AUSTRALIAN
Anaesthetist
THE MAGAZINE OF THE AUSTRALIAN SOCIETY OF ANAESTHETISTS • **DECEMBER 2023**

PREHABILITATION: A NEUROPSYCHOLOGICAL PERSPECTIVE

2023 NATIONAL SCIENTIFIC CONGRESS

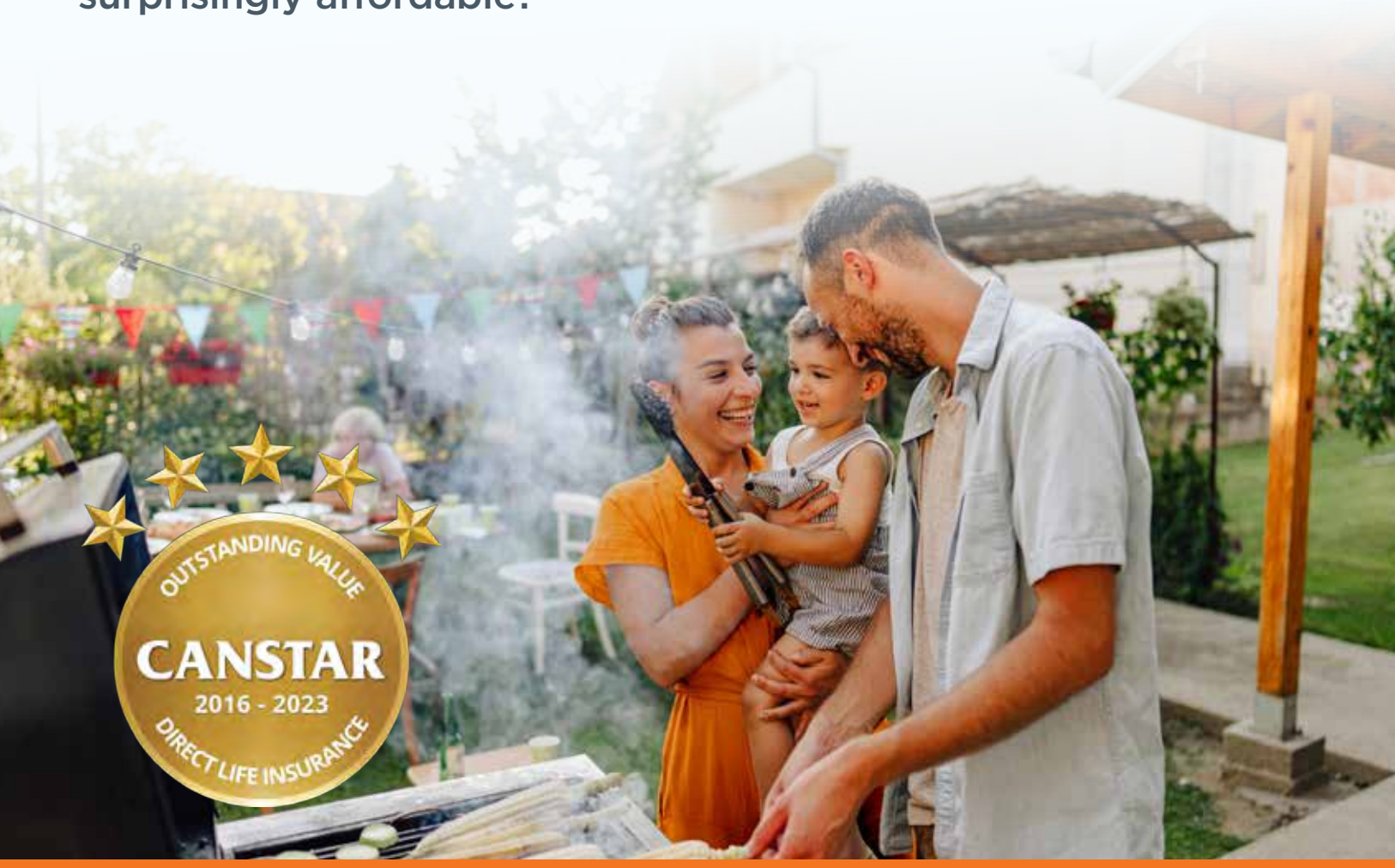
FAILURE TO PREPARE, OR PREPARING TO FAIL

ENHANCING PERIOPERATIVE CARE THROUGH PREHABILITATION AND COLLABORATION

Australian Society of Anaesthetists®

Spend less, live more

ASA members, did you know Life Insurance can be surprisingly affordable?



