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

AGEING AND THE ANAESTHETIST

N95S, ELASTOMERICS, FIT-TESTING AND COVID-19:
RESPIRATORY PROTECTION FOR FRONTLINE HEALTHCARE WORKERS IN AUSTRALIA

SURVEYING THE COVID-19 PANDEMIC:
IMPACT ON AUSTRALIAN ANAESTHETISTS

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Dear colleagues: The NZSA was looking forward to jointly hosting you with the ASA at the Combined Scientific Congress in Wellington this year. While this event had to be postponed, the NZSA will now host a smaller two-day meeting on the same dates (16-17 October). We are delighted to offer you a virtual option to attend. It will be an informative, and thought-provoking meeting – we invite you to join us.
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Letters to *Australian Anaesthetist*:
Letters are welcomed and will be considered for publication on individual merit. The Medical Editor reserves the right to change the style or to shorten any letter and to delete any material that is, in his or her opinion, discourteous or potentially defamatory. Any major revisions required will be referred back to the author for approval. Letters should be no more than 300 words and must contain your full name and address. Please email editor@asa.org.au to submit your letter or to contribute.

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Contact us:
Australian Society of Anaesthetists,
PO Box 6278 North Sydney NSW 2059, Australia
T: 02 8556 9700
F: 02 8556 9750
E: asa@asa.org.au
W: www.asa.org.au

Printed by:
Ligare Book Printers Pty Ltd

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A MEMBER SOCIETY OF THE WFSA

REGULARS

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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 October 2020.
- Final article is due no later than 17 October 2020.

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

REGULAR

EDITORIAL FROM THE ASA PRESIDENT

DR SUZI NOU
ASA PRESIDENT

As the ASA Communications Committee (aka the *Australian Anaesthetist* editorial committee) met to prepare this issue, we initially discussed the theme of 'ageing and the anaesthetist'. Like the adjustments that so many of us have made over the course of 2020, the theme to this edition has diversified as we focus on the changes made throughout our lives and not just at the time of retirement.

No doubt the biggest development this year has been the impact of COVID-19. The ASA has surveyed members and Australian anaesthetists not once, but three times so far during this pandemic. I thank you for giving up your valuable time in responding to these surveys. It has helped shape the advocacy of the ASA. In this edition Specialty Affairs Advisor Jim Bradley reminds us of the context of when these surveys were undertaken, reminding us that it was only a few months ago, in March when the COVID-19 case numbers in Australia were increasing by 25% every day. Executive Councillor Nicole Fairweather shares the frank and sobering comments we received regarding concerns about personal protective equipment (PPE) that encouraged the ASA to demand better levels of protection. Public Practice Advisory Committee Chair (PPAC) Julie Lee shares what you told us about the economic impact and discrimination that arose due to the pandemic.

Almost all of us have now experienced wearing higher levels of PPE and overcoming the challenges this presents, whether this be in a simulated or actual clinical environment. Likewise, almost all of us have experienced a change to our workflows at some stage. The WebAIRS report in this edition focuses on the impact of these changes due to COVID-19 on providing anaesthesia care.

Four months ago, only a few of us who had perhaps worked in industry or overseas had heard of the words 'fit-testing' or 'elastomeric masks'. Given the amount of queries I have received over the months, many of us have rapidly gained knowledge, if not expertise in this area. ASA members Isaac Cheung, Caitlin Low and myself share the results of the recently conducted ASA fit-testing session in Melbourne as well as some thoughts on the role of elastomeric masks in healthcare. Further discussions are available via podcast and on the ASA Forum: https://asa.org.au/asa-forum/

In the most recent wellbeing and welfare survey, as reported by Wellbeing Advocate Peta Lorraway, a number of respondents indicated that they have chosen to retire early, due to the pandemic. In this issue, Reg Cammack, Chair of the History of Anaesthesia Library Museum and Archives (HALMA) shares his reflections and experience of his transition to retirement as well as some interesting COVID-19 related statistics on the impact of staying at home. Communications Committee Chair David Borshoff muses on the impact of ageing on our careers, how to maintain our abilities and when to "put down the laryngoscope". A question frequently asked is "How much do I need to retire?". The complex answer to this question is addressed in this edition by Stuart Chan and Mike Cooney from Cutcher and Neale investment services.

Whilst it would appear that COVID-19 is the biggest threat to the health of anaesthetists, one of the biggest potential threats to the Australian health system is by private health insurers…

At the other end of the career journey, ASA member Maryann Turner shares her experience from criminal lawyer to paediatric anaesthetist and the 2020 ANZCA New Fellow Councillor, demonstrates that transitions can occur at any stage in our lives.

Whilst it would appear that COVID-19 is the biggest threat to the health of anaesthetists, one of the biggest potential threats to the Australian health system is by private health insurers, as outlined in Mark Sinclair's EAC Report. No matter where you are on the public vs private healthcare spectrum, I hope you share my concerns about a non-medical entity interfering with patient care, especially when they are for-profit companies. We are experiencing a boom in offers to enter into bundled care payment agreements. Whilst the aims to reduce out-of-pocket

fees for patients are laudable, insurers need to realise that these have arisen due to the lack of indexation of Medicare and insurers' rebates over many years. Insurers such as Medibank Private have also started purchasing private hospitals, or at least a 49% share in them. What price do we place on the value of clinical autonomy, patient choice and doctor-led models of care?

I would like to take a moment to reflect on the sad passing of John Richards, ASA President from 1990 to 1992. Unfortunately I never had the opportunity to meet John in person, but we shared letters where his warmth and dedication were clearly apparent. I share his words delivered by his grandchildren at his funeral, "Never give up, never give up, never give up." I look forward to revisiting the contributions he made to the ASA and WFSA, and his many other accomplishments and interests, when his obituary is published in the December edition of *Australian Anaesthetist*.

So yes, 2020 has been a year of many new changes affecting almost all of us. Some transitions such as retirement and new careers would have occurred regardless of the novel Coronavirus. Many others have been thrust upon us at a breathtaking pace. I hope you enjoy this edition of *Australian Anaesthetist* which celebrates the transitions that many of us have made, are yet to make, or ponder making, because whether we like it or not, change is here to stay.

CONTACT

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

QUEEN'S BIRTHDAY HONOURS

Congratulations are in order for ASA members who were acknowledged in the 2020 Queen's Birthday Honours in recognition of their significant service to medicine and in particular anaesthesia.

The ASA would like to thank you for your contributions to our speciality and being such outstanding representatives of our profession. Your awards are well deserved.

Associate Professor Richard Walsh AM, was acknowledged for his significant service to medicine, anaesthesia and perfusion, and to professional societies including the ASA, ANZCA and the World Federation of Societies of Anaesthesiologists (WFSA).

Richard was ANZCA President 1998-2000 and recipient of the ASA's 1996 Gilbert Brown Award. He was an active member of many ASA committees during the 1980s including:

- NSW Committee of Management (1982-1987)
- Federal Executive Committee (1982-1987)
- Reporting Member (1988-2000)
- Honorary Assistant Federal Secretary (1982-1983, 1986-1987)
- Honorary Federal Secretary (1983-1986)
- Federal Education Committee (1984-1987)
- Federal Financial Committee (1985-1987)
- AGM Scientific Programme Committee (1987).

From 1986, Richard was the Convenor of the 1996 World Congress of Anaesthesiologists Steering Committee, and then Chair of the World Congress of Anaesthesiologists Organising Committee, and finally President of the 1996 World Congress of Anaesthesiologists in Sydney. He continued his global interests serving on the Executive Committee of the WFSA from 1998 to 2008, including eight years as Treasurer of the WFSA.

Dr David Fahey AM, also featured on the 2020 Queen's Birthday Honours list and was recognised for his significant service to emergency response organisations (including St John Ambulance) and to medicine in the field of anaesthesia.

We were was also pleased to note that two members of the *Anaesthesia and Intensive Care* Editorial Board were made Members of the Order of Australia in June 2020.

Congratulations to Dr Richard Morris AM, recognised for his significant service to medicine, and to emergency and disaster medical response as well as Professor Jeffrey Lipman AM, for his significant service to medicine, anaesthesia and critical care, and education.

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ASA UPDATE FROM THE CEO

MARK CARMICHAEL, ASA CEO

Ah where were we… March 18, the day the ASA secretariat, along with many other businesses made the decision to operate remotely, in light of the COVID-19 pandemic. It seems so far away and yet at the same time it seems like yesterday. Terms such as 'Zoom', social distancing and flattening the curve have become the new normal.

Much has happened since that day in March. Sadly, many people have had their lives impacted upon greatly, with the loss of jobs, separation from family and a range of other experiences, not to forget the over 300 people who sadly have lost their lives as a result of COVID-19. Members as we know, have not been exempt from the impact, be it in a personal or economic sense, and I hope that as we continue to work our way through the maze that this pandemic has created, the difficulties are gradually overcome.

During this period, the Board, Council and individual members have been extremely active in relation to positioning the Society as an active contributor to discussions and decision making. Engagement with Government and with the Chief Medical Officers at both a Federal and State level, led by President Dr Suzi Nou and supported by a number of members who stepped forward to assist has seen the ASA included in a number of discussions. Difficult decisions in relation to such matters as elective surgery, the availability of PPE, advocacy for telehealth for anaesthetists, the public/private contract arrangement and the value of fit-testing were all progressed in a very short space of time and in a way that positioned the Society as a valuable contributor to the whole pandemic issue.

It has been gratifying to receive regular and positive feedback from members in relation to the COVID-19 webpage that was created. It was interesting to note that the COVID-19 page received in excess of 25,000 hits during March, as members and others accessed the guidelines, resources and regular press releases which were made available, three times per week. Importantly the role played by a number of staff in terms of making these available must be recognised and acknowledged.

Throughout the pandemic the Society has maintained regular contact with our Common Issues Group members i.e. Association of Anaesthetists in England, and the societies in Canada, USA, New Zealand and South Africa. As always this contact has provided for the valuable sharing of resources, learning and support.

Compared to other countries the incidence of COVID-19 in Australia appears to be relatively low at this time, although the spike in cases in Victoria in early July and the outbreak in NSW is indeed a warning to the whole country that this pandemic is far from over. The impact both economically and socially can't be underestimated. We are well aware of the economic difficulties faced by some members following the disruption to elective surgery, indeed a number of ASA Board and Council members who are private practitioners, experienced the issues first hand.

In order to gain a better understanding of the pandemic from the members' perspective ASA ran three surveys. They were ASA COVID-19 Survey focussing on determining practitioner perspectives on the risks of the pandemic, the second being the ASA COVID-19 Response Survey which focussed on members' responses to the pandemic professionally as it was happening and finally COVID-19 Wellbeing and Welfare Survey, addressing the individual experiences during the pandemic to date. I do thank everyone who completed those surveys as the responses have been most helpful in allowing the Society to report back to Government and you the membership.

The Society itself has been impacted by the pandemic. The extremely difficult decision to postpone the 2020 Combined Scientific Congress (CSC) scheduled for October in Wellington, New Zealand, was a prudent one, however it does have financial implications. We have, with the support of the New Zealand Organising Committee, been able to place the CSC in hibernation until October 2022, when the great work of the Committee will be on display.

At the same time the forced cancellation/ postponement of other ACE-related educational programs undertaken in conjunction with ANZCA and the New Zealand Society, will impact during this financial year.

Despite the difficulties arising from COVID-19, membership renewals have remained strong which is very much appreciated. In fact 72 lapsed members have 'rejoined' the Society with many citing its work during COVID-19 as the primary reason. This has been most gratifying and ideally it will continue.

During these unusual times it is easy to miss some of the positives. The recent Queen's Birthday Honours presented such an opportunity when four members of the profession were honoured all with Member (AM) in the General Division. Congratulations to Dr David Fahey (NSW) Dr Richard Walsh (NSW), Dr Richard Morris (NSW) and Professor Jeffrey Lipman (Qld) who received this honour.

I would also like to congratulate and welcome Dr Peter Waterhouse (PIAC Chair) who was recently elected by his Council colleagues to the ASA Board of Directors as one of the two Council elected directors. Peter replaces Dr Antonio Grossi who retired recently from the Board. Economic Advisory Committee Chair Dr Mark Sinclair is the other Council elected director.

I would like to take this opportunity to thank and congratulate the ASA staff who have worked extremely hard under less than ideal circumstances to provide service and support to you the members. I know it is appreciated.

CONTACT

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

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/

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WEBAIRS NEWS

IMPACT OF COVID-19 ON ANAESTHESIA SERVICES

The current COVID-19 pandemic second wave has seen an increased workload and levels of fatigue throughout the front-line healthcare staff working in anaesthesia in Australia. The incident reports received by webAIRS have been categorised into those pertaining to personal and protective equipment (PPE) use, other equipment problems, staff and facilities shortages, issues relating to deviations from usual practice, and delayed management due to COVID-19 status or the current perceived risk climate.

We are continuing to monitor the webAIRS incidents reported in relation to the COVID-19 pandemic, particularly in view of the current outbreaks in NSW and Victoria, and add these as an ANA-Alert to the webAIRS website. These are some of the issues identified from the reports received already.

PERSONAL PROTECTIVE EQUIPMENT (PPE)

- PPE was not available or inadequate: There have been delays or case cancellations at different sites, due to PPE not being in stock, or not being made available where aerosolisation might occur – such as ear, nose and throat (ENT), maxillofacial and endoscopy procedures. There may have been a disagreement between whether or not full airborne precautions should be used, and up-to-date guidelines are necessary.
- The type of PPE was unfamiliar to staff, creating a risk of not wearing it correctly.
- Fogging of the protective goggles led to difficult visualisation during intubation.
- Interpretation of the guidelines for use of PPE was reported as inconsistent.

EQUIPMENT

- Lack of the anaesthetic trolley present in the room led to delays with emergency drug availability.
- Equipment was unfamiliar to anaesthetic staff who do not usually work in the emergency department. This in turn led to difficulties with patient management.
- Bag mask ventilation (BMV) equipment for COVID-19 cases was unfamiliar to anaesthetists and assistants.
- An endotracheal tube (ETT) failed on two occasions during a planned fibreoptic nasal intubation: A patient with no known risk factors for COVID-19 presented with pain and limited mouth opening for incision and drainage of an abscess. After assessment and consent, an awake fibreoptic nasal intubation was planned. The intubation was successful but associated with a large leak and inability to inflate the ETT cuff. A tube exchange was performed with an airway catheter but there was still a large leak from the ETT. Ear nose and throat (ENT) surgical assistance was requested and a decision made to proceed to surgical tracheostomy. However, the ENT team was concerned about aerosolisation and insisted that a powered air-purifying respirator (PAPR) be worn by each of their team. There was a delay as a result, but fortunately, there was no desaturation despite the large leak from the ETT. This case illustrates the heightened awareness of the possibility of undiagnosed COVID-19 cases in the community and the impact on current surgical practice. The patient had the procedure and recovered well, without any harm as a result of these events. However, there was a prolonged period where the patient airway was not completely secured, as a result of COVID-19 concerns, which in turn meant that the patient was exposed to an additional hazard.
- New anaesthetic machine circuits had only recently been acquired, as the normal supplier was not able to meet the necessary requirements during COVID-19. The patient's inspiratory and expiratory CO_2 rose rapidly with an inspiratory level of 40-50 and an expiratory level of 60-80. The soda lime was changed without any change, and the patient was hand ventilated without any improvement. The machine was quickly changed for another. It was discovered that the circle circuit inner tubing had disconnected from its mount at the machine end of the circuit, within the outer tube. This had allowed

all gases to mix and therefore not be isolated to inspiratory and expiratory limbs. It was described as a scenario leading to extreme anxiety, with a prone patient and CO_2 levels that were rising despite normal operation of valves, soda lime and DFend. In hindsight, the circuit was the obvious problem but difficult to detect visually and there was no problem ventilating the patient or maintaining oxygenation.

STAFF/FACILITIES SHORTAGES

- Lack of personnel present in the room led to a delay in obtaining a replacement piece of equipment that had been requested when the original ETT encountered a leak.
- Closure of elective allergy testing facilities may have prevented necessary surgery occurring in a timely manner. A patient suffered anaphylaxis and after successful management of the incident the procedure was postponed. It was planned that the patient would have skin testing and after the results were available the patient was to be rebooked. However, COVID -19 preparation had resulted in the closure of elective allergy testing facilities. The procedure was not urgent but was required within a timeframe of weeks. At the time of reporting it was not clear whether the clinic would reopen in time, or the procedure would go ahead in the absence of formal testing of the agents previously used.
- ICU bed delays and shortages occurred due to COVID-19 preparations.
- Operating room entrances were not clearly marked that PPE precautions were in place.

UNEXPECTED EVENTS

- Drugs were left unattended following an intubation in a negative pressure room: The patient was transferred to intensive care accompanied by the anaesthetist and the anaesthetic assistant. When the anaesthetist and the assistant returned to the negative pressure room it had been cleaned and there were no staff present. The anaesthetic drugs were left on a tray outside the room and were left unattended due to a lack of a clear plan for drug disposal. This raises two issues: firstly, the drugs and tray were potentially infected, and also controlled drugs were left unsupervised and unlocked which contravened the state regulations.
- Difficulty ventilating a patient occurred during an emergency gastroscopy: After a difficult visualisation of the larynx, it was determined that a bougie was required and there was a longer than usual delay before it was produced. During the delay it was difficult to ventilate the patient. The anaesthetist reporting suggested that if COVID-19 precautions are in place, it would be a good idea to routinely preload a bougie into the ETT during intubation.
- Absence of usual equipment required in the operating theatre affected patient outcome: A patient suffered what appeared to be a severe bronchospasm, following an intubation with COVID-19 precautions in place. The patient had a history of TB and it transpired that there was a tension pneumothorax present, either prior to intubation, or as a result of the high ventilation pressures required. It was difficult to diagnose a pneumothorax, perform initial chest decompression, and insert a chest drain in these circumstances as the usual equipment required was not in the room.

HEIGHTENED TENSION AND ANXIETY

- Managing patients with difficult airway anatomy can be difficult even in normal circumstances, but much more difficult where there is potential for the spread of a COVID-19 viral infection.
- Difficulty deciding whether an emergency case merits full COVID-19 precautions especially with ENT, maxillofacial, endoscopy and any other procedures where aerosolisation might occur, could cause surgical delays.

We encourage anaesthetists to report any incidents, including those with COVID-19 patient management issues, and regular notifications will be provided via the ANA-Alerts.

Please login or register: webAIRS website.

Reporting an incident also qualifies for CPD points.

ANZTADC Case Report Writing Group

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LETTERS TO AUSTRALIAN ANAESTHETIST

THANKS TO ASA

May I take this moment to personally thank the ASA for its tireless and dedicated support of its members and indeed all anaesthetists. In the 30 plus years that I have been a member, I have benefited from the efforts and professional support of the ASA through its political lobbying, continuing medical education, enhancing the public profile and value of anaesthetists and for its fight for fair remuneration. My sincere appreciation goes to the many unpaid office bearers who have worked so hard for their members.

I wish the ASA every success into the future as it continues its support of anaesthetists throughout Australia and New Zealand.

Anonymous

HAVE YOUR SAY

We would love to hear your feedback on our magazine and its content. All letters are welcomed and will be considered for publication. The Medical Editor reserves the right to change the style, shorten any letter and delete any material that is, in his or her opinion, discourteous or potentially defamatory. Any major revisions required will be referred back to the author for approval.

Letters should be no more than 300 words and must contain your full name and address.

Please email us at editor@asa.org.au to submit your letter.

Patient information pamphlets are available for members to download and distribute to their patients as a member service.

The pamphlets can be found on the ASA website:

asa.org.au/member-resources/

SPOTLIGHT ON CONSENT

Impact of COVID on Consent

COVID has disrupted and altered work practices in Australian hospitals. And new "contactless" processes are having unintended consequences for the communication process between anaesthetists and their patients in pre-admission.

While some aspects of the consenting process have traditionally been done just prior to surgery, social distancing, the use of personal protective clothing and equipment, and complex COVID focused admission processes are limiting the time, access and quality of the communication anaesthetists have with their patients. This has the potential to compromise the consenting experience for patients and place anaesthetists at increased legal risk. To counter these changes, some anaesthetists are adopting new ways of interacting with their patients prior to surgery. Videoconferencing, facetime, email and phone calls are now becoming the new norm for many, replacing the traditional pre-admission consultation. Some anaesthetists are establishing new patient workflows and telehealth-based practices to connect with their patients in their homes and undertake informed consent well before their admission to hospital. From adopting technologies for consent to extended personal telehealth calls with patients, read how one Sydney anaesthetist has adapted to these changes.

Member Perspective

Dr Ajay Kumar, Anaesthetist, Sydney

Sydney anaesthetist Dr Ajay Kumar works in three major private hospitals in Sydney's north west, all of which have adopted similar COVID measures. He dons personal protective equipment for certain procedures before he speaks with at-risk patients. He has found hygiene protocols and social distancing are making communication more challenging. The pre-COVID consenting process has substantially changed as his patients move through a largely contactless pre-admission process. Dr Kumar now contacts his patients by phone, facetime or videoconference before their admission to hospital, and uses an online consent tool to manage the formal aspects of informed patient and financial consent. Many of his patients are elderly or from non-English speaking backgrounds. He sets up telehealth consults and invites them to print off materials he's sent to them electronically. He has found the consenting process is taking in some cases up to half an hour longer, but patients are accepting of the new electronic communication. Starting the consenting process earlier and using technology to help manage it with pre-op patients in the home has been key. Dr Kumar says it's a difficult time for everyone – patients as well as doctors - but forward planning and technology are helping to smooth the way.

Advice and Actions

Explaining the risks of anaesthetic procedures to patients can be challenging, and none more so than in this changing COVID environment. COVID is interfering with the normal consenting process, making it more difficult for anaesthetists to ensure that patients have properly comprehended the material risks. The courts have made it clear that the obligation to ensure patients have properly heard and considered the information rests solely with the clinician. And that responsibility will not be diminished by environmental factors such as COVID. Whilst COVID restrictions have resulted in a greater acceptance by patients of electronic communication instead of face to face consultation, the problem for doctors who use electronic communication poorly is that it can undermine the clinical relationship with their patients.

An integrated online consenting tool – like MedConsent – can assist in ensuring not only that the consent process is streamlined, but that the anaesthetist/ patient relationship is safeguarded and proper information is conveyed. But when adopting any new tool, ensuring that it's user friendly, secure and provides content which is peer reviewed and health literacy compliant is critical.

FEATURE

ONE ANAESTHETIST'S TRANSITION TO RETIREMENT

As I am a recent retiree, I was asked to write about my personal experience and journey to retirement – the decision I made in that regard; my transition to that state with the relevant considerations; and my early experience as a retiree.

Having turned 70 in October 2019, I pulled up the last stump in the first week of the following December with a genuine feeling of excitement towards the new phase; obviously nothing to do with COVID-19 but serendipitously just before that particular problem caused disruption to our profession and world-wide chaos. I say the 'last' stump, because my retirement was not like at the end of a full-on cricket match when all the stumps get pulled at once. I slowed gradually, looking for a 'soft landing' to the innings (to mix metaphors!).

I have always thought of retirement as part of one's career – a large and significant part of it. Although it is the penultimate step before death and legacy, one certainly should not be morbid about such a period. Hence, my planning for retirement started not long after I began my specialist practice. I did not set a firm age to do it, just a rough figure. One needs to be a bit flexible when making such a decision because life can bring many unforeseen changes throughout a long career. I can only emphasise that, to be able to be flexible about a date for cessation of work, it really is essential to start planning early! I also did not want to work to the point where colleagues would feel it necessary to 'tap me on the shoulder' because of deteriorating standards and I certainly wanted to be sure of continuing good health so that I might be able to enjoy myself during retirement. Early plans (after listening to a very wise old grandmother who lived through the Great Depression) were aimed at a financially independent retirement, so broad-based investments were the targets. And, being in this profession, you do have to take into consideration that you and your partner will be the only providers for your retirement as you are unlikely to qualify for Government pensions.

At the age of 64, coming up to signing

for another quinquennium and faced with the proposition of going back onto public hospital after-hours rosters (having enjoyed the courtesy of none of these as a VMO from the age of 60), I decided the time had come to start slowing down. Thus, I did not renew my public appointment and just continued with my private lists. These I gradually gave up until, for the last two years, I had only a couple of simple and easy lists, which I had already enjoyed for a long time, thus providing the aforementioned 'soft landing'.

Note that in slowing down, one must take into consideration AHPRA's minimum requirements for continuing registration, which I would like to summarise, having investigated them for my own purposes. The following categories of registration are available.

Firstly, if you fully retire and do not wish to practice in any form, you can forfeit your registration completely, incurring no fees from AHPRA. After also notifying your medical indemnity company of this decision, there will be no premium to pay and the company will notify AHPRA that they have moved you over to the Run-Off Cover Scheme (ROCS). Under this registration category, you are entitled to call yourself 'doctor' but not 'medical practitioner'.

Secondly, if you wish to call yourself 'medical practitioner' as well as 'doctor', you will have to pay AHPRA's current 'non-practising registration' annual fee of $153 just for the privilege.

Thirdly and lastly, there is full registration. Even if you wish to only retain the ability to write prescriptions and referral letters, you must be fully registered and pay the full specialist registration fee, currently $787 per annum. For this, even as a retiree, you must also fulfill AHPRA's definition of 'Recency of Practice', which is defined as spending a minimum of 152 hours per year (or 456 hours over a three year period), counting no more than 38 hours in any one week, in either clinical or non-clinical but medically-related work. If only non-clinical work is involved, a reduced minimum of 80 points of CPD over three years must be earned, with no emergency response or practice evaluation required. Of course, for clinical work in this category, both full CPD program and full medical indemnity cover are required as usual. The insurance premium for the latter may be greater than normal as some companies allege that 'older' doctors cause more incidents. If you only intend to write scripts for family members and the occasional letter of referral then your indemnity company may offer you a much-reduced premium.

…it is important to develop non-clinical interests throughout your career so that when you do retire you will have something with which to occupy your own mind and time and will still be an interesting person…

I have chosen category one for myself as I feel the requirements demanded of someone who has competently practised medicine for 46 years and who just wants to be able to write a prescription or referral for a family member are ridiculously excessive, so I really can't be bothered trying to comply with the demands of category 3 or care to make any significant distinction between 'doctor' and 'medical practitioner'. AHPRA's red-tape wins!

