AUSTRALIAN
Anaesthetist
THE MAGAZINE OF THE AUSTRALIAN SOCIETY OF ANAESTHETISTS • MARCH 2020

ANAESTHETISTS ON ASSIGNMENT – OUR VALUABLE VOLUNTEERS

- News from the fire front
- Before the Medevac repeal
- Volunteering with Rafiki in Tanzania
- High speed anaesthesia: medical support to motor rallies
- Volunteering in anaesthesia

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

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

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Australian Society of Anaesthetists

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INSIDE YOUR SOCIETY

WOULD YOU LIKE TO CONTRIBUTE TO THE NEXT ISSUE?

If you would like to contribute with a feature or a lifestyle piece, the following deadlines apply:

- Intention to contribute must be emailed by 6 April 2020.
- Final article is due no later than 17 April 2020.

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

REGULAR

LETTERS TO AUSTRALIAN ANAESTHETIST

DECLINING TREATMENT. 'PRIMUM NON NOCERE' WHAT DO YOU THINK?

An article in a recent issue of *Avant Anaesthetist News*: 'Not in your best interests: the challenge of declining treatment', piqued my interest. Dated 16 August 2019, it was written by Georgie Haysom, Head of Research Education and Advocacy, Avant. We were invited to consider the following scenario.

You are called to see a patient who has presented to the ED after a fall. The patient is 85 years old and an X-ray shows a fractured neck of femur. He also has respiratory failure. He is confused and has been given endone. He is accompanied by his son and daughter-in-law. You do not think that surgery is in his best interests given his co-morbidities. The patient and his family are keen to "have everything done".

Now before you prepare your 'exam answer' you should think about the last 50 #NoFs you anaesthetised. And the fact that it was initially published in the *Australian Orthopaedic Association Bulletin*, winter edition.

Anaesthetists are usually the last clinicians in the line of decision-making to decline treating a patient, unless the patient is well known to them through many procedures in the past.

Even so, the accepted anaesthetic management would be to proceed carefully, after full discussion and consent from the patient and his family, with spinal anaesthesia containing a drop of narcotic. The patient, rendered pain free, would usually tolerate a skilful internal fixation. Whether he would survive that admission is far more difficult to tell, but at least he should be pain free.

However, the article goes on to discuss the situation where the patient wants or expects a procedure that the surgeon does not believe is in the patient's best interests.

This scenario was not the best example, but we anaesthetists do need to consider the question of unnecessary surgery on the elderly ill patient, advantages and disadvantages.

The advantages should be quite obvious: relief of severe pain, cessation of bleeding or haemorrhage, to make the patient more comfortable in relation to the ability to manage, or for a carer to manage his day to day activities.

Unnecessary surgery is often in the eye of the beholder (anaesthetist): a surgeon not competent or sufficiently knowledgeable to perform the operation, an obvious unnecessary prolongation of severe pain, bleeding, or the ability to be cared for adequately postoperatively.

The situation is clearly far more difficult when the family demands that everything should be done; even more difficult when a physician or GP demands it.

Guilt can be a major factor here; the family having not spent enough time with their 'loved one', the physician having missed the diagnosis, disregarded, or not been informed of significant results or evidence (observations by others).

Then again the patient may not ultimately survive their hospital admission, battling POCD, bronchopneumonia, hospital acquired infections, cardiac failure, or cerebrovascular accidents. After all, a small CVA is often the precipitating cause of the fractured neck of femur!

We need to have this discussion with our colleagues, not only anaesthetists but others of all descriptions, so that we are aware of prevailing attitudes as well as our own feelings.

The Avant article concludes:
Further Information.
These are situations many doctors feel poorly-equipped to manage. To support clinicians, End of Life Law for Clinicians (ELLC), a free national training program for clinicians and medical students, has been developed by researchers at the Australian Centre for Health Law Research, QUT and the Institute of Health and Biomedical Innovation, QUT. The program is funded as part of a national Palliative Care Grant from the Commonwealth Department of Health. Avant is represented on the advisory committee for the project.
ELLC aims to improve doctors' legal knowledge to help manage legal issues in practice, to help clinicians deliver high quality, appropriate end of life care, and to improve communication with patients and families. The training modules attract CPD points and are available through the End of Life Law in Australia website.

Ken Sleeman MBBS (Hons) FAMA FANZCA
Chairman ACE Day Care Anaesthesia SIG

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ASA EDITORIAL FROM THE PRESIDENT

DR SUZI NOU
ASA PRESIDENT

There have been a few adjectives that have described this summer: unprecedented, overwhelming, catastrophic, devastating, threatening.

At the time of writing, our bushfires have burnt over 18 million hectares, destroyed over 5,000 buildings, of which about half were homes, and sadly, at least 34 people have died and an estimated one billion animals killed with the fear that some species may have been lost from our planet forever.[1] There are over 40,000 confirmed cases of the novel coronavirus (2019-nCoV), including one of vertical transmission, with at least 1,000 reported deaths from the virus. It has spread to over 25 countries[2] and least 20 million people have been quarantined in containment efforts.[3] There are brave people, including many volunteers, who are going into these areas to work and offer assistance. This issue highlights some of the volunteers amongst us and is dedicated to all volunteers, some who have made the ultimate sacrifice and, who have helped our community weather this summer.

Many months ago when we put forward Dr Bruce Paix's name as a potential contributor to this edition, the Australian Anaesthetist editorial committee couldn't have anticipated the devastation that would follow from the bushfires. In this edition, Dr Paix provides a gripping first-hand account of being a fire-fighting anaesthetist. I first met Bruce during military training, and he introduced himself as a 'serial volunteer'. It then came as no surprise that he volunteered two articles for this edition. In 'High Speed Anaesthesia' he also shares with us his experience as medical support as well as a competitor in rally car racing. One of my first medical volunteer experiences as a junior doctor was providing support for car rally races. Armed with three months experience in anaesthesia, I would have been quite nervous if I had known that there was an anaesthetist carrying a scalpel and defibrillator amongst the competitors!

Dr Barb Robertson, a personal friend and mentor writes about her more than 20 years' experience in Asia in 'Volunteering in Anaesthesia'. It is to her that I credit my ongoing work over there and firmly establishing a path that women can and do work in these challenging environments. Whenever I talk of my overseas work, many ask if I went with the Red Cross or Medicins Sans Frontieres. What this piece, as well as the article 'Volunteering with Rafiki in Tanzania', highlight is the multiple large and small, local and international organisations involved. Dr Wild's experiences may be in a different continent but the shared rewards and challenges are global.

The ASA has always advocated that anaesthetists should maintain professional autonomy. Likewise, the independence of the medical profession to undertake assessments 'absent of any broader advocacy agenda' was an important distinction made by the group of doctors involved with implementing the controversial Medevac legislation. 'Before the Medevac Repeal' describes the voluntary work that many anaesthetists performed through the eyes of two of our colleagues, Drs Nicole Phillips and Jennifer Dixon and demonstrates again our value outside of operating theatres.

Of course, there are many volunteers amongst us who contribute to sports teams, schools and other community groups, that have not been included in this edition of Australian Anaesthetist. This edition celebrates you too and all the work that you do. At the last census, 31% of Australians participated in voluntary work, contributing over $40 billion to the economy.[4] Volunteers can often work much harder than they would in their paid jobs and, as all have mentioned in this edition, the work may be more stressful than their paid work. Ultimately, volunteering offers rewards which mitigate the absence of income and the stresses of the job.

To this end, the ASA is composed of many committees which in turn, are formed by more than 250 hardworking volunteers. To you and your families, I am truly grateful. You are contributing to an important legacy for future generations of anaesthetists. Everyone will have their own reasons for why they choose to get involved but one that I sense commonly is the desire to make a difference, to add purpose and meaning to our lives and to form a deeper connection with our community and potentially ourselves. It is true that the more you put in, the more you get out and with this, I invite anyone interested in getting involved to contact us.

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REGULAR

ASA UPDATE FROM THE CEO

MARK CARMICHAEL, ASA CEO

Welcome to 2020, a new decade and a time of optimism as we all look ahead. Sadly the year has opened with the tragedy and destruction of the bushfires which have impacted greatly on vast areas of the east coast and other parts of Australia. The support extended by so many in the community to those affected has been heart-warming. The ASA, in its own small way, was, through the sale of its merchandise products during January, able to make a donation to assist those in need. Thank you to those members who generously purchased items and assisted in this initiative.

This year does hold a great deal for members to be optimistic about. The 2020 Combined Scientific Congress in Wellington, New Zealand will be a special event. Hopefully the dates of October 16-20 are already in your diaries. I am delighted to confirm the international faculty of Professors Denny Levett, Steven Schafer and PJ Devereaux, who will add significantly to what is indeed an exceptional program. On behalf of the organising committee, I look forward very much to seeing you in Wellington.

The MBS Review remains ongoing. As indicated previously Drs Andrew Mulcahy and Mark Sinclair along with Professor David A. Scott continue to represent the specialty on the Anaesthesia Information Liaison Group (AILG), with Dr Mulcahy being the ASA's nominated representative. Members would be aware that the first tranche of changes came into effect on November 1, 2019. Dr Sinclair presented a comprehensive overview of the current position at the 2019 Sydney NSC and again to the Victorian members at their October 10 meeting. His presentation at the NSC was filmed and members may view it on the ASA website. Associate Professor David M. Scott, who as President of the ASA 2016-18, was intimately involved in all discussions concerning the MBS, presented a similar overview to NSW members at their Members Forum in November.

Suffice it to say the MBS issue has not yet been fully resolved. The ASA, courtesy of Dr Mulcahy, along with Dr Sinclair and others will continue to engage on behalf of members in order to secure the best possible result. Members are reminded that a comprehensive coverage of the MBS Review is available on the ASA website, and I encourage all members to take some time to look at how this issue has unfolded over the past four years.

As we enter the new year it is important to reflect on the services the ASA offers to members and the various groups within the Society. Sometimes the changes can be quite significant and apparent to all, for example the revamping of the website which occurred during 2018/19, while others can be much more subtle and can sometimes be overlooked.

The ASA has, in recent times, implemented a number of those subtle or incremental changes. For instance members can now make tax deductible cash donations to the Harry Daly Museum and/or the Richard Bailey Library, to go with the ASA Benevolent Fund. Members are now able to renew their membership in a variety of ways be it by direct debit, B Pay or online payments, again a small change but one designed to make things easier for members. At the same time the very popular Patient Information Pamphlets are now available online via the ASA website at

NEW CEO AT INTERPLAST

Interplast Australia & New Zealand appointed a new Chief Executive Officer, Cameron Glover, in December 2019 following the resignation of Prue Ingram after eight years. Cameron joined the organisation in 2018 as Deputy CEO after a long period as an external adviser. He has proven expertise in the not-for-profit sector across a diverse range of organisations and during his time with Interplast, Cameron has overseen the strategic fundraising efforts as well as extensive involvement in stakeholder management, strategic planning and team leadership. In announcing the appointment, indicated under Cameron's leadership, Interplast will grow and maintain its positive impact across the Asia Pacific region.

asa.org.au/member-resources, for members to download and distribute to patients. Each of these developments is designed to improve the services and make the ASA an important resource, and I am pleased to report that members, in increasing numbers are taking advantage of these services.

The ASA only exists because of the members and the Board, and staff are as outlined above, always looking for ways to improve the value of membership. We are quite pleased that overall, membership continues to grow and the Society has a member renewal rate in excess of 92% across all of the member categories. We do know however that the rate of ASA membership is not growing commensurate with the increase in the numbers entering the specialty and this is something we are looking to overcome. In saying this, I would like very much to thank those members who actively promote the Society and its value to colleagues. 'Professional Citizenship' is the phrase often used when asking why someone is a member of the Society, and it is greatly reassuring that so many feel that responsibility and actively promote the Society.

An extension of that professional citizenship is reflected in the number of members who are seeking election, and re-election in many cases, to the various committees of the World Federation (WFSA) at the upcoming World Congress in Prague from September 5-9. The ASA is delighted to support their candidacy and wishes them well.

Let's look forward to a positive 2020, with much to do and achieve.

2020 AWARDS, PRIZES & RESEARCH GRANTS

PRE-NSC ADJUDICATED

ASA PhD Support Grant

Kevin McCaul Prize

NSC PRESENTATION AWARDS

ASA Best Poster Prize

Trainee Member Group Best Poster Prize

Gilbert Troup Prize

NON-NSC PRESENTATION AWARDS

Rupert Hornabrook Day Care Special Interest Group Prize

For more information on Awards, Prizes and Research Grants visit:

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

REGULAR

WEBAIRS NEWS
WEBAIRS INCIDENT REPORTING

The New Zealand Civil Aviation Authority and the Australian Civil Aviation Safety Authority issue notices regarding aviation incidents shortly after they are received to warn the industry of safety issues. In 2020, ANZTADC has decided to issue similar notices related to anaesthetic incidents. After the safety notice has been issued it will be followed by a full analysis and review where warranted.

A 66-year-old overweight patient with diabetes and renal impairment was being assessed in the Pre-Admission Clinic. The anaesthetist noticed that the patient's 12-lead ECG (demonstrating atrial fibrillation) was identical to that of the previous patient. Both ECGs were labelled with the appropriate patient adhesive label. A repeat ECG using a different ECG machine revealed that the second patient was in fact in sinus rhythm whereas the first patient was in atrial fibrillation.

Further investigation of the first ECG machine determined that the machine's memory cache was full. Had the ECG operator entered any patient details prior to performing the recording, an error message would have alerted them to this fact. However, because this step was bypassed, the machine proceeded to print out the most recent data in the memory – that of the previous patient.

'ECG Machine Groundhog Day'

Incident type:	Equipment usage
Equipment:	ECG machine (unknown model)
Incident:	Repeated print of previous patient's ECG
Location:	Pre-Admission Clinic
Attention:	Anaesthetists, PAC nursing
Outcome:	Near miss
Novel report:	There has been a report published by NSW Health in 2018 but not widely publicised nationally in Australia.*

* For example reference see http://www.health.nsw.gov.au/sabs/Documents/2018-sn-017.PDF

Anaesthetists and PAC nurses are advised:

- to ensure that ECG machine memory caches are emptied at intervals appropriate to usage (see manufacturer's Operating Manuals).
- where the function exists, to ensure that patient ID is entered directly into the machine memory (and therefore onto the printed ECG) as well as affixing locally authorised ID labels.

FOR MORE INFORMATION

Find out more about ANZTADC/WebAIRS: http://www.anzca.edu.au/fellows/safety-and-quality/incident-reporting-webairs

Are you contributing to quality improvement in anaesthesia? Register yourself on webAIRS: www.webairs.net

THE AIRWAY LEADS' ROLE IN GUIDING VIDEOLARYNGOSCOPE PROCUREMENT

Currently, there is a wide range of videolaryngoscopes on the current market.[1] The choice of a particular device depends on individual case scenario, local resources, operator familiarity, and dexterity with the device.[2] The costs incurred by the initial capital outlay followed by ongoing maintenance and replacement of disposable parts makes the choice of videolaryngoscope financially difficult, especially in low budget clinical areas.

While videolaryngoscopy reduces the number of failed intubations, improves glottic view and reduce airway trauma,[3] there is no evidence that videolaryngoscopy reduces the number of intubation attempts, the incidence of hypoxia and respiratory complications or time required for intubation.[4] Despite these results, videolaryngoscopy has been suggested as a first line laryngoscopy device during all elective anaesthesia[5] and specifically for obstetric[6-8] and bariatric anaesthesia.[9]

Relatively inexpensive disposable videolaryngoscope blades include those with sheaths that fit over an articulating arm (e.g. Medtronic® McGrath™ MAC videolaryngoscope, Karl Storz C-MAC® S video laryngoscope, Verathon GlideScope™ AVL videolaryngoscope) and plastic blades (e.g. Verathon® Glidescope™ angulated LoPro series™ and DirectView™ MAC S3 and S4). The videolaryngoscopes with sheaths that fit over an articulating arm are slightly larger than reusable blades and this makes it difficult to manipulate the tracheal tube and introducers in a narrow airway.[10] These types of disposable blades are therefore better suited for routine and low-acuity difficult airways.