For a limited time only receive $20,000 of bonus Life cover**

GET A QUOTE

Get a quote in **less than 5 minutes:**
www.nobleoak.com.au/anaesthetists

Or call NobleOak on **1300 108 490**
and mention 'ASA - ANAESTHETISTS'.

NOBLEOAK
LIFE INSURANCE

Important Information - ASA members are entitled to a 10% discount on NobleOak's standard Premium Life Direct premium rates for its term life cover. In addition to term Life Insurance cover, NobleOak also offers Income Protection, TPD, Trauma and Business expenses cover. Our website contains details.

**Bonus $20,000 Life cover offer - The bonus $20,000 Life cover offer applies for all applications with a minimum of $200,000 of Life cover benefit received before 21 December 2023. If you make an application before 21 December 2023, then you will receive a bonus $20,000 Life cover on a minimum of $200,000 of Life cover.

The offer(s) are available for new customers only and can be used only once. Not able to be used in conjunction with another advertised offer.

Legal statements. Premium Life Direct is issued by NobleOak Life Limited ABN 85 087 648 708 AFSL No. 247302. Address: 44 Market Street, Sydney NSW 2000. Phone: 1300 108 490. Email: sales@nobleoak.com.au. Cover is available to Australian residents and is subject to acceptance of the application and the terms and conditions set out in the Premium Life Direct Product Disclosure Statement (PDS). Please also read NobleOak's Target Market Determination (TMD) at www.nobleoak.com.au. This information is of a general nature only and does not take into consideration your individual circumstances, objectives, financial situation or needs. Before you purchase an Insurance product, you should carefully consider the PDS to decide if it is right for you. The PDS is available by calling NobleOak on 1300 108 490 or from www.nobleoak.com.au. Clients should not cancel any existing Life Insurance policy until they have been informed in writing that their replacement cover is in place. NobleOak cannot provide you with personal advice, but our staff may provide general information about NobleOak Life Insurance. By supplying your contact details, you are consenting to be contacted by NobleOak, in accordance with NobleOak's Privacy Policy.

Australian Society of Anaesthetists®

Make membership fees easy
Sign-up for direct debit today

Don't miss out on your key ASA resources

Renew your ASA membership before 31 January 2024 to access valuable member resources including the:

- ***Relative Value Guide 2024****
- ***Anaesthesia & Intensive Care***
- ***Australian Anaesthetist Magazine***

Have any questions about your membership or the renewal process?

Contact our Membership Services Team at membership@asa.org.au

*for eligible categories only

Pay by annual or monthly direct debit

Take the hassle out of renewal and sign-up for direct debit today.

Pay by BPay

www.asa.org.au/payments

Click 'view renewal invoice' and download your invoice as a PDF to view payment details.

Pay online

visit: www.asa.org.au/paynow

AUSTRALIAN
Anaesthetist
THE MAGAZINE OF THE AUSTRALIAN SOCIETY OF ANAESTHETISTS

The Australian Society of Anaesthetists (ASA) exists to support, represent, and educate Australian anaesthetists to protect the status, independence, and best interests of Australian anaesthetists and to ensure the safest possible anaesthesia for the community.

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.

CONTACT US:

AUSTRALIAN SOCIETY OF ANAESTHETISTS,
PO Box 76 St Leonards NSW 1590, Australia
T: 02 8556 9700 E: asa@asa.org.au W: www.asa.org.au

DESIGNED BY:
Joanna Basile, Hopping Mad Designs

PRINTED BY:
Ligare Book Printers Pty Ltd

This book has been printed on paper certified by the Programme for the Endorsement of Forest Certification (PEFC). PEFC is committed to sustainable forest management through third party forest certification of responsibly managed forests. For more info: www.pefc.org.au

Australian Society of Anaesthetists®

A MEMBER SOCIETY OF THE WFSA WORLD FEDERATION OF SOCIETIES OF ANAESTHESIOLOGISTS

Contents

Would you like to contribute to the next issue?