During my gradual reduction in clinical exposure, I also furthered an interest in the history of our specialty as I neither wished to abruptly end an involvement in what I had spent my life doing nor lose contact with like-minded colleagues – I joined the ASA's History of Anaesthesia Library, Museum & Archives (HALMA) committee and particularly now continue to enjoy creating a timeline of the history of anaesthesia, which is available via the Harry Daly museum section of the ASA website.

Apart from easing me into my retirement lifestyle, this gradual slowing also prevented a sudden in-your-face-all-the-time event for my wife! I believe it is particularly important to discuss one's retirement plans well in advance with your spouse/partner. He or she will not be used to seeing you so much because of the amount of time you will have spent at work throughout your career, so a mutual consensus on what the two of you will do is required. Your other half may also have to plan for their retirement and that must be taken into consideration as well.

Pause for a moment to consider a couple of statistics related to this last concept: firstly, the age group for the highest divorce rate is the over-50s! Secondly, according to a survey by Relationships Australia, isolating at home during COVID-19 caused 42% of 739 respondents to experience a negative effect on their relationship, 55% felt 'challenged' by the enforced living arrangements and there was a 300% rise in couples thinking of separation! The message from these stats – do not plan to retire and stay at home all the time. Therefore, it is important to develop non-clinical interests throughout your career so that when you do retire you will have something with which to occupy your own mind and time and will still be an interesting person to be with. Nonetheless, some or all of those extra-curricular interests could be shared with your partner. I am only too aware of a surgical acquaintance who had an extremely busy practice, with no free time, who worked until his health suggested otherwise. He stopped working completely at the end of one week and has found life totally boring ever since. I can only advise to avoid that situation and, when considering retirement, aim to convert the old aphorism – 'don't know where I had time to go to work' – into a truism.

My own agenda for retirement, apart from tending to our investments and the previously mentioned HALMA work, has

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been a touch hampered for the present by COVID restrictions. However, the number one priority is to stay fit, especially so I can do things like get out of a chair unaided in the future, which, I gather, can be quite an issue for the elderly. For this, my wife and I walk a 6.5km circuit in an hour, two or three times per week. Daily weight exercises at home with acceptably-sized dumbbells help keep the top half up to strength. The eventual resumption of tennis and golf is also an aspiration once restrictions are further lifted.

There are numerous occupations that people can take up or re-familiarise themselves with in their retirement. I would like to mention, as an excellent example, what one of my fellow HALMA-ites did when he started thinking of retirement. He took up painting as a pastime and, if anyone has been to St Vincent's Hospital, Darlinghurst, theatres, they will be able to view a magnificent triptych of anaesthesia-related flowers hanging on the wall by Bill Herlihy. Regrettably, I have trouble drawing a stick figure.

Gardening has come into greater focus as we have a largish plot and, because we do not wish to down-size in the foreseeable future, this will also occupy a reasonable amount of time ahead, not just during the enforced 'stay-at-home' rules. If and when down-sizing occurs, it will bring with it a raft of decisions including the actual size of the new abode, its proximity to transport, shops, friends and health services for ageing people – considerations currently left for another day. Regarding transport, remember to consider your state's licensing requirements for the elderly driver.

I have always enjoyed cooking the fancier dishes and, despite warnings from my wife about making the kitchen messy and potential weight gain, I must admit to the not infrequent indulgence. I have also found time to approach the piano to tinkle the ivories again purely just to remind myself of one of the enjoyments of my younger days. I note, for anyone like-minded, that a retired surgical friend regularly plays the cello in a 'medical' orchestra that performs around NSW – not that I aspire to anything similar!

Of course, travel will figure when it becomes permissible and more feasible as we have children living in different spots around the globe and it will be good to catch up with them as well as visit places we have not yet been to. When it comes to family closer to home, minding the grandchildren is a time-occupying experience that fulfills the extremely important function of keeping one in contact with the younger members of the clan. I find this is rewarding mentally, physically and emotionally. I do believe they help to keep you young and active in thought. I have been teaching my seven-year-old grandson the rudiments of chess and what one should try to do with a tennis racquet as well as stressing over such games as *Quadrillion* (produced by Smart Games) while being amazed at the expertise of my four-year-old granddaughter with this form of amusement. The word 'Pa', combined with a hug, has a most pleasing and warm ring to it.

Looking more outwardly, though, I believe it is important to remain connected with society. The daily newspaper and evening news broadcasts are essential to keep abreast of what's happening in the world. Keeping in touch with friends, with the resultant social interactions, also helps to preserve one's sanity. I do not wish to isolate myself into a lonely future. Perhaps now, with the free time and the (hopefully) waning/soon-to-be-vaccinated COVID-19, joining the local Lions' or Rotary Club will also help me keep social discourse and camaraderie ticking over at the same time as providing some assistance to members of the community who might need it.

I would sincerely like to encourage everyone to look forward to the retirement phase of your own careers with excitement and confidence knowing that you 'have a plan'! And I wish you all well in it.

Finally, for those wishing to keep in touch with their life-long career interest and their colleagues, I would suggest checking out the benefits offered to retirees by both the ASA and ANZCA.

Reg Cammack

A DOCTOR AND A LAWYER WALK INTO A BAR…

THE JOURNEY FROM SOLICITOR TO ANAESTHETIST

I have a confession to make. With a signed staff specialist employment contract in my email outbox, I can finally come clean about my past. I only hope the fallout will be minimal.

Here goes – in 2006 I was admitted as a lawyer of the Supreme Court of New South Wales.

I worked as a Legal Officer for the Commonwealth Director of Public Prosecutions (CDPP), responsible for assisting with the prosecution of white-collar crime. Before that, I was employed in various corporate and criminal paralegal and clerkship positions as I traversed the hallowed halls of law school. The practice of medicine could not have been further from my mind in those years; I had never even heard of paediatric anaesthesia, let alone considered it as a career option.

Why the reluctance to reveal this truth?

Sadly, experience. There is a view held by some practitioners that one's focus on clinical medicine must be singular at all times, particularly in early career stages. As a result, on the occasions I have chosen to disclose information about my past, the response has often been negative. There's the "I hate lawyers, horrible people, my wife's brother's golf buddy got done over by those bloody lawyers, let me tell you a lawyer joke" response. On occasion, there's the more informed "oh that's handy, I never know when I will need a lawyer" reply, but take note – most lawyers who are now doctors do not have a current practicing certificate, cannot represent you in the family law court for your divorce proceedings and no, Gary, I can't get you off that completely appropriately issued speeding fine because you were most definitely doing 85 in a 60 zone.

Does having a legal background change your approach to the practice of anaesthesia? In my experience, it certainly has, in a positive way. For example, I am a stickler for a high-quality informed consent. I have been trained to look at risk holistically and I think my approach to problem solving differs from my colleagues. Where many Australian doctors have never worked in a professional environment outside healthcare, those of us engaged in 'career

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meandering' offer a range of diverse views and experiences, which I believe serves to strengthen our anaesthetic community, rather than diluting it. The hospital system is a unique microcosm which at times fosters unreasonable expectations and behaviours. Without diversity of experience, it would be easy to overlook this situation.

Another question I am often asked is why I changed careers. The most poignant occasion this has arisen saw me on my hands and knees in a cardiac theatre, emptying a patient's amply filled urine bag into a collection jar while sleep deprived from the throes of studying for a college exam. In that moment, I wondered myself why I had chosen this life. So here are some quick thoughts on my journey from law student to paediatric anaesthetist, in 1,500 words or fewer.

Truth be told, Ally McBeal is the reason I enrolled in law school. Working with funny, quirky, intelligent and argumentative people who wore nice suits and were progressive enough to share a unisex bathroom was incredibly appealing to my 17-year-old self. Law school was wonderful. I made a like-minded friend in my criminal law class and we developed a solid plan to start an all-female law firm. Everyone wrote 'it's the vibe' at the end of our constitutional law exam and we all thought it was hilarious. The study of law sat well with my love of learning, arguing and the humanities and those undergraduate years were glorious, with the obvious exception of exams. University exams coincide with the flowering of jacaranda trees in Brisbane, and the sight of the beautiful purple flowers to this day gives me tachycardia and a feeling of impending doom.

I learnt a lot about rejection from my time at law school through the 'rite of passage' of summer clerkship applications. Law students would apply to various corporate firms for the privilege of attaining one of these highly coveted clerkship positions. The prize – working for several weeks for free during your summer holidays! One year, the law society held a social event where attendees were given a free drink for every rejection letter they received. We all had so many letters! In retrospect, I think this early normalisation of 'failure' provided a really grounded approach to the usual ebb and flow of success we all experience. I am grateful for it. I still celebrate rejection in a similar fashion to this day.

To pay my way through law school I worked as a deckhand and ticketseller on board the commercial catamarans on the Brisbane River – my beloved CityCats. There was a solicitor who regularly caught my boat and we got to chatting over several months of cruising up and down the river, culminating in an invitation to interview (successfully!) at her firm. My first ever law job, to the best of my recollection, lasted approximately three weeks. The morality of bankruptcy and insolvency law did not sit well with what I saw as my glowing future as an international human rights lawyer! I moved on to dispute resolution in a large corporate firm, then ultimately found my home in crime.

By the end of law school, however, I was disillusioned with the practice of law and unsure of my next move. The issues that face women in the law today, brought to the attention of the mainstream media by recent allegations against Dyson Heydon, have been unfortunately endemic in the profession. Tired of the 'boy's club', tired of the politics, unsure whether I wanted to stay in a profession where everyone at the top seemed burnt out and unhappy, I needed an 'eat, pray, love' epiphany, before that was even a thing.

So I jumped on a plane. I had taken on a job as a travel agent near the end of law school, and to my parent's dismay I sold myself a wholesale one year 'round the world' plane ticket.

Without further ado I quit my jobs, gathered my meagre savings and boarded a plane to Asia. I had only left Australia a few times before this, never for more than a few weeks, and never alone. Many adventures were had – I taught English in Guilin, worked as a legal secretary in Dublin, drank vodka with locals in St Petersburg, hiked in Canada and took a road trip around California.

And in between the overnight train rides and the backpacking, my epiphany arrived! I was volunteering as an intern at the South Asian Human Rights Documentation Centre in Delhi, recording the plight of refugees who had fled from Myanmar to India. The futility of fighting for human rights in the absence of essential medical care and basic public health requirements became apparent almost immediately. Anything the law could offer was nothing compared to health care, clean water and vaccinations. At the same time, a loved one in Australia was diagnosed with cancer. These combined experiences resulted in a sense of utter helplessness – what use is a law degree in the face of illness and disease? Far better to be a doctor, for sure! Decision made, I finished off my gap year and came home to set the career transition wheels in motion.

On my return to Australia, I crammed for the medical school entrance exam for a few months (read: taught myself physics and re-learned my high school chemistry and biology) while employed at the CDPP, where I was also studying towards admission to the Supreme Court by completing the Graduate Diploma of Legal Practice. The CDPP were kind enough to re-employ me, and I worked in both general and commercial prosecutions, on diverse matters including drug smuggling, online child sex offences, fraud and counter terrorism offences. As a paralegal and a junior legal officer, my duties varied daily, and included collating and organising evidence briefs, writing assessments, checking financial statements, briefing barristers and

appearing in the magistrate's court for callovers. My first solo court appearance remains memorable for all the wrong reasons – I was more anxious about driving the large government fleet car out of the tiny inner-city multi-level carpark than I was about presenting before the magistrate!

By the end of the year, I was an admitted lawyer with a place in medical school. I handed in my resignation as a legal officer at the CDPP and rang the CityCats to ask them for more hours as a deckhand so I could support myself as I returned to the world of being a student. Hello new beginnings!

Medical school is an uncomfortable place for lawyers, particularly lawyers without a science degree. Coming from an academic background where independent thought was encouraged to the algorithmic, rote-learning, formulaic structure of medical school was a difficult transition. I found no joy in the 'problem-based' 'teach yourself medicine' approach adopted by universities. As a humanities student, I found it difficult to understand the attraction of the mysterious pink and purple swirls of the histology slides, the fascination with cadaver dissection, and the need for rote learning endless lists of differentials to pass exams. My 'controversial' comments in class, made with a view to stimulate discussion, were not welcomed by my tutors. One of my friends told me (years after we graduated) that she had serious concerns for my ability to pass first year medical school after I asked her what a mitochondrion was.

In the second year of medical school I enrolled in a Master of Health and Medical Law, hedging my bets in case the practice of medicine had not been as an inspired decision as first thought. Suffice to say, this decision was met with some raised eyebrows at the time, which continued through my early training years. I still struggle to understand the reasoning behind the resistance. Why is multi-passion perceived as a fault in the pursuit of clinical medicine?

As an intern in a busy emergency department in tropical north Queensland, I continued to find discordance with my previous life in law. In my first week I asked the ward clerk to send a fax and was met with gasps of dismay from the surrounding senior doctors and a contemptuous look from the ward clerk. As a junior lawyer I had shared a wonderful secretary with several others and was accustomed (indeed encouraged) to delegating administrative work to those employed in that role. It remains an intriguing mystery to me why doctors spend four years learning medicine to then be treated as glorified administrative assistants for the first two years of their careers.

So what have I learned from my experience as a lawyer-doctor?

- Stay multi-passionate and don't let anyone tell you that having a diverse background is incompatible with being a good doctor. Be interesting. See the world. Speak your truth.
- In your junior years, say yes to every opportunity! You never know what it may lead to or who you may meet. Sure, you'll be busy, but if you have capacity to get involved, do it.
- Apply for all the things that catch your attention and make your peace with being rejected. One day you will be the perfect fit, or maybe you will win by default as the only person who applied! Look at every 'failure' as an opportunity to learn and develop.
- Be curious and learn about everyone you work with – many people are doing interesting things outside of clinical anaesthesia. Be warned though – this tactic has been known to lead to an hour-long one-man diatribe about a new road bike!
- If someone offers to mentor you, accept graciously. You never know when you'll need an office to cry in and you won't get your own until you're a consultant (maybe).
- Advocate for things that matter. Don't be that doctor whining in the department tearoom – be the person who gets involved and tries to make things better.
- Be kind, you never know what someone else is going through.
- Respect is earned, not conferred with the award of a FANZCA alone.

With the full weight of this confession lifted from my shoulders, I look forward to the opportunities and challenges that the next phase of my life will bring, as consultant paediatric anaesthetist, ANZCA New Fellow Councillor and ASA member.

Dr Maryann Turner

FEATURE

APPROACHING RETIREMENT AND THE ANAESTHETIST
FROM A PARTNER'S PERSPECTIVE

The ASA NSW State Committee kicked off on 1 August with an informative webinar on retirement living. The 'Approaching Retirement and the Anaesthetist' interactive platform included presenters currently retired and planning to retire. It is personal, consider planning early, involve your support person(s), and find joy in "someone to love, something to do, or something to look forward to".

Dr Reg Cammack provided his early experience as a retiree and further shared his journey in the article 'One anaesthetist's transition to retirement', *Australian Anaesthetist*, September 2020, page 12.

There was a presentation on 'Health, family and the ageing anaesthetist' by Dr Bernard Kelly. The talk raised the topic of unrecognised neurocognitive impairment in the ageing anaesthetist. It also raised the issue of medical screening for older clinicians. Some USA hospitals have commenced neurocognitive and dexterity testing for clinicians 70 and older as a condition of reappointment. The Civil Aviation Safety Authority encourages doctors who are pilots to train to perform aviation medicals. Should anaesthetists take the initiative and propose a similar agency for our craft group as medical examiners? A recording of this presentation can be found here: https://bit.ly/3fGZrpF

Other topics included were from Avant Insurance for an update on the medical practitioner indemnity run-off insurance cover and Cutcher and Neale provided investment considerations including a recommendation not to "put all your eggs in one basket". The NSW committee can further host specific financial education services platform for members if requested.

I appreciated the opportunity to deliver and practice my pet topic on 'mindfulness' in the morning session. The mindfulness exercise consists of four points:

1. Learn to stop.
2. Learn to poise (sit, stand, walk).
3. Learn to breathe.
4. Learn to apply the 5 aggregates (5 Fs).

I presented on the '5 aggregrates' or building blocks of how to be aware and present of one's dialogues, and pointed out the practical steps to embrace one's thoughts and feelings so as to become

more light-hearted in preparation for the day. It's a difficult mental exercise until it becomes more of a habit. Overall, it's a conscious decision to look after one's well-being.

For myself, it has been rewarding practising mindfulness. In particular, when I return from an intensive day's work and my partner has been out in the sun or having a lovely lunch – I take delight in hearing about his man's shed. Also, it has been an interesting experience to find as my best friend approaches retirement, that upsizing instead of downsizing our abode has been recommended, so that we can have different territories at home. Personally it has been effective and I have discovered where his man's shed resides!

The quality of marriage pre-retirement will effect the quality of marriage after retirement. Cultivate common interests but as importantly pursue your own interests and pursue some separate friendships. Establish separate territories in the home. Know that you are not alone: Lots of contented couples run into obstacles and being aware adds normalcy to the event.

Companionship is great for emotional support and continuity helps with a disrupted routine. A honeymoon period is common. But issues can arise with out-of-synch expectations especially feelings of resentment. Perhaps it's a generalisation but women tend to better grasp the importance of social connectivity.

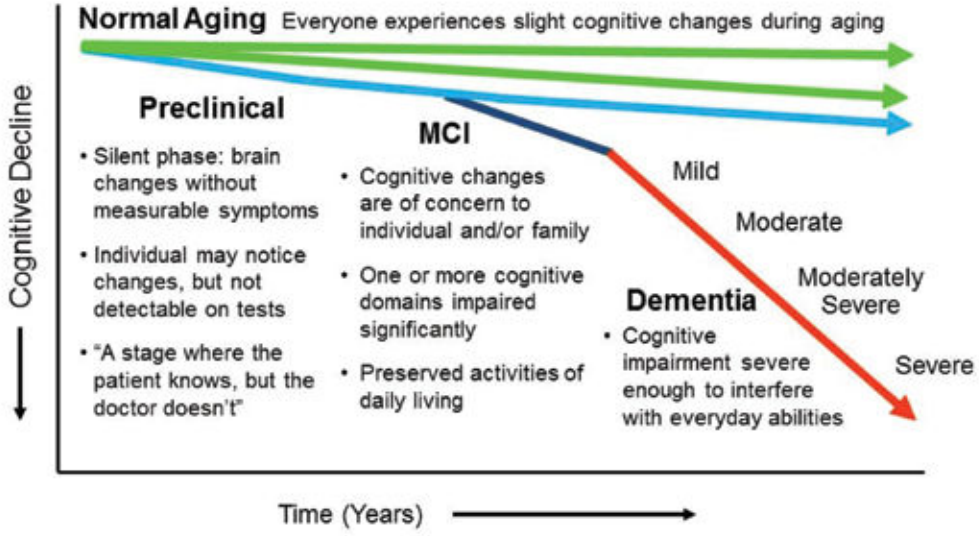
There have been requests for a way to network with other approaching retirees and to connect with retired anaesthetists. Perhaps share your tips and journey, and start the chats on the ASA forum.

I'd like to take this opportunity to thank our attendees, invited speakers, the NSW Committee hosts and our President Dr Suzi Nou for their contributions.

Wishing you all the very best on your personal journey.

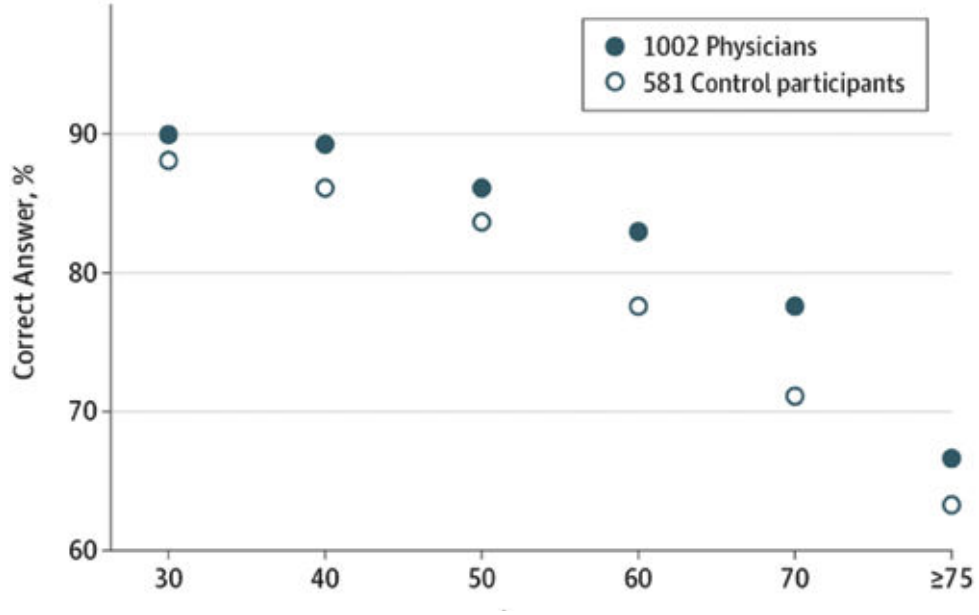
Dr Lan-Hoa Lê
Chair, NSW State Committee

Age and cognitive function



'Health Family and the ageing anaesthetist', Dr Bernard Kelly presentation 1 August, 2020

Short-term memory



'Health Family and the ageing anaesthetist', Dr Bernard Kelly presentation 1 August, 2020

FEATURE

AGEING AND THE ANAESTHETIST – TAKING TIME SERIOUSLY

The enforced downtime from cancellation of elective lists during the first phase of the SARS-CoV-2 pandemic left many anaesthetists with time to reflect.

Type A, competitive, perfectionistic and ambitious doctors sometimes fall into the trap of becoming a human 'doing' with work becoming all-consuming while life sneaks by in the process. We don't often get a chance to truly recalibrate as human beings. For some of us approaching the tail end of our career, this respite brought into focus the passing of time, life outside the operating theatre and other (perhaps confronting) issues that may have stayed blurred in the background.

As chairman of the ASA Communications Committee and working on this particular issue of the *Australian Anaesthetist*, I did some reading around ageing. Given my anaesthesia career began last century, it was apparent I might be both researcher and subject, as I ticked an increasing number of boxes.

The consequences of ageing are sobering at both individual and societal level. Sustainable pension funding, workforce management, community connection, urban design and healthcare expenditure are all impacted. Financial crises or stagnant economic growth (combined with a simultaneous increase in beneficiaries as we are currently experiencing with the SARS-CoV-2 pandemic), make it more challenging for governments.

It is likely our own retirement age will be affected and the number of workers continuing with both minor and major health issues will increase. In the UK, contract and pension changes mean all consultants starting in their post in 2016 will have to work until they are at least 68 to receive their pension in full.[1]

But the potential effects on healthcare systems are also vast. Older patients, chronic disease, comorbidities and increasing complexity confront those who distribute the healthcare dollar. The cost of technological advances, breakthrough medications as well as new treatment modalities all weigh heavily on the minds of health ministers.

And not just the minds of ministers. The

anaesthetist is also burdened with the consequences of a well-fed, sedentary, medically complex and perhaps more demanding population living longer and expecting joint replacements whenever the need arises. This case-mix is challenging enough for the 40-year-old consultant but what about the 60-year-old navigating shift work, sleep disturbance, cognitive decline and increasing bureaucratic demands?

Taking time seriously can lead to existential angst. If we are fortunate enough to live into our 80s, how much of that historical eye-blink should we devote to the operating theatre? What choices do we have? Do we get too comfortable, financially hamstrung or beholden to societal expectations? Can we escape if we wanted?

And if we choose to work into our 60s or 70s, what should we be conscious of as we age, and can we actually be conscious of changes with our own cognitive decline? None of us get out alive. We are all subject to the ageing process and regardless of the myriad cosmetic procedures appealing to our vanity, we know for the moment at least, cellular ageing is unavoidable.

The bad news is age comes with the following:

1. Circadian rhythm disruption and sleep disturbance.
2. Neuronal loss and decreased white matter volume.
3. Neurocognitive impairment, particularly executive planning and function.
4. Deteriorating eyesight.
5. Deteriorating hearing.
6. Musculoskeletal degeneration.

Physical changes may not necessarily impact on day-to-day anaesthetic performance and subtle neurocognitive changes may only be unmasked only with significant stressors. This in itself may have implications for anaesthetic crisis management.

But it's not all bleak. The relationship between age and work ability is not easily elucidated and there's considerable individual variation.[2] Indeed, I am aware of a former ASA WA state chairman and paediatric anaesthetist remaining clinically competent in his early 70s, still doing the occasional patient retrieval/transfer. Another colleague in his 60s established a paediatric cardiac service in the Middle East – testament to how experience, job understanding, education and motivation can (to some extent) compensate for the inevitable changes. However, although declining physical and cognitive abilities do not necessarily have a negative impact on work performance, evidence is emerging that in anaesthesia, ageing clinicians may be an independent risk factor for safe practice. One Canadian study demonstrated a 50% higher incidence of litigation involving anaesthesiologists over 65 compared to those under 50.[3]

When all is said or done, how do we decide enough is enough? And if we choose to continue, how do we maintain our performance?

This dilemma for governments and for those involved in the safe delivery of healthcare will persist. Solutions might require significant cultural and structural change: a mix of longer working lives, better long-term financial planning by both government and individuals, the inevitable stretching of the pension, and the (less palatable) acceptance of a lower standard of living. Priorities may need to change. All seem likely given the 'support ratio' (how many people working aged 20-64 years relative to the number of retired over 65 years) has steadily decreased from 7.2 to 1 in 1950 to a projected 1.8 to 1 in 2050.[1]

For the ageing anaesthetist to continue working, institutional support is needed. Surveys suggest the most common reasons cited for retirement include work pressure, domestic issues and (in the UK at least), dissatisfaction with the health system. I expect similar sentiment exists in Australia.

Work environment, demands, hierarchies, shift work, bullying, and even safety issues such as inadequate PPE during pandemics can impact on the mental health of workers of all ages but may be felt more acutely in those with decreased neurophysiological reserve.

Good staff management can lead to better health, wellbeing and better performance.[1] Roster changes, case selection, registrar allocation and providing assistance to navigate IT systems are key to retaining and supporting ageing workers. Of course, there are mutual benefits. In return, this support is repaid with corporate memory, the sharing of vast clinical experience with diverse caseloads (often in more difficult and less sophisticated times) and historical perspectives of anaesthesia that not only entertain but help broaden perspectives. The passing on of tips and tricks is also not to be underestimated.