In contrast, reusable videolaryngoscopes are often low profile (e.g. C-MAC™ blade 3 and 4 Macintosh-style and D-blade and the GlideScope® Titanium™ laryngoscopes) and allow more room for manipulating the tracheal tube. There is usually a higher initial capital outlay but they may be considered as cost effective for high-acuity difficult airway cases as well as a backup when low-cost disposable videolaryngoscopes fail.

It is important that the Airway Lead plays an active role when purchasing a videolaryngoscope to ensure its cost-effectiveness in all clinical areas. Each videolaryngoscope has its own nuances and the integrated procurement process should involve the local Airway Lead to consider how best videolaryngoscopy matches the needs of each critical area. There will be more on these roles during the current review process of PS56 Guidelines on Equipment to Manage a Difficult Airway During Anaesthesia in 2020.

Please consider becoming an Australian Airway Lead for your hospital. Applications are through the following website:

http://www.anzca.edu.au/fellows/safety-and-quality/airway-leads

For further information contact ANZCA at: sq@anzca.edu.au

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FEATURE

NEWS FROM THE FIRE FRONT

It's shaping up to be another crazy week: yesterday 'urology', the day before 'cath lab', today, back to Kangaroo Island for another three days firefighting with South Australia's Country Fire Service (CFS). Last week was the same, with three nights on the Island, and before that, two days at the Adelaide Hills 'Cudlee Creek Fire'.

Big fires always start out the same, firefighters know they are coming. They come on hot windy days in drought years. We don't need the warnings, we can feel the menace in the air as soon as we get out of bed. The sky is already brown, full of dirt picked up from dry paddocks by hot northerly winds. The lawn is so dry it crunches when you walk across it.

On the worst fire-weather days, the 'catastrophics', we try to stay home, or even go on 'active standby' at the station. Staying home may not be easy if you have a regular list, particularly if you have already accepted one of those difficult cases you wouldn't really ask anyone else to do. If we can't stay home, we carry our pagers everywhere, in my case, even into the operating theatre. You won't make the first truck, but you can get back for the second, or the night shift, or the next day.

Big fires go for weeks, even after they are contained, and even after rain. At Cudlee Creek I have seen houses burn down a full 48 hours after the fire front passes, and trees are still falling down, having been burning internally for nearly four weeks. Gum roots, too, can smoulder underground for 50m or more, before finally surfacing outside the perimeter and restarting the fire. This is why these fires are going to burn until serious rains come, possibly for months.

Initial response to a major fire is always chaotic, you don't really know where it is or what its doing, and as you enter the fireground, the smoke blocks out the sun and day literally becomes night. Our automatic response to a reported fire on a fire ban day is four trucks, each with a crew of five and carrying 3,000 litres of water. If available, the 'waterbombers' will be sent as well. Swiftest to respond are the 'Airtractors', big agricultural turboprops that carry 3,000 litres also. Often, they will drop a load on the fire before the first ground units get there. The aim is to knock the fire down early, before it can grow. If we fail at that, it's going to get away and we are going to have a big fire. The helicopters are more commonly used to manage established fires, shuttling repeat loads from dams or swimming pools to the fire, and the very large bombers are used to lay foam or retardant lines, hundreds

Dr Bruce Paix at the fire front

A quiet fire edge after a waterbomber drop

of metres long, at more established fires. Response escalates rapidly, and soon dozens or even hundreds of our 'big white trucks' (red in other states!) may be committed to the fireground.

During its first few hours, a major fire runs swiftly downwind for 10, 20 or 30km and cannot be stopped – we concentrate our firefighting efforts on 'asset protection', not extinguishment. We try to stop your house and sheds burning down whilst accepting that the fire is going to go over and around them. You can make this easier for us if you have already cleared the leaves from your gutters and the fuel from around your house. If you have a fire pump and reel, we will use that too; if you have a water source, we use that too. If you have built your house in heavy bush, not cleared around it, piled up combustible materials around it, and have gutters full of leaves, we will 'triage it to expectant' and go and save someone else's house.

After a period of hours, the weather usually moderates. This happens because the weather pattern that causes the strong, hot northerlies, carries behind it a cooler westerly change. Cooler,

Fire fighting is exhausting work: returning to staging after a night shift on Kangaroo Island

Mopping up

FEATURE

Refilling with water at 4am

moist air dampens fire behaviour, but not immediately. This produces the second phase of the fire, when the long easterly flank turns into a broad head fire and is driven northeast by the wind for another 10 or 20 km before finally slowing and stopping as it cools.

What follows is then days and days of 'mopping up', dirty, difficult, dangerous work as the hot spots are extinguished, smouldering structures and hay sheds are patrolled and fallen trees are removed from roads. It is amazing how many large trees come down in big fires, and how early they come down. I drove through a still-burning gum forest on Kangaroo Island an hour after the fire front passed through, and the road was already cut by fallen trees in multiple places. We could hear others crashing down in the darkness around us.


The aftermath on Kangaroo Island, even the topsoil has burned

After our third night, we were flown home. I had slept 15 hours in the last 80. I had a day's recovery, then it was time to go back to work: Tuesday: cath lab, Wednesday: urology, Thursday: Kangaroo Island. Next week, who knows? It's going to be a long summer!

Dr Bruce Paix MBBS FANZCA

ABOUT THE AUTHOR

Bruce Paix (MBBS FANZCA) is an Adelaide Hills resident and semi-retired anaesthetist working part time at Adelaide's Flinders Medical Centre. He has been a volunteer firefighter for 30 years and has deployed to multiple large fires over the current fire season.

FEATURE

BEFORE THE MEDEVAC REPEAL

THE ROLE ANAESTHETISTS PLAYED IN MEDICAL TRANSFERS FROM PNG AND NAURU

In the dying days of the 2019 Australian Parliament, a lot of focus was on the impending repeal of the Medevac legislation that had seen the medical evacuation of refugees and asylum seekers from offshore processing locations throughout the year. Although a number of medical professionals were vocal in the media about their concerns over the repeal, many others were mournful out of the spotlight including the dozens of anaesthetists who had been volunteering behind the scenes for months.

The start of 2019 looked promising for the hundreds of refugees and asylum seekers who had been languishing in Papua New Guinea (Manus Island or Port Moresby) and Nauru without access to the medical care they needed. New medical transfer provisions introduced in March meant the assessment and application process for urgent medical evacuation to Australia would involve the expertise of health professionals and not just politicians.

Before Medevac, critically sick refugees were waiting an average of two years to be transferred for urgent medical treatment. Some were waiting up to five years and for many that was too long with 12 refugees and asylum seekers having died in offshore processing in the five years before Medevac started. Medical transfers were solely at the discretion of the minister and if they were refused the matter was challenged in the courts. This generally resulted in a court order for transfer for urgent medical treatment to fulfil Australia's duty of care to people in offshore places.

Sydney GP Sara Townend helped establish a group of doctors who, by default, became almost exclusively responsible for the medical assessments

Some were waiting up to five years and for many that was too long with 12 refugees and asylum seekers having died in offshore processing in the five years before Medevac started.

of refugees and asylum seekers in offshore processing locations. In a submission to the Senate Inquiry into Migration Amendment (Repairing Medical Transfer) Bill 2019, Sara and her colleagues stressed "the medical assessments we have undertaken are independent, and absent of any broader advocacy agenda". Their submission outlined "Although the medical transfer provisions became law in March 2019, it was not implemented in any way by the Government. No funding source or bureaucratic procedure was established and it fell to a small group of independent doctors to implement this legislation, by creating a pathway by which refugees and asylum seekers in offshore processing locations could access health assessments by independent Australian doctors".

Medical evacuation under this legislation required two independent Australian doctors to recommend temporary transfer after a comprehensive assessment. Volunteer doctors read through medical records and interviewed applicants as part of the Teleconference Assessment Group (TAG) to assess the nature of health needs, and establish eligibility for further specialist assessment. TAG was one of the many working groups that medical volunteers were involved with during the lengthy process and anaesthetists quickly gravitated to this early triaging role.

ANZCA SUPPORTED JOINT MEDEVAC STATEMENT

"Every person should have access to necessary and appropriate medical care and, as clinicians, we have a duty to uphold this basic human right. The Medevac legislation has improved access to appropriate healthcare for refugees and asylum seekers being held offshore. It allows medical experts to make decisions about health care for seriously ill individuals and ensure that they receive the medical treatment that they need in a clinically appropriate timeframe. Previous delays and failures to transfer ill asylum seekers resulted in preventable suffering. We call on the Australian Parliament to maintain the standard of health care and information that has now been achieved through the Medevac legislation."

October 2019 statement by leading medical colleges in Australia including ACEM, ACD, ACRRM, ANZCA, CICM, RACP, RACMA, RACGP, RANZCOG, RANZCP and RANZCR

Dr Sara Townend (second from right) with AMA Federal Executive Dr Paul Bauert (right) and supporters outside Parliament House. Photo: AAP Image

FEATURE

Dr Jennifer Dixon from Melbourne and Dr Nicole Phillips from Sydney were part of the first group of anaesthetists to be inspired by Sara's work and to get on board and volunteer. Both admit they were surprised to discover just how valuable their skillsets were for this role.

The TAG members were tasked with capturing medical histories by reviewing files, identifying health needs and formulating reports to support further investigation on the eligibility of applications. In the early days many of these health volunteers were general practitioners and emergency critical care physicians before it became apparent just how appropriate anaesthetists were as experts in multi-system disease.

"The volunteers were from all walks of life and medicine," Nicole Phillips explains. "When I first got involved, I thought what can I do, how can an anaesthetist be any good here? And then it became clear. We are really good at taking people's medical history in a time-limited fashion. We know how to identify what is serious and not serious. We've been trained for this and we were well suited to preparing the comprehensive reports needed."

Jen Dixon's initial reaction was the same. "What am I going to be able to do? I'm not a GP, what on earth can an anaesthetist do to help? But we were excellent for this triage process. We're able to look at all the health factors involved. Our speciality has really embraced the perioperative medicine model and to look at the whole picture to see what has to be done to optimise someone's health. Anaesthetists have really good skills for this and it was great to put them to use outside of the operating theatre."

As most anaesthetists have training in pain management issues this also proved a handy skill with many of the patients interviewed suffering chronic pain. Nicole recalls a particularly difficult teleconference with a young man who was in so much pain he could hardly communicate. "He had been a well young man but a minor injury that hadn't been attended to had left him in so much pain that he couldn't sleep," she said.

Over several months there were more than 800 medical volunteers (80 in TAG) involved in health assessments of transfer applicants. Nicole is proud to note that many of these volunteers were anaesthetists.

"When I first got involved, I thought what can I do, how can an anaesthetist be any good here? And then it became clear. We are really good at taking people's medical history in a time-limited fashion. We know how to identify what is serious and not serious."

During the medical assessment patients were asked, through interpreters in many cases, to provide details of their most serious and urgent medical complaints. The volunteers found that many of the patients under-represented the number and severity of their health conditions. It was often the case that they were presenting with several health problems and the volunteers noted "the burden of disease high as a consequence of their circumstances".

The teleconference assessments were lengthy processes addressing a range of health issues with a high rate of gastrointestinal disease, renal disease and cardiovascular concerns as well as mental health issues particularly with pre-existing PTSD. It was challenging work but the apolitical group remained focused on the severe unmet health needs that confronted them. The situation was compounded with patient's mental health deteriorating and medical conditions worsening as time went on.

The Senate submission noted "some of the documented health problems resulted directly from the conditions under which this cohort of refugees and asylum seekers resided. A high rate of kidney stones, for example, related directly to poor diet and inadequate hydration. Others were caused by inadequate medical care, with treatable complaints turning into chronic problems through lack of resolution. The

SUMMARY OF HEALTH BURDEN EXPERIENCED BY REFUGEES AND ASYLUM SEEKERS ON PNG AND NAURU

- More than 97% of patients had significant physical health issues.
- Some 91% of patients experienced one or more psychiatric health problems.
- The great majority (88%) experienced both physical and psychiatric health problems.
- On average each patient had 4.6 distinct physical ailments (one patient had up to 15).
- "The high rate of illness reflected not only the socioeconomic conditions in which this cohort resided, which contributed directly to a number of health conditions that are vastly overrepresented (compared even to other disadvantaged populations), but also the lack of resolution to even treatable medical problems which consequently become chronic problems."

Source: Submission to the Senate Inquiry into Migration Amendment (Repairing Medical Transfer) Bill 2019.

Data collated from reviews of medical information by Dr Sara Townend, BEd (Eng), MBBS, FRACGP, Dr Natalie Thurtle, MBChB, DTMH, FACEM and Dr Neela Janakiramanan, MBBS (Hons), MPH, FRACS.

high prevalence of surgical pathology, for example, is as a result of an accumulation of untreated disease over six years".

The teleconference assessments proved more challenging than both Nicole and Jen expected. Unreliable phone coverage often meant the patients had to call back 20 or 30 times to complete the session. And then there was the horrific content of the information shared.

"Such terrible stories," Nicole recalls. "One man I spoke to for three hours was in such a state of distress. They have endured so much. For many they had rather minor ailments which had been left so long that they became chronic and life-threatening".

Jen is also haunted by the assessments she did. "It was really confronting. These men suffered and suffered and lost hope. To think what they have had to put up with, it was just awful."

Dr Jennifer Dixon

Dr Nicole Phillips

This experience was a chance to see first-hand the human impact when individuals have little to live for. The desperation of the patients they dealt with has had a profound effect on the volunteers…

Mindful of their own wellbeing, Nicole and Jen were well aware of the impact this may have on them and their fellow volunteers, especially when they were hearing time and again reports of self-harm by the patients they were interviewing.

Jen notes the enormous support they felt when ANZCA and other medical colleges in Australia came out with a strongly worded statement to the Australian Government. Despite tackling this volunteering position as an individual, she appreciated the broader support in the medical community that welcomed her and other TAG supporters.

It wasn't long before Nicole's additional skills as a training supervisor came to the fore and her voluntary role morphed into one of recruitment and training of new volunteers. This leadership role meant she was keen to ensure that all the volunteers had a sense of belonging and support. They were all acutely aware of the need for self-care during this time. Working in a big department in Sydney, Nicole had the daily support of other colleagues but she was concerned for the volunteers working in rural and remote areas. Regular communication and contact attempted to bridge this gap and while many have never met, there is a real sense of family amongst this tight group of volunteers. Some gathered after the Medevac repeal vote to console each other and to acknowledge the amazing work they had all done throughout the year.

While there is still some confusion about what has happened or will happen with the refugees who had transfer applications underway when the legislation was repealed – the one statistic that has been publicly revealed by the Senate is that between March 2 and October 21, 2019, there were nearly 200 refugees and asylum seekers transferred for emergency medical treatment under the Medevac legislation. Going forward, the people in need of urgent medical care will once again be at the mercy of ministerial discretion.

For the anaesthetists who were involved as volunteers when Medevac was in place, even briefly, the effects will be long lasting. Jen is quick to say she gained a greater appreciation for the medical care that many in our community take for granted. "It reinforced my support for universal healthcare and reminded me just how much medicine can do," she said. "I'm very grateful for the experience and for knowing that as a single person I can make a difference – individuals coming together can make a huge difference."

