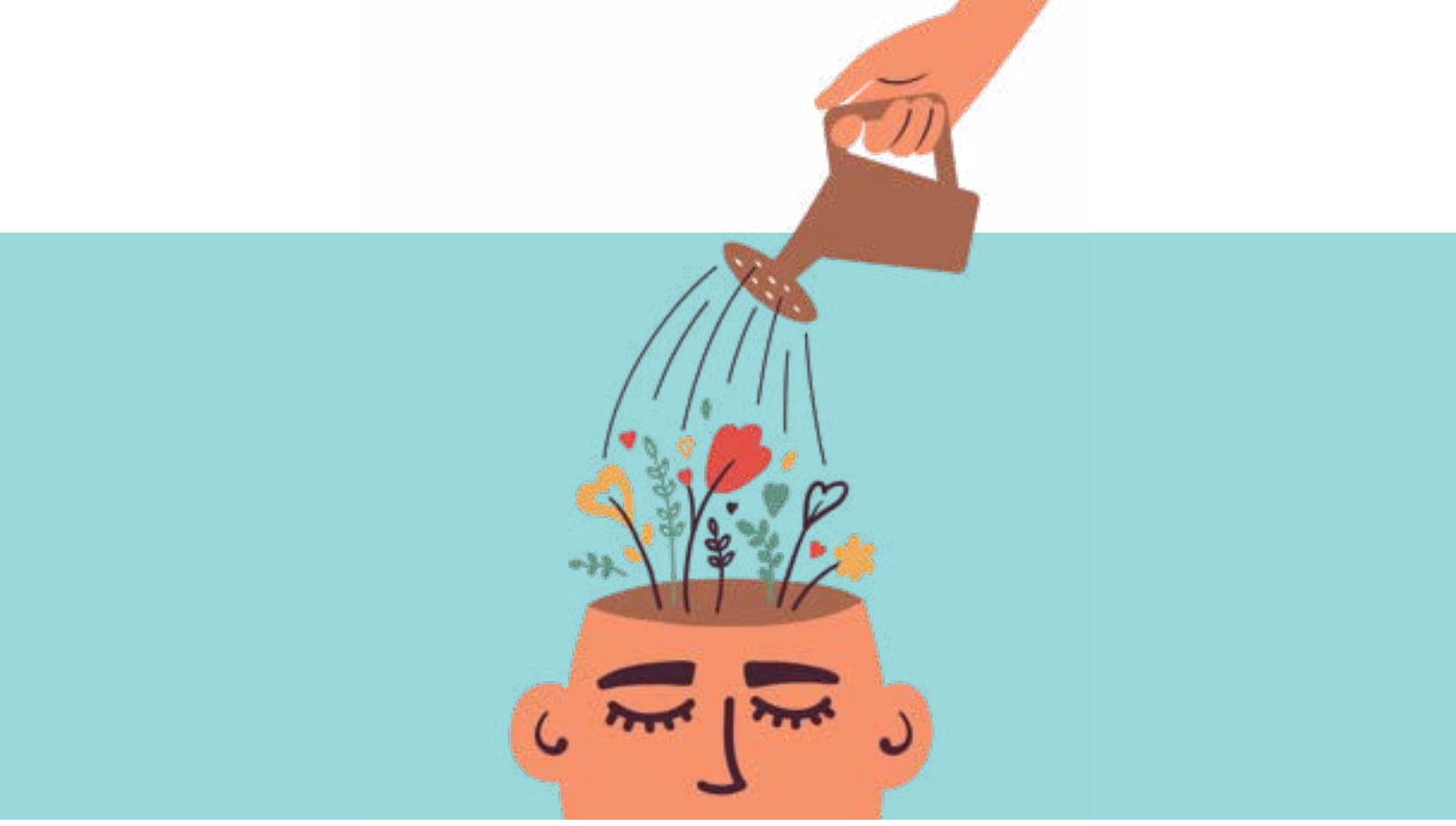
The ASA education team is always hard at work producing content and hosting online sessions. I regularly get emails for viva sessions, both first and final exam specific, viva bootcamps and links to ASA Ed resources (https://asa.org.au/asaeducation/). From what I have seen they are a treasure trove of pearls of wisdom and topics to cover. As I get closer to my final exam I plan to make heavy use of the viva sessions to get in as much practise as I can. Fingers crossed my final exam does not take the nine months the primary did to complete. With the ASA resources at my fingertips, I'm sure my first go will be my best go!

The conjoint ASA NSC/QLD ACE meeting is happening right now, as I write this the trainee day is in full swing. Sadly, the fluctuating COVID situation across the country and the various stages of lockdown has impacted on the convening committee's ability to run an in-person event. Thankfully, the conference has transitioned almost entirely online so I am able to attend as my (not digitally altered in anyway) virtual self. I hope you also had the opportunity to attend!

Represent

The ASA TMG Committee is seeking expressions of interest for members to join our committee from ACT and QLD. We meet regularly to discuss trainee specific issues and events and have regular communication with the ASA Council and other relevant committees. We are supremely supported by the association and regularly plan, run and facilitate some amazing trainee-centric events! TMG committee members both current and past have significant roles in a variety of AMA, ANZCA and ASA committees where we advocate daily for ASA members and all anaesthetic trainees. Please apply by sending your CV and a one page covering letter to mwade@asa.org.au.