Institutional appreciation and understanding of 'human factors' are critical to providing appropriate and safe work environments. Designing and modifying systems to support those working within (making it easier to do things right), should underpin any workplace change accommodating ageing staff. Established consultants "are vulnerable to delusions of adequacy and resistant to change, particularly if it means unlearning a cherished habit"[1] and implementing change can be difficult.

When all is said or done, how do we decide enough is enough? And if we choose to continue, how do we maintain our performance?

In high-stakes industries like aviation and medicine, awareness of psychological, cognitive and physical decline is paramount not just for patient safety, but also for the wellbeing of the worker. Like pilots, the knowledge of this decline with

Membership benefits

SUPPORT

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At a wide range of levels including federal and state governments, private health insurers and regulatory bodies.

REPRESENT

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- Awards, prizes and research grants
- National Scientific Congress
- Trainee members workshops
- Practice managers conference
- CMEs

Publications

- Anaesthesia and Intensive Care
- Australian Anaesthetist
- Relative Value Guide

EDUCATE

Historical collection

- Harry Daly Museum
- Richard Bailey Library

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For further information visit www.asa.org.au
or contact our Membership Services Team

Email: membership@asa.org.au

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age would support 12-monthly medicals, particularly for procedural clinicians (including a work clearance component), not just for patient safety but also the practitioner. Modifying James Reason's Swiss cheese metaphor,[4] regular exercise, good nutrition, sleep hygiene and some kind of supportive relationship (whether it be with partner, family or friends) are the 'barriers' to holes lining up and help prevent decreased job satisfaction, irritability, burnout, anxiety, depression and fatigue. Remaining engaged, completing CPD, stimulating yet manageable challenges and feeling supported by both colleagues and hospital administration are additional protective layers.

This holistic approach to ageing practitioners contributes to work enjoyment and patient safety, yet contemporary public hospital practice suggests there is significant room for improvement. Regardless, there is onus on all of us to look out for our colleagues by checking they have these barriers in place. Taking time to know more about work colleagues not only strengthens the safety net but can also enrich our own lives.

The question of when to finally put down the laryngoscope is complex and depends on individual circumstances. Making the rather hopeful assumption our retirement isn't forced upon us through accident or ill-health, the equation is complicated by financial security, attachment to work, employment opportunities, work-life balance, caring responsibilities, and social policy. Often, it's the desire for financial security keeping us in the game.

It is also difficult determining exactly how much money makes us financially secure. When we plan to retire will obviously influence this figure, but our relationship with money is fraught. It depends on personality, family responsibilities, domestic harmony, cultural background, consumerist drive, ego (and susceptibility to societal markers of success), outside interests and social support – issues that keep our psychotherapist colleagues busy.

With apologies to The Verve, are we all just "a slave to the money and then we die"?

In their 1999 article entitled 'Taking time seriously' Carstensen et al[5] described the following:

> *When people perceive their time as limited (as older workers do), emotional goals take priority and workers tend to focus their attention on effective rewards and resources rather than on material or career-based rewards.*

It might be with age comes enlightenment but looking around at our hard-working older colleagues, the transition from material to emotional goals is obviously challenging. How many of us remain behind bars when the door is actually open? Do we become too comfortable or too locked into a less than healthy reward system? What is the 'emotional opportunity cost' of writing yet another journal article? More property? European luxury cars? Are we hooked on the dopamine, busy planning our next fix while life rushes past?

Medicine is a varied, challenging and rewarding career but as Robin Williams passionately announces in *Dead Poets Society*:

> *Medicine, law, business, engineering, these are noble pursuits and necessary to sustain life… But music, poetry, beauty, romance, love… this is what we stay alive for.*

None of us know our expiry date so all the more reason to heed Carstensen's advice… take time seriously.

David Borshoff

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FEATURE

PLANNING FOR YOUR RETIREMENT

SO, HOW MUCH DO I NEED TO RETIRE?

This is a common question, and unfortunately it is impossible to give a simple answer. It is a highly personal issue as the amount of money needed depends on a wide range of variables. This includes how long you will live, the current state of your health, the rate of inflation, the earnings on the assets you own and how often your children reach out to the bank of mum and dad. Not forgetting any other possible tax implications.

LIVING LONG IN THE LUCKY COUNTRY

Aussies are lucky to be living in a country with one of the highest life expectancies at birth in the world, trailing only Japan, Switzerland, Singapore, Spain and Italy.

The good news, once you've made it to age 60, is that older Australians also have one of the highest life expectancies in the world. For a couple currently aged 60, there is an 83% chance that at least one of them will live until the age of 85.

Life expectancy in Australia over the next few decades shows the Government expects Australians to continue living longer. Much of this is due to the fact that medical and lifestyle advances continue to improve mortality (or death) rates in Australia so we are all living longer. So, when planning your retirement, it's important to remember that reaching a ripe old age is not something that happens to only a few people, we all need more in our retirement savings.

DON'T SHUT UP SHOP TOO EARLY

A common mistake by many retirees is to believe that once you have retired all investments should become conservative and you should minimise the allocation to 'growth' assets such as shares. If you retire at 65 and are likely to live until 85, that is a 20-year investment timeframe which is a very long time in anyone's books. Unless you have an extremely large nest egg to keep pace with inflation (should it return) and your desired standard of living, you should keep an open mind to some appropriate risk in your portfolio to ensure you have a great retirement.

As you can see on the right from the Vanguard 30-year index chart of several major asset classes, the stock market is a roller coaster, yet in the long-term its returns have out-performed most other asset classes – but you need to be taking the long view. There will be stock market corrections, on average there is one (a fall of 10% or more) at least every year. However, when you zoom out from a yearly graph into a 30-year graph, these 'corrections' just look like a blip on the

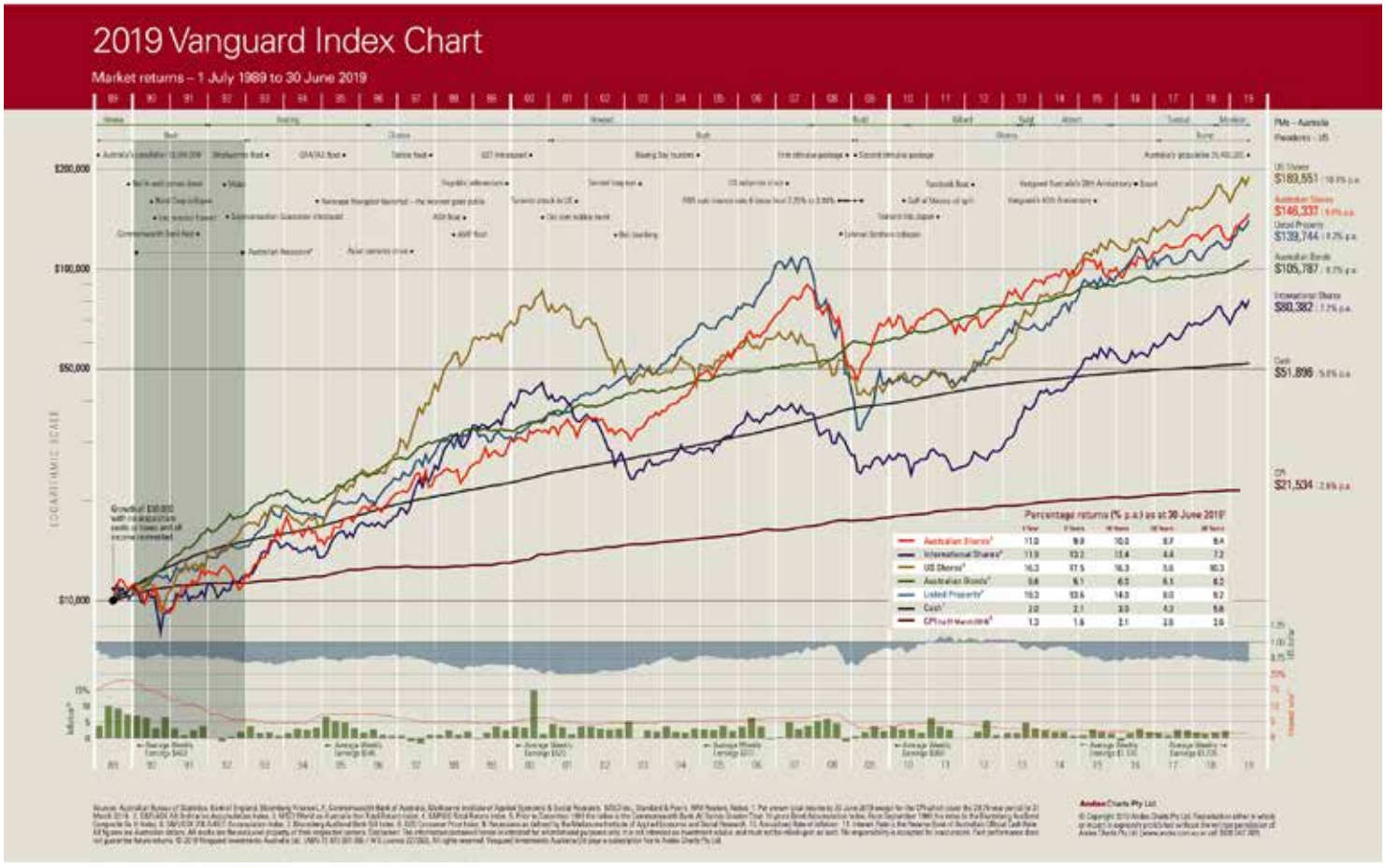

Image: Vanguard (2019)

radar on an otherwise consistent upward sloping line from the bottom left hand corner to the top right.

THERE IS NO CRYSTAL BALL: DIVERSIFY

A long-held strategy for Australians in retirement is the income producing blue chip stocks that pay out most of their profits in dividends. These dividends under the Australian tax imputation system can become fully franked, which can also create a tax refund to people in their retirement. This has been done successfully for decades. However, to achieve the income, you are likely forgoing growth.

Growth companies retain earnings, reinvest into research and development can provide growth in the stock price which can outpace the old blue-chip dividend strategy. No better example is there of these two stock types than in our two largest stocks on the Australian Bellwether index the S&P/ASX200, that is CBA and CSL.

The COVID-19 recession creates challenges for all investors. But among the hardest hit are those in retirement who are relying on regular income from their investments. Australian share market dividends are forecast to fall by about a

10-year total return (incl. dividends) CBA vs CSL (Bloomberg)

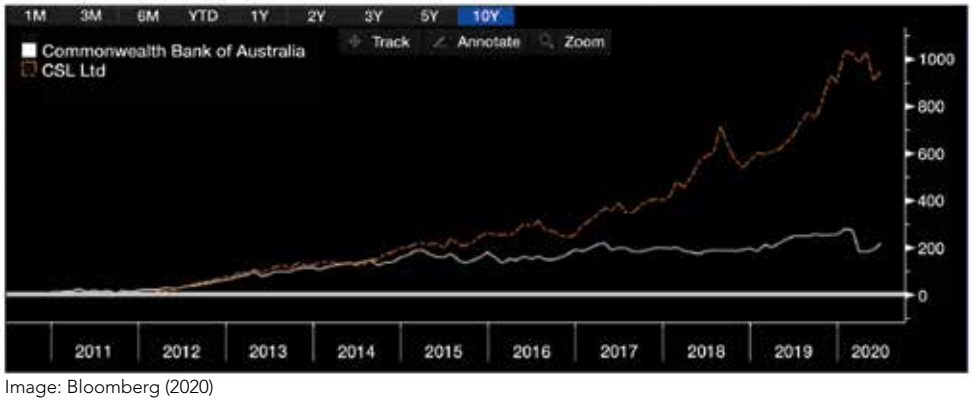

Image: Bloomberg (2020)

FEATURE

third over the next year which will disrupt the generous dividend streams income focussed portfolios once generated.

Geographical diversification into overseas markets will reduce country concentration risk and provide access to important innovative companies that have global reach. As important as we think we are in Australia, we make up merely 2% of global stock markets (the US are 50%).

IT'S SIMPLY SUPER!

Another reason why we are living in the lucky country is that while we are working, we can add funds (and save some tax whilst doing it) into a superannuation account. In retirement superannuation can be a tax-free environment (up to certain limits) meaning all the money your super makes and all the money you take out can be tax-free. You did read that correctly – tax free! 100%!

So, getting as much money as you can into super is the number one strategy for building wealth for your golden years because you can save tax when you contribute, as well as in retirement your super is in a tax haven.

If you cast your mind back 11 years, the limit to contribute to your super fund with a concessional (15%) tax rate was as high as $100,000, those lucky baby boomers. Despite the Australian Government wanting you to be self-sufficient in retirement they also don't want you to have too much tax-free fun. Hence why they have restricted the amount you can contribute with a concessional tax rate of 15% to just $25,000 per financial year since 1 July 2017.

So, when making the maximum $25,000 concessional contributions you are simultaneously reducing the tax payable at your highest marginal income tax rate. This is what is known as a no-brainer – assuming you can afford too.

There are other ways you can put money or assets into your super that allow you to build your balance, such as after tax contributions or non-concessional contributions. There is no tax benefit on the way into super with these contributions as the tax has already been paid but in the meantime your investments are in a better tax environment. Don't forget the tax-free haven that awaits.

The Australian Government wouldn't want you to live tax-free forever and have applied limits on the amount you can have in this tax-free (pension) environment. At present this is $1.6m per individual. This is called the 'Transfer Balance Cap' and will increase over time with expectation the Australian Tax Office (ATO) will let this rise to $1.7m as at the 1st of July 2021 – this is to be confirmed.

Despite the Australian Government wanting you to be self-sufficient in retirement they also don't want you to have too much tax-free fun.

So, let's say after fees you were able to achieve a net 7% return from a pension balance of $1.6m, this equates to an income of $112,000 per annum, again with zero tax. A 7% return is an average balanced investment return for the past 10 years, including the recent market turbulence.

For the over achievers that can surpass the $1.6m mark, any investment past this current cap is no longer in the 'no-tax' bracket and is taxed at the 15% super rate, but potentially that is still better than in an individual's own name.

HOPE IS NOT A STRATEGY

You may have come across the 5 Ps in sports: proper preparation prevents poor performance. Preparing a road map as to how to achieve your retirement goals and navigate the complex superannuation system is strongly recommended. Making clear, specific, achievable targets are an important start. Giving these targets a timeline with clear measurable objectives and being kept accountable is imperative. Hope is not a strategy, so don't leave it to luck.

No plan should be a set and forget strategy, especially one where you only get one shot at it such as your retirement. For starters the government is regularly tinkering with the super rules and creating an ever more complicated system. People expect future events to be positive, yet we know that life happens, and our situations can change quite unexpectedly and quickly. Having a regular check-up of your retirement strategy will keep your plan on target or allow you to pivot should those unforeseen situations occur.

Think of it like a gym membership, for some who are extremely self-disciplined and motivated that's great, they will make it part of their regular routine and workout consistently and be forever motivated. But for most of us and I mean nearly all of us, having a gym membership alone is pretty much useless. We need a trainer with us to keep up our visits and keep pushing us to work harder and keep us on track to achieve our fitness goals. This is what good financial advice should be doing for you.

REAL WORLD EXAMPLE

Here's a recent example of retirement advice, a client with a family trust that had several long held Australian shares, was performing miserably during the recent market events. Not only were the shares cut in half at the nadir in March, the couple's family trust structure had long served its purpose and the couple's now high-income earning children no longer allowed for tax effective distributions.

One of the couple's Self-Managed Super Fund balance (SMSF) had some room below the 'transfer balance cap' of $1.6m. They also hadn't utilised the 'non-concessional contribution' limits of late. An 'in specie' transfer of the family trust shares to the SMSF as a 'non-concessional contribution' at the recent trading lows

allowed for a hugely reduced capital gains tax event. The long-held shares although changing beneficial ownership were retained in the couple's SMSF at now a considerable discount to the current market levels given the rally from the first quarter lows. If the client does decide to sell these shares when they retire, they will be doing so without any tax implications.

SAFETY NET

We all dislike paying insurance premiums but are forever grateful when we hit that 'hidden' pylon in the car park, and we know we are covered. Personal insurance cover is something we never wish to claim on, but without personal risk cover it can derail even the most robust financial plan and quite possibly destroy your ideal retirement.

As we get older the insurance premiums can rise steeply and again having this reviewed regularly becomes important, as being over-insured is more common than you may think. You don't ever want to be worth more dead than alive and nor should it be a lottery result for your partner.

Make sure your children have adequate insurance. It's much more affordable than your funding their misfortune.

BE A SNOWBALL

"My wealth has come from a combination of living in America, some lucky genes, and compound interest" – Warren Buffet

Knowing your risk capacity and becoming knowledgeable on investments with the right partnership can guide you through the opportunities and challenges you will face.

Warren Buffett is known as 'Snowball', not for the colour of his hair. A snowball compounds during its travel down the hill. The bigger it gets, the more snow it packs on with each revolution. The snowball effect is a metaphor for compounding. It explains how small actions carried out over time can lead to big results.

If you're interested in using compound interest to help your savings grow, then the sooner you start, the better. That's because, like any good snowball, the earlier it starts rolling, the more snow it will collect along the way.

It is never too late to start. If you would like to start planning your snowball please contact Stuart Chan, Partner or Mike Cooney, Senior Investment Advisor.

Stuart Chan and Mike Cooney
Cutcher & Neale Investment Services

ABOUT THE AUTHORS

Stuart Chan has been with Cutcher & Neale since 2009 and is a Partner of our specialist medical services division, providing specialised accounting and financial services to both medical and dental professionals, in addition to providing specialist advisory services to private clients and small to medium enterprises. He is a regular presenter of training programs for professional organisations including the AMA (NSW), the AAPM and other general and specialist medical associations.

Mike Cooney, Senior Investment Advisor, joined Cutcher & Neale Investment Services in 2019. He has more than 25 years of experience working in financial markets and financial services in London, Sydney and Hong Kong. Mike has specialist skills gained from his time abroad working in global investment banks, with significant experience in Asian and derivative markets. He enjoys building long term relationships with clients through ongoing education to help demystify financial markets.

FEATURE

N95S, ELASTOMERICS, FIT-TESTING AND COVID-19:

RESPIRATORY PROTECTION FOR FRONTLINE HEALTHCARE WORKERS IN AUSTRALIA

There were a lot of things we didn't know prior to COVID-19: how to tackle remote schooling, how to use Zoom and how to self isolate with a sustainable toilet paper supply without joining the ranks of hoarders. Other things many Australian anaesthetists have become better acquainted with in 2020 are terms like N95 respirators, elastomeric respirators, fit-testing and fit-checking. This has been a highly topical area for anaesthetists during the course of the pandemic, as we navigate the dynamic guidance issued by our hospitals and government bodies who have worked at breakneck speed to respond to this crisis.

Frontline healthcare workers are at particular risk whilst delivering care to infected patients be they of known or unknown status. This necessitates consideration of appropriate personal protective equipment (PPE) for staff who have a high risk of exposure to virally-loaded aerosol and droplets from COVID-19 patients. Of particular risk are the aerosol generating procedures (AGPs) encountered by anaesthetists on a daily basis through procedural airway management.[1] These particles are small enough to remain suspended in air for a prolonged period of time and retain their infective capacity.[2] Surgical masks do not confer sufficient protection from aerosols.[3]

A key element of PPE is respiratory protection by way of a filtering respirator. These can be classed as disposable and reusable. Unlike surgical masks, these are designed to filter all the inspired air to remove significant particulate matter, including those carrying infectious agents. Respiratory protection is a major part of PPE and many of the recommendations from overseas call for a fit-tested N95 respirator.[4]

WHAT IS FIT-TESTING?

To work effectively, an N95 respirator must form a tight seal against the user's face such that all inhaled air traverses the filter material rather than through the gaps between the face and respirator. When an N95 respirator is worn poorly, it is only as effective as a surgical facemask.[5] Since we all have different facial characteristics, fit-testing is required to ensure that the

chosen N95 respirator is able to create a seal on the user.

In the largest study to date, over 6,000 healthcare workers in South Australia were tested as part of pandemic influenza response in 2006-2007.[6] In this study, out of 5,024 healthcare workers who had completed the questionnaire, 4,472 (89%) could be successfully fitted while 552 could not be fitted with three or more N95 respirators. Of those who were successfully fitted, 3,707 (82.9%) were able to be fitted with the first N95 respirator that was tried, a further 551 (12.3%) required testing with a second model and 214 (4.8%) required three or more models to be tested. Healthcare workers who identified as Asian were the cohort that was most likely to fail fit-testing (16.3% vs white 9.8%) [p=0.011].

In Canada, McMahon et al conducted qualitative fit-testing on 1,271 health care workers. Only six were unable to be fitted and 95% were able to be fitted with the first N95 respirator that was tried. A total of seven types of N95 respirator were available for testing.[7] A further study on qualitative fit-testing was conducted in a Darwin ICU. In this study, 50 volunteers underwent fit-testing with three types of N95 respirators. Fourteen participants found that none of the N95 respirators fit, 18 passed with one type, eight with two types and 10 with all three types.[8] This highlights the importance of fit-testing and for hospitals to stock more than one brand of N95 respirators.

A fit-test is not the same as a user seal check, or fit-check. A user seal check is a self-determined test which is done every time a respirator is worn. It can involve a negative and positive pressure check as well as checking that the respirator and straps are seated correctly. The positive pressure fit check confirms that a positive pressure is generated in the respirator during exhalation while the negative pressure check confirms that a vacuum is created causing the respirator to be drawn in slightly during inspiration. Many studies have shown that fit-checking is a poor surrogate for fit-testing. A study on Canadian healthcare workers by Danyluk et al found that out of 643 participants that identified as having an adequate seal after the fit check, 25% failed the subsequent quantitative fit-test and 14% failed the qualitative fit-test.[9] This result has been replicated in many other studies. Lam et al tested 638 Chinese nursing students and found that fit checking was not helpful in identifying gross leakage.[10] Similarly in Huh et al the sensitivity for a user fit check for determining passing a qualitative test was low at 17.5%-53.8%.[11]

According to Australian Standards (AS/NZS 1715:2009) fit-testing of a tight-fitting respirator such as a P2 or N95 respirator is mandatory.[12] However this is not legislated. Fit-testing is also recommended by the NHMRC[13] and more recently both the ASA and ANZCA have joined the call for fit-testing.[14,15]

There are two methods for conducting fit-testing; qualitative or quantitative. Qualitative testing is performed by aerosolising a sweet or bitter substance (saccharin or Britex®) into a clear hood that is worn by the user while wearing a N95 respirator.[16] A series of dynamic movements such as bending over and talking are performed according to the test protocol. If the user cannot taste the substance throughout the test, then the fit-test is successful. If the user can taste the substance at any time, then an adequate fit has not been obtained. This test can only generate a pass or fail outcome and is dependent on the user being able to subjectively taste the substance.

On the other hand, quantitative testing uses a machine such as the TSI PortaCount to sample the number of microscopic particles in ambient air and compares it to the microscopic particles within the N95 respirator. Again a series of dynamic movements are performed. To pass fit-testing, the overall fit factor calculated by the machine has to be greater than 100. This means the microscopic particles in the N95 respirator have to be 100 times less than ambient air. Unlike qualitative testing, quantitative testing is objective and generates a 'fit factor' which reflects how well the N95 respirator fits the user.[17] In Australia, testing can be done by any

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Table 1: Number of respirators which passed fit-testing

Respirator	Pass	Total	Percentage
3M 1860/3M 1860S	51	63	81
BSN Medical Proshield (S) or (M)	8	32	25
Halyard	5	13	38
3M 8210	3	7	43
3M 1870+	5	5	100
Other disposable N95 respirator*	1	9	11
Sundstrom Elastomeric Half and Full Face (SR100/SR 200)	26	26	100
3M Elastomeric Half and Full Face	22	23	96
Total	**121**	**178**	**68**
Total disposable N95 respirators that passed	**73**	**129**	**57**
Total elastomeric respirators that passed	**48**	**49**	**98**

* Only respirators with five or more counts were analysed individually. Respirators with less than five counts were grouped together in 'other'.

competent person although processes for credentialing fit-testers are currently in development. Another benefit of quantitative testing is the 'real time mode' which is available on the PortaCount machine. This mode can be used to educate users on how to correctly don the N95 respirator as adjustments to the respirator are reflected in a real time fit factor.[18]

ASA AND FIT-TESTING

Due to interest by members, the ASA organised fit-testing in Epworth Richmond and in Albury-Wodonga Health. Katie Blair and Alycia Campbell from Onsite Safety Australia (NSW) were enlisted to help us with testing. Katie is the respiratory specialist from Onsite Safety, with over 15 years of experience in respiratory safety including fit-testing.

Over two days, we tested 60 participants and 178 N95 respirators and elastomeric respirators. There were 33 male and 29 female anaesthetists. The results for respirators which resulted in a pass are shown in Table 1.

The most commonly tested disposable N95 respirator were the 3M 1860 and 3M 1860S as these were provided by the ASA from OnSite Safety Australia. Other disposable respirators that were tested were provided by the participants. The BSN Medical Proshield N95 was the second most commonly tested disposable N95 respirator, as these respirators are commonly available in public hospitals in Melbourne and can be purchased from pharmacies. Other N95 respirators that were tested include the Halyard N95 respirator, 3M 8210 and 3M 1870+. A total of 12 different types of disposable N95s were tested.

Overall the pass rate of the disposable N95 respirators was 73/129 (57%). It is interesting to note that the combined 3M 1860 and 3M 1860S pass rate is 51/63 (81%) compared to the BSN Medical Proshield N95 (in either S or M) which is 8/32 (25%). Amongst other disposable N95 respirators, the Halyard had a pass rate of 5/13 (38%), 3M 1870+ had a pass rate of 5/5 (100%) and 3M 8210 had a pass rate of 3/7 (43%). Note however, that it would be inaccurate to compare the respirators which have a small denominator with those with a larger denominator. Furthermore, this is not a formal study where comparisons between the different N95 respirators were sought, thus statistical tests cannot be applied. Nonetheless it is interesting to note that the BSN Medical Proshield, which is so prevalent in Melbourne, had a very low pass rate during our testing session. The overall results are consistent with the industry experience of our professional fit-testers.