This experience was a chance to see first-hand the human impact when individuals have little to live for. The desperation of the patients they dealt with has had a profound effect on the volunteers and Jen understands better than most now that "life must have hope and purpose and meaning".

Both Nicole and Jen are thankful they found some of this purpose and meaning through their volunteering. They also found hope.

Cindy Jones
ASA Media and Communications Advisor

FEATURE

VOLUNTEERING WITH RAFIKI IN TANZANIA

Rafiki is a small Perth-based volunteer organisation which has been running surgical plastic and reconstructive trips to Tanzania since 2004. It started off performing cleft lip and palate repairs and operating on skin cancers of patients with albinism, but over the years, the scope of procedures has expanded to include acute burns and disabling burn contractures as well as most other types of plastic reconstructive surgery.

I have been fortunate in going on 14 trips over the years after initially filling in when an anaesthetist withdrew at short notice. Being available at short notice endears one to any organisation and I can recommend it if you want to get involved! Although I'm most certainly no expert in volunteerism I can share a few thoughts.

Tanzania has a population of 55 million but no plastic reconstructive surgeons and only a handful of doctor anaesthetists. Most anaesthetics are administered by nurse anaesthetists with widely variable skill sets and training.

Most plastic and reconstructive surgery is not life threatening, even if extremely disfiguring and devastating to one's life prospects, so has been considered a low priority in Tanzania.

SERVICE VS CAPACITY BUILDING

Providing the surgeries certainly makes a massive difference to the patients' lives, their family, school class and even the whole village, as we witnessed on a trip to follow up patients some years down the track. Lives are transformed. Patients can literally change from village pariah with little prospect of an education or marriage to attending school, getting married and becoming Village Chief!

However, the 'drop in the ocean' and 'teach a man to fish' argument has resulted in Rafiki evolving into a more capacity building-oriented organisation in recent years. Last year Rafiki organised and launched Tanzania's first Plastic Reconstructive Specialist Training Program in conjunction with the National Hospital and its associated university.

The move from a primarily service focus, to a primarily training-focused organisation does require some adjustment of attitude and practice. Surgeons love operating on as many patients as possible, anaesthetists love providing safe, smooth, incident free, timely anaesthesia and donors love seeing incredible before and after photos at fundraising events. While the rewards of capacity building (training), are in fact greater they can take longer to be realised. In my opinion, there is a place for

both service and training trips especially if the service trips still incorporate a significant amount of teaching.

This year, Rafiki plans four purely teaching trips and two service/teaching trips. The two Tanzanian surgeons enrolled in the Plastic Reconstructive Masters degree will attend all trips for hands-on teaching.

Patient checks and the safe, smooth workings of an operating room are something we take for granted, but are not necessarily present in Tanzania and knowledge transfer in this area is also important. Our in-theatre anaesthetic training is very practical and most appreciated by the local anaesthetists who have a strong desire to learn and improve.

On one of our trips to a large teaching hospital in Mwanza, there were two patients awaiting surgery by a Tanzanian team in an adjacent theatre – one required a craniotomy and the other had a broken leg. The patient with the broken leg had the craniotomy. On asking the ironically named check-in nurse Fortunata, how this had occurred, he stated that it wasn't his fault as both patients had the same name!

MOTIVATION

If you are expecting a holiday, not only will you be a much less useful team member, but you will be very disappointed, as in my experience the two-week trips are the most stressful, demanding, hard-working weeks of my year. However, they are also the most rewarding.

Other motivations may include a desire to share the fantastic medical education and experience we enjoy in Australia with those not as lucky, the challenge of working in different and sometimes difficult environments, being a part of a team, gaining perspective and extra purpose in life and career, escaping the family for a while, CPD points and an improved curriculum vitae. I think everyone has their own mix of motivations, but in general it's best if you try and be a giver rather than a taker, as one of my wise mentors used to say. You will be a better, more useful team member, and the rewards of volunteering will take care of themselves.

STRESSES OF THE JOB

Although rewarding, volunteer trips can be very stressful, especially for many anaesthetists like myself who are somewhat prone to anxiety. In fact, it's common for me to spend long periods awake in the early hours of the morning, worrying about the next day on these trips, and wondering why I agreed to go on another trip in the first place! Even though I'm very experienced and more than capable, jet lag and the exhaustion following 26 hours of travel contribute of course. Fortunately, this subsides pretty quickly once the first day or two of operating is over and I'm in the swing of things. If anxiety is an issue, you're not alone. Many team members feel much the same and I've found it useful to talk with others about it

TEAM SPIRIT

Being part of a team of like-minded people, with the same goals, working in an often-challenging environment is certainly one of the special things about volunteer surgical trips. You spend a lot of time with the other team members, working, eating, exercising before work (great for anxiety relief) and relaxing together. In fact, I would suggest a quite unique, long lasting bond is formed between team members, be they nurses, physiotherapists, anaesthetists, surgeons or self-funded volunteers.

ANAESTHETIC EQUIPMENT AND DRUGS

In Rafiki's experience, situation appropriate anaesthetic machines are the key. Tanzanian hospitals are littered with broken down first world anaesthetic machines donated by well-intentioned but misguided first world countries. Some have been donated already partially broken, others have broken down over time due to lack of maintenance and the lack of anyone able to fix them.

On one of our visits to a large teaching hospital in Mwanza, we were very surprised to find the theatres had recently been decked out with top-of-the-range GE ADU anaesthetic machines. In fact, the same ones we had in our biggest private hospitals in Perth at the time. This was quite a jump from the EMOs the anaesthetists had been using until then, and in fact still were still using for difficult cases as they didn't fully trust these new high-tech machines. We helped set the ADUs up and instructed on their use.

A year later the soda lime had not been changed and had turned to concrete. The CO_2 monitors stopped working over the next couple of years followed by many other components, all due to a lack of servicing which was considered too expensive and not in the budget.

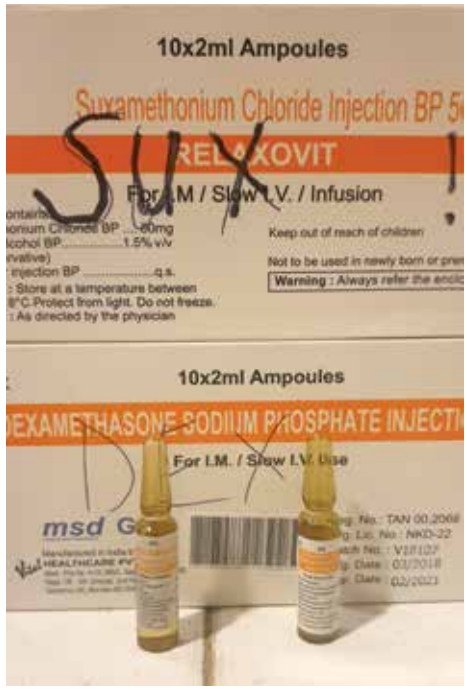
Worse still, some years down the track and after the EMOs had been discarded, the town's oxygen plant which filled the essential size G oxygen cylinders broke down and was not operational for several weeks. With no pressurised oxygen, the hospital could not provide anaesthesia having only the ADUs, and numerous patients died for the lack of surgery.

In a country where pressurised oxygen can be scarce and there are several blackouts per day, an appropriate anaesthetic machine which can remain operational under such conditions and has a local service facility is vital.

In the early days, ULCO kindly made such a machine for us at cost price. Named the ULCO lite, it was a portable machine built into a blue Bunnings toolbox. It required no electricity and could run off pressurised oxygen or an oxygen concentrator. It was so simple even I could understand its workings. It required no maintenance and was almost indestructible. It served us well for years.

FEATURE

Happy, calm patient walking to OR



What could go wrong?!

I quickly discovered how to plug an oxygen concentrator into the back bar of the ULCO lite, when my butt knocked over the only available size G cylinder just after intubating the first case of the trip. As it toppled, the cylinder smashed a theatre window before hitting the concrete floor. The first stage regulator shot across the theatre with a deafening roar of escaping oxygen which cleared the theatre of all local staff and waiting patients, who thought a bomb had exploded. Certainly, one of those "I can't believe this is happening" moments saved by an ambu bag and the one remaining local theatre nurse quickly sourcing an oxygen concentrator from elsewhere in the hospital, while a capable colleague managed to close the cylinder so we could hear ourselves talk.

Recently we purchased two diamedica Glostavent Helix machines. These quite remarkable machines can run off a built-in oxygen concentrator which generates 10 L per min of 100% oxygen or use pressurised oxygen if available. If all else fails it operates as a drawover machine entraining room air. It has an uninterruptible power supply and a battery for when the frequent blackouts occurs.

In short, it can operate under almost all conditions experienced in Tanzania. The availability of a local service agent and in-servicing support is also extremely useful. The self-inflating reservoir bag takes a bit of getting used to, but overall, it's a great machine and can be recommended.

In this day and age, taking out-of-date consumables into Tanzania is forbidden, even if they are in perfect condition. Although frustrating, when it is only the packaging which is out of date and the item may be in perfect condition, it's important to respect this not unreasonable Tanzanian position.

In recent years we did come across a dozen or so pallets of in-date consumables that were going to landfill from one of our large teaching hospitals. Apparently, a department was moving to a new site and the system didn't allow for the consumables to be transferred between hospitals. This certainly demonstrates

Ulco lite

the terrible waste in our health system but on the upside, the several thousands of dollars' worth of gear was gratefully accepted by Tanzania.

At present we take most of our drugs with us from Australia except for locally sourced halothane, the volatile of choice in Tanzania, suxamethonium and pethidine, the opiate of choice in Tanzania. At the request of the Tanzanian Government, we are endeavouring to source more drugs in Tanzania although this is not completely without hazard. We were recently surprised to find that the locally supplied 2ml vials of suxamethonium and dexamethasone came in identical sized and coloured packaging, and vials. The only difference was the small black lettering! What could go wrong?!

RISK TAKING IN TANZANIA

What is an appropriate level of anaesthetic risk to take when volunteering in Tanzania?

The previous medical director of the hospital we visit, always starts his farewell speech with "This has been a very successful mission. There have been no deaths".

We endeavour to set the bar a little higher! While we have had no deaths of elective patients in 15 years, there have unfortunately been several avoidable deaths in adjacent, locally run theatres while we have been visiting. This highlights the importance of our ongoing attempts to improve the safety of anaesthesia and surgery in Tanzania.

No parents, no EMLA, no worries

Undoubtedly, we anaesthetise out of our personal comfort zone, but it's important that you're not so far out that you are taking unnecessary risk. Some current or at least recent paediatric anaesthetic exposure is highly desirable. The patients are often sicker and smaller children than we would normally anaesthetise as non-paediatric subspecialised anaesthetists in Australia. We have an age limit of one-year-olds and weight limit of 8kgs with Hb guidelines.

Thorough preoperative assessment is difficult, with more than one hundred patients to see on the first day and unrecognised severe anaemia, malaria and chest infections some of the commonest problems we encounter.

Difficult airways from severe head and neck burns present from time to time and are managed with judicious use of LMAs, a Macgrath video laryngoscope, and AMBU fibreoptic laryngoscopes. Taking excessive risk in these cases is to be avoided and any patient requiring complex postoperative airway management in ICU is usually declined surgery.

HOW TO VOLUNTEER

I would highly recommend volunteering with an established, respected organisation if possible, rather than venturing out on one's own.

A good organisation will have thought through the most ethical, effective, safe and coordinated way for you to work and have protocols and a range of experienced people to guide you.

A good organisation will respect anaesthetists and the vital role we play. They will also have a team of people other than doctors performing vital tasks such as fundraising. Rafiki is fortunate to have a very effective voluntary fundraising committee and all the trips are funded by an annual Rafiki Ball.

Bureaucracy and paperwork can be daunting in Africa, having the Honorary Consul of Tanzania as our Chairman certainly smooths the way.

Lastly, a good organisation has a strong, hardworking team coordinator/ leader to keep trips on track. Rafiki is most fortunate to have Taka, my long-suffering wife in this important role. As I advise team members – do what she says, yesterday if possible, and your volunteer experience will be good!

Dr Andrew Wild

FEATURE

Caption 2: Side impacts with fixed objects can still cause serious injury and entrapment

HIGH SPEED ANAESTHESIA: MEDICAL SUPPORT TO MOTOR RALLIES

MOTORSPORT IS DANGEROUS

Motorsport is dangerous – it says so on the tin – and if you miss the warning, there are other clues, such as the mandatory presence of fire and medical first intervention vehicles (FIVs) at the start line, and the periodic stage stoppages when they respond to incidents.

Motor rallies are amongst the most risky of all motorsport events, typically taking place on winding public roads, often tree-lined, rather than on the sanitised tarmac of the dedicated motorsport track. A typical rally stage might be 10-15 km long, include many blind crests and corners, changing road surfaces, and could be run at night. A full event might total 250 competitive kilometres on such stages, and the fastest team wins. Events range in scale from small club meets with perhaps 25 entrants, up to national or international level with hundreds of competitors. Car speeds are considerably faster than these roads are designed for, and can easily exceed 200km/hr in places, including along narrow dirt tracks in pine forests.

In consequence, crashes can be frequent and severe, and a comprehensive system has evolved for managing injury risk. Rally cars are fitted with a suite of safety equipment including roll cages, racing seats, 6-point harnesses, fire extinguishers and G sensors. Drivers and navigators wear helmets, neck restraints and fire-resistant suits. Dedicated fire and medical FIVs are required at the start of every stage, and longer stages may have them at midpoints as well. Optimally, the lead clinician on the medical intervention vehicle (MIV) will be experienced in managing severe trauma in the pre-hospital setting. They should be capable of opening a bloody airway in a still trapped occupant, chest tube insertion or finger thoracostomy, difficult IV access, and field analgesia, particularly with ketamine. These skills are most frequently found amongst acute care anaesthetists, ED physicians and prehospital retrieval doctors. They should be aided by a second clinician comfortable in assisting such procedures, typically an ED, ICU or anaesthesia nurse, or a senior paramedic.

WHEN A CRASH OCCURS

Traditionally, when a rally crash occurs, the first task of the crew of the crashed car is to exit their vehicle and warn following cars, which may be arriving shortly at very high speed. In the majority of cases no fire or medical response is required and this is signified by the crew displaying an OK board. Alternately, if assistance is required, an SOS board is displayed, or no board is displayed, and the next two cars must stop to assist, with the third pausing to gather details before continuing through the stage to get help. Increasingly, rally cars are carrying G sensors that notify rally control in real time when a significant impact occurs, allowing an immediate response by the fire and medical emergency vehicles. Initial medical care, if required, is 'buddy care' provided by the crew themselves, or following cars, using the specified onboard first aid kit backed up by the MIV, which should arrive within ten minutes of impact.

When responding to a rally crash, a number of challenges are encountered which are seldom met by hospital doctors. Firstly, as the MIV approaches the incident, I am cognisant that my eyes are the first professional medical eyes to appraise the scene and those of my fire officer are the first fire and rescue eyeballs to do so. My arrival SITREP (Situation Report) includes three key pieces of information for rally control: Is it a big crash? Is there any fire? Is anyone still in the vehicle? In most cases, both crew members will be out of their crashed vehicle and if they are not, it probably means someone is seriously hurt and/or physically trapped by compression. Even the most robust of roll cages can be seriously deformed in a rally crash, particularly by side impacts into trees. Unlike 'civilians', who often remain in their seats, mentally shocked and immobile after a serious crash, most rally competitors have been through it all before, and exit their cars promptly after even major crashes. They know the next competitor may be coming over the crest that claimed them, in as little as 30 seconds!