The managed care debate is rapidly gaining momentum. Just recently a plethora of articles, opinion pieces and mainstream media news pieces have been published. ASA President Dr Suzi Nou has featured heavily and ASA comments have been republished, reiterated and highlighted by AMA, RACS and others. Even the Federal Health Minister, Mr Greg Hunt, weighed in on the debate. The Australian Society of Ophthalmologists have coined the phrase 'Send the Eagle home' (https://www.sendtheeaglehome.com.au/) in reference



to the similarities between a US-style of healthcare and the trajectory of managed care in Australia. Dr Anthony Coorey, in his session during the 2021 ASA NSC trainee day, highlighted the impact Managed Care will have on our entire future career and the importance of learning about what it may mean. I am still learning about how this will affect my entire career and I would strongly encourage all trainees to engage with their consultants and the ASA about what it means, how it may affect you and how you can help stop these types of changes destroying the Australian healthcare system.

Support

After the success of the 2020 Mental Health First Aid program facilitated by Amanda Lambros we have secured a further 20 positions for the 2021 program. The course teaches participants strategies to provide mental health first-aid to their friends, family, colleagues or anyone who is experiencing a mental health issue or crisis. They learn skills to recognise problems, reduce risk factors and how to provide initial help and support and when and how to take further action. These courses have been developed from the work of a wide range of researchers, clinicians and mental health professionals across the world.

Our last issue of Australian Anaesthetist had the theme Wellbeing, but I don't think we can limit the discussion of mental health and wellbeing to just one issue. I am sure we all have personal experience with mental health struggles whether that be personally or through friends. Healthcare institutions, colleges and the government are increasingly providing support and training for mental health management. As I've said previously, 2020 was a challenging year for everyone and 2021 is shaping up to be challenging in its own way. Courses like the mental health first aid above and others like it are exceptionally rewarding and helpful in helping us all to deal with the challenges we face daily. I know my department has some amazing wellbeing officers who are exceptionally approachable, always ready and willing to help someone in need. I encourage all of you to reflect on how you're going at the moment and really take the time to look after yourself. We have a long road ahead of us and there will always be challenges to face. Having your own 'outs' to take a break from the realities of our work will help along the way. And of course, make use of the health and wellbeing resources available through your department, your hospital and through the ASA (https://asa.org.au/welfare-of-anaesthetists-2/)

By the time you're reading this, it will be September. The sun will be shining, the birds will be singing and, in the immortal words of Friend Owl from Bambi, we'll all be twitterpated.

Dr Alex Courtney

Footnote:

Twitterpated (adj.) – a past-participle adjective formed from twitter in the "tremulous excitement" noun sense + pate "head"

ASA SCIENTIFIC PRIZES, AWARDS & RESEARCH COMMITTEE (SPARC)

ASA grants are advertised in the first 6 months of each year. https://asa.org.au/asa-awards-prizes-and-research-grants/

The ASA congratulates Dr Premilla Chinnappa-Quinn PhD, recipient of the ASA PhD Grant in 2012

The ASA has a long history of supporting research excellence dating back to the generous endowment of its first research grant by Professor G. Jackson Rees in 1963. Other grants were added later and recently Council approved a significant increase in the volume of funds available to members to support research initiatives. In 2021 almost $200,000 is available for prizes and grants. The ASA is keen to support members in their pursuit of higher degrees and other research especially in its chosen target areas; currently these are Environment & Sustainability in Anaesthesia, Innovation in Anaesthesia and Safety in Anaesthesia.

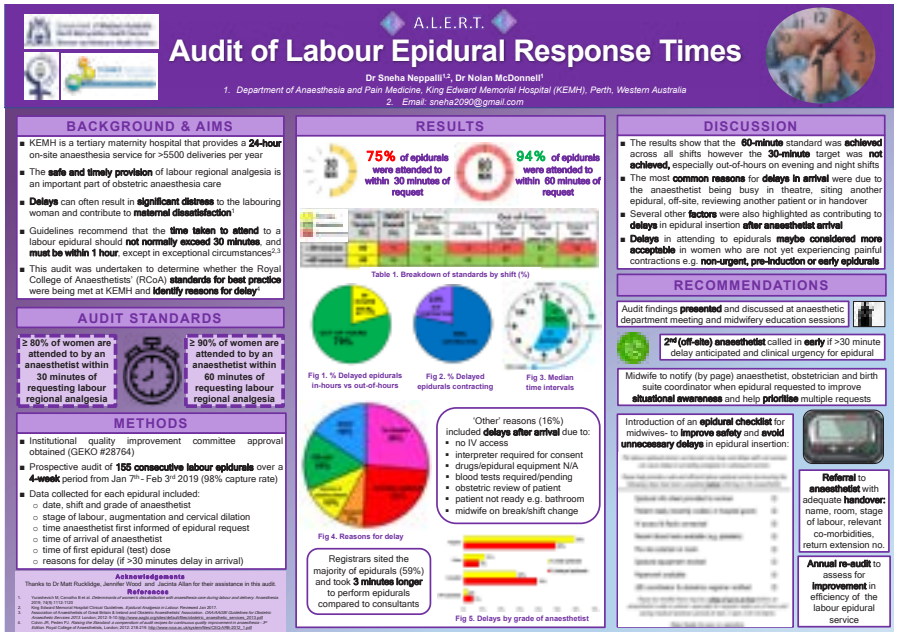
The ASA is proud to have supported the work of Dr Premilla Chinnappa-Quinn, a recipient of the 2012 PhD grant. Premilla, now a VMO Anaesthestist at Eastern Health and an Honorary Lecturer, School of Psychiatry, UNSW was recently awarded her PhD from the UNSW for her work "The association of acute illness hospitalisation with cognitive trajectory in the Sydney memory and ageing study".