In our dataset, there was no difference in the overall pass rate for both disposable and elastomeric respirators between men (67/99 respirators tested) vs women (54/79 respirators tested). There were also no obvious differences in pass rate between people of different age groups, height, BMI or ethnicity.

During the ASA testing session, there was also the opportunity to purchase and test elastomeric respirators. According to the Australian Standards, any tight fitting respirator including elastomeric respirators should also be fit-tested.[12] The elastomeric respirators available included the 3M half face and full face series; and the Sundstrom half face (SR100) and full face (SR200) respirator. Compared to disposable N95 respirators, the pass rate for these respirators were significantly higher. Out of 49 elastomeric respirators that were tested, 48 passed fit-testing. The single failed fit-test was of a member who tried two different sizes of the 3M full face elastomeric and found that the small size fit but not the medium size.

ELASTOMERICS

Elastomeric respirators are a class of respirators designed to be reusable. These include the Sundstrom and 3M half and full face models used in the ASA Fit-test Session. Elastomerics are so named due to the rubber material comprising the facepiece and can be used as an alternative to N95 respirators when mounted with a user-replaceable filter. These filters perform to specifications rated by the manufacturer for their suited purpose. They are at least as protective as N95 respirators. The Sundstrom SR510

and 3M 6035 filters perform to a P3 rating, although overall protection on a half-face respirator is capped due to a rating limit in assigned protection factor (APF) placed on the design.[19]

Elastomeric respirators are not widely used in Australian healthcare. They see more common use in industrial settings where exposure to fine particulate matter such as asbestos, silica or concrete dust can result in chronic lung disease.[20] They can be useful under the crisis conditions of a pandemic when national stockpiles and manufacturer supply chains can be stretched, or when frontline healthcare workers fail fit-testing of hospital supplied N95 respirators.[21] Elastomerics are seeing successful deployment overseas where major PPE shortages and price rises have driven a need for alternative solutions.[22,23]

Impediments to wide use include lack of familiarity within the health sector, reduced clarity of speech, increased involvement with donning and doffing, perceived complexities with disinfection as well as upfront costs.[21] When compared, 3M 1860 N95 masks showed superior speech intelligibility to 3M 6000 series elastomeric half masks, though both exceeded the minimum communication criteria as set by the National Institute for Occupational Safety and Health (NIOSH).[24]

Institutional elastomeric respirator programs require additional consideration for cleaning, disinfection, storage, consumables and maintenance. They can allow a more forgiving seal due to deformability of the rubber compound and presence of adjustable straps, as reflected in their high pass rate in our results. Personnel can be rapidly fit-tested and trained in the use of these devices.[25] They offer advantages including higher APF,[19] reduced waste and reduced cost in the long term.[21,22]

Concerns about cleaning and disinfection can be overcome by instituting a set of standard operating procedures for healthcare workers which are concise, efficacious and simple to follow. Where a hospital network has multiple sites, a protocol that is broadly applicable to the conditions at each site allows them to be rapidly implemented with minimal training, as is required for pandemic conditions.[26]

Some manufacturers recommend discarding the filter after each use during conventional demand settings. The Centers for Disease Control and Prevention (CDC) recognises that shortages during contingency or crisis situations may warrant cleaning of the filters. Care must be taken to only clean and disinfect the filter housing, unless the filter media itself has been shown to withstand exposure to the cleaning solutions without degrading performance. occupational safety and health administration (OSHA) only deems it necessary to replace filters when soiled, contaminated or clogged.[21]

SUMMARY

As case numbers rise and parts of Australia re-enter heightened restrictions,[27] it is prudent to evaluate our approach to staff protection and ensure use of respiratory protection is consistent with global standards on fit-testing. Hospitals should stock multiple types of N95 masks as it is unlikely for a single type and size to provide adequate protection for the entirety of their frontline staff. The level of protection can only be ascertained through formal fit-testing as embodied by our own Australian Standards, as well as the standards of our craft group representatives ANZCA and ASA.[12,14,15]

Elastomeric respirators provide a solution for those who fail fit-testing and beyond

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that, can be an alternative to disposable respirators with at least equivalent protection and viable long term cost-effectiveness.[21,22] With no clear end in sight to the COVID-19 pandemic, healthcare providers need to explore sustainable PPE options. Elastomeric respirators are able to augment existing supplies of respirators for hospitals and in cases where a dedicated program exists, have the potential to successfully replace N95s as the sole respiratory protection.

Dr Isaac Cheung
Dr Caitlin Low
Dr Suzi Nou

Note: The fit-testing was conducted on 2-3 June at Epworth Hospital, Richmond and 4 June at Albury Wodonga Hospital. Victoria has since seen several further escalations with Stage 4 restrictions underway at time of publication.

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SURVEYING THE COVID-19 PANDEMIC: IMPACT ON AUSTRALIAN ANAESTHETISTS

In order to advise the ASA Council in its various and protracted deliberations, discussions and submissions, members were surveyed three times from March through to June 2020. Elements of the findings follow this introduction from Dr James Bradley, Specialty Affairs Adviser. In the first article, Dr Nicole Fairweather addresses the fraught issue of Personal Protective Equipment (PPE), which continues to evolve and is as yet unresolved in the view of the ASA. Dr Julie Lee then explores some of the differing impacts of the pandemic on public and private practice and finally Dr Peta Lorraway assesses the impact on the wellbeing of survey respondents and the psychological distress experienced by some.

The first survey was conducted from 23 March 2020. A 'pandemic' had been declared by the Prime Minister on 27 February, and by the WHO on 12 March. Australia was experiencing a 25% increase in daily numbers at that stage, and in many ways, appeared to be following the Italian and Spanish trajectories. This survey focused on practice intention at the time of the pandemic declaration, the level of preparedness of responders and the facilities, the level of clinical activity at the time, the availability of PPE equipment and training, the willingness to 'up skill' for Intensive Care or Emergency Department practice, and satisfaction with COVID-19 screening procedures. Survey findings were reported to members through the President's e-news and other broadcasts. This was a time of real trepidation: 1,716 cases had been diagnosed when the survey was initiated; a week earlier, cases numbered 376. A particular concern throughout has been with preparedness and PPE. Nicole Fairweather focusses on the PPE findings in her accompanying article.

In the second survey, which closed on 6 May 2020, improvements in the level of preparedness and the availability of PPE equipment, access to 'donning and doffing' training, attitudes to screening and quarantining, and actual exposure to COVID-19 patients were surveyed. At this time, 6,875 cases had been diagnosed, and the 'curve' had been 'flattened' – an increase of only 129 from a week earlier.

The third survey closed on 22 June 2020. Clinical activity levels and the reasons for it (voluntary or involuntary) were surveyed, along with ongoing concerns about PPE availability, training and testing, wellbeing in general, possible discrimination, effects on household income, impacts on training (particularly in relation to trainees and examinations), and quarantining. At this time, 7,474 cases had been diagnosed,

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with the 'curve' remaining flat. Julie Lee addresses these elements in her accompanying article. The final questions of the third survey incorporated the ten questions of the Kessler Psychological Distress Scale ('K10'), and were asked to give a measure of anxiety experienced by responders in the four weeks prior to survey (this being a time when Australia was seen to having 'dodged a bullet'). Four weeks later, there has been a dramatic increase in the number of cases in Melbourne and the Mitchell Shire (almost 3,000 cases in the fourth previous week). It is interesting to contemplate how the responses to a 'K10' conducted today would compare with the responses of one month ago…

COVID SURVEY DEMOGRAPHICS

The first survey had 581 responders (almost 25% of the clinically active membership), and the subsequent surveys 371 and 458. These response rates are regarded as excellent for surveys of this type, and comparison with the known ASA demographics confirms that the surveys are representative of the ASA membership. Of the 60% identified as being in private practice, three-quarters were male and one-quarter female, and a large percentage reported public hospital appointments. Of the 40% identified as being principally employed practitioners in public teaching hospitals, 50% were male and 50% female.

Survey findings partially addressed or not addressed in the accompanying articles include the following:

Practice intentions

Ninety percent of all responders stated that they were planning to continue to work through the pandemic. This included 94% of public anaesthetists, but only 65% of private anaesthetists, with 28% of this group unsure and 6% not planning to continue to work.

This is considered to reflect uncertainties about the likely elective private procedural caseload, given that 60-65% of all procedures are conducted in the private sector. Intuitively, it was widely perceived that public hospitals were likely to be increasingly busy as the pandemic evolved, with the workload considered likely to incorporate a variable commitment to intensive care. However, as 'the curve flattened', it became apparent that the public elective caseload had been considerably reduced, with the anticipated COVID-19 caseload failing to eventuate. The private caseload had been reduced due principally to government dictate, in anticipation of providing support for the public hospitals.

Members had been asked if they were willing to work temporarily in another health service during pandemic. There was wide support for this:

- Public: Yes 32%, No 37%, not sure at this stage 31%.
- Private: Yes 49%, No 24%, not sure at this stage 27%.

But support was subsequently tempered by elements of the private hospital support contracts that were offered. Very few anaesthetists are known to have signed contracts which would have enabled their reassignment to other facilities.

At the time of submission of this article for publication, clinical activity with the exception of Victoria has returned to close to pre-pandemic levels. Current practice intentions are untested.

Preparedness

The first survey showed a low level of personal and institutional preparedness, but by the time of the second survey, there had been a considerable improvement. This is also addressed in Julie Lee's article.

The first survey had shown both public and private anaesthetists had reported virtually identical preparing this to deal with ongoing patient care; in the order of unprepared 22-23%, somewhat prepared 69-70%, and prepared 8%.

These near identical responses can be seen as surprising given that much of the comment regarding 'unpreparedness' had been targeted at the private sector.

The second survey was worded somewhat differently, but it was reported that public facilities were regarded as being fully prepared to deal ongoing patient care by 48%, somewhat prepared by 47%, and unprepared by only 1%. Private facilities were regarded as fully prepared by 41%, somewhat prepared by 54%, and unprepared by 3%.

Elective surgery levels

Non-urgent elective surgery was suspended in both public and private facilities on 1st April 2020. At this stage, the 'curve' seemed to be 'flattening', with daily increases in diagnosed case numbers falling from about 25% to about 10%: prospectively, things seem to be improving, and with hindsight benefit, this proved to be correct: or was correct until the second half of July.

Later in April, elective surgery was recommenced at a reduced level (25%, although the actual caseload permitted varied).

Responses to the second survey which covered the two weeks following the restart showed that elective surgery had restarted at a reduced rate in 80% private and 73% of public hospitals, but remained considerably reduced in 20% of private and 22% of public hospitals, with 5% of the latter having restarted at a normal rate.

'Up-skilling'

The first survey canvassed the intent of anaesthetists to 'up-skill' in intensive care and emergency medicine. Public anaesthetists were somewhat more likely than private anaesthetist to up-skill in intensive care (68% and 53%).

Up-skilling was not explored further in the second and third surveys.

Dr James Bradley

#PPEMATTERS

Every great disaster movie begins with a scientist being ignored. The ASA undertook three member surveys during the initial surge of COVID-19 in Australia. Members were able to add free comments and these were a sober and foreboding read. They told a story of committed anaesthetists who felt unsupported, ignored, threatened and deceived. A loss of trust in administrations and management was obvious, and comments relayed a litany of 'despicable' behaviours and 'cloak and dagger' techniques.

The first survey just preceded the Federal Government's cancellation of most elective surgery. Five hundred and eighty-one members in a 50/50 mix of public and private replied, with more than 90% of public and 65% of private anaesthetists planning to work through the pandemic. Commentary highlighted concern about PPE: PPE is something that anaesthetists probably thought they understood – after all, essentially everything they do is an 'aerosol generating procedure' (AGP).

PPE concerns then are considered almost exclusively in this article:

- When first surveyed, 92% described varying levels of unpreparedness for ongoing patient care and surge capacity, proffering 496 free comments. At this stage only a handful of members had cared for a COVID-19 positive patient. 'No PPE' was a common comment.
- 61% had experienced a shortage of PPE first-hand, 76% had not been fit-tested, only 59% had received training in donning and doffing PPE, and only 37% had been able to participate in simulations for COVID-19 intubation scenarios. Their comments revealed that this level of preparation was not through a lack of trying. Those in public and private made similar remarks, and upper case and italics were frequently used:
  - "We are only being reactive, not proactive".
  - "When is the government going to make an assertive decision to listen to their front line?".
  - "It's hard not to feel like cannon fodder".
  - "… is not heeding our warnings".
  - "Poor communication from management regarding plan. Suggestions/concerns from frontline staff ignored. Have to organise own simulation but need to jump through multiple red tape/political hoops for management to allow staff to attend. Lack of crucial protective equipment".
  - "I haven't been N95 fit-tested, yet asked to use one if required. They showed us how they would put one on but didn't let us practice with the actual mask".
  - "Private hospitals REFUSE to allow you to VIEW the PPE, won't tell you what it is, REFUSE to allow training".

The second survey closed on 6 May 2020, at a time when some elective surgery was restarting. By now, 10 respondents had cared for a COVID-19 positive patient. By now the goalposts had started to move with definitions of AGPs changing, and PPE requirements being softened.

Responders reported that public hospitals were fully (48%) or somewhat (46%) prepared, compared with private (41% and 54%). Drug shortages were being experienced by many: mainly propofol and suxamethonium. A large majority (78%) had still not been fit tested, although most wanted to be in accordance with AS/NZS 1715:2009 which mandates it. Reassuringly, 97% had been able to undergo donning and doffing training and 92% had done simulated intubation scenarios. PPE shortages were rife, most commonly N95 and surgical masks, and face shields.

Comments included:

- "PUBLIC HOSPITAL is DENYING people fit-testing".
- "Very disappointed in ASA and ANZCA for not pushing harder for mandatory fit testing".
- "We have paid to have private fit-testing done and the results were enlightening".
- "Most PPE is locked away".
- "It's all about the PPE. There is not enough freely available and N95 masks are guarded. If we can't look after the staff then we've lost before we start".
- "I would prefer unpleasant truths rather than lies. For Infection Control Expert Group (ICEG) to say that severe coughing doesn't generate infectious aerosols is laughable".
- "Goggles are unavailable".
- "I notice in private hospitals… that management has restricted… even basic levels of PPE like normal surgical masks which I think is despicable".
- "It's been an absolute shitstorm and unnecessary anxiety provoking and head butting with cloak and daggers regarding availability of PPE".
- "Some policies on PPE use are influenced by availability, rather than purely by clinical considerations".
- "Doctors have to seek their own supply".

The third survey, which closed on 22 June 2020, concentrated on welfare but continued to outline the litany of PPE problems contributing to the long list of stressors.

Dr Andrew Miller (ASA Vice-President and AMA WA President) summarises PPE concerns well in his YouTube video (https://www.youtube.com/watch?v=3oTzF0VFvqM), detailing why PPE is vital to anaesthetists. He explains that systemic measures which are beyond our control, and which should come before the use of PPE, are not being undertaken:

1. Elimination of COVID-19 from the hospital environment (aside from

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positive patients) by screening and testing.

2. Engineering of hospital air-flows and 'no-touch' entry and thoroughfares.
3. Administrative controls of rostering, with team cohorting, paid quarantine leave and single hospital employment to allow for quarantine of potentially exposed workers whilst still allowing operational continuity.
4. Mandatory PPE provision, training and fit-testing.

In this author's opinion, when there is no evidence base upon which to base guidelines, we must err on the side of common sense and the safest possible option to provide the highest level of safety to health care workers (HCW). Given the high HCW infection rate in Victoria at the time of writing (requiring nursing staff to be flown in from interstate), the standards for PPE are clearly inadequate, and need to be raised.

Dr Berger describes it well in his *Sydney Morning Herald* piece (https://www.smh.com.au/national/please-stop-calling-healthcare-workers-heroes-it-s-killing-us-20200723-p55ev2.html): We don't want thanks. We don't want medals and awards. We just don't want COVID-19.

ASA PPE guidelines have not been fully endorsed by the ICEG but are available on the ASA website and are currently under review by a Senate Committee (https://asa.org.au/position-statement-20-iceg-reply-asa-rebuttal-senate-submission/).

Although the members of ICEG are undoubtedly dedicated and knowledgeable professionals (https://www.health.gov.au/committees-and-groups/infection-control-expert-group-iceg), they have no skin in this game – certainly not exposed skin. For decades anaesthetists have fumed when told by well-meaning physicians to avoid hypoxia and hypotension. Now with Ivory Tower bodies controlling our PPE, perhaps the call should be for those on such committees to come and undertake a newly redefined non-AGP with little more to protect them than a plastic apron and a surgical mask, reused throughout the entire list because that is all that they are allowed. Either that or heed our informed pleas for change to PPE standards.

When anaesthetists cannot trust in their administrations and management to manage the systemic issues, they must be absolutely certain in their PPE. It represents their last line of defence and is the only one over which they have any control. So when inadequate or absent PPE is all they have, with none of the usual redundancies for safety, they are shouting #PPEmatters!

Dr Nicole Fairweather
ASA Executive Councillor

HOW COVID-19 HAS IMPACTED PUBLIC AND PRIVATE PRACTICE

Three separate surveys regarding the impact of COVID-19 were administered to our members, in late March, late April and early June this year. COVID-19 has undoubtedly impacted our personal and professional lives in a multitude of ways.

We are now adapting to a new 'normal' way of living. The recent surge in new cases within Victoria and New South Wales and misdemeanours in Queensland are a cause for concern. This has heightened our uncertainty for the future and left the rest of the nation bracing for episodes of recrudescence. Losses of jobs and dramatic decreases in incomes across all industries, including our profession, have significantly dampened our livelihoods. In addition to financial concerns, the global shortage of personal protective equipment (PPE) and healthcare worker infections have contributed to the pandemic-induced anxiety. The COVID-19 pandemic was declared in March, but we are already seeing evidence of responder fatigue amongst the community. This type of community behaviour could lead to recurrent surges in cases, amplifying the ongoing impact of COVID-19 on our wellbeing and way of living.

Other articles in this issue of *Australian Anaesthetist* explore personal protective equipment (PPE) issues and the effect on the 'wellbeing' of anaesthetists. This article presents survey findings about pandemic preparedness, the economic effects on anaesthetists, 'pandemic-induced discrimination' and the 'opportunities' presented by the pandemic for the offering of regressive contracts and 'managed care proxies'.

PANDEMIC PREPAREDNESS

The reported rates of personal pandemic preparedness were identical for public and private responders in the initial survey (prepared 8%, somewhat 70% and 69%, unprepared 22% and 23%)

In the first survey, 67% of public and 55% of private responders reported having experienced a lack of relevant personal protection.

In relation to PPE fit testing, in the first survey, 33% of public responders said they had been 'fit-tested'. However, in the second survey, 25% public had been fit-tested, with 60% of those expressing a wish to be 'fit-tested'. It is likely that

there was confusion about the differences between 'fit checking' and 'fit-testing' early in the pandemic. Only 15% of private responders reported as having been 'fit-tested' in both surveys.

The greater PPE shortage in the private sector may be attributed to private hospitals having poor or lack of access to national stockpiles.

In late March, 57% of public but only 20% of private responders had participated in simulation training for performing intubations on suspected or known COVID-19 patients and this had increased to 92% and 64% by late April.

Many respondents commented that they would be uncomfortable with treating a suspected or confirmed COVID-19 patient in private practice with limited training and adequate protocols in place.

In the first survey, only 24% of our respondents were satisfied with the level of COVID-19 screening procedures in the public sector compared to 34% in the private sector, though this improved to 55% and 75% respectively in the second survey.

In the second survey, 7.6% (7 of 92) of public responders had treated a known COVID-19 infected patient, and 4.3% (4) had intubated a patient for respiratory failure. No private responder reported having treated a COVID-19 infected patient.

ECONOMIC EFFECTS

The cessation of elective surgery lead to grave economic consequences for those of us in private practice, with ongoing room fees, registration and indemnity costs despite a complete or significant loss of income. Overall, 78.22% experienced a reduction in their usual workload during the first three months of the COVID-19 pandemic. Household income changed during this time by more than 75% for 12.7% of respondents, 51-75% for 19%, 26-50% for 30.1%, <25% for 19.4% and remained unchanged for only 15.2%. This is alarming, as 52.21% of the respondents who experienced a reduction in income were the sole income earner for their household. This significant drop in income was due to a lack of available work in 87.3%, a personal decision to reduce workload due to concerns of contracting COVID-19 in 9.5%, medical illness in 4.3%, enforced isolation due to confirmed or probable COVID-19 exposure in 1.9%, and the need for being quarantined for 4.3%. The drop in household income was also attributed to spouses being made redundant, given income cuts or losing their businesses, and the requirements of home schooling and childcare responsibilities.

In early June, only 18.7% of our members who responded to this survey experienced a return to what it was like in the pre-COVID-19 era. During this time, 1.8% retired and 75% of these had done so 1-12 months earlier than anticipated due to COVID-19, whilst 12.5% retired more than two years earlier than anticipated due to non-COVID related reasons. Not surprisingly, no-one returned from retirement to assist with the COVID-19 response. In order to mitigate financial loss from the reduction in household income, 53.8% reduced discretionary spending, 39.2% did nothing to mitigate reduced income; 9.5% took on clinical work that they were less familiar with; 7.8% refinanced their loans; 3.1% sold investment assets; 2.8% withdrew money from their superannuation funds; 2.8% accepted JobKeeper payments and 2% sold personal assets.

DISCRIMINATION

At the start of the pandemic, as frontline healthcare workers, both public and private, we were hailed as heroes. However, some survey responders (5%) also experienced discrimination for being a healthcare worker and being potentially infectious. Fear and anxiety amongst the community about COVID-19 with its varied and broad-ranging symptomatology has also resulted in some of our colleagues (2.8%) experiencing social stigma in the form of racial discrimination. And in the workplace, 6.2% experienced discrimination regarding availability and access to PPE.

- "My extended family wanted to isolate from me and my immediate family due to my work".
- "I felt a slight feeling of discrimination from other parents at school and day-care due to my potential workplace exposure with insufficient PPE."
- "Friends refused to have contact with me and they still refuse to socialise with me to this day even with the relaxation of restrictions."
- "A teacher at school showed surprise that I showed my face at school."
- "Friends and relatives are just more wary about being close to me and this was a bit isolating."

Some of our colleagues made the difficult decision to move out of their family home temporarily to minimise exposure to their family.

Meanwhile, gender and age discrimination remained largely unchanged during this period. Although disappointingly, responders noted that:

- "Many women in our workplace were silenced and department meetings were held at inaccessible times".
- "The response to COVID-19 at my hospital has been overwhelmingly dominated by male colleagues with the active exclusion of female colleagues from contributing, collaborating or implementing plans."
- "I have facial hair and cannot shave. N95 masks are not adequate; PAPR are the preferred option, but it was not made available, and I was not allowed to buy my own. Rather, I was given the option to be deployed to non-COVID duties."
- "I was considered by management to be vulnerable to serious infection due to my age and was asked to give up remaining lists."

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COVID-19 SPAWNS MANAGED CARE AND CONTRACT DEBATES

Compounding this economic stress were uncertainties and difficulties in contract negotiations lead by our ASA state representatives regarding contracts for treating public patients in the private sector and contracts for VMOs in the public sector. Prior to negotiations, the contract terms and conditions offered in each state and territory were mostly considered to be substandard.

In amongst the chaos of the pandemic, health funds have also attempted to promote 'managed care models'. The 'no gap' obstetric models are an example of initiatives that will further erode remuneration rates while denying patients a choice of providers.

More than ever, it has become apparent during this pandemic that it is increasingly important for an organisation like the ASA to advocate for, support and represent our specialty.

Dr Julie Lee
Chair, Public Practice Advisory Committee

HOW COVID-19 HAS AFFECTED OUR WELLBEING

Members are thanked for the very high response rate (92-97% of completed surveys) to questions assessing the impact on wellbeing and degree of psychological distress experienced as a result of the COVID-19 pandemic. It is acknowledged that completion may have been confronting for some.

This survey was conducted in June, roughly three months following the pandemic declaration. 'Wellbeing' was assessed through four specific questions along with ten questions from the Kessler Psychological Distress Scale, a well validated self-reporting tool used as a measure of psychological distress (Kessler RC, 1996, Harvard, Boston).

Over one-third of people (36%) indicated they had wanted to take time off work during this three month period. Of this third, again one-third included reasons associated with wellbeing (noting that for each individual these may not have been the only or primary driving force, with concerns re inadequate PPE, inadequate work processes and other factors also prevalent, as discussed in the accompanying articles). Responder free comments (with many volunteered multiple times) included:

- "feeling overwhelmed";
- "suffering mental strain";
- "tiredness";
- "mentally exhausted";
- "burn out";
- "needing a break";
- "general stress and anxiety";
- "depression and anxiety".

Half (nearly 60%) of respondents felt their wellbeing had declined over the three months. For those experiencing lower levels of wellbeing, numerous mitigation strategies were employed, the most common being exercise (35%), alcohol consumption (21%), mindfulness techniques (18%) and peer support (15%). 5% sought professional assistance; 12% did not utilise any particular mitigation approaches. Further exploration of the ease of application and effectiveness including detrimental effects of these techniques could prove useful.

Various tactics utilised were described and these included:

- "taking opportunities to have extra time off";
- "spent more time with family";
- "connected with friends";
- "consciously reduced amount of news media consumed";
- "recommenced antidepressants";
- "hobbies".

Some increased self-education and new skills acquisition; or changed work hours (both increased and reduced). Some used extension of routine practices, for example:

- "maintained exercise, sleep, good diet";
- "yoga";
- "prophylactically exercising more";
- "continued with usual strategies".

While others explored new methods like:

- "found alternative ways to communicate";
- "attempted mindfulness".

It was encouraging to see numerous members display an awareness of potential effects on wellbeing, and describe steps taken to lessen the impact.

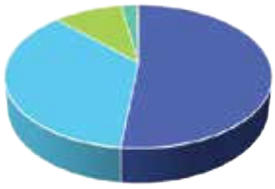
Responses to the Kessler Psychological Distress questions are scored from 1-5 then summed, to grade distress as low, moderate, high or very high. As survey responses are de-identified it is not possible to ascertain any individual's result, but the following are a snapshot of the responses to some of the questions, which show group spread and the trending of severity of impact on the group.