C-ABC

If both crew members are out and apparently okay, the priority is to restart the stage as soon as possible. Often the fastest course is to seat them in the MIV and take them immediately out of stage, with formal assessment taking place after exiting the stage. I am aware that physicians rarely see trauma physiology so acutely – head injuries seen early tend to look more severe than they actually are and circulatory and skeletal injuries look less severe.

If someone is still in the vehicle, but not apparently injured, they may respond to a gentle request that they climb out under their own power. This certainly speeds extrication if the vehicle is on its side or upside down, as rally cars often are. Where an occupant remains in the vehicle, and serious injury is suspected, the stage is shut down and a formal emergency response is initiated via rally control. Care is then commenced using the modern ATLS 'C-ABC' algorithm, as follows.

- C – Control catastrophic haemorrhage: Fortunately, in blunt trauma, major external haemorrhage is uncommon. I have never needed serious direct pressure or a tourniquet to achieve haemostasis, although I have encountered catastrophic upper airway bleeding due to a basal skull fracture
- A – Airway (with C-spine control): On five occasions I have encountered deeply unconscious competitors, still trapped in their cars, in urgent need of airway control. In all cases, a cuffed tube was required below the cords, yet the complicating factors of entrapment, trismus without IV access, and the presence of helmet and neck restraint precluded attempts at conventional intubation. I solved this problem in three cases with a primary scalpel surgical airway[1], and in the other two cases by triaging the casualty to 'expectant' whilst I worked on the other unconscious crew

Extensive safety systems can be protective in even severe crashes – driver pondering his repair bill

FEATURE

Moving crashed vehicles is an under used technique that speeds up extrication

member. I have reviewed the literature regarding the benefits of acute 'C-spine control' in severe vehicular trauma and find it unconvincing, particularly when weighed against the time costs, hence rarely prioritise formal C-spine protection protocols, including cervical collars, in the rally setting.

- B – Breathing: I have only seen one serious chest injury in rallying – a flail chest in an unconscious driver after a high-speed side impact with a tree. This was managed with IPPV via a surgical airway and bilateral finger thoracostomies, which is a swifter and simpler solution for pneumothorax than the formal intercostal tube. It was notable in this case that I arrived at the scene as a 'following competitor', not a formal medical responder, reinforcing my practice of carrying more than the standard first aid kit in my rally car!
- C – Control lesser bleeding, splint fractures, consider pelvic binder: As noted, compressible external bleeding is unusual in rally crashes although fractures are sometimes encountered. Where IV access is gained, I mainly use it for analgesia, not volume, and avoid it until after extrication if possible as IV lines are easily dislodged by casualty movement. Inhaled methoxyflurane is a valuable analgesic modality where IV access is absent and the upper humeral IO route may be the fastest way of gaining vascular access in a heavily trapped casualty.

RAPID EXTRICATION

The 'golden hour' concept reinforces the need to prioritise swift extrication of the seriously injured patient from the vehicle. Unfortunately, this has long conflicted with the time-consuming traditional practice of dismembering crashed cars to effect casualty removal under 'spinal precautions'. I prefer a minimalist approach, aiming for rapid extrication via 'many hands' if possible, and limit medical interventions whilst still in the vehicle to surgical airway (if required) and IV access

(for analgesia, not volume). It is better to keep your medical responders out of the vehicle unless strictly needed, and to let the rescue workers concentrate on casualty removal. This is especially true in the case of traumatic arrests in crashed vehicles. These can rarely be resuscitated at all, and cannot be resuscitated whilst trapped. I have dealt with two of these in rallies, both in the same car. One we managed to extricate immediately for attempted resuscitation, the other was declared dead in the vehicle. In managing blunt traumatic arrests, it is important to address potentially 'fixable problems', particularly impact apnoea, the bloody obstructed airway and compressible haemorrhage, rather than to apply ALS standard CPR, in the hope that it will somehow wake up the dead. I was long sceptical of the impact apnoea phenomenon (the suggestion that many immediate blunt head injury deaths were due to concussion of the respiratory centre and could recover fully if promptly ventilated on-scene) until I saw it in person at a horse event where a blue, apnoeic fallen rider recovered within minutes after I gave a few breaths with bag and mask.

In managing blunt traumatic arrests, it is important to address potentially 'fixable problems', particularly impact apnoea, the bloody obstructed airway and compressible haemorrhage…

Another valuable but little used technique for expediting rescue in side impacts is to winch the crashed vehicle off the tree it is wedged against. This allows casualty access directly from the point of impact, and may increase space within the cabin as the degree of compression reduces somewhat when the vehicle is moved. Sadly, formal rescue crews almost never consider this option and I find we need to do it early, before the professionals arrive.

EXPECT THE UNEXPECTED

Unlike major circuit events, motor rallies often take place long distances from major centres, with crews camping onsite or staying at the local hotel or caravan park. You become known by many of the crews and may well be the only medical practitioner in the district so you should be prepared for incidental and out-of-hours calls. I have been called to manage severe asthma, anaphylaxis, burns, MI, acute abdomen and sudden cardiac death, so I make sure to carry general medical supplies including a defibrillator, nebuliser, adrenaline, antihistamines, diarrhoea medications (!) and script pad. You should also expect calls to sort out volunteer officials with complex medical problems who have left their medications home for the weekend. I have also arrived at a rally crash with both competitors unconscious, whilst competing myself. I now carry significantly more medical equipment in my rally car than the rules require, much to the chagrin of my engineer and his obsession for weight reduction in the car.

Dr Bruce Paix MBBS FANZCA

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Beyond the call of duty, the author at the helm, researching this article

ABOUT THE AUTHOR

Bruce Paix (MBBS FANZCA) began pre-hospital care as a volunteer ambulance officer in Adelaide in the 1980s, before continuing as a member of the South Australian Country Fire Service since 1990, in which capacities he has attended hundreds of serious road crashes. Having recently retired as a Retrieval Consultant with SAAS-Medstar, he continues working as a Senior Staff Anaesthetist at Adelaide's Flinders Medical Centre. Also a military reservist, with disaster and wartime deployments, he has long experience providing field medical care to 'dangerous sports', including horse trials and motor rallies, as both competitor and first responder.

FEATURE

VOLUNTEERING IN ANAESTHESIA

One of the most enjoyable, challenging and memorable activities that I have been involved with as an anaesthetic specialist has been volunteering overseas. I have been a member of a number of multidisciplinary groups going to various hospitals in Vietnam and Cambodia for over 20 years. The majority of the trips have been with ENT surgeons and ancillary staff to both NGO and government hospitals, and one ASA trip to Battambong in Cambodia.

Professionally, I have learnt a lot, worked with many wonderful people and been challenged with some complex situations with only limited resources. I have developed some very special and enduring friendships and continue to communicate with these colleagues to this day.

I first started volunteering with an Australian ENT team, who had partnered with some French surgeons forming a coordinated program doing regular visits to Vietnam. The team included ENT surgeons from a number of Australian, Nepalese and French hospitals, along with anaesthetists, audiologists, audiometrists and theatre nurses. They had already established solid links with a local ear care team and had commenced a comprehensive training program for a cohort of young enthusiastic Vietnamese ENT surgeons.

The program included theatre time, clinics, tutorials and planning for the participants to attend international conferences or clinical attachments to Australian hospitals. A lot of work had gone into ensuring excellent preoperative assessment, preparation for surgery and follow up for patients. They also had a local team on the ground to ensure good social support for families throughout the perioperative period. The main surgeries performed were mastoidectomies and myringoplasties in children with middle ear disease.

I was lucky enough to be invited to join one of these trips in 1999 and was impressed by the coordination and work that had already occurred. I was able to contact an anaesthetic colleague who had been part of a previous trip and get a good handover of the types of cases, the equipment and the drugs available. The brief was that the Australian anaesthetist would be giving the anaesthetics alongside Vietnamese anaesthetic staff, when they had someone available, with ample opportunity for clinical discussion and sharing of information. It would involve some teaching sessions outside the theatre time to allow further learning and reflection of anaesthetic practice. It was also understood that we may be asked to assist with other non-ENT cases both in and out of hours. Not surprisingly, this

proved to be the most interesting part of the work!

Our flight to Vietnam was certainly eventful with an obstetric emergency on the plane. It is hard to ignore a call for a doctor when you have an ENT surgeon, an audiometrist and a theatre nurse all digging you in the ribs to go and help!

The most memorable thing about arriving in Vietnam was the heat and humidity. Our destination was Danang, a regional city in central Vietnam which in those days had a network of chaotic and noisy roads. Occasionally we travelled to the hospital by motor bike, with no helmets, few road rules and often three of us on one bike with bags of equipment dangling from the sides.

The theatre complex was very hot with no air-conditioning. The windows were open to the outside to allow some airflow – also to allow the family of a patient to come to the window and have a briefing by the surgeon and be shown a specimen of a cancer when required! The drug selection was extremely limited with a variable supply of ketamine, thiopentone, pancuronium and suxamethonium (which often didn't work due to the unreliable refrigeration and hot theatres). The monitoring equipment was limited (ECG, manual BP and oximetry that we brought) with oxygen supplied from an oxygen concentrator and a draw over vaporiser for halothane.

In the midst of all of this was a team of very keen, hard-working and resourceful anaesthetic nurses and several doctors. They were anaesthetising patients of all ages (down to neonates) having general surgical, orthopaedic, obstetric and urological procedures as well as seriously injured trauma victims. Anaesthesia for middle ear surgery in children was considered reasonably mundane. The formal anaesthetic training was quite short but their experience impressive. The interactions were rich and rewarding for all of us. The commitment to providing

Patients outside Emergency Hospital, Battambang

Recovery in the corridor, Bambino Gesu Children's Hospital, Takeo, Cambodia. Patient in the background waiting for surgery.

General ward, Emergency Hospital, Battambang

Supervising from the theatre floor, Battambang, 2005

safe anaesthesia was taken very seriously by everyone. At times the hospital would run out of basic drugs, power and water. There were no anaesthetic rooms or recovery room and the ICU was very basic. Recovery was largely done in the passageway before the patients were whisked away to the general ward.

The experience in theatre was interesting and fun. We discussed many topics although the language barrier proved a significant challenge. I learnt that you could do almost anything using ketamine and this largely obviated the need for opioid analgesia. Early on in my involvement, laryngeal masks hadn't reached these hospitals and most patients were intubated with reusable red rubber tubes. Everything that could possibly be reused was reused.

I learnt a lot about fixing anaesthetic equipment. The local anaesthetic teams were highly skilled and resourceful in resurrecting broken machines. They worked together well and seemed to have a solution to any problem.

The cases that we were asked to help with away from the ENT theatre were generally the most challenging. One day, we were asked to anaesthetise an 18-month child who was accidentally shot with an arrow from a crossbow, lodging in the left side of her chest. She had been transported down from the mountains in a taxi. Another day a patient arrived with bilateral pneumothoraces and lung contusions, multiple long bone fractures and a lacerated liver after being hit by a truck. We saw a number of patients with subdural haematomas from road accidents.

Not infrequently, there would be two patients having operations in the one theatre. On one occasion I did an anaesthetic for an emergency caesarean section for twins while there was a laparotomy underway on the opposite side of the room. I was also given the babies to resuscitate when they were delivered. Thankfully they didn't require too much assistance from me.

These visits continued four times a year for many years. The equipment in the theatres gradually improved, and the training of the young anaesthetists moved along well. The group of young ENT surgeons developed into solid consultants.

Some years later, the multidisciplinary team was asked to start a program in Cambodia. This continues at a variety of locations and still involves a French team. The Australians are largely self-funded, but many Australian hospitals have contributed equipment including microscopes, instruments, monitoring equipment and anaesthetic machines. There have also been significant donations from various Rotary clubs, individuals and specialist colleges in Australia. One of the issues with donated equipment has been that there was no screening process for many years, resulting in literally tonnes of useless, broken, inappropriate, out-of-date and complex equipment that required regular servicing by specially trained staff who were not necessarily available in these regions. Every hospital I saw has a storeroom full of this sort of equipment and it is usually covered by a thick layer of dust. If you do get tempted to take stuff with you, I suggest only taking things that will be used on your trip.

I really recommend volunteering as an anaesthetist. It is an incredible experience that can enrich your professional life. At times it can be stressful and frustrating, but overall it will be memorable and a lot of fun.

Dr Barbara Robertson
Director of Anaesthetics
Albury Wodonga Health

NEWS

THANKS TO GENEROUS DONORS

Thanks to the generosity of NSC 2019 delegates we have been able to support a variety of charities including Lifebox, Street Level Hostel (Salvation Army), Orange Sky Australia and the Indigenous Marathon Foundation. We look forward to CSC 2020 being just as generous so thank you in advance.

Suzi Nou, ASA President and Anne Jaumees, NSC 2019 convenor with products that were donated to OrangeSky

Su-May Koh presents Interplast CEO Prue Ingram with a cheque for $10,120 donated to Lifebox

Sheets, blankets and pillows used in workshops were donated to the Street Level Hostel (Salvation Army)

Phil Morrissey, ASA ACT State Chair, presents Rob de Castella with a cheque for $500 for the Indigenous Marathon Foundation

REAL WORLD ANAESTHESIA COURSE (RWAC)

23–27 November 2020

Christchurch Hospital, Christchurch, New Zealand

This is the 29th Australasian course and the fourth to be held in New Zealand.

The aim of RWAC is to prepare anaesthetists for work in low- and middle-income countries ('the real world') in a variety of humanitarian aid situations.

The course consists of a series of interactive lectures, case-based discussions, practical equipment sessions and in-theatre teaching of drawover anaesthesia. A simulation session is also planned.

Some topics include:

- Drawover equipment
- Oxygen supplies
- Ketamine and halothane
- Equipment maintenance
- Obstetric and paediatric dilemmas
- Psychological adaptation
- Ethical dilemmas
- Tropical medicine

The number of participants is limited to 18 to maximise interaction and hands-on learning. To participate in theatre teaching sessions, you will need to be registered or eligible for registration in New Zealand.

The course cost is NZ$3,500 (including GST) and is payable if your application is successful.

For further information please contact:

Dr Wayne Morriss
RWAC Convenor
w.morriss@xtra.co.nz

ONLINE APPLICATIONS

Applications will open at approximately 10am AEST (12pm New Zealand time) on **Wednesday 1 April 2020**.

Please complete and submit the online form on the ASA website.

The course has regularly been oversubscribed in the past, so places will be allocated on a 'first in, first on' basis. Successful applicants will be notified as soon as possible and given instructions on how to pay the course registration fee.

ASA
Australian Society of Anaesthetists

NEWS

REAL WORLD ANAESTHESIA COURSE 2019

In October 2019, I attended the five-day Real World Anaesthesia Course (RWAC) held in Frankston, Victoria. Without question, this is the most rewarding course I've been on in my 34 years of anaesthetic practice!

Every year, around 20 anaesthetists have the opportunity to learn about teaching and practising their specialty in low to middle income countries (LMICs), as well as practising in areas hit by natural disasters and conflict. In reality, medical work in LMICs can be constrained by limited resources, training deficiencies, cultural misunderstandings and unanticipated barriers to safe practice, such as inadequate electrical safety and personal illness through to malfunctioning essential equipment with no access to replacement parts. The course rotates among three centres – Frankston, Christchurch and Darwin – overseen by three dedicated individuals, respectively Chris Bowden, Wayne Morriss and Phil Blum.

The collective medical and life experiences of the presenters provide a depth and breadth of understanding of many issues. Each member of the faculty brings a unique perspective to the course, but they share certain things in common. They are knowledgeable, humorous, humble, approachable and inspiring (real people practising real anaesthesia, alongside real people providing real equipment expertise). Some of the issues addressed on the program include different anaesthetic techniques (use of draw-over vaporisers and ketamine), tropical medicine, psychological preparedness, our sense of perspective and expectations, and cultural sensitivities. And things I had never considered, like what to pack!