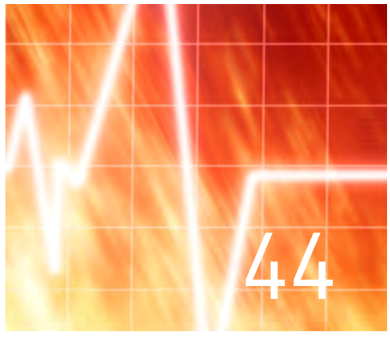
If you would like to contribute a feature or lifestyle piece for the March 2024 edition of Australian Anaesthetist, the following deadlines apply:

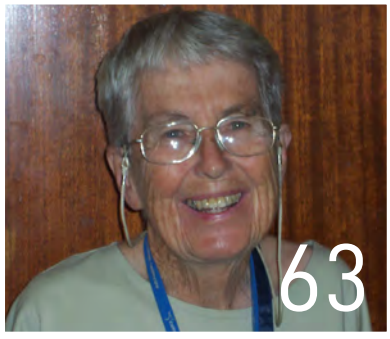
- Intention to contribute must be emailed by 6 January 2024
- Final article is due no later than 25 January 2024

Please email the editor at editor@asa.org.au. Image and manuscript specifications can be provided upon request.

ASANSC
4–8 October
Melbourne 2023

7





DR MARK SINCLAIR
PRESIDENT

FROM THE ASA PRESIDENT

At the recent ASA National Scientific Congress (NSC) in Melbourne, I had the honour of becoming President of the ASA. I look forward to serving you in this capacity for the next two years.

I would like to congratulate and thank Dr Andrew Miller, now Immediate Past President (IPP), for his excellent term of service as President. I am fortunate that Andrew will continue to serve on the ASA Board and Council as IPP, and I look forward to continuing to benefit from his wise counsel. Dr Suzi Nou now steps down as IPP, and I would also like to thank and congratulate her on her (record) seven years of excellent work as Vice President, President, and IPP. Fortunately, Suzi will continue to work with the ASA in her communications and Australian Medical Association (AMA) roles, so luckily, we don't have to say goodbye to her yet! If I can even approach the excellent level of service to the ASA that Andrew and Suzi have provided, I will be well satisfied.

My congratulations also go to Dr Vida Viliunas OAM (ACT), who now takes on the role of ASA Vice President. I'm sure Vida is very well known to many of you for her expertise and enthusiasm as an educator, including of course in her role as ASA Education Officer, as well as other roles such as Chair of the ASA ACT Committee of Management. Vida has already been a most valuable contributor to the Board as a Council-Elected Board Member, and again I will, I'm sure, continue to benefit from her wisdom.

Dr Peta Lorraway (QLD) was elected to the position of Executive Councillor, and I congratulate her and welcome her to the Board. We all very much look forward to working with her in this position. As members will no doubt be aware, Dr Nicole Fairweather (QLD) has served the ASA in this role for the last five years, and now steps down. All of us on the Board thank her for her most valuable work over that time.

I would also like to take this opportunity to thank NSC Convenor Dr Grace Gunasegaram, Deputy Convenor Dr Michelle Horne, Scientific Convenor Professor Laurence Weinberg, Federal NSC Officer Dr David Elliott (NSW), and all of the NSC Organising Committee, for an excellent Congress. You can read more about the 2023 NSC in this edition of Australian Anaesthetist.

As always, the primary duty of ASA office bearers such as myself is to serve the ASA membership. To that end, it is very important that you, the ASA members, continue to communicate with us. The role of the ASA is to support, represent and educate its members, in order to empower you to continue to provide world-class anaesthesia care to Australian patients. We can only do that to the best of our ability if we know your opinions, ideas and requirements.

As always, the primary duty of ASA office bearers such as myself is to serve the ASA membership.

So please do contact us at any time. There are, as always, numerous issues and challenges we face as a specialty, and you will be able to read about some of those in this edition. Should any of the articles provided by our excellent team of anaesthetists and ASA staff members raise any issues in your mind, or if you have ideas about solutions, please do get in touch with us.