Forty-six percent of anaesthetists felt depressed a little or some of the time, and 66% felt nervous. Over half (53.5%) felt everything was an effort a little or some of the time, and a small percentage (3.45%) experienced this most or all of the time. Two percent felt hopeless most of the time.

Reassuringly this might point to a low or moderate score overall for most respondents but the responses do display how the majority of anaesthetists have felt impacted to some degree.

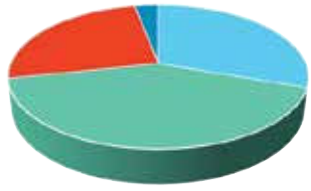
Downey et al surveyed anaesthesia trainees using the Kessler questions in 2017 and found a significant number to be suffering high or very high levels of psychological stress during training.[1] This

How often did you feel depressed?



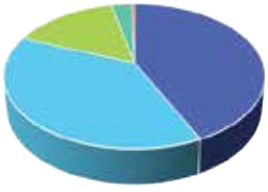
None of the time 52% A little of the time 36% Some of the time 10%
Most of the time 2.25% All of the time 0.23%

How often did you feel nervous ?



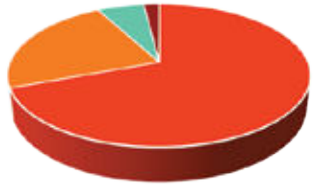
None of the time 30% A little of the time 41% Some of the time 25'
Most of the time 3% All of the time 0%

How often did you feel everything was an effort?



None of the time 43% A little of the time 38% Some of the time 15.5%
Most of the time 3% All of the time 0.45%

How often did you feel hopeless?



None of the time 70% A little of the time 23% Some of the time 6%
Most of the time 2% All of the time 0%

group might benefit from further analysis to assess if this has changed and needs addressing in current times with the additional stressors that the COVID-19 pandemic has produced.

It is well established that medical professionals, in particular anaesthetists and critical care physicians suffer significantly higher rates of psychological distress and burnout than the general population.[2,3] Personality traits commonly represented in our speciality may render us more susceptible to psychological distress.[4]

Of concern in our cohort of survey respondents is that there is a small group response that would suggest some are experiencing a high degree of psychological distress, and we would strongly encourage anyone who may identify with this to seek support, if they have not already done so. The disparate responses of what has been utilised to lessen negative effects highlight there is no single best fit for what each individual may find effective. A range of resources are available, and we would direct anyone seeking help to the following as a starting point:

- ASA/ANZCA/NZSA wellbeing resources on website.
- https://www.asa.org.au/wordpress/wp-content/uploads/News/eNews/covid-19/ASA_wellbeing_resources.pdf
- https://www.acecc.org.au/pageBANK/documents/Looking.pdf
- Local welfare advocates (details should be available from the secretariat of the ASA/ANZCA/hospital/private groups).
- Your GP.

In summary, this brief review of findings from the third ASA 'pandemic survey' shows that the majority of responders have reported some impact on wellbeing. The impact on most seems to have been of mild to moderate severity, and reassuringly significant numbers of responders have used numerous strategies to lessen these impacts. Some have been more severely affected and again are encouraged to seek some support, "you will not be alone".

A protracted response, unlike anything the majority of us have experienced before, is required, with an as yet unknown time frame. At the time of writing this report we have again seen significant increases in COVID case numbers and spread therefore it is unknown whether the current findings would be reproducible. It is suggested that ongoing surveys would be useful to assess further changes in the degree of psychological distress being experienced by the anaesthetic community.

Dr Peta Lorraway
Wellbeing advocate

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FEATURE

FINAL EXAM PERFORMANCE IMPROVEMENT CLINIC... IN THE TIME OF COVID

Dr Vida Viliunas, ASA Education Officer and EPIC boot camp convenor provides a wrap-up of the recent weekend Zooming from Canberra.

Yes, it was 'epic'. The annual ASA exam preparation weekend had a substantial re-work to accommodate a new exam format for those candidates who sat the written section in March (and who will not have medical vivas with patients) and a new boot camp format via Zoom.

The registrants were surveyed prior to the weekend to find out about their expectations, special requests and exam cohort. There was an approximately 50:50 split between those from 2020-1 and those preparing for 2020-2 and beyond, together with a number of International Medical Graduate Specialists.

PREPARATIONS AND LOGISTICS

Many hours were dedicated to the question of how to engage a group of close to 90 people via Zoom. Ultimately, the obvious choice was to create 'Hollywood in the Home'. This allowed a combination of TED-talk style and screen-shared presentations. As always with Zoom, pants were optional but candidates were asked to try out the rest of their exam wardrobes on-screen.

An extended 'arrival window' at the beginning of each day was an opportunity to chat and meet individual participants and gave the weekend a personal feel. Candidates were encouraged to commit to the weekend as if they were in a lecture – without distractions or phones, and with Zoom cameras and exam-brains on.

PRESENTERS AND OTHER SUPPORTERS

Thank you to the examiners who participated in the exam panel. They answered candidate questions and provided commentary on the ingredients of good and great exam performances. Dr Steve Davies, Dr Nicola Meares, Dr Carmel McInerney, Dr Prani Shrivastava and Dr Sally Wharton volunteered their time, experience and knowledge of what appeals to examiners and what garners extra marks.

Sunday morning with the Final Exam Chair Dr Sharon Tivey was another opportunity to clarify the exam process for candidates. All participants gained insights into the diabolically difficult jobs of conducting exams, training, and studying during a pandemic.

The weekend would not have been possible without my co-hosts Dr Rod Katz and ASA office super-hero Kym Buckley. They co-ordinated chat responses, answered private questions and ensured the smooth running of the production.

EXAM SECTIONS

Each exam section (MCQs, SAQs and Vivas) was addressed and ingredients for success outlined.

For multiple choice questions the tips were mainly straightforward. Since there is no negative marking, each question should be answered. Strict timing is important to allow review of all responses.

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

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

Viva deconstruction, viva creation, practicing in sections, role-playing as examiners and video review were suggested techniques to improve viva performance.

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

The examiners stressed that the entire curriculum was examinable in all sections of the exam including the vivas.

How to manage 'viva-brain': what to do and what not to do when a candidate is faltering or uncertain were part of recovery techniques discussed.

STUDY TECHNIQUE

Most examiners are active clinicians. Candidates should not make the mistake of thinking that time spent in operating theatres and other clinical activities is not useful exam preparation.

The value of a range of techniques including individual and group study, a study plan that covers the entire curriculum and practicing past questions under exam conditions was stressed as an important part of exam success.

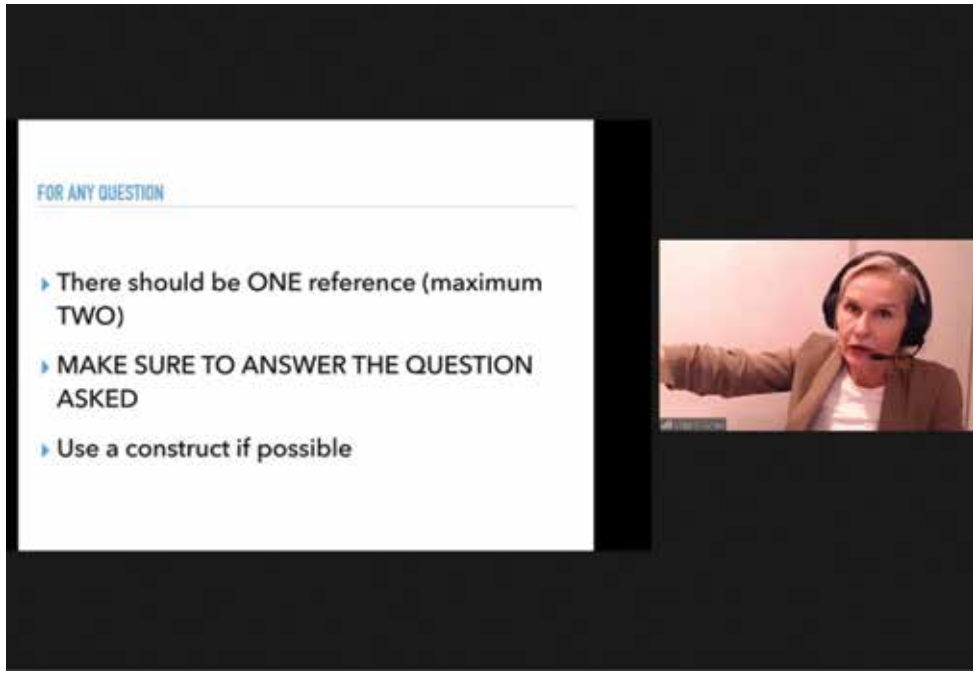
POST EPIC

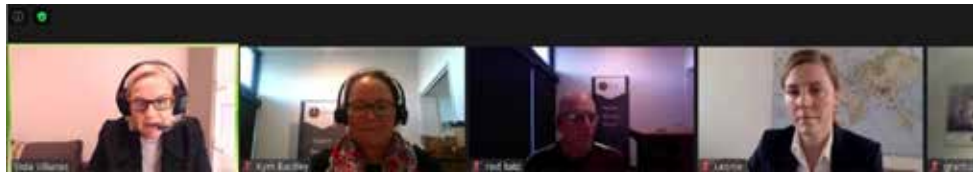
Details of EPIC participants were shared after the weekend. This is intended to help candidates in things such as forming study groups and developing and sharing practice questions. One of the points that was made through the weekend was that there is a real benefit to collaborating and no real downside. The exams are intended to test judgement and knowledge and not designed to rank candidates. A higher success rate reflects well on candidates, examiners and teachers. Collaboration and working together will also be of benefit through post-exam professional life.

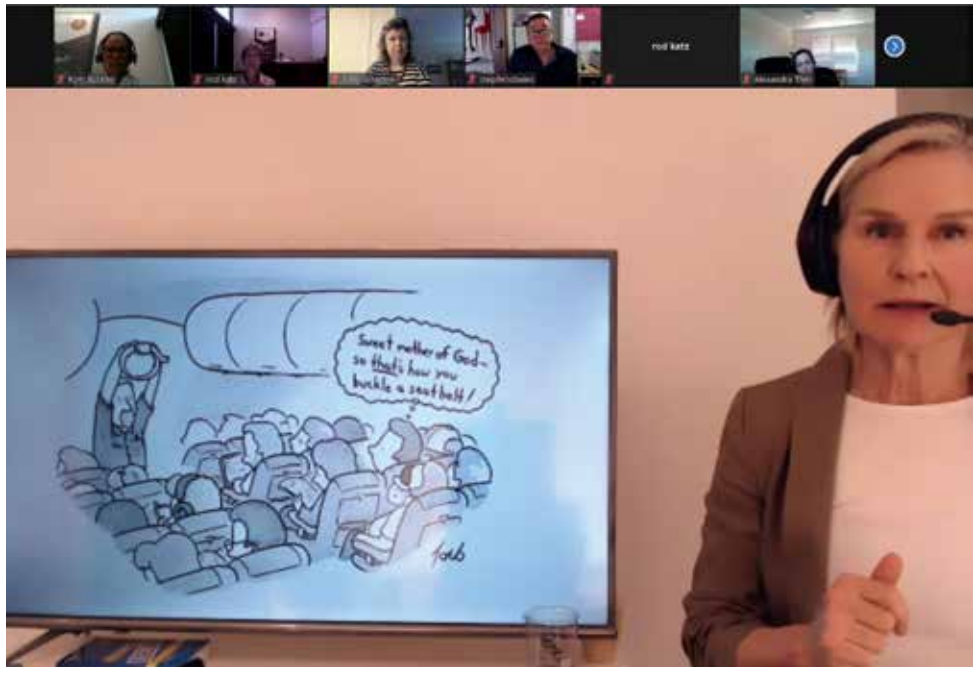
MORE INTELLIGENCE

Artificial intelligence expert Patrick Winston of MIT created a lecture series on how to speak: https://vimeo.com/101543862

Professor Winston's suggestion of an empowering promise was embedded in the plan for our weekend. All candidates were promised extra marks if they engaged and concentrated during the two days. Candidates listed what they learned that would most help them to earn those extra marks in the chat at the end of each day. That summary of what was meaningful to candidates also informed the lecture series for the future. However, we all agreed that we will never do it again… until next year.







INSIDE YOUR SOCIETY

ECONOMICS ADVISORY COMMITTEE

DR MARK SINCLAIR
EAC CHAIR

The COVID-19 pandemic has had an enormous impact on the day-to-day life of Australians, and of course this impact was felt in the areas of surgery and anaesthesia. Other ASA reports will deal with many of these various issues; this report will be confined to matters relevant to the Economics Advisory Committee's (EAC) work.

TELEHEALTH AND MEDICARE

A range of telehealth items were introduced into the Medicare Benefits Schedule (MBS) on 13 March 2020. These were intended to cover video and telephone consultations, so that patients could continue to receive Medicare-funded services, without the need for face-to-face contact with doctors (and potentially with other patients, and medical reception staff) during the pandemic. They were introduced by the authority of the Minister for Health, utilising the powers available to him to make alterations to the MBS at any time, without the need for processes such as a formal Medical Services Advisory Committee (MSAC) scientific and economic assessment.

Two temporary items, 91822 and 91832, were introduced for an initial attendance via telehealth (video and telephone attendances, respectively) by a specialist medical practitioner. They were described as applying to the services of "specialists, consultant physicians and psychiatrists".

The Department of Health (DoH) also stated:

> *Videoconference services are the preferred approach for substituting a face-to-face consultation. However, in response to the COVID-19 pandemic, providers will also be able to offer audio-only services via telephone if video is not available.*

The ASA initially received confirmation from DoH, verbally and in writing, that anaesthetists' services would be covered under the term 'specialists'. The ASA membership was immediately informed of this. While the best data we have indicates that less than 3% of pre-anaesthesia consultations are performed on an outpatient basis, it was clearly essential that patients have funded access to such telehealth services.

Very soon afterwards, however, it became apparent that all claims for anaesthesia services were being rejected by Medicare.

Initial queries by anaesthetists, practice managers and the ASA were met with a range of inconsistent and variable excuses. However, at about the two-week stage, we were informed by DoH that the reason for rejection was that the new items were the telehealth equivalents of face-to-face general specialist attendance items 104 (initial attendance) and 105 (subsequent attendance). Since the introduction of anaesthetist-specific attendance items in 2006, anaesthesia services have been ineligible for items 104/105 (although they certainly were eligible, for many years prior to 2006).

To us, the solution appeared simple. The Minister certainly had the power to extend the coverage to anaesthesia services. After all, the items had at that stage were already being extended, to eventually include "specialists, consultant physicians, psychiatrists, paediatricians, geriatricians, public health physicians and neurosurgeons" (admittedly these specialties are all eligible for items 104/105).

But DoH was adamant this simple, straightforward concept of an extension to include 'anaesthetists' was not acceptable. No specific justification was given at that stage, other than the 104/105 argument, which could be easily countered under Ministerial authority.

The ASA urgently sought a meeting with DoH. A teleconference was held with senior DoH personnel, with the ASA represented by Dr Andrew Mulcahy and myself.

We were somewhat taken aback, to put it mildly, that the very first issue the DoH representatives raised was along the lines – surely pre-admission consultations by anaesthetists are not necessary? Can the surgeon and GP not prepare the patient and the anaesthetist just see him/her face-to-face on the day of admission?

Needless to say, this was very disappointing given the years of effort people such as Drs Mulcahy and Deacon

put into securing specific MBS items for anaesthetists' attendances, including outpatient loading item 17690. Pre-admission pre-anaesthesia assessment is an essential tool in the care of many surgical patients, and has proven clinical and economic benefits. Dr Mulcahy set the matter straight immediately, and we believe the DoH representatives came around to the correct way of thinking.

Nevertheless this raises an important concern. The DoH representatives clearly came to the meeting having made a prior judgement (uninformed though it was) that the ASA was lobbying for unjustified Medicare funding.

The ASA does not, under any circumstances, submit requests for funding of anaesthesia services to any third party payer, unless such funding is for clinically relevant services, of importance to patient care.

The DoH representatives were concerned that granting access to these items would mean that anaesthetists would "want access" to items 104 and 105. We explained that this was not the case, and that anaesthetists would continue to use items in the range 17610-17690 for face-to-face attendances.

Their further concern was that approval of anaesthesia-specific items might result in a sudden explosion in claims and expenditure. Why this concern should apply specifically to anaesthesia, when every other specialty including general practice had unlimited access to their new items, was never explained. But it was abundantly clear that this anaesthesia-unique concern was not to be overcome. Therefore, in order to make progress, we agreed that the new anaesthesia items should cover attendances with a duration of greater than 15 minutes, with equivalent complexity requirements to item 17615. (It should be noted that the rebates for the general specialist initial telehealth attendance items, and the new anaesthesia items now in place, are the same as 17615. The general specialist items only require an attendance of over five minutes).

Another DoH concern was that "doubling up" would occur, with a telehealth item charged on an outpatient basis, and a further attendance item charged on the day of surgery. We had to explain that this can well be appropriate, depending on individual patient needs, but that a charge for a second consultation does indeed need to be justifiable, not routine. This is already the case for the existing face-to-face items.

The meeting ended with a commitment by DoH to sort the problem out. But, as we have become accustomed to, there was to be no rapid solution. Further email exchanges, and telephone calls (including a direct approach from Immediate Past President A/Prof David M. Scott to Minister Hunt) occurred over subsequent weeks, with us still highlighting the fact that the easiest solution by far was to extend the descriptors to include anaesthetists.

Finally, at the 10-week mark, anaesthesia-specific telehealth items were introduced. Unfortunately however, there was to be no retrospective application to services provided between 10 March and 22 May. Services provided during that time were only eligible for Other Medical Practitioner (OMP) telehealth items. Their Medicare rebates are in the range $11.00 (5 minutes or less) to $61.00 (over 45 minutes).

There are ongoing issues with respect to telehealth in the MBS:

- A strong push for telehealth to be better embraced by Medicare, given we are now in the 2020s, and for the items to be extended beyond the current end date of 30 September.
- Concerns that, as was predicted, some entrepreneurial doctors (and others, such as pharmacists) are enthusiastically pursuing new telehealth models, designed to maximise their incomes. The AMA and RACGP shared this concern. From 20 July, all GPs and OMPs working in general practice can only claim telehealth items where there is an existing relationship with the patient.

ANAESTHESIA IN MEDICARE

The difficulties faced by the ASA in having the DoH appropriately recognise and

Item 92701

Telehealth attendance by a medical practitioner in the practice of anaesthesia for a consultation on a patient undergoing advanced surgery or who has complex medical problems, involving a selective history and the formulation of a written management plan documented in the patient notes, and lasting more than 15 minutes (other than a service associated with a service to which any of items 2801 to 3000 of the general medical services table apply)

Fee (July 2020) $89.55 **85% $76.15**

Item 92712

Phone attendance by a medical practitioner in the practice of anaesthesia for a consultation on a patient undergoing advanced surgery or who has complex medical problems, involving a selective history and the formulation of a written management plan documented in the patient notes, and lasting more than 15 minutes (other than a service associated with a service to which any of items 2801 to 3000 of the general medical services table apply)

Fee (July 2020) $89.55 **85% $76.15**

INSIDE YOUR SOCIETY

value the role of specialist anaesthetists is, unfortunately, nothing new. Consider the following:

- The rebates for surgical services are significantly higher than those for anaesthesia, often as much as three to four times higher. Surgical assistance items are, by definition, funded at 20% of the surgical rebate. The Medicare system values us only slightly more than surgical assistants, who may be only a couple of years out of medical school, with no postgraduate specialist qualification. And with no disrespect intended, the anaesthetist has a much greater responsibility for patient outcomes than a surgical assistant. It is true that Medicare expenditure on anaesthesia services is hundreds of millions of dollars more than expenditure on surgical assistance items, in absolute terms. But this is merely because the vast majority of procedures involving a proceduralist and an anaesthetist do not require a surgical assistant.

  No doubt the argument about aftercare will arise. Medicare rebates for surgical services cover both the procedure, and any necessary aftercare. But given the very large number of same-day discharge and other less major procedures performed in the private sector, this argument does not hold water when it comes to a fourfold greater funding of surgical services. Furthermore, this argument has a significant inconsistency. We are told on the one hand that anaesthesia rebates are lower because of the lack of need for routine aftercare by anaesthetists. Yet on the other hand, it is definite policy that any routine aftercare we do provide attracts no Medicare funding, over and above that for the original service.
- Items 591 and 600 for after-hours emergency attendances by doctors other than vocationally registered GPs (who have their own specialty-specific items) can apply to the services of recent graduates with no extra qualifications. DoH had accepted for years that where such services were provided by specialist anaesthetists, these items could likewise apply. This all changed as a result of the MBS Review, and we were specifically informed that anaesthetists could no longer claim such items. Only items in the range 17610-17680 can be claimed. As a result, the rebate for the after-hours services of a junior doctor can be up to three times as high as that for a specialist anaesthetist. The ASA has been informed, in meetings regarding the MBS Review, that DoH has no sympathy for arguments regarding improving funding for after-hours emergency attendances, by specialist anaesthetists.

We are told on the one hand that anaesthesia rebates are lower because of the lack of need for routine aftercare by anaesthetists. Yet on the other hand, it is definite policy that any routine aftercare we do provide attracts no Medicare funding, over and above that for the original service.

- The MBS Review could have made the situation even worse. The recommendations of the carefully selected Anaesthesia Clinical Committee (ACC), to which no ASA or ANZCA nominee was appointed, could have reduced Medicare anaesthesia funding by 18-20%. Of course the increases in funding the ACC recommended for certain items, to 'compensate' for their massive recommended cuts, would have reduced this 18-20% figure substantially. But it was made quite clear by the MBS Review Taskforce, prior to the appointment of any clinical committees, that new funding, or increases to existing funding, would not be considered by the MBS Review. Such recommendations would be referred to MSAC. Given our experiences with MSAC, this would have been equivalent to rejection, or at least, a delay of some years before perhaps a few of the increases occurred. The 18-20% figure is therefore entirely plausible.

So what must we do?

Quite simple. Continue to provide first class services to Australian patients.

Develop good relationships with your patients pre-operatively. Provide an excellent anaesthesia service. Let your surgical and nursing colleagues continue to see the value of your work. Continue to produce world's best patient outcomes. Visit your patients post-operatively. And observe best possible informed financial consent (IFC) practices – the importance of this cannot be overstated.

If the administrators choose to value you well below your true worth, make sure the only truly important people in this whole process do value and respect you – your patients and their families. And of course, your surgical and nursing colleagues.

And when government officials decry the 'very high' out-of-pocket expenses charged by anaesthetists (which they have indeed done; it is on the record, despite existing data showing the contrary), keep the above discussion in mind. Fully inform your patients of the decades-long history of poor Medicare rebates for anaesthesia services, and the poor or non-existent annual indexation of these rebates, which have led to this situation.

PRIVATE HEALTH INSURERS

While much attention has been placed on the implications of COVID-19, certain players in the private health insurance (PHI) industry have been working steadily in the background, in pursuit of a managed care agenda.

HCF is actively pursuing a 'gap free' experience for its customers requiring

obstetric services. Obstetricians, anaesthetists and other doctors have been asked to express interest in this scheme, whereby doctors will receive a separate 'top-up' or 'uplift' fee in return for guaranteeing to use the HCF 'no gap' product. Doctors agreeing to the scheme must also agree to bulk-bill any outpatient services; of course HCF has nothing to do with the funding of these services. Additionally (see later) HCF has failed to index anaesthesia rebates in July 2020, and has in fact decreased the rebate for some items. This is hardly consistent with a stated aim to decrease out-of-pocket expenses.

HCF states that the scheme is designed to improve the uptake of PHI by customers in the younger age groups, and to reverse the trend of obstetric patients dropping PHI because of the large out-of-pocket (OOP) expenses involved in choosing private care. In and of itself, these are worthy aims.

However, several aspects of the agreement are of significant concern.

Under the terms of the Competition and Consumer Act (2010), it is illegal for doctors to collectively negotiate on fees and charges with HCF, or with any other body. To do so would likely lead to prosecution by the Australian Competition and Consumer Commission (ACCC). Therefore, each doctor must discuss the HCF 'uplift' fee individually. Clearly, it is in the best interest of HCF to engage doctors who charge the lowest fees. A system where doctors are employed purely on the basis of the cheapest fee will likely lead to a "race to the bottom", where the quality of services, patient choice, and well-established professional relationships between doctors, are all ignored.

Doctors participating in the scheme must formally agree to perform their duties with "care and diligence" and "in compliance with all laws". It is somewhat offensive to suggest that doctors might do otherwise, but these clauses are typical in such agreements and are not of major concern.

It is also stated, in the accompanying information, that doctors will be expected to "take a haircut" when it comes to their fees.

Of more concern however, are the USA-style managed care requirements.

Doctors participating in the scheme must agree to act "in every respect to the reasonable satisfaction of HCF" and also "in conformity with all directions and requirements of HCF".

There is no further information about what these 'directions and requirements' might be. The wording is completely open ended. Typically, insurers will state when challenged that they will never interfere with clinical decision making, but such statements are meaningless in the face of the actual terms in the agreement. The ASA maintains its position that:

- Obstetricians must remain free to refer patients to their chosen anaesthetist(s) and other service providers, based purely on professional grounds, with no interference by outside parties.
- Anaesthetists should remain free to charge a fair and reasonable fee, based on the ASA RVG, with best possible informed financial consent (IFC) practices in place. The fee is a matter between doctor and patient, and should remain free from interference by third parties such as insurers or hospitals.
- It is entirely inappropriate for insurers to make 'directions and requirements' of doctors, and the only parties who should be 'satisfied' with obstetric anaesthesia care are the referring doctors, and (most importantly) the patient and her family.

Medibank Private is also pursuing a similar agenda, related to orthopaedic surgery. In February this year, Medibank Private CEO Mr Craig Drummond stated:

> *We are considering selectively partnering or co-investing with… hospital operators and doctors to enable a more widespread roll out of the zero or reduced out-of-pocket cost experience. Initially, this will be for customers seeking joint replacements and other orthopaedic procedures. Over time we hope to expand to include other major modalities.*

Information to hand indicates that orthopaedic surgeons will be offered the AMA Fee, and anaesthetists a fee at around the level of the current rebate (approximately 40% of AMA), or possibly less (if for example, local anaesthetic nerve block and/or patient modifier items would currently apply).