Premilla reflected on her experience: "An initial interest in post-operative cognitive dysfunction led to my enrolment in a PhD in 2011 at the University of New South Wales. This evolved into a broader analysis of the effects of acute hospitalisation on cognition. My project analysed longitudinal cognition data from a thousand older age adults from metropolitan Sydney combined with electronically linked NSW Health hospitalisation data. I found that acute hospitalisation was associated with a small long-term decrease in global cognition and that this association was greater for medical rather than surgical hospitalisations.

I found that the development of research skills was enhanced within a research team and in the context of a university enrolment. The ability to learn relevant statistical expertise and work in an experienced team, provided me, a clinician, with necessary back-up to progress a research idea.

Furthermore, anaesthetists provide clinical services to a range of specialties and are thus well-positioned to conduct multidisciplinary research. In my case, my research involved a neuropsychiatrist, anaesthetists, psychologists with statistical expertise, and a neuropsychologist and my results are broadly relevant to geriatrics, psychiatry, acute medicine and surgery, anaesthesia and epidemiology.

Doing research 'on the side' as a clinician can be relentless and all-consuming. However, the benefit of job security and financial stability conferred by a consultant anaesthetist position presents the opportunity to take left-field



The winner of Trainee Audit Survey Prize
Dr Sneha Neppalli
An Audit of Labour Epidural Response Times at a Tertiary Maternity Hospital

research leaps. Clinicians can investigate novel questions without the pressure of research metrics which can stifle genuinely risky research.

The ability to think, analyse and write is a precious commodity to be prized during the challenging years of caring for young children. I learnt to be efficient and opportunistic, using every minute in the school carpark or waiting for a patient delayed in coming to theatre! Inadvertently the pandemic provided opportune injections of time during Melbourne's lengthy lockdown, both at work due to decreased theatre activity, and at home with less scheduled activities, to write up my thesis.

I am indebted to the ASA in awarding me a research grant in 2012 and continuing its support for my PhD project from its inception to conclusion. My thesis can be viewed via the QR code link.

So far 2 review publications have resulted from the work with the results still to be published.

1. Chinnappa-Quinn L, Bennett M, Makkar SR, Kochan NA, Crawford JD, Sachdev PS. *Is hospitalisation a risk factor for cognitive decline in the elderly?*
2020, 33(2):170-177 DOI: 10.1097
yco.0000000000000565 PMID: 31652137

2. Chinnappa-Quinn L, Makkar SR, Bennett M, Lam BCP, Lo JW, Kochan NA, Crawford JD, Sachdev PS. *Is hospitalization a risk factor for cognitive decline in older age adults?*
Int Psychogeriatr. 2020 Sep 28:1-18.
doi: 10.1017/S1041610220001763.

Clinical Associate Professor
Stephanie Phillips

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MOVED BY THE EFFORT … ONE BOX AT A TIME

The History of Anaesthesia Research Unit (HARU) is very excited about the current move to the new ASA headquarters. We will have greater space for both our Richard Bailey Library and Harry Daly Museum as well as greater capacity for attendance at our history seminars. Entering the new headquarters by the lift will take visitors directly into and through the museum, which will also feature a history of the ASA itself. Once the huge task of re-displaying our historical objects is finished, we will be providing information about each object via iPads/Tablets for visitors to use while exploring the cabinet contents.

The past few months have seen extraordinary activity in packing all our museum objects ready for the move. This has also provided an opportunity to ensure each item has been cleaned before being securely packed. With members of the HARU committee helping when possible, this has all been done under the strict guidance of our Curator, Ms Kate Pentecost, who, it should be said, has been responsible for the great bulk of this work. Kate has borne this burden because of the interference of COVID regulations and restrictions on committee members.

Attached are some photos of the packing-up process and of the new quarters prior to the unpacking. We are hoping the latter will begin this August – COVID permitting!

Once ensconced in the new quarters, we will be warmly welcoming all ASA members to come and visit.

Dr Reg Cammack
Chair, History of Anaesthesia Library Museum and Archives Committee

INSIDE YOUR SOCIETY

AROUND AUSTRALIA

New South Wales

Dr Lan-Hoa Le

Chair of the New South Wales Committee of Management

COVID-19 Stimulus Measures

As members may be aware there are a number of support measures that may be accessed to assist businesses impacted by the Covid Health Orders. At a high level, the primary measures available to doctors include:

1. NSW Government Business Grants – to cover business costs in the first 3 weeks of the lockdown
2. NSW Government Jobsaver – cashflow support from week 4 of the lockdown
3. Federal Government Disaster Payments – supporting workers impacted by reduced hours

Visit service.nsw.gov.au, and my.gov.au for details. Cutcher & Neale (Accounting and Financial Services) has created access to relevant information and provided a complimentary consult for ASA members - https://www.cutcher.com.au

NSW Annual General Meeting

The Annual General Meeting of the NSW Section of the ASA was held via Zoom on June 29. Below is the Report presented by Committee Chair Dr Lan-Hoa Le

The Committee has been very active over the past financial year – and I thank them for their ongoing commitment towards our anaesthetic profession in NSW. The Committee of Management held 5 meetings during the period 01July 2020 to 30 June 2021.

I am pleased to report over the financial year, an increase in NSW membership to 1,192 members (across all categories).