This is an extremely well-organised course. Behind the scenes, anaesthetic department staff ensured that everything ran like a well-oiled machine. It all flowed seamlessly – theatre sessions, meals, lectures and of course, the social functions showcasing this beautiful part of the country. Additionally, operating theatre staff and Frankston Hospital administrative staff were very supportive, facilitating our practical experiences in the theatres.

The timetabled reflective sessions were a particular highlight for me. A number of faculty members spoke of their personal experiences, with fascinating insights from the interesting to the challenging to the confronting. First impressions of people rarely give you a true measure of their qualities.

If you think that working in low to middle income countries could be a part of your career journey, please consider applying for this course. Search for RWAC on the ASA website. The opportunities are myriad: from Pacific island locums through to contracts with such disparate groups as MSF, Interplast, other private service groups and seemingly innumerable NGOs providing surgical services. The secret to making a success of this type of work is good preparation and extensive networking.

I know that the three course co-ordinators and all the faculty members are very proud of this course and justifiably so. I am so grateful to have had the opportunity to be a part of it. And the cream on the cake for me personally? I have now acquired a couple of handfuls of new role models to inspire my continuing journey through medicine, and through life.

Dennis Wooller FANZCA

NEWS

ENHANCED RECOVERY AFTER ARTHROPLASTY: A TEAM EFFORT

This article will outline the collaborative approach undertaken between anaesthetic and orthopaedic specialists at Vermont Private Hospital in Victoria to facilitate the successful undertaking of a trial program of enhanced recovery after total joint arthroplasty. The rationale of this approach is that short-stay or outpatient arthroplasty is an emerging model of care that should not be a goal in itself, but rather be the result of specialised multidisciplinary coordination implementing a holistic program that can optimise patient recovery. For enhanced recovery to be achieved in this model, an investment in time and resources is required by healthcare providers to deliver and support a unique skillset and willingness to collaborate closely with relevant team members involved.

Total hip and knee arthroplasty are common orthopaedic procedures, which are continuing to increase in frequency in the setting of rising rates of obesity and osteoarthritis, and an aging Australian population which desires to maintain their functionality.[1,2] Arthroplasty procedures have typically been associated with an average hospital length of stay of 5.4 +/- 1 day duration after which 43% of patients proceed to ongoing inpatient rehabilitation.[3]

Several overseas countries have well-established fast track arthroplasty programs in which patients undergoing elective hip and knee replacements remain in hospital for 1-2 days, and in some instances less than 24 hours, with the bulk of the recovery process occurring in the outpatient setting.[4,5,6] Until recently this approach has not been commonly practiced in Australia due to factors that include lack of familiarity with the process by healthcare providers, particularly in regards to patient safety and outcomes, private health insurance reimbursement criteria, competing interests of specialists and a lack of coordinated processes between the hospital and specialists. To challenge these problems and overcome the barriers to implementation there needs to be a supportive healthcare provider environment, a well-coordinated and specialised multidisciplinary team in place and private health insurance involvement.

When patient care interventions operate in isolation it is unlikely to lead to beneficial healthcare value or improved outcomes for patients. Enhanced recovery protocols are bundled interventions of integrated multidisciplinary care that allows patients to benefit from a variety of evidence-based care targeted at a shared objective – global modulation of the surgical stress response and early mobilisation of the joint to facilitate improved range of movement and patient outcomes.[7] Meta-analyses indicate that patients have the potential to benefit significantly from enhanced recovery after arthroplasty programs.[8] In addition to the psychological benefit and satisfaction of recovering in the home rather than the hospital setting, patients have been shown to experience reduced mortality, reduced morbidity in the form of thromboembolic events, cardiopulmonary complications, delirium and sleep disturbance, and better analgesia with less pain and joint stiffness, all without increasing the risk of readmission or adverse events.[9-13]

The ERAS® Society suggests that there are many components of care that go into the implementation of 'enhanced recovery programs' and as a result the development of our rapid recovery after elective hip and knee arthroplasty trial pathway at Vermont Private Hospital is a multidisciplinary endeavour involving the orthopaedic surgeon, anaesthetist, orthopaedic nurse practitioner, physician, physiotherapists and nursing staff. The anaesthetist has a vital role to play in every stage, from pre-admission to well after discharge, to ensure that patients are able to progress smoothly through this 'novel' model of care and thus facilitate a significant opportunity for patient-centric gains. Whilst an in-depth discussion of every component is beyond the scope of this article, the generic framework is divided into the key three phases of the patient journey: pre-operatively, intra-operatively and post-operatively. The highlights of the trial pathway are as follows:

Pre-operatively:

- Patient selection: Patients are assessed for their appropriateness for this model of care based on the combination of results from an anaesthetic pre-assessment including a risk calculation, and an orthopaedic pre-operative survey constructed to predict discharge disposition after total joint arthroplasty known as RAPT.

- Medical optimisation: This comprehensive screening allows for early physician intervention to address modifiable risk factors and also allows post-operative planning for management of medical co-morbidities in an outpatient setting.
- Patient education: All patients are encouraged to attend a 'joint school' run by an orthopaedic nurse practitioner, where they are taught what to expect at each stage, given advice about the surgical and anaesthetic plan (type of anaesthesia, fasting/diet/aperients and the analgesia plan from PACU to post-discharge), and are provided with hands-on instruction about physiotherapy and post-operative mobilisation. The key aim is active participation of the patient in their own recovery and setting of appropriate expectations.
- Pre-operative fasting/carbohydrate loading: There is limited data in regards to metabolic state and recovery after joint arthroplasty, but given the evidence in other surgery our aim is for well-hydrated patients in a 'fed' state.[14]

Intra-operatively:
The orthopaedic surgeon needs to collaborate closely with the anaesthetist to facilitate a plan that will modulate the surgical stress response and allow early mobilisation. This cooperation is a critical component of enhanced recovery after surgery pathways.

- Anaesthetic technique: In our protocol we prefer a 'low dose' (5-7.5mg bupivacaine) neuraxial technique. Evidence indicates that this provides the optimal attenuation of the surgical stress response and acts as a bridge to early post-operative analgesia, significantly reducing the risk of moderate-to-severe postoperative pain, 15 whilst still allowing resolution of the motor block and ambulation within ≤300 minutes in 95% of patients. This rapid improvement facilitates physiotherapy intervention from PACU onwards, with improved mobility and rehabilitation.[16,17] There is also evidence that it may even reduce in-hospital complications and 30-day mortality.[18,19]
- Anaesthetic adjuncts: There are a number of controversial areas that require further research to clearly elucidate the best outcome for arthroplasty patients, and our pathway will evolve with the results from continued research. Based on currently available evidence we use the following adjuncts: maintaining normothermia,[20,21] prevention of hypertensive anaesthesia with the use of neuraxial anaesthesia, blood conservation strategies with the use of tranexamic acid and cell salvage,[22,23] TIVA and opioid minimisation for sedation/GA,[24] goal-directed fluid therapy with early return of oral intake,[25] weight adjusted cephazolin as anti-microbial prophylaxis to target adequate joint concentration,[26,27] pre-operative pregabalin to reduce opioid consumption and neuropathic pain,[28,29] and peri-operative systemic steroid.[30]
- Surgical interventions: Minimally invasive surgical techniques such as anterior approach hip replacement are usually required to facilitate early discharge. In knee replacement surgery, minimising tourniquet time and using a kinematic alignment protocol to reduce soft tissue trauma may assist in rapid recovery.

Post-operatively:

- Opioid-sparing multimodal analgesia: Paracetamol and NSAID's are the backbone of the analgesia regimen. With respect to advanced analgesic modalities, intrathecal opiates +/- PCEA, peripheral nerve block and peri-articular injection all appear reasonable options. The challenge is that there are few studies which directly compare these modalities, although a recent meta-analysis by Xing et al has demonstrated that there is a synergistic effect between LIA and ACB which resulted in a statistically significant improvement in analgesia and lowered opioid consumption when these two modes of anaesthesia were used in combination rather than individually.[31,32] As such, this is the approach we have implemented within our protocol. Continuous peripheral nerve block

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provides the same efficacy of analgesia as PCEA,[33] allowing reduced subsequent opioid consumption, but with decrease in nausea and vomiting, improvement in mobilisation, reduction in the ongoing surgical stress response and potentially a reduction in morbidity and mortality. With appropriate pre-operative education and follow-up patients can be discharged home with their CPNB in-situ, with no evidence of increased risk of falls,[34,35] thus allowing the same analgesia they would receive within the hospital setting.

- Team-effort and follow-up: From admission to discharge everyone involved in the patient's care needs to be educated on the components of the pathway. Once patients are settled into their own environment at home it is imperative that they have clear guidelines on how to access extra assistance if required, such that there recovery is enhanced rather than hindered.

In order to change the current approach to enhanced recovery after joint arthroplasty, development of process, practice and communication is required. This includes a multidisciplinary team, of which the anaesthetic practices outlined above are integral component. There must be a holistic and targeted approach that works in a coordinated fashion to support improved outcomes for the patient, and as a result facilitate an early discharge from hospital. Overall the implementation of such an approach aims to challenge the status quo model for elective hip and knee procedures with Australasia, but the early results from the implementation of this collaborative approach between orthopaedic surgeon, anaesthetist, nursing staff, allied health practitioners, hospital and health insurer highlights the potential to facilitate early discharge, with improved patient experience and outcomes, without compromising safety.

Mr Daevyd Rodda
Dr Dwane Jackson

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ABOUT THE AUTHORS

Mr Daevyd Rodda is an orthopaedic surgeon with extensive experience in hip and knee arthroplasty. He has a special interest in rapid recovery surgical techniques, and teaches these techniques to surgeons around Australia and internationally. Mr Rodda established the rapid recovery joint replacement program at Vermont Private Hospital and is a strong advocate of value-based health care in orthopaedic surgery.

Dr Dwane Jackson is a consultant anaesthetist with significant experience in arthroplasty surgery. He is actively involved in research, having published articles in peer-reviewed journals and has several research projects underway. With a special area of interest in holistic perioperative medicine utilising enhanced recovery after surgery techniques he has been a key driver in implementing the latest evidence-based techniques into various specialities at both tertiary public institutions and privately such as this current orthopaedic project.

INSIDE YOUR SOCIETY

ECONOMICS ADVISORY COMMITTEE

DR MARK SINCLAIR
EAC CHAIR

MEDICARE BENEFITS SCHEDULE (MBS) REVIEW

As previously reported, the Anaesthesia Implementation Liaison Group (AILG) will continue to meet during 2020. The first meeting of the year (via teleconference) will have already been held by the time this edition of *Australian Anaesthetist* is published. Members are advised to watch their email inboxes for their regular ASA President's e-news updates, as well as visiting asa.org.au for online updates.

The AILG's role is to "support the effective implementation of changes to anaesthesia MBS items resulting from the MBS Review". This will involve drafting wording for MBS item descriptors and explanatory notes, and developing communication and educational material for the specialty as these changes are put into effect. The AILG will also perform "further review of the anaesthesia schedule".

ILGs are also being formed for other specialties, and will have similar roles. Interestingly, it has been stated that ILGs will not have the power to reconsider or overturn decisions and recommendations that were made by the Government or the MBS Review Taskforce. Clearly however, as a result of the work of the MBS Review working group initiated by the ASA, certain recommendations of the Anaesthesia Clinical Committee (ACC) have not progressed at this stage. To the ASA this means two things:

- The Government has the power to accept, modify or reject MBS Review recommendations.
- The large number of ACC recommendations which have not yet been implemented, due to the intervention of the ASA and the specialty but with which the ASA strongly disagrees, have not been officially rejected by the government. They remain in place for further consideration. The ASA will continue to work to ensure that these ACC proposals, most of which are seriously flawed, are not implemented.

Clearly, the early 2020 meetings of the AILG will be crucial. The ASA will keep members updated, as mentioned above.

Members will recall that item 25015 (modifier for patient age – formerly less than 12 months of age or 70 years or greater) was changed on 1 November 2019. The upper limit was changed from age 70 years to 75 years. The ASA definitely did not support this change. There is clear evidence that each step up in age results in an increase in the risks of anaesthesia and surgery, independent of all other factors. The age of 70 years had always been the accepted age for item 25015, with evidence to support it. Item 25015 was also introduced into the MBS on a cost-neutral basis in 2001 (that is, other new MBS RVG items were set at a lesser value, to compensate for new item 25015). In the view of the ASA, the change to 75 years can only possibly have been motivated by cost savings. There is no evidence that definitely supports 75 years as opposed to 70. The government has certainly achieved significant cost savings, with this change being responsible for over one-third of the eventual amount cut from Medicare anaesthesia expenditure. This calculation takes into account the increase in the lower age range from less than 12 months to less than four years.

Unfortunately, due to an administrative oversight in the new wording of the item, the eventual outcome was that only patients up to 36 months of age currently qualify for 25015. The intention of the Department of Health was always to have it apply until a child reaches the age of four years.

Therefore, for the moment, item 25015 ceases to apply in a child who has reached the age of three years. However, this error has been rectified by the introduction of a temporary age modifier item (25012) which will apply to children aged between their third and fourth birthdays. The item has been backdated to 1st November. Members should be aware that any previously rejected claims for three-year-old children (using item 25015) from the 1st November, can now be re-submitted using the new item 25012.

The AILG will work on a correction to this issue, but this is unlikely to be included in the MBS until at least May 2020. The likely outcome is two separate items, one for each end of the age ranges.

The AILG consists largely of practising anaesthetists, as well as representatives from other fields. Its members are (in alphabetical order):

- Ms Bridget Carrick
  Director, Dept of Health
- Ms Lucy Cheetham
  Australian Private Hospitals Association
- Dr Matthew Doane
  Academic Anaesthetist – Independent
- Dr Simon Fraser
  Private Healthcare Australia representative
- Dr Michael Jones
  ANZCA representative
- Ms Helen Maxwell-Wright
  Consumer representative
- Mr James McRae
  Dept of Health
- Dr Andrew Mulcahy
  ASA representative
- Dr Charles Nadin
  College of Rural and Remote Medicine representative (GP anaesthetist)
- Ms Gayle Oldham
  Deputy Director, Dept of Health
- Prof David A. Scott
  Academic Anaesthetist – independent, Past President ANZCA
- Dr Mark Sinclair
  AMA representative
- Dr Andrew Singer
  Medical Advisor, Dept of Health

OTHER

Not surprisingly, the large number of changes to the MBS RVG has resulted in many queries being received from ASA members. Excluding the changes to the time items, there are five new items, 16 amendments, and 12 deletions.

The ASA website has details of the changes (member logon required) at: https://asa.org.au/mbs-review-package-for-november-1-change/

There are also useful documents for patients on this page ('Why the Gap?' and 'November 1 Changes – for Patients'). These and a number of other useful documents can also be found by clicking on the link to the MBS review, on the home page of the website.

The ASA members' forum (https://asa.org.au/asa-forum, or follow the link at the top of the home page – 'Educate/Forum') also provides useful information and all ASA members are welcome to post questions or comments here.

The 21st edition of the RVG booklet should have been received by members by the time this edition of *Australian Anaesthetist* is published. Electronic versions are available by following the link on the home page of the website ('Educate/Relative Value Guide'). Members are reminded that they are entitled to a second hard copy of the booklet free of charge if they require it – please contact the ASA to organise this.