Medibank Private is understood to have made a 49% acquisition of East Sydney Private Hospital.[1]

This initiative raises further concerns that insurers such as Medibank Private, whose only motive is financial profit, are actively pursuing a USA-style 'managed care' agenda, in order to have more control over the private healthcare system. One only need compare the healthcare costs and outcomes in the USA compared to Australia,[2] to realise the danger of handing control over healthcare to for-profit companies. Medibank Private must make profits for its investors. Investors are not interested in patient outcomes.

Members should visit the ASA website regularly, and watch for their monthly enews updates from ASA President Dr Suzi Nou, which will provide updates on such insurer-led initiatives as more information comes to hand.

MEDICARE AND PRIVATE HEALTH INSURANCE REBATES

The MBS RVG items were indexed by approximately 1.5% on 1 July 2020. The MBS Fee for the RVG unit was increased from $20.10 to $20.40, with similar levels of indexation applied to the consultation and attendance items. As usual, the indexation was less than CPI, which is around 1.7%

INSIDE YOUR SOCIETY

Most PHI companies also indexed their rebates for anaesthesia items, as can be seen in Table 1. However, Bupa applied 0% indexation to the RVG, as did HCF.

Bupa has indexed other parts of the schedule variably, with some items having an indexation of around 0.9%, but many others have also had zero indexation.

HCF has actually decreased the rebates for a number of items in its "no gap" schedule. For example, the basic pre-anaesthesia attendance item 17610 has been dropped by 20%, and item 22900 (anaesthesia for dental extractions) by 17%.

The ASA has written to Bupa and HCF to seek an explanation. At the time of writing, we are awaiting a response from HCF. Bupa has responded to our query along the following line:

1. Bupa currently pays rebates that are the highest in many states.
2. Ninety percent or more of claims are 'no gap', making it hard to justify an increase.
3. Bupa is in a 'tough position' as there was no increase to premiums in April.

With independent reports indicating that the COVID-19 pandemic has massively increased the profitability of for-profit PHI companies such as Bupa (due to a decrease in surgical services), it is hard to accept that they are in a 'tough position'. Furthermore, point 2 is proof of what the ASA has always told its members – that accepting whatever is on offer from PHI gives them no motivation whatsoever to make improvements. It is also worth noting that a 0% indexation in fact increases Bupa profits by several million dollars in the case of anaesthesia, and potentially tens of millions of dollars across the whole MBS. Medicare has indexed rebates by 1.5%, meaning that Bupa now pays less toward each non-indexed MBS item, and pockets the difference.

References

1. 'Medibank Private on the Acquisition Trail', *The Australian*, 14 July 2020.
2. www.commonwealthfund.org/chart/2017/health-care-system-performance-rankings

Table 1
RVG Unit Values and Indexation

Fund	RVG Unit Value	July 2020 Indexation
MBS	$20.40	1.5%
DVA	$33.75	1.5%
AMA	$88.00	2.2%[1]
CPI		1.7%[2]
Known Gap		
Medibank Private	$33.70	1.5%
AHSA[3]	$36.11	1.4%
HBF	$30.60	1.5%
St Luke's	$35.35	1.6%
HCF	$33.50	0.0%
Bupa[3]	$34.39	0.0%
No Gap		
HCF	$34.70	0.0%
NIB	$33.65	1.5%
HBF	$39.20	1.5%

1. AMA RVG unit value was indexed on 1 November 2019.
2. The CPI figure is for the 12 months to September 2019.
3. Average value – varies from state to state.

PROFESSIONAL ISSUES ADVISORY COMMITTEE

DR PETER WATERHOUSE
PIAC CHAIR

Quite apart from the disruption caused by COVID-19, there are several ongoing professional issues for Australian anaesthetists to be aware of.

PBS CHANGES

The first of June marked the introduction of changes to opioid prescribing under the Pharmaceutical Benefits Scheme. Short term post-operative use of slow release opioids does not meet the new PBS criteria. The PBS makes no distinction between pure opioid agonists including oxycodone, and newer atypical agents such as tapentadol.

While the goal of reducing opioid related harm in the community is shared by all, many anaesthetists and surgeons safely utilise short courses of slow release opioids in their treatment of patients who have undergone painful surgery. These doctors now find themselves practicing outside the recommendations of the PBS.

BUNDLED CARE

Recently health insurers such as HCF have been attempting to introduce no-gap obstetric and orthopaedic services. Under such schemes, doctors including anaesthetists sacrifice considerable autonomy in order to participate. These schemes reduce patient choice, while eroding doctors' clinical and financial independence. The path to managed care must also reduce quality of care as a powerful funder is introduced into clinical decision-making.

Anaesthetists are encouraged to think very carefully before entering into any bundled care arrangement. The ASA is advocating for clinical autonomy, patient choice and remuneration based on the Relative Value Guide.

REAL TIME PRESCRIPTION MONITORING

In order to address drug misuse, several Australian states are introducing real-time monitoring of prescriptions. Opioids, benzodiazepines and other drugs including gabapentin and tramadol will be subject to this new process. Victoria's system, Safescript, is already operational. The ASA is involved in advocacy to ensure that the introduction of these systems does not lead to an administrative distraction from patient care during surgery.

OFFICE BASED ANAESTHESIA

Recent media coverage of legal action against providers of out-patient cosmetic surgery highlights the risks inherent in this type of work. Anaesthetists must exercise extra caution when providing their services outside the conventional operating theatre environment. ASA PS14 summarises the most important considerations for those involved in office-based surgery.

PUBLIC-IN-PRIVATE SURGERY

The COVID-19 pandemic has raised the prospect of increasing utilisation of the private hospital sector to address public surgical waiting lists. The capacity and appetite of the private hospitals to undertake such work has yet to become clear.

Challenges associated with this type of work include adequate patient pre-assessment and access to hospital records.

Various funding models have been proposed, from traditional RVG billing, modified MBS schedules, to hourly rates. Contracts for such work should be scrutinised very closely. The ASA can help members to become better informed when faced with employment contracts.

ASA ADVOCACY

In addition to professional advocacy for the specialty as a whole, the ASA is able to provide individual assistance to members. Recent examples of this type of advocacy include liaison with medical indemnity organisations and private hospital operators. When facing professional challenges, consider drawing upon the corporate knowledge, contacts and resources of the ASA.

INSIDE YOUR SOCIETY

POLICY UPDATE

EMPLOYMENT CONTRACT GUIDELINE

Members often ask the Australian Society of Anaesthetists (ASA) for advice concerning the legal standing of their appointment to a hospital facility at which they enjoy clinical privileges. Many problems that arise could be avoided if parties to medical service contracts were aware of the key issues in drawing up contracts. This is not always easy because the complexity of employment laws is such that the contractual parties may not have adequate information to come to a reasonable agreement that meets their interests.

WHAT YOU NEED TO KNOW

Contracts are legally binding agreements between two or more parties.[1] Ultimately, it is up to you to decide whether you are willing to accept the terms and conditions of the contract. An Australian medical practitioners' contract will involve either a public or private hospital, the provision of services as a visiting medical officer (VMO) or as an employee (e.g. staff specialist). Depending upon the jurisdiction, some of those arrangements may be documented in the form of a written service contract or employment contract.[2] In other cases, the sources of rights and obligations will be found in awards and other documentation (e.g. letters of appointment).

In the private hospital system, the terms of engagement are commonly found in the hospital bylaws, letters of appointment or hospital policies and procedures rather than in a written service contract. In many situations, regardless of the arrangement, standard contracts may be used. Therefore, it is fundamental that both parties' situations, rights and obligations are clearly understood and well documented before any work commences. This enhances the working relationship and helps to prevent unnecessary disputes.

You should take the time to consider the terms within the contract before signing and seek an explanation for anything you do not understand. If you do not agree with an explanation or clause you may be able to negotiate this with the healthcare facility. Remember to make sure with the help of the ASA, Australian Medical Association (AMA) or the Australian Salaried Medical Officers' Federation (ASMOF) that any documents referenced are enclosed and attached to the contract. This will ensure you are not in breach of any regulations should you not be provided with a subsequent variation of the document.

It is important to remember that the financial standing of healthcare facilities will inevitably change within the environment they operate. Therefore, the ASA considers it best practice to avoid any provision which will enable the other party to change the rules or terms within the contract without the agreed consent of both parties. This should be added as a specific clause to the contract.

KEY CONTRACTUAL TERMS

We encourage you to consider the following contractual terms[3] before signing any contract.

Parties

Properly identifies the contracting parties by their names or legal entities, ABN (if appropriate) and contact details.

Term

Specifies whether the engagement is ongoing (unless terminated in accordance with the contract), for a fixed term (ending on a specified end date) or for a maximum term (ending on a specified end date unless terminated earlier in accordance with the contract).

Services

Details the services provided. The nature of the services will depend on the type of contract and who is providing services, i.e. whether the practitioner is providing services to the practice or the practice is providing services to the practitioner.

Fee

Specifies payment for services and the method and timing of those payments. Practices usually pay a percentage of gross receipts/billings or a specified hourly/daily rate.

Insurance

Identifies the insurance obligations of the parties.

Indemnity

Allocates legal responsibility/liability between parties.

Notice of Termination

Specifies when and how the parties can end the contract.[4] For fixed or maximum term contracts, the contract will automatically terminate on the specified end date. For maximum term and ongoing contracts, this term will state the period of notice that the parties must give to terminate.

Restrictive covenants

An exclusivity clause may seek to prevent the practitioner from practising for a competing practice in a specified area while the contract is in operation. A non-compete clause may seek to prevent a practitioner from practising in a specified area or for a specified period after termination. A non-solicitation clause may seek to prevent a practitioner from soliciting patients, clients or employees for a specified period after termination of the contract.

Confidential information

Requires parties to keep information confidential. There may be specific provisions that relate to patient records.

Dispute resolution

Sets out the processes for resolving any dispute between the parties. The parties may be required to appoint a mediator if the dispute cannot be resolved within a specified period.

Entire agreement

Makes clear that the contract constitutes the whole agreement between the parties. This ensures contractual certainty and may limit liability for misrepresentation and other potential claims.

UNDERSTAND WHAT YOU'RE SIGNING

Ultimately, regardless whether you are an employee or contractor, the ASA would like to emphasise that the onus is on you to understand the terms and conditions of your engagement (not just the remuneration) and that they are appropriately clarified before commencing service. The rules governing appointments and award conditions differ between each state and territory and even between each healthcare facility.

The best negotiating tool is information and as such, if you are about to renew or start new contract negotiations, the ASA would encourage members to talk with your colleagues. While negotiated agreements will be different, knowledge of what has previously been achieved will be of benefit when negotiating your own requirements.

The ASA is certainly happy to assist with any questions. If you are an AMA or ASMOF member we also encourage you to discuss your options with your local branch or representative. These bodies can provide dedicated advice on employment and contract issues as well as assist with negotiations.

Jacintha Victor John
Policy Manager

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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.

ASA SEREIMA BALE PACIFIC FELLOWSHIP – VACANCIES FOR 2021

The ASA ODEC committee is seeking Australian and New Zealand anaesthetists with a passion for teaching and an interest in working in developing countries.

Three month scholarships are now available for 2021. The role involves teaching and clinical support for Pacific trainee anaesthetists based in Suva, Fiji Islands.

The Fellowship is named in honour of Dr Sereima Bale, Senior Lecturer at the Fiji National University and the founder of post-graduate anaesthesia training in the Pacific region.

The ASA provides financial support to the value of AUD$12,500 and an accommodation allowance is provided by Fiji National University.

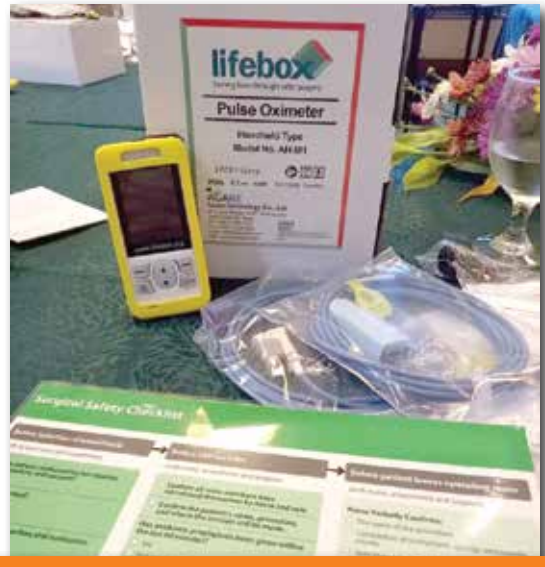
FANZCAs and experienced Provisional Fellows are encouraged to apply. It is a family friendly environment.

Please contact Justin Burke for further information. Email: j.burke@alfred.org.au

Lifebox Australia & New Zealand is a joint, regional project developed to ensure access to life-saving monitoring during surgery, through the purchasing and distribution of pulse oximeters to hospitals across the Asia Pacific region. The project also focuses on training local personnel in the use and maintenance of the pulse oximeters. This project, building on the work of the Lifebox Foundation in the UK and US, enables supporters in Australia and New Zealand to make tax-deductible donations directly to this work, and for hospitals across the region to request pulse oximeters and support in their use.

lifebox
Australia & New Zealand

ANZCA ASA Interplast New Zealand Anaesthesia



DONATE NOW TO THE LIFEBOX AUSTRALIA & NEW ZEALAND PROJECT!
https://www.lifebox.org/lifebox-australia-and-new-zealand-lifebox-anz/

INSIDE YOUR SOCIETY

TRAINEE MEMBERS' GROUP UPDATE

The world is changing so quickly right now. As I write this, I'm a couple of weeks into Melbourne's second Stage 3 lockdown, waiting for my first COVID-19 swab. I am sure that by the time this is published and you're reading it, things will have changed again.

I know what a difficult and challenging time this is for trainees at the moment, particularly those stuck in exam limbo, with your lives and families on hold.

It's also okay to be feeling worried and uncertain during this time, even if you don't have exam pressure looming. I came across the term 'toxic positivity' recently – it refers to the overgeneralisation of a happy, optimistic state that results in the denial, minimisation and invalidation of negative emotions in yourself or in others. Just because you don't have it 'as bad' as someone else, doesn't mean you can't acknowledge you have cause to feel upset or disappointed at your own situation. In the competitive world of anaesthetic training, we're very used to putting on our poker face and acting like everything is under control in a crisis in clinical situations, and this often spills over into our interactions with each other outside of the theatre environment. The COVID-19 pandemic is looking to be a marathon, not a sprint, and we need to arm ourselves with the appropriate tools to look after ourselves and others as we experience the highs and lows of life during a pandemic.

As you'll read in other sections of this magazine, the ASA has conducted a number of member surveys this year. Thank you to all the trainees who took the time to answer these – we appreciate the significantly increased survey burden you're all likely experiencing this year. It's clear from the trainee specific questions in our most recent third survey that in addition to concerns common to the general anaesthetist population, there is considerable trainee concern regarding the ability to progress through training, examinations, and other similar issues.

Significantly, 32% of trainees who responded had wanted to take time off, but couldn't. Reasons for wanting leave included mental exhaustion, anxiety, burnout, and a fear of becoming unwell and transmitting COVID-19 to family members. About a quarter of trainees reported a significant reduction in their household income, for a variety of reasons. Encouragingly, many trainees reported utilising positive wellbeing strategies, such as increasing exercise, mindfulness, and increasing peer support. It's clear that our social networks at work are an important wellbeing resource.

With this in mind, the ASA Trainee Members' Group are pleased to announce that we will be running an online Mental Health First Aid Workshop targeted specifically at anaesthetic trainees. We hope it will arm you with the tools needed to identify possible mental health issues in your peers (or possibly in yourself) and arm you with the tools required to facilitate support or intervention. It's currently in the early stages of planning, so watch this space.

We've also facilitated a corporate hotel deal for group bookings at a Sydney CBD hotel for final exam accommodation, with flexible cancellation options, to help ease the financial burden of exams. We're aware that with the pandemic, the exams are a frequently evolving beast, but we're aiming to continue to facilitate discounted hotel rates for the future.

We're excited to announce that Lifebox ANZ will soon be calling for expressions of interest from Australian and New Zealand trainees to fill a newly created trainee position on the Lifebox ANZ committee. This is a great opportunity to learn about how a non-governmental organisation works and be a part of Lifebox's decision-making for our region. Stay tuned for more information. If you want to see what Lifebox ANZ have been up to, check out https://www.interplast.org.au/learn-more/our-work/lifebox-australia-new-zealand/.

The ASA as a whole are also looking to enhance the online education resources that we offer, with a plan to include trainee specific content. We've got a number of other initiatives in the pipeline at both state and national levels to help Support, Represent and Educate you. As always, if you've got any ideas on how we can better be there for you, please don't hesitate to email us at trainees@asa.org.au or contact one of your friendly state representatives. We're here for you!

Dr Emily Munday
Chair, ASA Trainee Members Committee

INSIDE YOUR SOCIETY

OVERSEAS DEVELOPMENT AND EDUCATION COMMITTEE

ANAESTHESIA IN THE TROPICS

As the plane skirts over coconut trees to land beside the river at Nausori, Suva, the first thing that strikes me is the distinct humidity in the air that signals my arrival in the Tropics.

It is my first half hour on the floor on my first day. I turn up awaiting orientation, but I'm asked to attend recovery to help with a patient. A young woman has had an eclamptic seizure en route to theatre. Her baby is stillborn. She has been extubated but in recovery has a sudden cardiovascular collapse. Despite best efforts at diagnosis and management with the resources available, she passes away of a differential I hadn't even considered – hepatic rupture secondary to severe HELLP. A complication I may have peripherally remembered from exam study (maybe, at a push), a complication of which there have only been 200 case reports recorded in the literature. What is rare back home, is not so rare here. A young woman and her baby die in pregnancy, leaving a devastated family behind. She is the first for me (ever), but not the last.

I finished working at a tertiary hospital in Sydney on the Friday and landed on the Sunday to take up a six-week posting at Colonial War Memorial Hospital, Suva, Fiji. The contrast couldn't have been any more different. It is Fiji's main tertiary referral centre, receiving patients from the more than 300 islands that surround Viti Levu (the main island) and the surrounding Pacific region as well. It provides a wide spectrum of surgical services including neuroanaesthesia (major craniotomies and spines), complex paediatric/neonatal surgery, ENT, thoracics, general, orthopaedic, plastics, obstetrics. But it provides this excellent care with a significant limitation of resources – and for me, I was continually struck by how much you could achieve with so little and have good outcomes.

Weekly departmental CME meeting

Whilst I could plan a detailed anaesthetic – it would ultimately be limited by what I had available that day. Drugs and equipment would frequently be out of stock, with availability changing daily and we would improvise where needed or make do without. I used pancuronium and suxamethonium or atracurium when it was available. There was plenty of major craniotomies, spines and ENT: with a choice of morphine or fentanyl and volatile (with a sparing use of propofol infusion). Some Pacific countries don't have end-tidal capnography or gas analysis: depth of anaesthesia is based on physiological parameters, not MAC. There's no

Beyond Basic Nephrology Course. Front row l-r: Dr Nilru Vitharana, Dr Kenton Biribo, Dr Peter Kruger, Dr Ross Freebairn, Dr Elizabeth Bennett, Dr Julia Coull and Dr Lewis McLean

metaraminol; phenylephrine very rarely, noradrenaline on some days – this leaves what they call "God's vasopressor": adrenaline, as the sole vasopressor.

In this setting, I would more frequently see the consequences of limited antenatal care – including many complex obstetric cardiac cases secondary to undiagnosed rheumatic heart disease, and delayed presentations of preeclampsia and eclampsia. Preoperative assessments would involve seeing otherwise healthy women and telling them of a new cardiac diagnosis that could impair their life or that of their unborn child. I had never before imagined consenting for a perimortem caesarean section.

I was struck by a sense of mixed satisfaction – finding a pathology with limited ability to diagnose and definitely a limited means to treat. There are no cardiac services in the Pacific until there is a visiting medical team. I quickly learned to remind myself that we were doing the best we could for very complex patients with what we had on the day available to us.

The Anaesthesia and Intensive Care Department is staffed by a number of highly-skilled consultants and it hosts a registrar training program modelled on the ANZCA curriculum adapted for the needs of the Pacific. The registrars come from all over region; Timor-Leste, Tonga, Tuvalu, Solomon Islands, Samoa and the Cook Islands. They either complete a one-year diploma course, or a four-year masters (equivalent to a FANZCA). They leave their families behind and travel huge distances to Fiji (for some, a distance of 6,000km) to undertake their training. English is the language of medical instruction, which for some, may be their third language. For the registrars, their colleagues and department become their second family whilst they train away from home. They're a wonderfully welcoming group of registrars and consultants who also warmly welcome Australian ASA Fellows like myself with open arms.

The ICU is headed by an Australian expat Dr Elizabeth Bennett (FANZCA and FCICM) who came here 17 years ago, fell in love and never left. She has done an enormous amount of work heading up the service and developing it to train future anaesthetist/intensivists of the Pacific.

Much of the role of the ASA Fellow involves teaching and registrar supervision. My time in Fiji coincided with being involved in teaching ICU courses – BASIC and Beyond BASIC Nephrology, for which a number of Australian intensivist/anaesthetists flew over including Dr Peter Kruger (CICM board member) and Dr Ross Freebairn (past president CICM) along with intensivists from The Alfred, Dr Julia Coull and Dr Lewis McLean. The registrars also receive a number of weekly tutorials (which are also teleconferenced to those remaining in the home countries) of which the ASA Fellow has a central role in teaching.

It is easy to see why you'd fall in love with the place – the people are delightful, the work is rewarding and essential, and you can't beat a Fijian sunset.

GLOBAL ANAESTHESIA NEEDS

Five billion people do not have access to adequate surgical, anaesthesia and obstetric care. According to The Lancet Commission on Global Surgery 2030, the world needs 2.2 million more specialist surgeons, anaesthetists and obstetricians.[1] Providing safe surgical and anaesthesia care not only improves health outcomes, disability and mortality; it also promotes economic growth and development.[1]

INSIDE YOUR SOCIETY

Dr Nilru Vitharana teaching an airway station for the BASIC course

Australia has 37 doctors for every 10,000 people. By contrast, PNG has just one, Timor-Leste seven and Samoa three per 10,000 people.[2] It is estimated that four specialist anaesthetists per 100,000 population is required to maintain adequate surgical and obstetric care.[3] Australia has approximately 19.1 anaesthetists per 100,000 people.[4] In contrast, the Pacific Region has 0.5 specialist physician anaesthetists per 100,000 people (not taking into account the needs of future projected population growth).[4]

Coronavirus is set to tip many low-middle income countries over the brink, and potentially undo the development progress that has been made. Latest research suggests that extreme poverty in some regions of the world could return to the levels of 30 years ago.[5]

Programs such as the Sereima Bale Fellowship and other initiatives of the ASA are an important part of supporting the training, development and capacity building of the healthcare workforce of low-middle income neighbours in the region.

SEREIMA BALE FELLOWSHIP

The ASA Sereima Bale Pacific Fellowship program is jointly funded by the Fiji National University and the ASA via the Overseas Development and Education Committee. The program has been running since 2003.

It is named in honour of Dr Sereima Bale, a trailblazing anaesthetist who has served the region for 50 years and is the founder of post-graduate anaesthesia training the Pacific region. This year, with the nomination of the ASA, she was awarded the World Federation of Societies of Anaesthesiologists 'Distinguished Service Award'.

As a new female consultant, it was an honour to undertake this position named after such an inspirational anaesthetist. ATY3 and FANZCAs are eligible to participate in the program which is usually of three months duration. I would highly recommend this posting as a well-supported and established program for anyone interested in global anaesthesia. It is easily the most clinically satisfying experience I have had the privilege to be involved in.

Due to coronavirus, the program is currently suspended. ASA ODEC is involved in a number of opportunities and programs throughout the Pacific. Please keep an eye out on the ASA website for future opportunities via this link: https://asa.org.au/odec-events-courses-workshops-and-ongoing-projects/

Dr Nilru Vitharana
MBBS, MPH&TM, FANZCA

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ABOUT THE AUTHOR

Nilru Vitharana is a first-year consultant anaesthetist based in Sydney. She is completing a second fellowship in paediatric anaesthesia at The Children's Hospital Westmead.

NOVEL REMOTE LEARNING PROGRAM

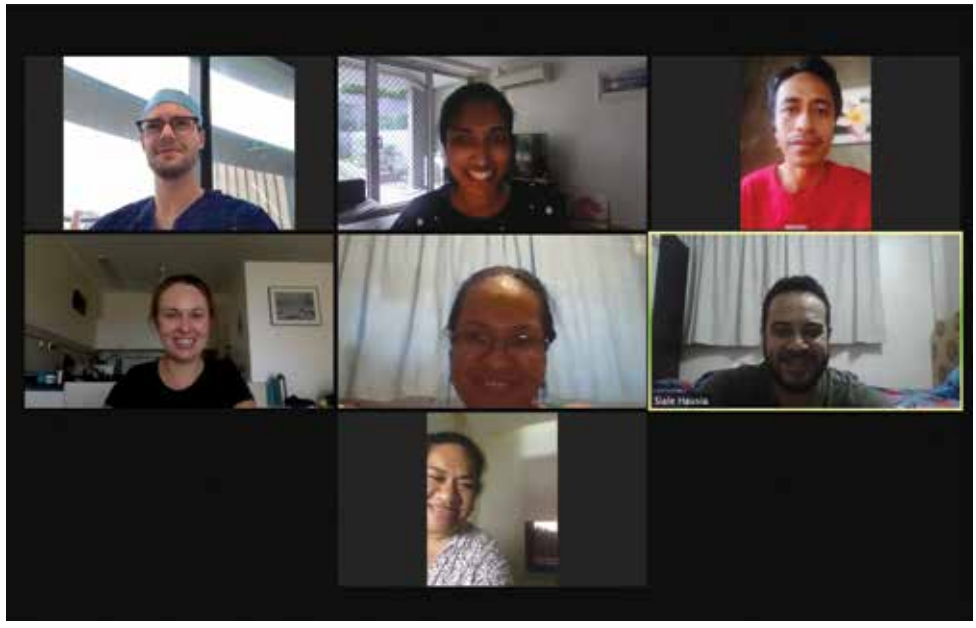
A group of motivated Pacific Island anaesthesia trainees and ASA anaesthetists have teamed up in a novel remote learning program during the pandemic.