While involved in a number of initiatives in the past year the key areas for the NSW Committee have included:

- COVID-19: PPE including fit-testing / vaccination rollout
- Elective surgery – Public and Private Hospitals
- Contractual Issues
- Managed Care/Bundled Care
- Regular meetings with the AMA and representatives of NSW Committee
- Meeting with Medibank Private and HCF

SUPPORT

The provision of support to members is a key pillar of the ASA, and was certainly an area of activity during the year, with highly successful *Wellbeing and Mindfulness Forums* being held along with webinars, including trainees' wellness and exam preparation.

Other support for trainees included accommodation bookings for the Final Exam and the provision of administrative services for ASA members to host a NSW Medical Viva event. Our ASA NSW Trainee Committee representatives were present at the NSW ANZCA Part 0 course, while the Part 1 Boot Camp mock exam and the Part 3 were also a highlight.

For those thinking of retirement a special article was published in the Australian Anaesthetists magazine.

A new initiative was *The (4D) Directors of Department Development Day* held to provide an educational and networking opportunity for immediate past, present and potential Directors and deputy Directors at public and private hospitals and MAC representatives at the private hospitals. The events were very well received and ideally will be staged again in the future.

The Committee also hosted virtual meetings to address current issues on managed care and the reduction of elective surgery waiting lists on their model of care and contracts.

REPRESENT

Representing members in areas of concern is important. The Committee were most active in this area, with some of the main initiatives listed below;

COVID-19: PPE, fit-testing and vaccination rollout.

Thank you again to the ASA COVID-19 Working Group for their advocacy. We certainly do welcome this support for members. We also thank the ACI Community of Practice (Anaesthesia) for their commitment.

Public in Private & Waiting Lists Blitz

The lack of clarity for anaesthetists around this issue, in particular regarding contracts was a point of concern, with some anaesthetists not having seen a contract but had provided services for public patients in private hospitals. ASA maintained close contact with the AMA (NSW) in order to provide information to members, while encouraging members to seek their own legal advice if necessary.

NSW Member's Forums

The forums gave an update to members on the looming issue of managed care and public patient waiting list blitzes. Again we have been in close contact with

AMA (NSW) with roundtable meetings involving other societies and associations to address these matters.

EDUCATE

It is pleasing to report that during the year some 14 educational opportunities, some of which I have already referred to, were made available ensuring all members were catered for. During a particularly difficult period arising from the COVID-19 restrictions this was a tremendous achievement and I would like to thank all involved, in particular the presenters, the office staff, our sponsors and of course you our members who supported these events and meetings.

Like all states the NSW budget is managed through the Federal office and I would like to thank the Board for its generous support which has ensured the planned activities have been able to proceed.

In closing I would like to thank Dr Simon Martel (Vice Chair) and all of the Committee members Drs. Murray Selig, Michael Levitt, Bruce Graham, Ming Chan, Helen Leggett, Katherine Jeffrey, Liwei Ren, Iain Stewart, Namrata Singh, Douglas Dong, Nishan Yogendran, Lukman Anderson, and Dushyant Iyer, and our recent past Committee members (Drs. Ammar Beck (Immediate Past NSW Chair), Anne Rasmussen and A/Prof. Stephanie Phillips), for their support and encouragement during what has been a difficult year for all.

As Chair I am happy to stand for another term and should I be re-elected, I very much look forward to continuing in the role as we continue to deal with the challenges and issues ahead.

Editors note: Dr Le was re-elected as Chair of the NSW Committee of Management for a second term.

South Australia

Dr Brigid Brown Chair

Chair of the South Australian Committee of Management

South Australia held its part 3 course on June 19 which was well attended and received. Special thank you to Julia Rouse, Nik Fraser, and Bec Madigan for organising such a great program! (Picture is of attendees and organisers of the part 3 course)

The state held the inaugural *'Bright Young Things'* networking evening on July 3, an event designed to bring together anaesthetists in their first 5 years as a consultant. It was enjoyable to be meeting face to face for events again! There were excellent questions collected from attendees about advocacy and representative issues which were addressed and sent out to everyone after the event.

There is now a statewide SA Anaesthesia Wellbeing Network with representatives from all public departments and private groups. Sophia Bermingham, an anaesthetist at Flinders Medical Centre and the ASA and ANZCA state wellbeing representative, has been leading this process with the aim to share resources and hold education sessions to assist and support our colleagues.

Victoria

Dr Michelle Horne

Chair of the Vicotorian Committee of Management

ASA Victoria would like to Congratulate A/Prof Alicia Dennis who has not only received the 2021 ASA President's Award for her significant contribution to the ASA but has also been appointed to the AIC Editorial Board.

We acknowledge the sad passing of member Dr Michael Boquest who is a previous ASA Victoria committee member and whose absence is being felt by many members.

In the last few months I have been gratified to note an increasing sense of a supportive culture evident amongst our colleagues in Victoria as we grow through our pandemic experiences and challenges. We have entered quite a busy time.

Statewide Standardised In-Hospital Emergency Number

There will be a statewide transition to a standardised emergency number. Already Alfred Health, St Vincent's Private, Ramsay Health and St John of God have joined NSW, ACT and Tasmania using a standardised in-hospital emergency number 2222. Standardisation improves staff recall and timeliness of response. The Department of Health Digital Health team are now aiming to have other Victorian health services transitioned by the end of the year.

SUPPORT

CRASH, instigated by two dynamic Victorian anaesthetists (Dr Kara Allen and ASA Victorian committee member Dr Janette Wright), was created to support anaesthetists and trainees who are returning to work after a career break with that transition. I was pleased to hear members are making use of CRASH scholarships which the ASA awards to members to support them to attend CRASH.