IMPORTANT INFORMATION

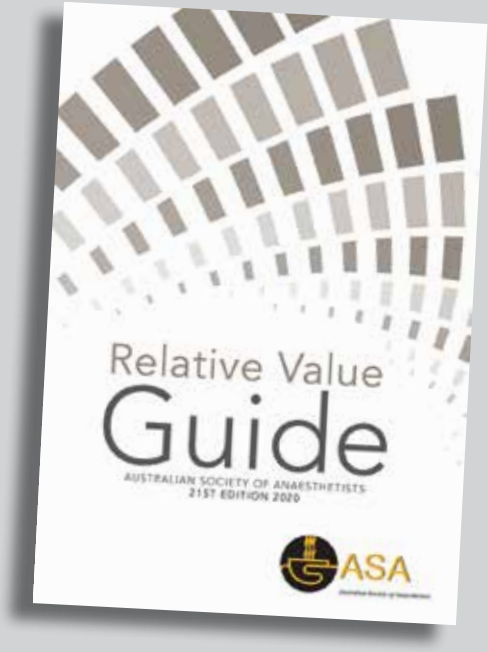
Members should have received their copy of the RVG 2020.

Please note that there is an error on page 79 of the book: Item CV084/22042 – the 1 should be under Units and not under MBS Fee or Units (if different).

We apologise for any inconvenience caused.

Therapeutic and diagnostic services (cont.)

ASA Item No.	Units	Description	MBS Item No.	MBS Fee or Units (if different)
CV083	5	MAJOR PERIPHERAL NERVE BLOCK, performed perioperatively, with the introduction of a catheter to allow continuous nerve blockade, to provide postoperative pain relief (not to be used in conjunction with items CV081 or CV082, or any item in the range CV200 to CV330)*		
CV084	**1**	Introduction of a nerve block performed via retrobulbar, peribulbar or sub-Tenon's approach, or other complex eye block, when administered by an anaesthetist perioperatively	**22042**	



INSIDE YOUR SOCIETY

PROFESSIONAL ISSUES ADVISORY COMMITTEE

DR ANTONIO GROSSI
PIAC CHAIR

It is with profound sadness that I write this PIAC update when reflecting on the immense loss that so many Australians have experienced, associated with the bushfire tragedies across the country. The courage, resilience and strength demonstrated by the affected communities, firefighters and many others should be an inspiration to us all.

Meanwhile, PIAC continues to support, educate and represent the membership.

INDUSTRIAL ISSUES

There has been significant discontent relating to out-of-hours rostering for anaesthesia services. Following last year's sudden unilateral communication by Ramsay that conditions and remuneration for anaesthesia obstetric services would be significantly reduced, PIAC received a flurry of member enquiries. After many discussions and teleconferences, PIAC was able to meet with senior chief operational officers in January this year. Ramsay representatives acknowledged that this was a senior central decision based on fiscal pressures and perhaps in retrospect should have been communicated and handled differently overall. PIAC highlighted the quality and safety issues relating to the provision of out-of-hours and emergency anaesthesia services and in particular how these relate to anaesthesia obstetric services. The impact on being able to work the following day, the impact of fatigue, the requirement to be close to the hospital to respond to true obstetric emergencies were discussed. A patient-focused approach requires timely access to experienced, quality anaesthesia services that may best be provided by a team of engaged local anaesthetists that work harmoniously with the local midwives, obstetricians and paediatricians. It is vital that communication with these groups is improved to develop local solutions to local challenges. There are regional differences even across one city that need to be taken into account. Having a single central formula imposed across all sites is unlikely to engage local anaesthetists or be successful. The potential patient harm and subsequent reputational damage arising from a poorly subscribed roster was discussed. It is now up to individual anaesthetists at a local level to continue these discussions with their administrations and other stakeholders to arrive at solutions that are mutually acceptable to provide the optimum patient care.

WORKFORCE ISSUES

Industrial issues do not arise in isolation. The oversupply of metropolitan anaesthetists has altered the traditional dynamics existing between referrers, hospitals, third party payers and other stakeholders, initiating and compounding workforce issues. An oversupply in the metropolitan areas will not fix the maldistribution of anaesthesia services in rural and remote regions. These require specific issues to be considered including professional and personal isolation, continuing scope of practice and professional development, annual leave, and opportunities for partners and other family members. The emergency medicine specialists and cardiothoracic surgeons are now in significant oversupply, and the anaesthesia specialty appears to the ASA to be heading in a similar direction. There needs to be a dynamic link between the service provision provided by trainees in public state hospitals, the benefits enjoyed by other stakeholders involved in training and a view to providing a sustainable anaesthesia workforce that meets the community's needs. Having highly trained chronically underemployed medical specialists does not make sense.

SAFESCRIPT AND THE OPIOID CRISIS

This was a Victorian issue discussed in the previous *Australian Anaesthetist* with the potential to be rolled out across the country. For the moment, anaesthetists prescribing discharge opioids and benzodiazepines will not be required to do a SafeScript check. The IT infrastructure currently is not robust enough to permit this without a significant impact on workflow and safety. As anaesthetists working in the perioperative setting, we have a unique opportunity and responsibility to minimise opioid

use and prescribing. In 'Opioid harm reduction strategies – stemming the tide', *Australasian Anaesthesia* 2019 , Michael H. Toon describes upstream, midstream and downstream initiatives.

PIAC has also been informed of a number of abnormal liver function test results in patients prescribed regular paracetamol and increases in significant renal dysfunction requiring interventions in some patients receiving non-steroidal anti-inflammatory drugs. A 'one-size-fits-all' approach is clearly inadequate and individual patient circumstances need to be considered in formulating an analgesia management plan.

SUBMISSIONS

The ASA has submitted a response to the Australian Government opposing the proposed Religious Discrimination Bill and to the Medical Board of Australia regarding 'Regulation Standard: Continuing Professional Development'.

PIAC has submitted a response to the Department of Employment, Skills, Small and Family Business arguing for the withholding of visas to overseas trained specialists seeking to practise in capital cities and associated metropolitan areas, on the the grounds that these areas have an oversupply.

SUSTAINABILITY

PIAC welcomes ANZCA's *PS64: Statement on Environmental Sustainability in Anaesthesia and Pain Medicine Practice* and background paper. The ASA has also been discussing ways members' sustainability concerns may be addressed and represented. The 2020 survey will include new questions on sustainability and gender equity. This is an issue that affects us all and considered broadly across the Common Issues Group.

CORONAVIRUS

This pandemic has created special challenges across society including health-care and anaesthesia. There are excellent up to date resources available and members are encouraged to visit the Department of Health website for more details.

FEDERAL BUDGET

The ASA will continue to lobby in 2020 for appropriate indexation of the MBS.

INFORMED FINANCIAL CONSENT

There have been many enquiries relating to IFC which substantially come down to communication issues. The ASA provides many resources and educational opportunities in this space. Please make use of them.

PRIVATE HEALTH INSURANCE INDUSTRY

There continues to be a push from the PHI towards a more managed care style approach which controls expenditure and optimises profits for PHI shareholders. Examples include increased exclusions and co-payments for patients, proposed bundled payments and pressure to enter into no-gap arrangements. Autonomy of practice to provide the highest quality of care for our patients requires ongoing vigilance at every level.

FAREWELL

This will be my last submission to *Australian Anaesthetist* as PIAC Chair as I am stepping down from this position and the ASA Board. I wish Dr Peter Waterhouse, the incoming Chair, the very best and I am confident he will lead the committee well in the years to come. It has been a privilege to serve the ASA membership. I invite all members to become involved wherever and however they can to advance the specialty. I would like to thank the federal secretariat Jacintha Victor-John, Patrick Gifford, Sue Donovan and Mark Carmichael for their support. A special thanks to Dr Jim Bradley who has always provided me with sound counsel during my chairmanship.

OPPORTUNITY TO DONATE

The ASA encourages donations to the Harry Daly Museum and Richard Bailey Library, the Benevolent Fund or Lifebox charity.

HARRY DALY MUSEUM AND RICHARD BAILEY LIBRARY: The ASA is pleased announce that both the Harry Daly Museum (HDM) and the Richard Bailey Library (RBL) have been granted deductible gift recipient status by the Australian Taxation Office (ATO). By receiving this endorsement from the ATO it means that any cash donations to the HDM and RBL are now tax deductible.

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

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

To make a tax deductible monetary donation or find out more please visit https://asa.org.au/donations/

INSIDE YOUR SOCIETY

POLICY UPDATE

ALLEGATIONS OF MISDIAGNOSIS OR MISCONDUCT? THE PROPER INVESTIGATION PROCESS

Anaesthesia is a high-risk speciality, and the general public is often not aware of the risks involved. With the advent of safer drugs, good quality equipment and high standards of monitoring, the practice of anaesthesia has become safe but despite this, complications can occur.

Due to commercialisation of modern medical practice and limited interactions, there can sometimes be a lack of mutual trust in the doctor-patient relationship. So, whenever an adverse event takes place, patient and attendants can suspect negligence on the part of the doctor and such cases are often taken to court.

Anaesthesia is a great achievement in modern society; however, it does carry some risks. Trained medical professionals must administer anaesthesia with precision, care and skill. Anaesthetists are specialists trained to work with surgeons to monitor the patient throughout surgery. Even with modern technology, anaesthesia administration can be dangerous. Anaesthesia errors, for example, using the wrong dosage or the wrong type of anaesthesia during a procedure, can have tragic consequences for the patients and their families.

MISDIAGNOSIS OF ANAESTHESIA ADMINISTRATION

A large number of medical negligence cases involve misdiagnosis or delayed diagnosis. Misdiagnosing a patient or delayed diagnosis of a serious illness can have damaging effects on a patient. Failing to diagnose a patient correctly can hinder them from receiving effective treatment early on.

Improper administration of anaesthetic drugs, inadequate monitoring, improperly positioned patients, or failure to adjust the anaesthesia levels are examples of anaesthesia malpractice that can cause irreparable brain damage and other injuries.

Not all mistakes in the administration of anaesthesia are the result of medical negligence. To prove that negligence has occurred there has to be evidence that shows firstly that the error caused harm or injury and it must be agreed that a similarly trained professional would not have made the same error.

Errors made involving anaesthesia administration are amongst the most serious medical negligence cases. Mistakes made by anaesthetists can result in permanent brain damage or death. Common examples of medical negligence committed by anaesthetists include failure to take into account a patient's medical history, insufficient delivery of information regarding risks, using faulty equipment or administering too much anaesthesia to a patient. If you or someone you know has been accused of medical negligence involving anaesthesia, it is important to consult with a legal professional immediately.

Not all mistakes in the administration of anaesthesia are the result of medical negligence. To prove that negligence has occurred there has to be evidence that shows firstly that the error caused harm or injury and it must be agreed that a similarly trained professional would not have made the same error.

MISCONDUCT

Misconduct or serious misconduct in the workplace includes theft, fraud, dishonesty, offensive behaviour, breaching health and safety rules, damaging property and attending work while under the influence of alcohol or illicit drugs.

No matter how serious an employee's conduct may appear, employers need to be mindful of the steps they should consider taking to avoid facing an unfair dismissal claim, general protections claim, discrimination/equal opportunity claim, breach of contract claim or workers' compensation claim. These steps will often be set out in the employee's contract or the policies, procedures and Enterprise Agreement covering the terms and conditions of their employment.

Even in the face of misconduct or misdiagnosis an employee is entitled to procedural fairness in accordance with the principle of natural justice.

Steps to follow:

1. Appropriate Investigation

Firstly, the employer should conduct a proper investigation into the allegations of misconduct or serious misconduct. It

is preferable for the investigation to be conducted by a qualified and independent investigator who can consider all of the available evidence and form an impartial view before making findings as to whether or not the misconduct or serious misconduct is substantiated.

During the investigation process, the employee should be permitted to bring a support person to any interviews or meetings and the employer should also offer them access to an employee assistance program or other support program for counselling if necessary. It is also acceptable for the employee to be suspended from attending work (at their usual rate of payment) during the investigation process.

2. Opportunity to Respond

Regardless of how much evidence the employer has before them substantiating the employee's misconduct or serious misconduct, the employee should be given a reasonable opportunity to respond to that evidence and the allegations against them.

The employee should firstly be invited to respond to the evidence and the allegations against them during the initial interview or meeting and within a reasonable period of time after the initial interview or meeting (for example, seven days after the interview or meeting). This also allows the employee time to obtain representation if necessary.

During the investigation process, the employee should be permitted to bring a support person to any interviews or meetings and the employer should also offer them access to an employee assistance program.

A court is likely to criticise an employer who does not provide their employee with a reasonable opportunity to respond to the evidence and allegations against them either verbally or in written submissions.

3. Consideration of Response

The employer needs to carefully consider the employee's verbal or written response to the evidence and allegations of misconduct or serious misconduct. Again, it is preferable to appoint a qualified and independent investigator to consider the response in order to form an impartial view as to whether the findings of misconduct or serious misconduct can be maintained notwithstanding the employee's response.

4. Show Cause

Once the employer is satisfied that the findings of misconduct or serious misconduct can be maintained, a 'show cause' letter should be issued to the employee. The purpose of the 'show cause' letter is to set out the findings of misconduct or serious conduct and ask the employee to 'show cause' (i.e. explain) why

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he or she should not be subjected to any disciplinary action.

TERMINATION AND NEXT STEPS

If steps 1-4 outlined above have been followed, an employer should be able to satisfy the requirement that the termination of an employee's contract is not 'harsh, unjust or unreasonable'. This is the standard required at law.

In a recent decision of the Fair Work Commission, it was determined that an employee (a hospital security guard) had breached the employer's protocol due to his treatment of an absconding mentally ill patient. The Commission also determined that the employee's misconduct was a valid reason for his termination. The pressing issue however was that the employer had not followed the disciplinary process set out in the employee's Enterprise Agreement and therefore the termination was found to be disproportionate to the misconduct and 'harsh and unreasonable' under the circumstances.

Within a medical practice setting, if the employee is a patient of the practice, terminating the therapeutic relationship between the practice and an employee terminated for misconduct or serious misconduct may also be necessary, particularly in the event that the employee commences legal proceedings against the practice flowing from their dismissal.

PROFESSIONAL ADVICE

If you are in a situation of alleged misconduct or involved in a misdiagnosis of anaesthesia administration, proceed with caution and contact your Medical Defence Organisation (MDO) for further advice in the first instance.

This article is provided for ASA members general knowledge only and is not a substitute for independent legal advice.

Jacintha Victor John
Policy Manager

References

1. *Hobson v Northern Sydney Local Health District* [2017] NSWSC 589.
2. *Dobler v Halverson* (2007) 70 NSWLR 151; [2007] NSWCA 335.
3. *Paul v Cooke* [2013] NSWCA 311.
4. *Scott v Latrobe Regional Hospital* [2019] FWC 5680.
5. *Sydney South West Area Health Service v MD* (2009) 260 ALR 702; [2009] NSWCA 343.

CONTACT US

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

Email: policy@asa.org.au

Phone: 1800 806 654.

ANAESTHETIC TROLLEY MINIMUM STANDARDS PROJECT

Please participate!

The Professional Issues Advisory Committee (PIAC) have been working on the ASA Anaesthesia Trolley Minimum Standards Project. The Committee has finalised a draft document on the recommended minimum standards for anaesthetic trolleys in hospitals across Australia.

The purpose of this document is to provide guidelines for the best layout of anaesthetic trolleys so that visiting medical officers (VMOs) working between multiple hospitals can adapt to their different work environments with ease, and to reduce confusion amongst members of the anaesthetic workforce operating at multiple healthcare facilities. A copy of this draft document is now available on the forum for feedback. We encourage you to take a look and post your opinion in the thread to join the conversation.

RELATIVE VALUE GUIDE 2020 SECURITY

All members will receive a hard copy of the RVG 2020 soon. As we could not secure the Excel version of the RVG from tampering, we have discontinued the RVG spreadsheet to ensure the accuracy of the ASA RVG.