In May, with COVID-19 threatening vulnerable Pacific Island nations and Australia imposing strict travel restrictions, the ASA's Overseas Education and Development Committee (ODEC) postponed all Pacific Fellowships for 2020. For first time since the program began in 2003, there would be no visiting FANZCA to support local Pacific Island trainees.

Encouraged by colleagues at the Fiji National University (FNU), a group of past Pacific Fellows turned to technology to salvage the situation. Since May, Drs Meg Walmsley, Nilru Vitharana, Andrew Downey and Chris Bowden have run weekly interactive Zoom tutorials for trainees in Timor Leste, Samoa, Solomon Islands, Fiji and Tonga.

Despite five time-zones and variable internet and mobile data connections, what started as an experiment has turned into a valuable learning exercise. The trainees are getting exam preparation and we are learning about the day-to-day challenges of preparing for a pandemic in remote and under-resourced environments.

The two stand-out features of the tutorials are the enthusiasm of the trainees and the past experiences that the tutors bring to the program. Meg, Nilru, Andrew and Chris have all lived and worked in the Pacific and understand some of the challenges of delivering safe anaesthesia when essential drugs and equipment are in short supply.



Exam preparation with anaesthesia trainees from the Fiji National University.
Top: Dr Andrew Downey (Melbourne), Dr Nilru Vitharana (Sydney), Dr Jonatas Madiera (Timor Leste)
Middle: Dr Meg Walmsley (Darwin), Dr Toko Amasone-Moulongo (Tuvalu); Dr Siale Hausia (Tonga)
Bottom: Dr Mua Arasi (Samoa)

For Dr Elizabeth Bennett, Anaesthetist, Head of Intensive Care, and Senior Lecturer at FNU, Zoom has been an essential tool well before the pandemic began. "We've been using it for PBL tutes for some time to include those in Lautoka and Labasa and those in the regions delayed due to flights or family issues". Unfortunately, internet connections can be problematic. "Mine goes off in the rain", she laments, not the ideal situation in the Tropics.

For the trainees juggling clinical commitments, COVID-19 preparations and study, the Zoom tutorials offer some hope they can progress through the academic year and pass their exams. A lost year of training would have a significant impact on each of them individually and also on the Pacific anaesthesia workforce for years to come. Trying to get this cohort through their training in a pandemic year is a top priority.

The ASA has a long history of collaborating with our Pacific neighbours and this program is just a small part in trying to continue that commitment. And despite the success of the Zoom tutorials, we're all hopeful the Pacific Fellow program resumes in 2021. As Dr Bennett summed up the situation: "I hope to see them (the ASA Fellows) back in Suva soon. I miss their smiling faces and on Zoom we mostly turn off the video to make the sound quality better!" I guess there are some things Zoom will never replace.

Dr Justin Burke

INSIDE YOUR SOCIETY

ODEC AND COVID-19

COVID-19 has impacted our lives in ways which were unimaginable a few months ago. The impact on our low and middle income country (LMIC) neighbours has been substantial, even for those countries with few cases. Whilst health systems in the Pacific have, so far, not been overwhelmed by COVID-19 cases, supply lines and income streams have been disrupted resulting in secondary effects on already vulnerable surgery, anaesthesia and critical care services.

The ASA Overseas Development and Education Committee (ODEC) has been working with our partners in LMICs as well as other organisations including the DFAT, NZSA, ANZCA, RACS, Interplast and Lifebox in assisting COVID-19 preparations and providing ongoing support for anaesthesia education.

Many of our Pacific Island neighbour countries, supported by the WHO, SPC, the ASA and ANZCA in a series of Zoom meetings with key healthcare leaders, have developed protocols, processes and PPE stockpiles in anticipation of COVID-19 outbreaks in the Pacific.

As outlined below, they face a number of significant challenges regarding manpower and access to equipment – the implications for COVID-19 infections within their clinical staff would be profound.

Fiji was quick to act in preparing their anaesthesia and intensive care staff for COVID-19. Dr Luke Nasedra, the Chief Anaesthetist is currently Head of the Fiji Emergency Medical Assistance Team and Acting Medical Superintendent of Colonial War Memorial Hospital, Suva, the country's main teaching hospital. Dr Nasedra has reported challenges in responding to COVID-19. Initially, adequate PPE was not available and it has been difficult to maintain supply of essential medications and single use consumables, such as dressings, intravenous equipment and airway devices as air and sea freight options diminished.

In addition, all the doctors in training from neighbouring Pacific nations were recalled to their home countries to prepare for COVID-19 and this had a great effect on the Fijian workforce as they are critical to maintaining normal service. Currently CWM is only undertaking the most urgent of cases. A side effect has been the disruption to post-graduate training programs at Fiji National University.

Unfortunately, the ASA has been unable to send our usual Pacific Fellows, who spend up to three months in Suva providing teaching and clinical supervision to the FNU trainees. ODEC has been working with FNU to provide remote teaching for Pacific trainees (as outlined by an article written by Justin Burke in this issue of *Australian Anaesthetist*) and a number of COVID-19 related sessions have been held for all staff both junior and senior.

The ASA has also coordinated a donation of over 230kg of essential consumables to CWM in Suva. This would not have been possible without Dr Martin Nguyen, ASA

Dr Martin Nguyen and the Medical Pantry team

239kg of essential consumables ready to go to Suva

member and CEO of the Medical Pantry, a charity which sourced and packaged the supplies. Members are encouraged to read more about Medical Pantry at https://medicalpantry.org

In many LMICs, oxygen and reliable pulse oximetry will be the mainstay of treatment for COVID-19 respiratory disease. This means that Lifebox, unlike many NGOs is having a very active pandemic. Lifebox has been working hard with Acare, who manufacture the Lifebox oximeter, to ensure continual supply with priority being given to those regions hardest hit by COVID-19. Lifebox has also produced and curated a number of educational resources and guides for use during the pandemic. These encompass oxygen therapy, PPE use and hospital preparation. These resources can be found at https://www.lifebox.org

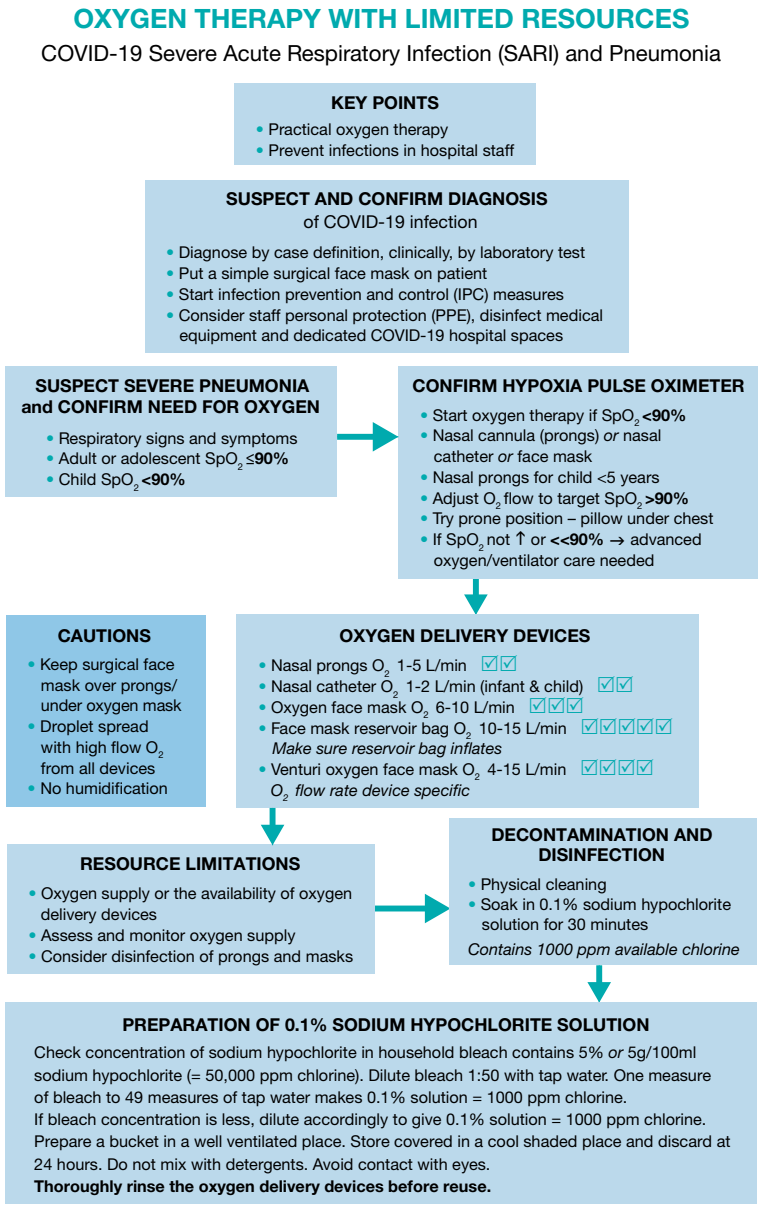
The ASA is a partner in Lifebox Australia and New Zealand. Lifebox ANZ acted quickly to conduct a needs analysis of critical care areas in our region and has subsequently received requests for over 170 pulse oximeters from Fiji, Timor Leste, Solomon Islands, Tonga, Samoa, Micronesia, Vanuatu, Laos and PNG. Fortunately, the Lifebox ANZ finances have been just sufficient to cover these orders and deliveries will begin soon! Thank you to the significant number of ASA members, who have contributed to Lifebox over the years. The recent end of financial year donation surge has permitted this strong COVID-19 response. Please take some time to read more about the activities of Lifebox ANZ at https://www.interplast.org.au/learn-more/our-work/lifebox-australia-new-zealand/

During COVID-19 there has been much discussion about the needs of Pacific critical care areas and it has been realised that strengthening critical care also strengthens anaesthesia and surgery. Many countries have made requests for such essential equipment as ventilators and oxygen concentrators. These requests have provoked discussions about how this equipment can be used post-COVID-19 for essential anaesthesia and surgery. Various groups are progressing this issue and this strengthening may be an unexpected COVID-19 benefit!

ODEC members have been active in other COVID-19 related areas. Dr Haydn Perndt assisted in the development of a WHO COVID-19 airway management, checklist and flowchart for use in the Western Pacific region. Special thanks to Drs Arthur Vartis and Tom Mohler for their efforts in arranging oximeter orders for Micronesia and Laos respectively.

Many face-to-face ODEC activities have been postponed, however we remain committed to supporting our anaesthesia colleagues fellow societies, particularly the Pacific Society of Anaesthetists, in any way we can.

Dr Rob McDougall



Oxygen therapy with limited resources wall chart developed for LMIC COVID response

INSIDE YOUR SOCIETY

HISTORY OF ANAESTHESIA LIBRARY, MUSEUM AND ARCHIVES NEWS

Unfortunately, due to the COVID-19 situation, many of the events and activities planned by the HALMA committee have been placed on hold, however, it is hoped that as things return to some normality these events will take place.

One of the most common questions I have been asked over this period as the Curator, Librarian and Archivist, is how can I work from home? This is a valid question, given that I'm not physically located with the ASA's collections, however, 90% of curatorial work actually involves doing paperwork, research and data entry, so I have been able to conduct this from the comfort of my home. There are some limitations to what I can do though, so I have spent a lot of time processing outstanding donations as well as a backlog of library and archive data. This means that going forward, the ASA is in a great position to keep developing as a research entity as the contents of both the library and archive are made much more easily accessible by adding them to the ASA's collection database.

YOU NEVER KNOW HOW THE ASA CAN HELP!

Earlier this year the ASA was approached by one of our members, Dr Graham Grant, with an unusual request. Unfortunately, Dr Grant's home had been the scene of a burglary, with the thieves making off with family heirlooms, including a medallion awarded to Dr Grant's wife, Lyn.

In 1996, the 11th World Congress of Anaesthesiologists was hosted in Sydney by the ASA. At this event an art show was held with Lyn Woodger Grant submitting her work *The Rockpool*, a 'plein air' oil painting on wood, depicting a pocket of temperate rainforest in the Blue Mountains. The work, measuring 2" x 3" was completed over several early morning sessions at a time when the light was most stable. Lyn recalls the subject as being both "magical" and "eerily ethereal". Lyn says it was a thrill to be able to express her love of nature through *The Rockpool* which was to become a pivotal painting in her future direction of environmental art.

The painting later featured in a retrospective at Meriden School; before two public exhibitions in London together with other studies of tropical rainforests, mangroves and coral reefs from Australia, Asia and the Pacific Rim, spanning several decades. The month-long public exhibition at Imperial College, London (*Spirit of the Rainforest* in 1998) led to the Royal Geographical Society (RGS) inviting Lyn to stage a similar exhibition *(Fragile Beauty – from the Rainforest to the Coral Reefs)* with more coral reef paintings, in their historic lecture theatre in 1999. Lyn was made a Fellow of the RGS the same year for highlighting environments under threat.

Lyn is an accomplished artist, having worked as a professional artist for over five decades with work in public and

The World Congress of Anaesthesiologists 1996 medallion

The *Rockpool* by Lyn Grant

private collections here and overseas. She has been a finalist five times at the Art Gallery of New South Wales in the Archibald, Wynne and Sulman Prizes and a finalist seven times in the Portia Geach Portrait Prize for Women. She holds an ASTC from the National Art School, a BA (Syd) – majoring in Anthropology and Fine Arts); and a postgraduate degree in Art History, MA (Syd). In December 2019, Lyn was inducted as a Fellow of International House, University of Sydney.

The theft of the engraved medallion for *The Rockpool*, awarded for the best work at the 1996 Congress, was particularly violating; not worth very much to anyone else, but to Lyn it represented a long journey of marrying art with conservation. Saddened by this loss, her husband Graham approached the Society to see if we had any way of replacing the priceless memento. Luckily the ASA has an amazing archive that was able to assist in the task almost immediately.

The Gwen Wilson Archives are a great repository for anyone seeking all kinds of unusual pieces of information. Within the archive not only did we have the original documents relating to the production of medallions but we found a few blank, identical medallions within the collection. It is not common practice for an archive to remove an historic artefact from the collection, however, in this case, the archive held more than the required number of blank medallions and, given the circumstances, it was only right to gift one of these to Lyn.

ADDENDUM

Dr Graham Grant and Lyn Grant would like to thank Dr Don Maxwell, who first suggested contacting ASA CEO Mr Mark Carmichael, who then passed the unusual request to Belinda McMartin, MA, Curator, Archivist and Librarian, Australian Society of Anaesthetists, who achieved a brilliant outcome.

Lyn and Dr Graham Grant

For Mrs Grant the art continues, despite various restraints of advancing years and a raft of numerous pathologies. She speaks of one last exhibition, ideally a retrospective spanning six decades, which would include many of the key works from the London public exhibitions that have yet to be seen here.

WHAT WAS HAPPENING AT THE ASA 60 YEARS AND 20 YEARS AGO?


ASA NEWSLETTER
AUSTRALIAN SOCIETY OF ANAESTHETISTS
SEPTEMBER 2000
President's Message—Principles and Principals

Sixty years ago at the ASA

If we delve into the ASA archives and review the *ASA Newsletter* (which later became *Australian Anaesthetist*) from June 1960, we can gauge an understanding of the issues facing both the ASA and wider community. The newsletter starts by saying "Like all men's tools the relaxants make good servants but bad masters". The opening remarks of the newsletter by Editor Dr Brian Crawshaw goes on to talk about the use of muscle relaxants, specifically the advantages and disadvantages.

He also discusses the use of different drugs from state to state with the revelation that Decamethonium was used more widely in New South Wales than any other state. Decamethonium was not as popular in the other states as there was no antidote for its effects. Why it was so popular in NSW is not mentioned, however those who worked with Dr Crawshaw, who was a pioneer in the field, remember that he utilised it in Sydney, so perhaps he set a trend in NSW.

Dr Crawshaw also explains how the newsletter was produced, which involved him writing his portion in Sydney and sending it to Melbourne on magnetic tape, from where it was published and posted to members. He asked members in his Editorial if perhaps it would make more sense to have the newsletter edited and published in the editor's hometown in the future. As we know this would eventually happen and today *Australian Anaesthetist* is published in the ASA North Sydney office before being sent to print also in Sydney.

Twenty years ago at the ASA

For this flashback we delve into the *ASA Newsletter* from September 2000. Much was said about the ASA's double booth that was presented at the 12th World


AUSTRALIAN SOCIETY OF ANAESTHETISTS
NEWSLETTER
JUNE
1960.
Editor:
Dr. Brian Crawshaw,
33 Martin Street,
Sydney, N.S.W.

INSIDE YOUR SOCIETY

Congress of Anesthesia in Montreal, Canada. The society's booth was located in 'publishers row' with the society's journal, newsletters, annual reports and both of Gwen Wilson's books *One Grand Chain* and *Fifty Years* being displayed. The exhibit was considered a success!

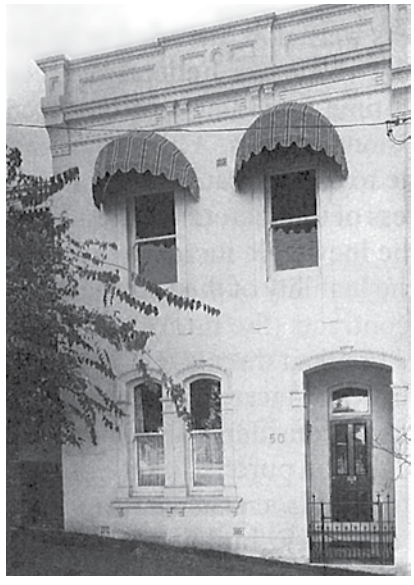
In overseas news the Overseas Aid Committee reported on the impacts of the June 2000 Fiji coup. Grave fears were held for not just the country's economy but also for the health of citizens as the armed uprising threatened stability. The committee expressed concern over the possible undoing of all the hard work the ASA had put into the region's Pacific Island anaesthesia assistance program. At the time the ASA was partly sponsoring the role of the Senior Lecturer in Anaesthetics at the Fiji School of Medicine, so a lot of time was spent discussing the impact this coup would have on the situation. When martial law was declared it seemed things would get slightly better and eventually by the end of the year things had stabilised in Fiji. Unfortunately, over 7,000 local jobs were estimated to have been lost due to the coup.

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

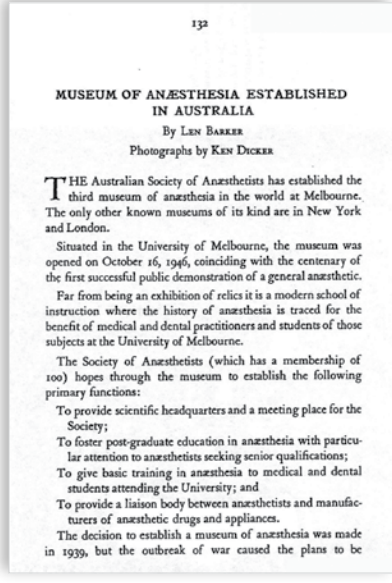
The Harry Daly Museum is closed temporarily until further notice.

A NEW LOCATION, A NEW BEGINNING

86 Elizabeth Bay Road, Sydney. Site of the Society's first permanent secretariat and its national headquarters, 1970-80



50 Gurner Street, Paddington, NSW. Purchased by the ASA in 1979 as its national headquarters



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MUSEUM OF ANÆSTHESIA ESTABLISHED IN AUSTRALIA

By Len Barker

Photographs by Ken Dicker

THE Australian Society of Anæsthetists has established the third museum of anæsthesia in the world at Melbourne. The only other known museums of its kind are in New York and London.

Situated in the University of Melbourne, the museum was opened on October 16, 1946, coinciding with the centenary of the first successful public demonstration of a general anæsthetic.

Far from being an exhibition of relics it is a modern school of instruction where the history of anæsthesia is traced for the benefit of medical and dental practitioners and students of those subjects at the University of Melbourne.

The Society of Anæsthetists (which has a membership of 100) hopes through the museum to establish the following primary functions:

To provide scientific headquarters and a meeting place for the Society;

To foster post-graduate education in anæsthesia with particular attention to anæsthetists seeking senior qualifications;

To give basic training in anæsthesia to medical and dental students attending the University; and

To provide a liaison body between anæsthetists and manufacturers of anæsthetic drugs and appliances.

The decision to establish a museum of anæsthesia was made in 1939, but the outbreak of war caused the plans to be

The announcement of the museum of the Australian Society of Anaesthetists, 1947[2]

With the announcement by the Australian Society of Anaesthetists' President Dr Suzi Nou on 4 February 2020 of the purchase of new headquarters for the Society at 86 Chandos Street, Naremburn, it seemed reasonable to review previous locations since Foundation in 1934.*

Below is listed the date of arrival, membership numbers (if documented) and addresses, with additional information re the Secretariat and the need for a headquarters.

1. From the end of 2013 (c. 3,000 members): Levels 7 and 8, 121 Walker Street, North Sydney.
2. From December 1985 (1,559 members in 1984): Edgecliff Towers, Edgecliff. Unit 604 initially, then U603 (mezzanine/ RBL dedicated on 18 June 1994) and finally U602 in line (R. Walsh AIC 1986).
3. In April 1980 we moved to 50 Gurner Street, Paddington (pp.432).
4. From 1969-1980 there were two different areas utilised at 86 Elizabeth Bay Rd, Elizabeth Bay by Ben Barry (pp.429-430).
5. From 1951 until 1955 (c.200 members): there was the ill-fated 49 Mathoura Road, Toorak, Melbourne, "Library, meeting hall, laboratory, workshop, museum, office and photographic dark room" opened officially on 5 March 1951 (p.285).
6. From 1946-1951 (22 known initially to 108) and designated the ASA's Scientific Headquarters, we were

49 Mathoura Road, Toorak, Melbourne. Headquarters of the Society 1950-55. The lower bay window, right, was that of the lecture room and the windows to the left of the front door were those of the library. The upper storey was the residence of Dr Geoffrey Kaye

Dr Geoffrey Kaye lecturing and demonstrating the principles of anaesthetic apparatus in the small lecture room of the Australian Society of Anaesthetists' first headquarters in the School of Physiology, University of Melbourne

housed at the old Department of Physiology at the University of Melbourne (pp.180-181).[2]

7. Not really a Headquarters but rather storage† for the Library/Museum during WW2, 1939-1945; (47 +7 Hon); was at the Royal Australasian College of Surgeons, Melbourne.

So much for physical locations, with the Secretariat from inception in 1934, really being Geoffrey Kaye's rooms at 14 Collins Street, Melbourne C.1. and his home at 449 St Kilda Road, Toorak (latter to be verified, due to unfortunate Kaye family circumstances; Rod Westhorpe, personal communication 2020).

From here, Geoffrey as ASA Secretary generated voluminous correspondence, memoranda etc. both locally and overseas, just carrying on his earlier interests after graduation from the University of Melbourne in 1926. These culminated initially in the visit to Sydney of Francis Hoeffer McMechan in September 1929[3] and ended in the founding of the proposed Society in January 1934.

Thus, the Secretariat remained with Geoffrey until 1946: "Oh, take heed that the ASA will have to elect a new secretary in 1946 – I think I've done my bit, …" (p.152).

From Collins Street, the Secretariat moved to Dr John Watson of Victoria, then to South Australia (1949-51 J. Barker), back to Victoria (1951-54, A.S. Ferguson and J.M. Bell) until to Sydney, NSW (1954-56), (pp. 493-494).

Dr Wilson very evocatively describes the induction of a 'new' Secretary (p.428): "And so the Society's address and records moved with each change of Honorary Federal Secretary… (the newbie, Ben Barry) now "on his own… you can ring me in Melbourne any time if you have a problem…"

Some weeks later, the Society's files and records arrived in Sydney from Melbourne, packed in tea chests and a battered old suitcase held together with a leather strap. A letter (to Ben) from Pat Maplestone included: "I've sent off the A.S.A. files. The suitcase is rather battered and I hope it holds together: you can keep it, but my daughter and her horse would 'appreciate the return of the leather strap'".

Ben did not keep that iconic suitcase but threw it out. He also sat in GK's personal chair till it fell apart finally (based on good authority, Colleen Barry, personal communication, 2020).

In summary, the Secretariat since 1934 was a peripatetic address, with the Headquarters being a necessity to house the Library and Museum (pp.134-139; 144; 427).

Other than the 1950s setback, 1970 was the start of the static Sydney Headquarters dynamic, Naremburn providing a new and exciting beginning.

Richard J. Bailey
Hon. Archivist

* As the Gwen Wilson Archives and Richard Bailey Library are currently inaccessible due to COVID-19, references in parentheses are limited to Gwen Wilson's *50 Years*.[1]

† RJB suggests hibellumernation, for all you neologisthesiologists out there!

References

1. Wilson G. *Fifty Years*. Australian Society of Anaesthetists, Edgecliff, Australia, 1987.
2. Barker L. 'Museum of anaesthesia established in Australia', *Br J Anaesth* 1947; 20:132-136.
3. Transactions of the Third Session, Sydney. International Medical Congress, *BMA* 1929; 146.

INSIDE YOUR SOCIETY

NEW AND PASSING MEMBERS

The ASA would like to welcome all new members from March to July 2020.