An ASA Vic Member Forum was held on 12 June (virtually) to discuss issues affecting members, particularly including public in private and elective surgery "blitz" in Victoria.

REPRESENT

Covid and healthcare worker safety

As you will have heard in previous updates from Dr Nou, ICEG (Infection Control Expert Group) have released new PPE guidelines after a lot of negotiation. With gratitude to Victorian members: Dr Philippa Hore, Co-Chair IPC; Dr Pieter Peach, ASA representative on Guidelines Leadership Group and ASA President Dr Suzi Nou for tirelessly advocating for precautionary work safe environments for healthcare workers. Airborne spread is now finally recognised and N95/P2 now recommended for care of sCOVID/COVID patients which is a huge improvement on previous national guidelines and required much effort on behalf of our representatives.

Myself and Suzi Nou have continued to regularly attend meetings of Chairs of Procedural Specialties convened by the Chair of VPCC Dr David Watters. At a recent meeting we discussed short stay arthroplasty and other elective surgery models. We continue to liaise with the Victorian Department of Health on the perioperative implications and role of anaesthetists.

ASA Victoria have continued to advocate within the state for prioritisation of anaesthetists as an integral part of our Phase 1a workforce and more recently for consideration of families of healthcare workers to be included as a priority group to vaccinated. Dr Nou continues as a member of the Victorian Department of Health Healthcare Worker infection Prevention and Wellbeing Taskforce which continues to meet on a monthly basis to discuss this and other issues.

Committee members attended the Health and Human Services Climate Change Draft Adaptation Action Plan in May

Private in Public

At the time of writing I am expecting to attend a meeting with Healthscope CEO and CMO with President Dr Suzi Nou, Dr Peter Waterhouse, Dr Mark Sinclair and ASA policy team. The meeting is to discuss ongoing issues experienced at Healthscope Hospitals by members regarding public in private, both from a safety, governance and resourcing perspective. Fit testing for staff is also on the agenda.

Managed Care

The ACCC received over 230 responses to its recent draft determination, including well over 30 from individual Victorian anaesthetists. Thank you also to everyone who has already encouraged their family or community to send a letter about preventing managed care to their local Member of Parliament. A final decision on the nib/Cigna matter is expected in late September however as you have heard from our President Dr Suzi Nou it is likely we will need to raise this issue with federal members of parliament moving forward as an election issue.

EDUCATE

The Melbourne Winter Anaesthetic Meeting is scheduled for 28-29 August. We made the decision in July to run this as a purely Virtual meeting including workshops and SGDs and are pleased to see as usual fantastic engagement with a virtual format. I am really very proud how Australians and Victorians have demonstrated flexibility and adaptability throughout the last unprecedented 18 months.

Thank you to Co-convenor Dr Kaylee Jordan (ASA Vic Education Officer) for a fabulous program highlighting the patient experience and to all the presenters who accepted our invitation to speak or deliver a workshop or small group discussion. The virtual format allows us for the first time to run concurrent sessions which has increased the number of topics covered to 15 plus the Quality Assurance session which we instigated at our last meeting in 2019 and was runs virtually this time. Successful small group reflection requires careful planning and the assistance of facilitators - of whom we had many, who generously accepted our invitation to be involved to deliver a high quality virtual meeting. We thank all of you.

Med Viva Boot Camp June 12

Our annual Medical Viva Bootcamp was this year held on 12 June. For the first time this education event was held virtually as Victoria went into lockdown 4.0 in the days leading up to the course. The day was run with great feedback as usual. Thank you to convenor Dr Debra Leung and facilitators Dr Trish Carroll, Dr Myat Aung, Dr Rebecca Zhao, Dr Aaron Paul, Dr Genna Verbeek and Dr Bernadette Wilks. Material to support trainees in their preparation for this exam hurdle was created which is now viewable on ASAEd website including video presentations we have created covering different medical systems, available to view any time.

Part 3 Conversations

ASA Ed also hosts Part 3 Conversations which can be viewed any time for members covering topics which may be relevant for new consultants and have been recorded with a number of Victorian anaesthetists.

Western Australia

Dr Mike Soares

Chair of the West Australian Committee of Management

REPRESENT

The WA State Committee congratulates Dr Andrew Miller on his successful tenure as AMA(WA) President and thank him for his significant contribution to the health and wellbeing of both WA and the broader community.

ASA(WA) actively encouraged submissions to the ACCC by requesting committee members to forward details of the proposal and the process for making a submission through their own networks.

Extensive discussion of the Honeysuckle proposal continues at National and State Committee levels.

The ASA(WA) has taken an active part in updating reporting for the WA Anaesthetic Mortality Committee. Links to the updated reporting process have been created on the ASA website.

Membership of the interview panel for the selection of Anaesthetic Trainees

continues to have an active ASA(WA) committee member. Interviews will be completed in early September.

The state committee would like to thank Dr Celine Baber (WA PIAC and State Committee Member) for her also providing WA representation on the new Gender Equity Working Group.

The next meeting of the state committee will be in early August, followed by an end of year meeting.

EDUCATE

MEDCON 21

MEDCON 21, an inaugural intercollegial conference organised by the AMA(WA) was held in late June in Perth. The conference was well attended by all major medical colleges and societies. ASA(WA) is grateful for the efforts of the ACE CME Committee, of which Dr Shrivastha (state ASA secretary) is co-chair.