To secure ASA intellectual property and for security reasons we have added a PDF embedded RVG viewer which is available on the ASA website. The RVG viewing portal is located on our Members website available at: https://asa.org.au/relative-value-guide/. We have disabled the ability for the ASA RVG to be printed or downloaded in light of its distribution to non-members.

Please respect that this is a resource developed by members, for members, from your membership fees. If you know of non-members who would like access to the ASA RVG, please encourage them to join the ASA.

We apologise for any inconvenience these changes may have caused. The ASA is committed to protecting the resources developed by its members, for its members, with their membership fees, and will seek to ensure the validity and integrity of those resources as its top priority.

We thank you for understanding.

Please contact the policy team at policy@asa.org.au for more information.

ASA MEMBER'S GROUPS UPDATE

TRAINEE WELLBEING

As we transition to a new registrar year, many of you will be moving into a new phase of your training, a new hospital, often a new city. This time of year is exciting and new, but often fraught with added dimensions of stress, in a training program which is by the nature of the job already a high-stress career. Add to that the horrendous bushfire season and natural disasters Australia has been experiencing, and it's highly likely that you or someone you know may be experiencing poorer than usual mental health. Look out for each other, be kind to each other, and if you need help, know that there are many options out there available to you. Have a look at the wellbeing section of the new trainee handbook for a range of excellent resources.

TRAINEE HANDBOOK

I'm excited to announce the ASA Trainee Members Handbook 2020 Edition! The aim of the handbook is to provide vital information for trainees at all stages of training. We know first-hand how stressful and overwhelming training can be, and we want to do everything we can to help our fellow Australian anaesthetic registrars and empower them to maximise the opportunities available during training.

Whilst some of you may already have access to much of this information, the secondary goal of this handbook is to level the playing field and information exchange between trainees at large, metropolitan hospitals and those who may be relatively isolated, such as those in rural areas, small departments, independent trainees and international medical graduates. Like our parent organisation, the ASA Trainee Member Group exists to Support, Represent, and Educate Australian anaesthetists and anaesthetic trainees – in other words, we're on your side!

I'd like to express my gratitude to everyone who contributed their time and expertise to pull such a great resource together, and a particular thank you to immediate past chair of the ASA TMG Dr Richard Seglenieks for his excellent work as editor.

The trainee handbook can be downloaded from the ASA website: https://asa.org.au/trainee-membership-benefits/

CIG SCHOLARSHIPS

Don't forget to apply for our Common Interest Group Scholarships. We offer one each for the Canadian Anesthesiologists' Society, the Association of Anaesthetists Trainee Conference in the UK, and the American Society of Anesthesiologists Conference. They include free conference registration, plus $4,000 towards flights, accommodation and other expenses, plus excellent networking opportunities with the local trainee group. Applications close soon after this magazine is published, on 9th March so don't miss out on a great opportunity.

RVG PROBLEM-BASED LEARNING

The Relative Value Guide provides comprehensive and accurate advice on billing and assists with deciphering Medicare and private insurance rebate systems. As ASA Members, Advanced Trainees receive access to the RVG. Members of the TMG have been working on ways to educate our trainee members on how to use this resource, and how to bill. Billing is a source of stress to many new fellows working in private practice, and something we hope to help with. The RVG 2020 is available to download from the ASA website, you can also head to the app store and download your copy of the RVG App!

COMBINED SCIENTIFIC CONGRESS (ASA AND NZSA)

The Combined Scientific Congress of the NZSA and ASA fast approaches! It's being held in Wellington, NZ from 16 to 19 October and looks like it'll be a great event. Registration opens in late March 2020 so get your leave requests in now! If you've got a research project or audit on

ASA TRAINEE MEMBERS APPLY FOR OUR 2020

INTERNATIONAL SCHOLARSHIPS

$4K*

Canadian Anesthesiologists' Society

HALIFAX, NOVA SCOTIA, CANADA

19-22 June 2020

Association of Anaesthetists

NEWCASTLE, UK

8-10 July 2020

American Society of Anesthesiologists

WASHINGTON DC

3-7 October 2020

APPLICATIONS CLOSE MONDAY 9 MARCH 2020

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

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

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

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

ASA
Australian Society of Anaesthetists

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the go, think about submitting it to the CSC – there are some great trainee prizes available.

ASA members are entitled to claim one complimentary NSC/CSC registration during their Advanced Provisional Fellow Training or in their first year as an Ordinary Member, provided they have been a financial APFT member for two years. For further information contact the ASA.

PMET TRAINEE MEMBERSHIP

The ASA is pleased to announce that junior doctors with an interest in anaesthesia can now join the ASA as Prevocational Medical Education and Training (PMET) members, without having applied to ANZCA. This membership category is complimentary, so if you have any prevocational colleagues who may be interested, suggest they apply here: https://asa.org.au/asa-membership-benefits/how-to-join/

I'd like to close by thanking you all for welcoming me as your new ASA TMG Chair for 2020, and to thank immediate past chair Dr Richard Seglenieks for his exceptional leadership over the past two years. We have an exciting year ahead!

Dr Emily Munday
Chair, ASA Trainee Members Committee

RETIRED MEMBERS' GROUP

SOUTH AUSTRALIA/ NORTHERN TERRITORY

Our RAG group meets for lunch on the second Monday of every odd month at the Kensington Hotel, where we have our own private dining room, and at most meetings, a guest speaker. Our membership, comprised of colleagues from anaesthesia, intensive care and pain medicine, now numbers more than 86. Some 20-30 colleagues plus partners/ guests regularly attend our meetings.

Last September, Dr Fred Gilligan AM, presented his lecture on 'The Evolution and Development of Intensive Care in South Australia', which he first presented at the ASA NSC in October 2018. The lecture included details of the anaesthetists and others who were involved in treating tetanus patients with curarisation and IPPV in the 1950s, which led to the institution of Fred and other anaesthetists establishing the ICU at the Royal Adelaide and other hospitals. Also, Fred was the initiator of the SA Critical Care and Medical Retrieval Service, the first to be established in Australia, and along with Dr John Williamson, now in Melbourne, the Hyperbaric Medicine Unit.

In November, our guest speaker was Professor Bill Runciman. Bill emigrated from South Africa in 1973 and completed his training in both Anaesthesia and Intensive Care here in Adelaide. In 1988 he was appointed head of Anaesthesia and Intensive Care at the Royal Adelaide Hospital and Professor at the University of Adelaide. He was founder of the Australian Patient Safety Foundation, and he has been a major contributor to the ongoing development of our specialities both locally and internationally. He retired in 2007 but continues his work on patient safety and welfare research as Professor at the University of South Australia.

Bill enlightened us with his presentation: 'Minimalist Flying and Basic Anaesthesia – getting it right in remote areas', a fascinating insight to his career and his experiences as a pilot of micro-light and gyroplanes. Recently he completed a flight around Australia.

Professor Don Moyes, also an immigrant from South Africa conveyed our thanks to Bill, and along with Dr David Fenwick, yet another such immigrant in the 1970s, gave us some insight into why they, Bill and so many other colleagues left that apartheid-torn country in those days.

Dr David Clayton, a consultant anaesthetist at The Queen Elizabeth Hospital and Dr Peter Lillie, director of anaesthesia at the Flinders Medical Centre, were welcomed as guests, both having been involved with Bill Runciman over the past 20 years.

After some six years as SA-NT RAG Convenor, I am handing over the chair to my good friend Dr Margie Cowling, a retired Flinders consultant anaesthetist, whom I hope will enjoy the fellowship and friendship of our RAG here in Adelaide as much as I have. To all who have helped me since 2013, I extend my sincere thanks.

Any retired or semi-retired colleagues in SA who have not joined our RAG are most welcome to do so, and any visiting colleagues from other states are most welcome to join us on the second Monday of each odd month. Guests/spouses/ partners are also welcome.

For further information contact Margie at: mcowling@senet.com.au.

Dr John A. Crowhurst
(Former) Chair,
SA Retired Anaesthetists' Group

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AROUND AUSTRALIA

NEW SOUTH WALES

Lan-Hoa Le, Chair

I'm pleased to introduce myself as the new Chair of the NSW ASA Committee. Our immediate past-Chair, Dr Ammar Beck, has been a fantastic mentor and it has certainly been a busy start to 2020.

The ASA has been active in representing our NSW members who have been affected by the obstetrics on-call remuneration issue. Delegates of the ASA led by Dr Antonio Grossi, Professional Issues Advisory Committee (PIAC) Chair, met with Ramsay Healthcare Senior Executives led by Ramsay's Chief Operating Officer Ms Kate Munnings (COO); those present offered an official apology for Ramsay's lack of correspondence and engagement with the ASA and its members. They expressed keen interest to work closely with the ASA going forward and to address a number of issues raised at the meeting. We hope to update members soon.

The NSW Committee of Management comprises enthusiastic, hard-working and friendly members who generously volunteer their time to support our state colleagues (along with the assistance of ASA staff). If you are interested in joining the Committee, we're looking for representatives in this new year, particularly in regards to welfare/wellbeing and environmental sustainability. Please contact Molly Jinta if you are interested on mjinta@asa.org.au

Planning is well underway for exciting new education and networking events this year. A busy weekend coming up on the Central Coast will include on Saturday 21 March 'Planning For Your Retirement' with an optional wellbeing and mindfulness class, and on Sunday 22 March 'ASA NSW 2020 & Beyond' – a fun fair, networking

NEW SOUTH WALES COMMITTEE

Dr Lan-Hoa Le

Lan-Hoa Le's parents left Vietnam as refugees in 1978, and she spent her childhood and schooling in Canberra.

Dr Le received her medical degree from the University of New South Wales. She later trained at the Prince of Wales Hospital and the Sydney Children's Hospital. Since obtaining her FANZCA in 2005, she has worked as a VMO anaesthetist in the Central Coast. She practices in both public and private sectors, primarily with interests around paediatric, general and bariatric surgery.

Core aims of her work are safety and quality, seeking to uphold anaesthetist well-being and welfare to increase patient safety. This is pursued through involvement in the Gosford Hospital Medical Staff Council, Gosford Private Hospital Perioperative Management Committee and the Patient Care Review Committee as chairperson. This work is continued through the Society's NSW Management Committee and Public Practice Advisory Committee. She also holds 'Leadership, Well-being and Mindful Practice' workshops at international congresses, local community events and high-schools.

It has also been her humble privilege to contribute to humanitarian overseas projects in Vietnam, the Pacific Islands and Interplast.

Her commitment to education involves forums such as Part 1 Boot Camps for trainees to an approaching retirement workshop. Through these and future events, Dr Le hopes to return some of the advice and support that first motivated her to join the ASA and its committees.

In their free time, Lan-Hoa and her family meditate, beach and bush walk at the beautiful Central Coast where they live. Dr Le also enjoys spending time with friends over 'high-tea'.

event with education booths and exam classes for trainees. Check the ASA website for more information.

On 4 April, the ASA Public Practice Advisory Committee (PPAC) will host the inaugural Directors of Departments Development Day (4D) in Sydney. It is designed for Directors (and Deputy Directors) of anaesthetic departments to come together and hone their skills as leaders, learn the latest developments in anaesthetic practices and build a strong network of professional connections. I look forward to seeing you there.

I'd like to close by sending my sympathy to everyone who has been affected by the recent and ongoing bushfires. I wish the rest of the new decade will bring harmony to your work and personal life.

VICTORIA

Jenny King, Chair

The Victorian Branch has held several successful events over the past few months.

The annual Part 3 Course was held in November 2019, ably lead by Dr Vanida Na Ranong and Dr Mark Suss. It was much appreciated by our more senior trainees, and enlightened them on how to prepare to become a consultant in anaesthesia.

The new year (and new decade) commenced with our Med Viva Bootcamp in January. My thanks go to Dr Deb Leung, Dr Kate Barrett and Dr Jennifer Reilly for all their work, our speakers and our medical student/junior doctor patients. Our second part candidates obtained some exam gems on the day, but I realised, listening to the banter, gave them a welcome release from hitting the books. We wish them every success in their forthcoming exams.

Lastly, on 9 February 2020, our Victorian ASA AGM was held. We had a fantastic night with 55 registrants at The European restaurant. This was my swan song event, and the baton was handed over to Dr Michelle Horne, the new Chair. I wish her every success in her new role and she will be ably assisted by Dr Grace Gunasegaram as her deputy. The highlight of our evening was the presentation by our guest speaker Professor Tilman Ruff AM, Australia's first Nobel Peace Laureate. He spoke on the International Campaign to Abolish Nuclear Weapons (ICAN).

I wish to thank the Federal ASA for their assistance throughout the years, my committee members for their contributions, and my family for their continued support.

L-R: Lucky De Silva, Mark Suss, ASA President Suzi Nou, Rebecca Zhao, Jenny King and Vanida Na Ranong at the Part 3 Course

RENEWING YOUR MEMBERSHIP HAS NEVER BEEN EASIER!

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

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

You would have received your 2020 membership invoice in December. If you have not received yours, please contact the **Membership Services Team** on **1800 806 654** or email **membership@asa.org.au.**

Please see payment options below.

1. PAY BY DIRECT DEBIT

1. www.asa.org.au/direct & download the Authorisation Form
2. Complete & sign the form
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ASA
Australian Society of Anaesthetists

INSIDE YOUR SOCIETY

Med Viva Bootcamp

Medical Viva sessions

Jenny King and Debra Leung

Professor Tilman Ruff spoke on the International Campaign to Abolish Nuclear Weapons at the Victoria AGM

Victoria AGM. L-R: Jenny King, Suzi Nou, Tilman Ruff, Michelle Horne

INSIDE YOUR SOCIETY

HISTORY OF ANAESTHESIA RESEARCH NEWS

2020 VISION!

2020 is gearing up to be a big year for the History of Anaesthesia Research Unit with lots of projects underway and a growing program of events for ASA members. This year we are focusing on bringing you more historical tales from the ASA's historic repository and making all three collections more accessible to members. To do this we are enhancing the existing museum displays, initiating a 'book of the month' program from the library and focusing on bringing you more stories from the archives.

The annual History of Anaesthesia Seminar will be held on Sunday 14 June. We are currently looking for speakers so if you are interested in presenting please contact the HALMA chair Dr Reg Cammack via ASA Committee Secretary, Maxine Wade mwade@asa.org.au

We are also excited for a number of other upcoming museum events, namely History Week when we join other organisations in celebrating this year's theme 'History: What is it good for?' More information on this and other events will be shared throughout the year.

RICHARD BAILEY LIBRARY

The January 'Book of the Month' was Frederic Hewitt's *The Administration of Nitrous Oxide and Oxygen for Dental Operations*. Published in 1897, the Richard Bailey Library has a second edition copy

2020 HISTORY OF ANAESTHESIA SEMINAR

A seminar to celebrate and discuss the history of anaesthesia

Invitation to speakers

If you are interested in presenting at this meeting please contact Reg Cammack: rjcammack@bigpond.com

SUNDAY
14 June 2020
9am – 1pm

HARRY DALY MUSEUM
RICHARD BAILEY LIBRARY
Australian Society of Anaesthetists
Level 7, 121 Walker St, North Sydney

For general enquiries, please contact Museum Curator and Librarian Belinda McMartin on: 02 8556 9708

which was published in 1901. Hewitt's contribution to the development of anaesthesia cannot be understated and in 1911 this saw him become the first anaesthetist to receive a British knighthood. The February feature book was G.A.H. Barton's *Backwaters of Lethe: Some Anaesthetic Notions*, and like Hewitt he wrote at length on the chloroform v ether debate. Barton's book was published in 1920 and was featured as a way of celebrating a century since it first hit the shelves.