TRAINEE MEMBERS

Dr Alexandra Mary Anderson	QLD
Dr Ben James Blackman	VIC
Dr Francene Christie Bond-Rhodes	NSW
Dr Katherine Amelia Carroll	VIC
Dr Julia Lee Carter	QLD
Dr Elaine Rea Chilcott	VIC
Dr Supriya Chowdhury	NSW
Dr Joseph Comben	QLD
Dr Emma Comiskey	NSW
Dr Robert Crowley	QLD
Dr Lucy Davidson	ACT
Dr Dustin Che de Jonge	SA
Dr Anne-Marie Dempster	NSW
Dr Karl Alexander Eisner	QLD
Dr Nicholas (Nick) Anthony Enzor	WA
Dr Stephany Game	NSW
Dr Michelle Haeusler	VIC
Dr Laura Jane Margaret Hamilton	WA
Dr Courtney Hawthorne	QLD
Dr David John Howell	VIC
Dr Narguess Jahangiri	WA
Dr Ezra William Keebaugh	VIC
Dr Kent Lavery	VIC
Dr Jaqueline Maree Laws	QLD
Dr Vivian Liang	VIC
Dr Benjamin James McDonald	SA
Dr Kathryn Louise Mence	ACT
Dr Briana Miller	NSW
Dr Sanjeev Prakash Naidu	ACT
Dr Grant Damien O'Brien	WA
Dr Jessica Monica Heather Paton	NSW
Dr Aaron Pym	ACT
Dr Aslam Rizvi	VIC
Dr Jam Sadullah	WA
Dr Stephanie Ann Samuelraj	QLD
Dr Danielle Scott	QLD
Dr Aylin Seven	NT
Dr Darren Paul Sherwin	WA
Dr Linda Trang	QLD
Dr Sanjeev Vijayan	NSW
Dr Brianna White	SA
Dr Nicholas Casimir Zichy Woinarski	VIC
Dr Kah Hong Yep	VIC
Dr Neeban Balayasoderan	QLD
Dr Kieran Peter Bates	VIC
Dr Scott Michael Brennan	NSW
Dr Matthew Bright	QLD
Dr Benjamin Lewis Cahill	QLD
Dr Vanessa Chen	NSW
Dr Victor Xin Yun Chen	QLD
Dr Erin Anne Chevis	WA
Dr Katherine Collins	WA
Dr Marena Cosman	NSW
Dr Alexandra Claire Fawcett	SA
Dr Elizabeth Ann Forrest	QLD
Dr Zenan Franks	QLD
Dr Melissa Fry	QLD
Dr Dominique Marie Grant	VIC
Dr Sidharth Gupta	NSW
Dr Leonie Madeline Harold	VIC
Dr Gerard Kenneth Harrop	VIC
Dr Susanna Hoffmann	QLD
Dr Madeleine Xi Xian Hollitt	VIC
Dr Madelaine Elizabeth Collins Howard	ACT
Dr Emily Louise Jenkins	VIC
Dr Antony Ji	QLD
Dr Damian Joseph Graham Johnson	SA
Dr Maggie Tess Keys	QLD
Dr Venetia Khambatta	NSW
Dr Geraldine Kong	QLD
Dr Kasia Kulinski	NSW
Dr Siobhan Lane	QLD
Dr Dustin Viet Anh Le	VIC
Dr Kathleen Anne Leaper	NSW
Dr Siak Khui Lee	VIC
Dr Jessica Arna Lewkowicz	QLD
Dr Si Ying Lim	WA
Dr David Liu	QLD
Dr Courtney Ellen Lloyd	SA
Dr Darcy Mark McFarland	ACT
Dr Andrew David John McKeown	NSW
Dr Michelle Wing Yan Miu	NSW
Dr Stephanie Naim	NSW
Dr Luke Daniel Nelson	VIC
Dr Lisa Katherine Paxton	VIC
Dr James Henry Phillips	QLD
Dr Jolene Ralph	SA
Dr Gowri Manohari Ravichandran	QLD
Dr Daniel Thomas Robertson	NSW

Dr David Robertson	WA
Dr Tom Nicolas Schoeman	ACT
Dr Melissa Jane Sharpless	QLD
Dr Annie Shi Ruo Shaw	NSW
Dr Ilan Sean Silberstein	WA
Dr Veeranjit Singh	QLD
Dr Patrick Smith	NSW
Dr Jarmila Sterbova	SA
Dr Dharan William Sukumar	ACT
Dr Andrew Seong Kiat Tan	VIC
Dr Laura Simone Thomas	NSW
Dr Sophie Louise Turner	QLD
Dr Liana Claire van de Veerdonk	SA
Dr Laltaksh Wangoo	NSW
Dr Rajeswari Ward	QLD
Dr Rachael Maree Weir	QLD
Dr Rebecca Francisca Ruth Wood	WA
Dr Jacob Woodward	WA
Dr James Edwin Yates	NT
Dr Hannah Elizabeth Vereker Bergin	VIC
Dr Ryan Christopher Broad	NSW
Dr Ashleigh Louise Cargill	VIC
Dr Nicholas Sam Carr	TAS
Dr Rachel Wai Wai Chan	TAS
Dr Joshua David Chugg	VIC
Dr Luka Cosic	VIC
Dr Nicola Alana Fraser	TAS
Dr Adrian Gasparini	ACT
Dr Gihan Hapuarachchi	QLD
Dr James Cheng Jiang	VIC
Dr Bonny Jones	QLD
Dr Ben Nelson Richard Maudlin	NSW
Dr Jesse McLellan	QLD
Dr Jennifer Kate Preddy	VIC
Dr Catherine May Rickard	VIC
Dr Kerrie Louise Tessier	SA
Dr Jacob van Tienen	NSW
Dr Brooke Michelle Ward	VIC

ORDINARY MEMBERS

Dr Naoko Nakaigawa	WA
Dr Jignesh Kumar Parmar	WA
Dr Luis Andres Sierra	VIC
Dr Hutchinson Thurairajah	VIC
Dr Matthew William Acheson	VIC
Dr Vanessa Kathryn Andean	VIC
Dr David Laurence Anderson	QLD
Dr Marion Irene Andrew	SA
Dr Jonathan Au	VIC
Dr Angela Jane Baker	NSW
Dr Ian Gregory Balson	VIC
Dr Ruth Elizabeth Barbour	NT
Dr Aradhana Behare	NSW
Dr Susmita Bhattacharya	NSW
Dr Jeremy David Broad	VIC
Dr Frank Frederick Buchanan	VIC
Dr Aisling Buckley	VIC
Dr David Eric Campion	NSW
Dr Jacob James Carter	QLD
Dr Elena Chernova	VIC
Dr Clara Anamaria Cotaru	VIC
Dr Rebecca Jane Cregan	NSW
Dr Sean John Davies	SA
Dr David Richard Denman	SA
Dr Sandra Derry	QLD
Dr Carolyn Ann Douglass	WA
Dr Patrick John Dunne	VIC
Dr Cormac John Michael Fahy	SA
Dr Ali Sabri Faris	VIC
Dr Kathryn Fry	QLD
Dr Kathryn Hersbach	VIC
Dr Joanne Frances Irons	NSW
Dr George William Kennedy	QLD
Dr David Andrew Kingsbury	WA
Dr Marcus Kornmehl	NSW
Dr Sally Lacey	VIC
Dr Cassandra Jane Lang	VIC
Dr Neil Andrew MacDonald	VIC
Dr Tejinder Mettho	VIC
Dr Lachlan Miles	VIC
Dr Martin Nguyen	VIC
Dr Sean Oberholzer	WA
Dr Olivia Solange Page	QLD
Dr Kalyana Chakravarthy Pothapragada	TAS
Dr Ayantha Harshini Ranasinghe	VIC
Dr Kim Adele Rees	VIC
Dr Helen Elizabeth Roberts	VIC
Dr Karl Alan Ruhl	VIC
Dr Kym Nicole Saunders	VIC
Dr Elliot Marcel Schulberg	VIC
Dr Neena Singh	NSW
Dr Christopher Slattery	QLD
Dr Jen Aik Tan	VIC
Dr Claudia Tom	SA
Dr Maryann Turner	VIC
Dr Liam George Twycross	VIC
Dr Radha Vivekananthan	VIC
Dr Suzanne Whittaker	VIC
Dr Peter Daniel Williams	VIC
Dr Benjamin Teck Hui Wong	VIC
Dr David Matthew Woods	NSW
Dr Ibrahim Yacoub	VIC

IN MEMORIAM

The ASA regrets to announce the passing of ASA members Dr Brian Keith Crawshaw, NSW; Dr Gavan John Carroll, QLD; Dr Kerry Michael Garske, QLD; Dr John Arthur Hickman, TAS; Dr Robert Eyres, VIC; Dr David Alexander Lindsay, VIC; Dr Eric Van Opstal, VIC; Dr John David Richards, SA; Dr David Griffin Woods, SA.

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

INSIDE YOUR SOCIETY

ROBERT LINDSAY EYRES 1944-2020

Rob Eyres was a colourful, larger than life character. Many developed a fierce loyalty to him. His message was often short and succinct, distilling a complex instruction into a few words. His was a different era; his brilliance and enormous contribution to research and improving clinical practice inspired many. George Chalkiadis was fortunate to share a long lunch with him every fourth Friday afternoon for over 20 years; he was a mentor, an inspiration and friend. George asked those who knew him for their anecdotes and recollections.

Rob was somebody that always looked over the horizon. He saw paediatric anaesthesia as being a global community and he inspired me to join that community. My best friends are paediatric anaesthetists from around the globe and without Rob's inspiration I would never have met them. Rob also had a profound impact on my understanding of research. His fearless and no-nonsense approach taught me the fundamental principle that good research should be driven solely by the desire to honestly collect and analyse data to find the best evidence to guide practice. This principle can easily be forgotten in a research world driven by ruthless competition for multimillion dollar grants and newsworthy outcomes.

Andrew Davidson
Paediatric Anaesthetist RCH

Rob was a force of nature. He had an amazing focus and drive for all aspects of his life, but for paediatric anaesthesia he was a global star.

When I first met him I was intimidated and he was disparaging about Great Ormond St and my particular role. Subsequently, Rob was a frequent visitor and got to know about our practice and we gradually became very good friends and colleagues. We socialised a great deal in both hemispheres and it was all enormous fun. Wine was a common interest.

He was extremely supportive while I was editor of *Pediatric Anesthesia* and we both nurtured a young Dr Davidson!

Ted Sumner
Paediatric Anaesthetist, London

Rob's reputation had spread to the Children's Hospital Camperdown well before I met him: an anaesthetist par excellence, an academic and a bon vivant. Over the years we met up many times, at various meetings around the world and while visiting RCH. He lived up to his reputation but there was more to him. He was friendly, generous and enormously entertaining.

David Baines, Paediatric Anaesthetist
Children's Hospital Westmead

I met Rob in Rotterdam during the 1st European Congress of Paediatric Anaesthesia in 1986. It was the beginning of a golden age. He chaired the scientific program committee for the 1996 WFSA congress in Sydney and asked me to participate. We met in various countries, changing the world over glasses of wine. He often visited Paris because his wife did business there, staying in a nice hotel in Saint Germain des Pres. During one of his stays, he invited me to Caviar House located in Place de la Madeleine. We spent over four hours there, drinking, eating and discussing. He was a very generous and genuine friend.

Isabelle Murat
Paediatric Anaesthetist, Paris

I first met Rob at a meeting in Brussels in 1985, shortly before going to RCH for six months. He gave me a warm embrace (to my surprise). I shared an office with Rob at RCH. He took me under his wing. Never have I come across an anaesthetist with Rob's phenomenal knowledge, scientific insight and technical skills. Rob and his wife Olivia became lifelong friends.

Three years later, he was working in Bergamo and called unexpectedly asking if he could visit for the weekend? He motorcycled to Rotterdam. During his year in Italy we met regularly either in Rotterdam or in Bergamo with Paolo Busoni and Andrea Messeri.

Anneke Meursing
Paediatric Anaesthetist, Rotterdam

Rob was very serious professionally and very good in everyday life. I remember our first meeting. He was working in the cardiac surgery department in Bergamo. We travelled on the highway from

Bergamo to Florence. He was driving at crazy speeds and I was terrified. He spoke continuously, while I was silent. Upon arrival in Florence he asked me, "why are you so pale"? This was Rob Eyres.

Paolo Busoni
Paediatric Anaesthetist, Florence

I met him for the first time during the paediatric anaesthesia meeting in Ballarat in 1987, then at other meetings and during his Sabbatical in Bergamo. I knew immediately he was an outstanding anaesthetist and a man capable of appreciating life's many pleasures. We discussed regional blocks, intravenous lines; but sport cars and good wine were also our hot topics… at that time he drove an Alfa Romeo and he thought, since I was Italian, I should drive a Ferrari!

Andrea Messeri
Paediatric Anaesthetist, Florence

Rob will always be one of my icons of paediatric anaesthesia. He came across as a lovable rogue in cowboy boots but beneath that façade there was an incredibly deep-thinking Aussie who had one of the sharpest minds I know. A highlight of any international paediatric anaesthesia meeting was spending time with Rob.

The only time I saw Rob lost for words was on the wine tour organised as part of a meeting in Cape Town. A pair of exceptional white wines was served. Rob bravely complained to the owner Boland Coetzee, a former Springbok rugby player, that there were no good red wines in South Africa.

Boland, a quiet soft-spoken man of few words, found me a while later and asked "Where is that bloody Aussie?" Rob was found and escorted by Boland to the vast wine cellar. "Sit!" Suddenly Rob found himself tasting some of the best reds he had encountered with two members of the British Wine Tasting Club 'inner circle' who were selecting wines for their members.

I valued Rob as a reviewer for *Pediatric Anesthesia*; he always gave insightful reviews. You knew when he was unimpressed. In classic response to a paper on the use of ultrasound for caudal placement all Rob wrote was "Why would you use a calculator to add 1+1!"

Adrian Bosenberg, Paediatric Anaesthetist, Capetown, Seattle

Rob and I were at medical school together, worked together at RCH for 10 years and remained friends afterwards.

Rob's somewhat unconventional dress, his extroverted manner and his joie de vivre endeared him to all who met him. When he visited Toronto I drove him around with my family. They loved Rob. My children always remembered him and told me "he was so cool" and so unlike other medical colleagues of mine, including me.

I would always try meet up on my trips back to Melbourne. Under Rob's tutelage we would go to Jimmy Watsons, Pellegrinis or wine bars down narrow city laneways. Rob invariably knew the staff and patrons and was always greeted enthusiastically as almost part of a family.

Geoff Mullins
Paediatric Anaesthetist RCH
Toronto, Perth

Rob was a loyal and valued friend to many people, including myself. I was always happy when Rob was my anaesthetist. He was quick, efficient and relaxed. If the child was sick, the operation difficult or dangerous, Rob was your man. He demonstrated extraordinary skills and was always calm under pressure. He was a member of the ICU team for many years. Staff and families were reassured when Rob was on duty to look after children who were desperately ill.

Alex Auldist
Paediatric Surgeon, RCH

Rob was a great teacher. He taught me how to insert a radial arterial line in 1979. I took this skill to Bristol where I introduced it to their neonatal intensive care.

We had great times at the RCH ski lodge in the '80s. I recall him each morning tucking into a bowl of cornflakes with his pharmacist mate Hurlo, washed down with a couple of glasses of red before facing the slopes and sitting in an igloo one night at 3am with him and Peter Loughnan solving the problems of the world.

Later when we both had executive roles at RCH, he provided me with great mentorship, gave me his wisdom and instilled in me confidence for which I shall always be grateful.

Peter McDougall
Neonatologist, RCH

Rob excelled as Director of the RCH Anaesthesia Department, its many staff and varied personalities. He reined us in whilst being supportive and encouraging. He was a pivotal supporter for anaesthesia technologists at a time when the profession was under threat. He supported a national drive to improve work conditions, remuneration, staffing and training. He improved morale and our internal organisation.

Paul Gleeson
Ex-Anaesthesia Technologist, RCH

I first met Rob when I worked in ICU as a biochemist and he would bring out blood gases. Cardiac cases would typically run late and we discussed life whilst awaiting results. Later, Rob suggested I join the perfusion team. He brought a textbook and said, "read it, especially the chapter on Tetralogy of Fallot". In the interview Roger Mee (Cardiac Surgeon) asked about Tets, Rob asked me about my car.

In those days, if we couldn't wean a patient off bypass we would stay on overnight, chatting for hours. If we were unsuccessful the next morning, CPB was ceased. Rob recognised the need for improvement and supported us developing an ECMO/VAD program. In 1989 we were the first to use a centrifugal VAD (the progenitor of ECMO) to support a patient for several days.

Steve Horton
Cardiac Perfusionist RCH

INSIDE YOUR SOCIETY

ARTHUR OLAP 1972-2020

Arthur Olap worked as a nurse anaesthetist for two decades on the islands of Chuuk and Pohnpei. These islands form part of the Micronesian archipelago that stretches across the north-west Pacific. It is a region challenged by both its geographic isolation and limited resources.

Arthur passed away unexpectedly earlier this year – he was aged 48. For the last three years of his life, Arthur had been the sole provider of anaesthesia to the 49,000 inhabitants of the Pacific island of Chuuk. Arthur was not a doctor – he was a nurse anaesthetist.

To understand Arthur is to understand the part of the world he worked and lived in.

Arthur's professional life epitomised the significant contribution nurses make to the anaesthetic workforce in low resourced countries. As a registered nurse with a postgraduate diploma in anaesthesia, he performed his duties with a high degree of independence, much like a rural GP anaesthetist would in Australia.

In Micronesia, nurse anaesthetists account for 50% of the anaesthetic workforce. In Chuuk, Arthur represented 100% of the workforce. This situation though far from ideal, is unfortunately the norm for many of these islands. These are the realities in a region unique in the Pacific, where remote island nations experience long stretches of anaesthetic services provided exclusively by nurse anaesthetists.

The impact of Arthur Olap's sudden loss has had a devastating effect on the delivery of anaesthesia in Micronesia and represents a staggering 17% fall in its anaesthetic workforce. It would be hard to imagine the catastrophic effect of suddenly losing one-sixth of the anaesthetic workforce in Australia.

Arthur was born and lived for much of his life in Chuuk. As a graduate nurse from the College of the Marshall Islands, he began working in the operating theatres in Weno, the capital of Chuuk. He was soon mentored by two other nurse anaesthetists, the late Kalisto Thomas and Aroy Modou, who taught Arthur the art and skills of anaesthesia. Arthur was successful in securing an overseas scholarship, and in 2002 he attended Chang Mai University in Thailand where he gained his Diploma in Anaesthesia.

Arthur returned to his home in Chuuk. Over the following two decades he worked alongside Aroy and later Martha Moufa, another nurse anaesthetist who had followed in his footsteps. Together they provided continuity of anaesthetic care. For a few years he worked with Dr Okai Johnson, a medical anaesthetist in Pohnpei, the capital of the Federated States of Micronesia about a 40 minute flight from Chuuk. For short periods there would be a locum anaesthetist, often from the Philippines. Mostly though, Arthur worked as part of a small workforce made up entirely of nurse anaesthetists.

Natural workforce attrition coupled with falling recruitment began to take hold and by 2016 Arthur found himself working alone on the island of Chuuk.

It is hard to fully appreciate the reality he was forced to face. For the last three years of his life he delivered anaesthesia in complete isolation and maintained call, 24 hours a day, seven days a week without reprieve. He did this without a nurse assistant and without biomedical support.

Arthur worked in an environment beset by a chronic state of shortages. Theatre stocks that are often depleted with unreliable supply lines and intermittent delivery. Pharmaceuticals and consumables that are nearly always well past expiry dates. The absence of biomedical support resulting in poorly maintained equipment. Component

Arthur Vartis presented Arthur Olap with a Certificate of Attendance at the 2019 Marshall Islands meeting

Participating in the Pacific Partnership 2019

failures which compromise functionality indefinitely. Vaporisers that have never been calibrated and capnography that no longer functions. A single pulse oximeter that services the entire hospital. The anaesthetic machine and theatre space that functions at times as a makeshift intensive care unit. Limited blood pathology and an absence of blood bank facilities.

Added to this was the profound challenges of working in complete professional isolation.

In so many ways, Arthur epitomised the realities of delivering safe anaesthetic care in low resourced parts of the world.

Chuuk is one of the four island states that form the Federated State of Micronesia. With a total population of 105,000, Micronesia now has a total of three medical anaesthetists and two nurse anaesthetists. This represents an anaesthetic workforce ratio of 4.9 per 100,000 of population. In comparison Australian anaesthetists represent 23 per 100,000 of population.

The Australian Society of Anaesthetists has been engaged in the region since 1994. It supported the founding of the Micronesian Anaesthesiology Society and has undertaken regular scientific meetings in the region. Today, the biennial Micronesian Anaesthetic Refresher Course is the only continuous running CME in Micronesia.

Arthur was an enthusiastic and highly engaged member of the society. During his time as office bearer he helped shape the society to represent the interests of the anaesthetic community.

Attending the society scientific meetings was always a challenge. The Australian Society of Anaesthetists facilitated this by providing locums to enable local providers like Arthur to attend meetings. At the 2017 meeting in Palau a missed connection meant that Arthur had the privilege of working with an Australian anaesthetist, the late Dr Peter Duff, during the week-long meeting.

At the last meeting in the Marshal Islands in 2019, Arthur delivered a presentation on the medical response following the 2018 crash of Air Niugini flight 73 into Chuuk Lagoon. At another meeting he gave an account of a patient who presented with two penetrating metal dart injuries to his sternum and abdomen. On both occasions he confided to the audience of the fear and anxiety that became palpable as these events unfolded. Events that would challenge even a well-resourced community. His personal resilience and tenacity held him in good stead.

Arthur carried an enormous responsibility in a demanding profession. He may not have been a doctor but he garnered tremendous trust and respect from his surgical colleagues.

The impact of Arthur Olap's sudden loss will be felt across this part of the world for many years to come. Following his passing, Martha, a nurse anaesthetist who had been working in nearby Pohnpei was relocated to Chuuk. At the time of writing, Martha continues to work on her own and attempts by the hospital to secure a locum remain elusive.

Arthur is survived by his wife Betty and his three children.

Arthur Vartis

INSIDE YOUR SOCIETY

FIONA CATHERINE SHARP 1964-2019

It is with great sadness we acknowledge our friend and colleague, Fiona Catherine Sharp, who passed away on October 17, 2019, aged 55. Sharpie, Fifi, Fifi le Trix, or F Sharp (F#), as she was otherwise known to her colleagues and friends, died suddenly during a technical dive trip in Bonaire. Having lived her life at full speed, and with an open heart, her death has profoundly affected many in the Western Australian healthcare community.

Fiona was born in Perth on the 15/5/1964 to Jill and Bob Sharp. She was the second in a family of four girls, and a boy. She went to Mercedes School where she excelled academically, attended the University of WA, graduated in medicine in 1988, and gained her Fellowship in Anaesthesia in 2004. For the rest of her career she maintained an unwavering interest in diving, hyperbaric medicine and Total Intravenous Anaesthesia (TIVA).

Fiona brought a flash of colour to our lives, turning black and white moments into exciting and vibrant memories. Whether shooting pictures of elephants, giraffes and hippos with her 'state of the art' camera in Kruger National Park or sipping champagne with friends at midnight in rooftop spas, she value-added to every occasion. Her courage through tough times (of which she had her fair share), will be an outstanding memory. Her fierce loyalty will also never be forgotten, and we are saddened at the prospect of never sharing another 'chardy'. Although unaware, she had a profoundly positive influence on many friends and associates. Sharpie was spirited, rebellious, enthusiastic, hardworking and never dull.

Fiona was not just a larger than life character, but a well-known and respected anaesthetist. She trained in the early '90s, when women in the operating theatre needed a thick skin, robust personality, and the ability to fight their corner. We worked with her at Royal Perth Hospital and then Fremantle Hospital where she always entertained, whether in theatre, meetings, or the hyperbaric chamber.

She loved her time in the new chamber at Fiona Stanley Hospital, after spending many years in the more antiquated but respected outfit at Fremantle Hospital. One of the authors credits her for hand-saving treatment in the hyperbaric chamber in 2017 – testament to her care and expertise. It was during those six weeks of treatment that her devotion to ICU patients, quadriplegics, and the walking wounded was readily apparent.

She excelled in crisis management and was much loved by recovery staff for her willingness to help. Her honest opinions helped modulate rigid department systems and we feel obliged to maintain her legacy of acceptance of individuality.

Highly regarded in the diving world, both as a clinician and technical diver, she reached a level of excellence achieved by few, making her accidental death ascending from a 90m rebreathing dive all the more confounding.

The outpouring of grief from her many dive friends, some of whom remain grateful for her medical expertise, reflected her standing as one of the world's more experienced 'dive docs'. Although colourful out of the water, her custom-made bright orange dive suit meant she also never went unnoticed below the surface.

Fiona loved her family, friends, dogs and adventure. She enjoyed travelling to global dive spots and international conferences (strategically chosen to include sightseeing or wildlife photography) but also relished 4WD camping trips in her own back yard.

Sharpie's uncompromising way of telling it how she saw it attracted a loyal following. Unique, often a total riot and with a dazzling smile accompanying her many funny stories, she undoubtedly leaves indelible memories for her many dive buddies and those with whom she travelled.

A wonderful friend, much-loved family member, respected medical colleague and raconteur. She will be remembered for her passion, loyalty, love and pursuit of excellence. There is little doubt of the significant loss felt by the anaesthetic and diving community.

Dr Stephanie Davies
MBBS FANZCA FFPMANZCA

Dr Jenny Stedmon
MBBS (UK) FRCA (UK) FANZCA

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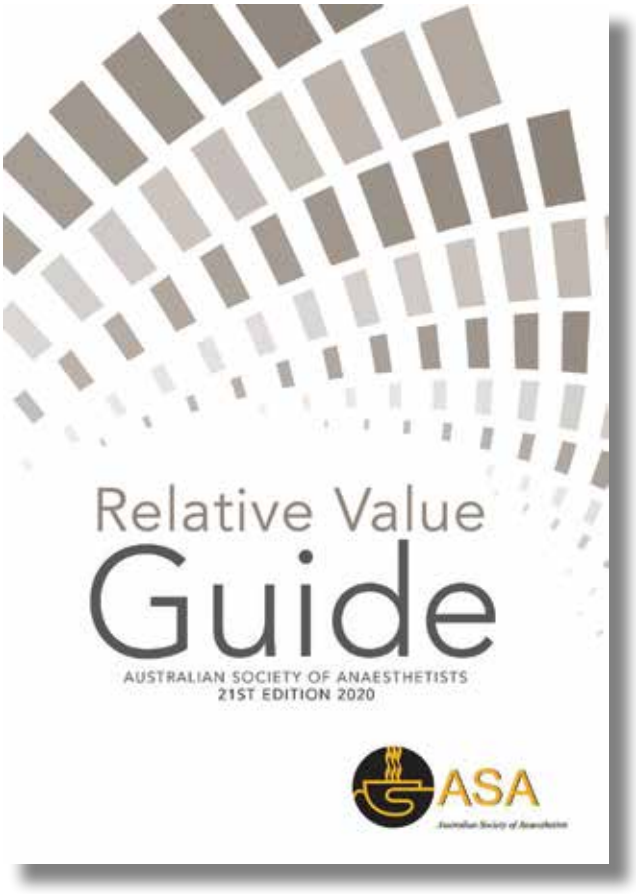

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