RIIACT Course

RIAACT (Readiness for the Initial Assessment of Anaesthetic Competencies Training) is a three-day course designed for new trainees. The next course will commence on 14 August. RIAACT has been developed with input from ANZCA and the ASA.

Voluntary Assisted Dying

The voluntary assisted dying act was implemented as of 1 July, 2021. Links to information from the WA Health Dept on legislated practitioner obligations has been added to the ASA(WA) website.

Queensland

Dr James Hosking

Chair of the Queensland Committee of Management

COVID seems to continue to throw out the challenges and Queensland is not immune. The Queensland Committee continues to advocate on various aspects of the COVID response including PPE access, fit testing, vaccine access, and the use of Surgery Connect (and the broader private system). Unfortunately COVID has also impacted on our conjoint ASA NSC & QLD ACE meeting this year with a conversion to a virtual format meeting. Our thanks goes out to Dr Peta Lorraway and all ASA members that have been involved in the preparation and presentation of the meeting.

QSCRIPT is coming: as part of the recently enacted Medicines and Poisons Act Queensland will have established by legislation a real-time prescription monitoring system. Relevant health practitioners will be required to check the patient's QScript record before:

- prescribing a monitored medicine
- dispensing a monitored medicine
- giving a treatment dose of a monitored medicine

ASA Queensland has met with QHealth to discuss its implementation and use. It will be a web-based system, with access from mobile devices and PCs. It will be a legal requirement for Anaesthetists to check the system. We have concerns in regard to impacts on workflow and administrative burden. We aim to deliver a webinar to demonstrate the system when functioning.

JOHN W SEVERINGHAUS MD

"A MASTER TINKERER"

6 MAY 1922 - 2 JUNE 2021

John Severinghaus, a pioneer and visionary in anaesthesia and medicine, and the first recipient of the ASA Pugh Award in 2003, died peacefully in San Francisco, aged 99.

Born in Madison, Wisconsin, where his father, the Professor of Medicine had an office adjacent to that of Ralph Waters, John was fascinated by electricity, radio, boat-building, and fixing things. He proceeded to Haverford College, Pennsylvania, majoring in physics and electronics. Exempted from military service to participate in secret research, he was sent to the MIT Radiation Laboratory ("Rad Lab") where he helped develop military radar equipment. It was at MIT, that he met and married his wife, Elinor.

He was so appalled by the dropping of the atomic bomb in 1945, that he immediately left Rad Lab and enrolled in medicine at the University of Wisconsin. After transferring to Columbia University, New York, in 1947 to gain more clinical experience, he graduated in 1949. As a medical student he was involved in several physiology research projects, emulating his father's interest in physiology and his own penchant for academia. In 1947, he developed the first portable electrophrenic respirator, using surface electrodes to stimulate the phrenic nerve.

In 1951, John visited several biophysics departments to consider post-doctoral research posts. He then met with Robert Dripps at the University of Pennsylvania in Philadelphia, and "within 5 minutes, he persuaded me that anesthesia would be the best field for me to apply electronics to medicine". He soon teamed up with another resident, Peter Safar. Testing the new relaxant, succinylcholine on each other, "Peter gave me 20mg, causing instant apnoea with my still mobile arm trying to grab the oxygen mask. I ached for a week from the fasciculations". This would be the first of many instances of self experimentation. After 6 months clinical work, John spent a research year under Julius Comroe, studying respiratory physiology.

In 1953, John joined the new Clinical Centre Anaesthesia Department at the National Institute of Health (NIH) as Director of Research. During the 5 years at NIH, he was able to devote 4 days a week to research, where hypothermic brain and cardiac surgery provided some of the stimulus. He developed a modified oesophageal stethoscope to transmit temperature and cardiac impulses, and perfected the calculations used during hypothermia for blood gas analysis, at the time using the laborious Van Slyke manometric apparatus and the Henderson-Hasselbalch equation.

His interest in measuring blood gases was stimulated by hearing Richard Stow describe his invention of the PCO2 electrode in 1954. The electrode comprised a pH electrode with a thin layer of distilled water separated from blood by a latex membrane. Stow described the problem of incurable drift, to which John suggested "Just add soda", to stabalise it. Stow didn't agree, but John, with his research assistant Freeman Bradley, went on to build an electrode a few days later with a solution of sodium bicarbonate between the latex film and the pH

sensitive glass. Further modifications included placing the electrode in a water bath at 37°C and confining the electrolyte with a layer of cellophane. The resultant electrode cut analysis time from one hour to 2 minutes.

Leland Clark developed the polarographic oxygen electrode in 1955, and in early 1956 he showed it to a group of respiratory physiologists at a meeting that John had convened in Atlantic City. With Clark's approval, John combined his electrode in the thermostat bath, with a tiny stirring paddle and tonometer to counter oxygen consumption by the electrode. This was the first blood gas analyser, displayed to the American Society of Anesthesiologists in 1957, and now residing in the Smithsonian Museum.

Soon after, John added a pH electrode and other refinements, leading to the forerunner of the blood gas analyser still used today.

In 1958, after completing his anaesthesia residency in Iowa (on leave from NIH), John joined Julius Comroe at the Cardiovascular Research Institute at UCSF, at the same time as Stuart Cullen was appointed chair of the new independent (from surgery) Department of Anesthesia. There, he was joined by Ted Eger, Larry Saidman, and many others who became life long collaborators and friends.

He and Eger had worked together in Iowa, where Ted became interested in the uptake and distribution of inhaled anaesthetic agents after hearing a talk by John. Ted argued with John for an hour after the lecture, convinced that John was wrong (he wasn't!). It was Eger who then introduced the concept of "MAC", and who later referred to John as "A master tinkerer".