For more information on these publications please visit the ASA website: www.asa.org.au. Also keep a close eye on our ASA Museum Facebook page and other digital media to see what book is featured in March and the coming months.

GWEN WILSON ARCHIVES

At the end of 2019 the ASA was lucky enough to host a Master of Museum Studies student from the University of Sydney. As part of their internship, our student catalogued all ASA newsletters from 1935-2007. The level of detail recorded is impeccable and has set the standard for what we hope to achieve with the rest of the archive. Once this is completed the catalogue will be made accessible online for members, just like the museum and library catalogues already are. This is a HUGE project, so is not likely to be completed until 2021 at the earliest.

As the past ASA newsletters have been our focus, we thought it would be a good place to start in sharing some of these stories from the archives. The ASA newsletter eventually evolved into *Australian Anaesthetist* (AA) and, because this is the March edition, we have a throwback to both 1970 and March 2010.

ARCHIVE THROWBACK

Fifty Years ago at the ASA

In the 1960s the production of the ASA newsletter varied year to year, however it was generally published two or three times a year. By 1968 it had fallen into a pattern of being produced in May, August (sometimes July) and December and this pattern remained in place until the mid-1970s when production became haphazard again.

Fifty years ago, in 1970, three editions of the newsletter were produced. The second was published in July and the third in December but what of the first? From cataloguing the collection in the archive and amalgamating the collection with that of the library, we have discovered a missing edition. From the existing pattern we know the first edition was likely published in May (possibly March or April) and from the volume numbers printed on the two later editions in 1970, we know there was a number 1 (the two other

editions in 1970 are numbered 2 and 3 respectively). Where is number 1 then?

According to the 1939 Library Act the ASA is required to provide copies of all publications to the State Library of NSW. This in turn means that the State Library has a complete set of ASA publications, however their newsletter collection only dates back to July 1979.

With this query in mind I ask our ASA members, particularly our long serving members, if perhaps you have an old copy at home? We are very lucky that many dedicated HALMA members have so diligently maintained our existing

DONATIONS WELCOME

The ASA is pleased to announce that both the Harry Daly Museum (HDM) and the Richard Bailey Library (RBL) have been granted deductible gift recipient status by the Australian Taxation Office (ATO). By receiving this endorsement from the ATO it means that any cash donations to the HDM and RBL are now tax deductible.

This also means that if you are donating an object to the HDM or a book to the RBL it may also qualify as a tax-deductible donation. For more information regarding donating an item to the HDM or RBL; or for information regarding making a cash donation please contact the **ASA's Curator, Librarian and Archivist on 02 8556 9708 or email bmcmartin@asa.org.au**

INSIDE YOUR SOCIETY

collection over the years which means we have few gaps in our collection, but if you feel you can assist in completing the archives set please contact me for a list of our missing publications.

So, what did happen in 1970? The ASA AGM was held in Canberra and the NSC was replaced by the Third Asian Australasian Congress in Anaesthesiology. The ASA's President was Dr Malcolm Newland of South Australia and he presented the closing speech to the 700 attendees of the conference, 253 of whom came from overseas and represented 32 countries across five world regions.

10 Years ago at the ASA

Sudan is a country that has been gripped by civil wars for the majority of its independent life. Sudan is located in northern Africa and borders Egypt and Libya to the north. The nation was governed by Britain and Egypt from 1898-1956. Since then it has been at war with itself. The human toll of this war is insurmountable and, in many parts of the country, continues today.

In March 2010 AA published an article by ASA member Hayden Perndt, who was a member of the International Committee of the Red Cross Field Surgical Team (FST), stationed in the Darfur region of Sudan. A separate armed conflict had begun in Darfur in 2003 with the FST established in 2005 to provide care for the victims of the ongoing violence. Government-led militia had occupied the major towns of the region and so the 'rebels', the Sudanese Liberation Movement and Justice Equality Movement, had nowhere to go for medical treatment.

In response to the growth of the liberation movement, which accused the government of oppressing Darfur's non-Arab population, the government-led militia undertook a campaign of ethnic cleansing. Hundreds of thousands of people were killed and millions more displaced. As this 2010 article was being written an arrest warrant for the Sudanese President had been issued by the International Criminal Court (ICC) for war crimes and genocide, however it was ignored. A few months after this article was published a second warrant was issued but it too was ignored.

The specific deployment discussed in Perndt's article was in response to a localised incident. While it was not a direct battle taking place within the conflict it represented the human toll. Two villages fighting for survival. During the night one village had attacked the other. One tribe had surrounded the other village and fired indiscriminately into the huts. Over 100 villagers were killed as they slept or as they tried to flee. Most victims were women and children as the men had been sleeping with the cattle, to protect them from being stolen.

Ten years on in 2020 what has changed? The Sudanese President was ousted by a military coup in April 2019. He was convicted of corruption and sentenced to two years in prison. He is yet to answer the charges of the ICC.

In the last decade the situation has worsened in Darfur with violence escalating. Those towns thought to sympathise with the rebels suffered the

full force of the government-led militia. In 2014, 221 women and girls in the small town of Tabit were raped by government soldiers in an act described as a crime against humanity. Property was looted and the men of the town were arrested. The town was believed to support the rebels and indeed they had control of the town at one time but when this incident occurred there was no evidence that rebel forces were anywhere to be seen. Sadly, this incident is not thought to have been isolated, with other such incidents taking place across the region as a way of 'ethnic cleansing' and the production of a new race-based generation.

In 2016 chemical weapon attacks by the government reportedly took place in the region with children the main victims. Over the 16 year conflict, working in dangerous conditions, anaesthetists have joined the FST and attempted to bring aid to victims. The small teams, comprising a surgeon, anaesthetist and two nurses, continued to do what they could against the odds.

In 2019 Sudan began to transition to democracy. In August a draft constitution was published with specific mention of the Darfur conflict. To obtain peace the transition government want the militia to be disarmed, for new settlers to be expelled from traditionally-owned land and for those charged with war crimes by the ICC to answer the charges.

Despite this the conflict continues. While much has changed during the last 10 years, for example South Sudan directly to the south of the region is now an independent country, much has remained the same. What will the next 10 years bring?

The original article 'Working for the Red Cross Darfur, Sudan' by Dr Hayden Perndt was published in the March 2010 issue of ASA News.

Belinda McMartin
Curator, Librarian and Archivist
Harry Daly Museum, Richard Bailey Library and Gwen Wilson Archives

CONTACT US

Contact us to arrange a visit to browse or for research. We are open by appointment 10am to 3pm. Please phone ASA head office 1800 806 654 or email: bmcmartin@asa.org.au

INSIDE YOUR SOCIETY

NEW AND PASSING MEMBERS

The ASA would like to welcome all new members from December to February 2020.

TRAINEE MEMBERS

Dr Aaron Anthony Paul	VIC
Dr Adelaide Denise Schumann	SA
Dr Andrea Kasthuri Jeyendra	NSW
Dr Angus Stewart-Charles McNally	NSW
Dr Annie Lin	SA
Dr Ashok Kumar Jayaraj	VIC
Dr Brandon James Kirsten Barks	NSW
Dr Daniel Philip Creely	VIC
Dr Dheeraj Sharma	TAS
Dr Divya Rattan	TAS
Dr Gabriela Diana Kelly	QLD
Dr Jane Thu Doan	VIC
Dr Kurtis Tadeusz Zapasnik	ACT
Dr Louise Marie Rafter	QLD
Dr Nathaniel John Hiscock	VIC
Dr Paul Hoang Nguyen Pham	NSW
Dr Stephanie Ann Cruice	QLD
Dr Xavier John Frawley	NSW
Dr Yi-Wei Baey	VIC
Dr Yu-Feng Frank Hsiao	VIC

ORDINARY MEMBERS

Dr Angelo Antonio Ricciardelli	SA
Dr Arturo Gomez de Castro	VIC
Dr Berni Frost	NSW
Dr Christopher Orlikowski	TAS
Dr Dmitry Samokhin	NSW
Dr Jack Jia Wang	VIC
Dr John Kenneth Falconer	QLD
Dr Justine Mary McCarthy	QLD
Dr Kaushik Saha	SA
Dr Louis Yin	QLD
Dr Lyndon Wai Lun Siu	VIC
Dr Mary Anne Holland	VIC
Dr Michelle Diana Gerstman	VIC
Dr Natalya Carol Von Papen	QLD
Dr Samuel James Fitzpatrick	WA
Dr Stefan Aveling	NSW
Dr Tessa Pamela Moylan Smith	VIC

IN MEMORIAM

The ASA regrets to announce the passing of ASA members Dr Ramanathan Gopalkrishnan, WA; Dr Kenneth Oldroyd, NSW; Dr Serge Bodlander, NSW.

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

BARBARA LEONIE SLATER 1939-2019

Barbara Leonie Slater was born in Sydney in 1939 and educated at MLC Burwood on a scholarship. MLC was one of the very few girls' schools to teach physics at that time and Barbara was already thinking of studying medicine. She graduated from Sydney University in 1961 and was a resident at Sydney Hospital where she had been a student.

She would tell stories of the on-call residents sleeping on the balcony overlooking Macquarie Street and being woken by the arrival of the night porter with a torch when needed. Times have changed.

Barbara did her anaesthetic training at Sydney Hospital Crown Street and RAHC, and then obtained her fellowship in 1968.

Intensive care was developing at this time and she was approached to take an interest in this field. She went to Massachusetts General Hospital for further training and also the original Charing Cross Hospital where she felt at home as it was an old hospital, just like the Sydney Hospital she had known – a great contrast to the up-to-date American buildings.

Returning to Sydney Hospital, she took over the intensive care unit being on call by herself for an entire year.

At this time, she met and married Roger Dunne, a scientist at Lucas Heights Nuclear Facility, and they had three children – Peter, Philip and Fiona.

Unfortunately, Roger suffered a severe head injury in a car accident which made it difficult for him to work so Barbara took on the task of full-time work and family care.

She was an HMO at Crown Street, Sydney and St George Hospitals; and when Crown Street and Sydney Hospitals closed, she was a full time HMO then VMO at St George.

Barbara was always on time and never missed an on-call roster despite family difficulties and raising three children. Her utterly calm manner and vast experience were a boon for all her colleagues. To see her dealing with a difficult patient (and surgeon) was a lesson to be emulated.

She retired from St George Hospital in 2007 and began to enjoy children and grandchildren, travel and photography – for which she won several prizes. She graduated with distinction as a Master of Medical Humanities from Sydney University. She loved babysitting and watching her grandchildren succeed in school and sport.

Sadly, this time was all too short as Alzheimer's began its insidious progress, leaving her with little memory and diminished ability to cope. She died in late 2019 surrounded by her family.

Dr Susan Kelly

Graduation day

INSIDE YOUR SOCIETY

UPCOMING EVENTS

MARCH 2020

Planning For Your Retirement Workshop

Date: 21 March 2020

Venue: Forresters Room, Crowne Plaza Terrigal

Contact: events@asa.org.au

NSW ASA 2020 & Beyond

Date: 22 March 2020

Venue: Wamberal Room, Crowne Plaza Terrigal

Contact: events@asa.org.au

APRIL 2020

Directors of Departments Development Day (4D)

Date: 4 April 2020

Venue: Hilton, Sydney

Contact: events@asa.org.au

Anaesthetic Emergencies

Date: 23 April 2020

Venue: HNE Simulation Centre, John Hunter Hospital, Newcastle

Contact: HNELHD-SC@health.nsw.gov.au

MAY 2020

ANZCA ASM

Date: 1-5 May 2020

Venue: Perth Convention and Exhibition Centre

Contact: asm@anzca.edu.au

Effective Management of Anaesthetic Crises

Date: 7-9 May 2020

Venue: Clinical Skills Development Service, Royal Brisbane and Women's Hospital, Brisbane

Contact: CSDS-courses@health.qld.gov.au

JUNE 2020

Rural SIG meeting

Date: 5-7 June 2020

Venue: Airlie Beach, Queensland

Contact: events@anzca.edu.au

ACT Exam Performance Improvement Clinic (EPIC)

Date: 13 June 2020

Venue: ANU Medical School Auditorium, Canberra

Contact: events@asa.org.au

JULY 2020

Combined SIG meeting

Date: 10-12 July 2020

Venue: Cairns, Queensland

Contact: events@anzca.edu.au

ANZCA Emergency Response Series: ALS

Date: 22 July 2020

Venue: HNE Simulation Centre, John Hunter Hospital, Newcastle

Contact: HNELHD-SC@health.nsw.gov.au

SEPTEMBER 2020

17th World Congress of Anaesthesiologists

Date: 5-9 September 2020

Venue: O2 Universum, Ceskomoravská, Prague

Contact: wcaprague2020@guarant.cz

OCTOBER 2020

Combined Scientific Congress 2020

Date: 16-19 October 2020

Venue: Wellington, New Zealand

Contact: events@asa.org.au

RVG 21st edition

Exclusive to ASA members

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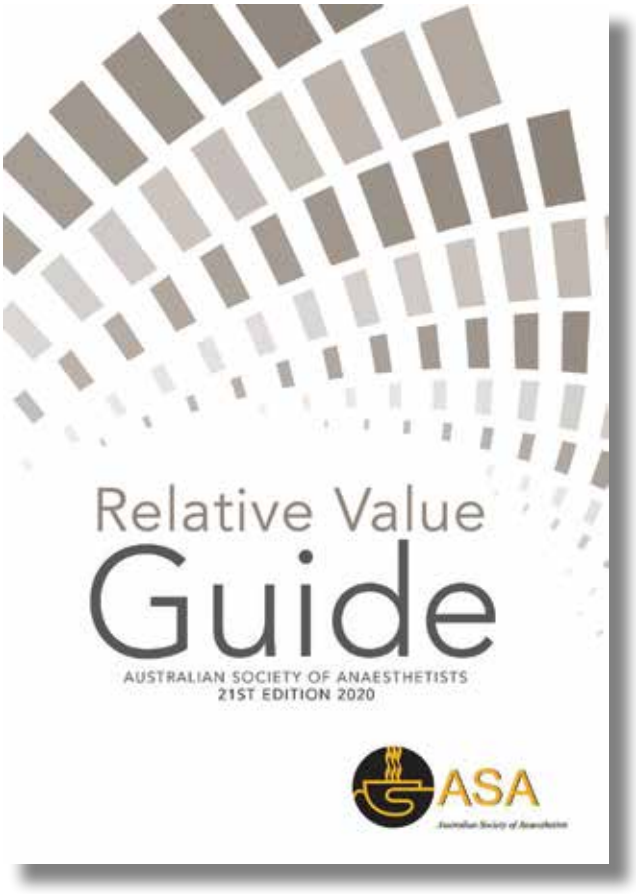

ALSO AVAILABLE AS AN APP

To download the App search for 'ASA RVG' in your App store and look for the following icon:

RVG

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The App can be accessed using your standard ASA member login details.

Please contact: membership@asa.org.au if you have misplaced your login details.

ASA
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SAVE THE DATE

16-19 October 2020

WELLINGTON, NEW ZEALAND

CSC2020
COMBINED SCIENTIFIC CONGRESS
NZSA & ASA - WELLINGTON NZ
16-19 OCTOBER 2020

INTERNATIONAL INVITED SPEAKERS

Prof. Denny Levett
University of
Southampton, UK

Prof. Steven Shafer
McMaster University,
CANADA

Prof. P.J. Devereaux
Stanford University
USA

INVITED SPEAKERS

Dr Tony Fernando

Dr Leona Wilson

Prof. Andrew A. Klein

For all enquiries please contact

Denyse Robertson • E: drobertson@asa.org.au • Tel:+61 2 8556 9717

www.csc2020.co.nz