The University of California built several high altitude research laboratories, including one at White Mountain in the Sierras, at 4342m elevation. There, with small groups of fellow researchers, John explored the relationships between CSF and blood acid-base, respiratory function and acclimatisation.

John contended that research was largely responsible for transforming anaesthesia from a surgical service into its central role in academic medicine

They regularly performed lumbar punctures on one another.On one occasion, the severe headache required John to lie horizontal in the station wagon as it travelled the unmade mountain road.

Further research involved studies of cerebral blood flow. These studies often required jugular bulb punctures. While on sabbatical in Copenhagen, "Niels Lassen, my longtime friend and colleague, having done hundreds of jugular bulb punctures, managed to nick my hypoglossal nerve and instantly paralyse the muscles of the right side of my tongue, making me almost speechless. He visited me every few hours for several days! It resolved on the third day without sequelae."

It was also while in Copenhagen in the mid 1960s, that John devised a blood gas slide rule for relating PO2 to haemoglobin saturation, and solving acid-base, pH and temperature effects. This led to his publication of the standard human haemoglobin oxygen dissociation curve with accurate corrections for temperature and pH.

In the mid 1970s at UCSF, assisted by Gerald Ozanne and Bill Young, John installed a single mass spectrometer to sequentially sample respiratory gases from patients in the 10 operating theatres at the Moffitt Hospital. The gases were drawn through 30m long catheters, and the inspiratory and end-tidal concentrations of O2, CO2 and anaesthetic agent were fed back to each operating theatre once a minute. Several hundred of these systems were installed in operating suites throughout the USA. The mass spectrometer terminal in each operating theatre became a communication system, using Arpanet, a precursor of the internet, linking computers over telephone lines. Bill Young relocated to New York, and on one occasion, phoned John from his office to enquire "why the patient in room 5 has a PCO2 of 80?"

John established the Human Research Laboratory at UCSF in 1985, and continued his involvement in ground-breaking research until well into his 90s. He was the recipient of many awards, including the Pugh medal in 2003. He contended "that research was largely responsible for transforming anesthesia from a surgical service into its central role in academic medicine and its many roles in today's health care." John was a towering influence in that transformation, but always remained self-effacing and humble. It was my privilege to have known him as a friend, and on numerous occasions, to enjoy his countless anecdotal stories.

In later years, he became the carer for his wife Elinor, as her health deteriorated. Elinor, an accomplished artist and teacher, died in 2015. John is survived by his and Elinor's four children and their families.

Acknowledgements:

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Dr Rod Westhorpe

NEW AND PASSING MEMBERS

The ASA would like to welcome all new members from 23 May to 26 July 2021.

ADVANCED/PROVISIONAL FELLOW TRAINEE

Dr Saman Ali	ACT
Dr Timothy Robert Charles	ACT
Dr Benjamin Darby	ACT
Dr Eranda Adikaram	NSW
Dr Lucy Andersen	NSW
Dr Simon John Cole	NSW
Dr Tom English	NSW
Dr Lachlan Frawley	NSW
Dr Mary Kathleen Grealish	NSW
Dr Karolin Sophie Heck	NSW
Dr Sam McCormack	NSW
Dr Daniel Kin-Shun Moi	NSW
Dr Victoria Ward	NSW
Dr Chantelle Willard	NSW
Dr Tessa Louise Jessica Finney-Brown	QLD
Dr Brendan Goodwin	QLD
Dr Robyn Julie Ison	QLD
Dr Catherine Mason	QLD
Dr Sean Morrow	QLD
Dr Munro Brett-Robertson	SA
Dr Shaun Campbell	SA
Dr Christopher Edwards	SA
Dr Ravindran Samuel Nathan	SA
Dr Rawaf Albarakati	VIC
Dr Grace Andrews	VIC
Dr Mark Gerard O'Donnell	VIC

ASSOCIATE

Dr Simon Sinclair O'Brien	QLD
Dr Zach Daniel Tappenden	QLD

INTRODUCTORY/BASIC TRAINEE

Dr Louise Theresa Buckley	NSW
Dr Lachlan Gan	NSW
Dr Anthony Hodsdon	NSW
Dr Nitesh Kumar	NSW
Dr Tanya Manolios	NSW
Dr Grant Willin Moore	NSW
Dr Harry James Pearce	NSW
Dr Jonathan Perry	NSW
Dr Eric Donald Quin	NSW
Dr Melissa Cathryn Smith	NSW
Dr Shelly Ying Bin Wen	NSW
Dr Keith Prashanth Chandrarajan	NT
Dr Lynsey Maree Cochrane	QLD
Dr Daniel Gillespie	QLD
Dr Abir Guha	QLD
Dr Robert Thomson	QLD
Dr Hannah Marie Woodcock	QLD
Dr Terence Guan Hui Kwok	TAS
Dr Abram George Boules Botros	VIC
Dr Lauren De Koning	VIC
Dr Christie Farag	VIC
Dr Mason Ross Habel	VIC
Dr Hamish Westcott Lanyon	VIC
Dr Andrew McNiece	VIC
Dr Christine Shanahan	VIC
Dr Marcus Jia-Sheng Yip	VIC
Dr Elizabeth May Carr	WA
Dr Emily Catherine Scott	WA

ORDINARY MEMBER

Dr Yvette Bostock	NSW
Dr Lisa Marie Doyle	NSW
Dr Martin Facini	NSW
Dr Daniel David Gorman	NSW
Dr Ian Lomas	NSW
Dr Yisha Minikus	NSW
Dr Meredith C. Tey	NSW
Dr Trylon Matthew Tsang	NSW
Dr Nikitha Vootakuru	NSW
Dr Rafik Monir Nessim Zakharious	NSW
Dr Tegan Nicole Burgess	QLD
Dr Etienne Anthony Du Toit	QLD
Dr Daniel John Hyde	QLD
Dr Alastair James Scarr	QLD
Dr Piret Vaughan	QLD
Dr Kate Sporne	SA
Dr Rani Chahal	VIC
Dr Sarah Ann Donovan	VIC
Dr Gavin Doolan	VIC
Dr Robert Mario Fabian	VIC
Dr Nathan Lindsay Fifer	VIC
Dr Natalie Gattuso	VIC
Dr Timothy Ho	VIC

Dr Nicholas Andrew Jansen	VIC
Dr Rebecca Edgeworth McIntyre	VIC
Dr David Moore	VIC
Dr Iraj Nik Pey	VIC
Professor Bernhard Riedel	VIC
Dr Frank Schneider	VIC
Dr Peter Stark	VIC
Dr Elliot Wollner	VIC
Dr Ebrahim Bham	WA
Dr Andrew Peter Challen	WA
Dr Kiara van Mourik	WA

PMET

Dr Matthew James Palmer	ACT
Dr Aleksandra Trajkovska	ACT
Dr Amy Benness	NSW
Dr Jacob Andrew Blumes	NSW
Dr Tarra Elizabeth Booth	NSW
Dr Danell Boshoff	NSW
Dr Hannah Bruce	NSW
Dr Gabriella Charlton	NSW
Dr Tamblyn Jimeoin Devoy	NSW
Dr Michael Anthony Gathy	NSW
Dr Dominic John Horne	NSW
Dr Anthony Peter Klironomos	NSW
Dr Georgina Clara Martin	NSW
Dr Christopher James Kuang Masters	NSW
Dr Samuel Michael Mathias	NSW
Dr Amir Mehanna	NSW
Dr Alfonse Nguyen	NSW
Dr Rhys Rodrigues	NSW
Dr Lala Sarkissian	NSW
Dr Joel Selby	NSW
Dr Simranpreet Singh	NSW
Dr Sherman Siu	NSW
Dr Erica Sorn	NSW
Dr Jovana Stojkov	NSW
Dr Leanne Joy Uren	NSW
Dr Li Zhou	NSW
Dr David James Athan	QLD
Dr Kin Man Choi	QLD
Dr Ben William Goodwin	QLD
Dr Chelsea Ho	QLD
Dr Daniel Christopher Jones	QLD
Dr Christopher Miller	QLD
Dr Pathmila Navaratne	QLD
Dr John Michael Parr	QLD
Dr Mackenzie Redhead	QLD
Dr Aaron Keith Kopeke Smith	QLD
Dr Samuel Laruence Rigano Smith	QLD
Dr William M. Song	QLD
Dr Joanna Elizabeth Tait	QLD
Dr Brenden Maxwell Borosh	VIC
Dr Thomas Butler	VIC
Dr William Nelson Clearfield	VIC
Dr Jarron Mitchell Dodds	VIC
Dr Duygu Durukan	VIC
Dr Margaret Hezkial	VIC
Dr Divya Iyer	VIC
Dr Taylor Vaughn Kline	VIC
Dr Alexander Ching Siong Lim	VIC
Dr Zheng Lim	VIC
Dr Brianna Martin	VIC
Dr Marcus Neo	VIC
Dr Blake Gregory Charles Nielsen	VIC
Dr Krushna Patel	VIC
Dr Ashleigh Rohde	VIC
Dr Nicholas John Wollert Shearer	VIC
Dr Lucas Taranto	VIC
Dr Max-William Ubels	VIC
Dr Lindsay Claire Green	WA
Dr Rachael Elizabeth Manning	WA

IN MEMORIAM

The ASA regrets to announce the passing of ASA members:

Dr Anthony H Atkinson	**VIC**
Dr Eric E. Goonetilleke	**VIC**
Dr Michael Alan Boquest	**VIC**
Dr Dorothy Flora Moody	**VIC**
Dr Rick Champion	**SA**
Prof John Severinghaus	**Overseas**

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

UPCOMING EVENTS

SEPTEMBER 1, 2021	SEPTEMBER 6, 2021	SEPTEMBER 11 2021
Mindfulness-Based Anxiety Therapy and Peak Performance 7:30pm – 8:30pm AEST Venue: Virtual	Real-Time Prescription Monitoring Webinar 7:30pm – 8:30pm AEST Venue: Virtual	Mental Health First Aid Course For ASA Trainee Members Venue: Virtual

OCTOBER 30 2021	NOVEMBER 20 2021
QLD Part 3 Course Venue: ANZCA QLD regional office	NSW Part 3 Course Venue: Virtual

SEPTEMBER 10 & 24 OCTOBER 8	SEPTEMBER 13 & 27	SEPTEMBER 17 OCTOBER 15
Practice Exam Evenings - Final Exam 7.30 – 8.30pm AEST	Practice Exam Evenings - Primary Exam 7.30 – 8.30pm AEST	Practice Exam Evenings - SIMG 7.30 – 8.30pm AEST

For any information about the above events please contact:
Rhian Foster at events@asa.org.au

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Dr Tony Fernando

Dr Leona Wilson

Prof. Andrew A. Klein

For all enquiries please contact

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