Our strength as an organisation is in you, our membership base. So, I encourage you all to get involved in our work. It can be tempting, given our very busy professional and personal lives, to sit back and let others get on with the job. But we are all part of a team, and you should be mindful that every member of that team has valuable contributions to make. Be assured that no issue facing you, as Australian anaesthetists, is so small that it does not need to be raised and discussed with the ASA. So, I look forward to hearing from you!

Dr Mark Sinclair

MB BS, GAICD, FANZCA

FROM THE CEO

DR MATTHEW FISHER
CHIEF EXECUTIVE OFFICER

Having given up being a dietitian over 20 years ago as my career changed direction, I have some stories of prehabilitation related to surgery and at a stretch, could argue that working for elite teams in high velocity, high impact sports meant they were likely consumers at some point. My experiences were broad in burns and trauma units but mainly in response to an acute need rather than planned. The main example of prehabilitation I recall relates to a middle-aged husband and father of two early teen girls who required a heart transplant in the latter part of last century. He had represented Australia in a sport and (not uncommon for his time) was a smoker and drinker who had gone onto graze in a lush paddock. You will probably be able to assign him an ASA classification based on that information which was exacerbated by heart failure. The challenge was to reduce his weight significantly to be accepted onto the list in accordance with guidelines at that time. The problem became that his exercise tolerance continued to diminish and therefore his energy needs also reduced. His strength of mind to achieve and commitment were incredible and fast forward, he lost adequate weight to receive a donor heart when a compatible match occurred. He received the donor organ and again, his attitude meant that he was committed to post-surgical rehabilitation and recovery. Ultimately, he gained another 12 or so years of life that he lived to the fullest with his family who supported him all the way. The other bonus that they received was winning one of those house, car, and gold bullion raffles so the family were well looked after! So, the prehabilitation enabled this opportunity and the win was a bonus on a bonus. As a dietitian with an academic mindset and used to dealing with the athletic mindset, I applied my skills within the context of the team to enable those with much greater and more specific skills to truly enable his additional years.

To continue my analogy of the past, through our Towards 90 initiative and our work towards being an exemplar society, our intent is to be at the table and not on the menu. Some of the initiatives we have undertaken to date include:

- A workforce demand and supply modelling project in addition to the usual ASA survey. This will enable us to advise governments and health departments on the anticipated needs for anaesthetists through to 2032. We have had productive discussion with the workforce unit advising the Minister to ensure that our methodology is unlikely to be contested and Services Australia have agreed to release some data to us because of this, which will make our modelling even more informative.
- Continued engagement with our public sector members and the health entities they are employed through, to enable us to influence planning and decisions. The ASA, through its NSW Committee, made a submission to the Special Commission of Inquiry into Healthcare Funding in NSW and continue to represent the interests of the sector.
- Continued considered discussion with the Department of Health and Aged Care (DoHAC) about the National Health and Climate Strategy. We have been clear in that we want to ensure robust engagement, co-design, and transparency of consultation so the specialty is an agent of evolution whilst ensuring that any change strategies impacting clinical decision making do not compromise the quality care provided by and the safety outcomes attributed to anaesthetists. This is where the engagement with clinicians is crucial, and this has been well received by the Department. Our position is 'the ASA remains committed to reducing the impacts of anaesthetists' patient care on climate change, and on environmental issues in general. With regards to desflurane, we have indicated our support to reduce its use. We must also ensure that clinicians are consulted appropriately with regards to decision-making, in the best interests of our patients, as always. With regards to nitrous oxide, again we are committed to a reduction in its atmospheric release. Keeping in mind that nitrous

Get involved in your ASA ...

Seeking new members

The Communications Committee is seeking new members who are passionate about effective communication. If you are interested in enhancing the communication strategies of the ASA please send an email to Marketing and Communications Manager, Kelly Chan at kchan@asa.org.au with your expression of interest.

Passionate about helping the ASA advance its cause?

Find out more about the Society's various committees and groups that work alongside the ASA to help support, represent and educate anaesthetists.

To inquire about how you can contribute and express your interest in being involved, email the Executive Secretary, Sue Donovan at sdonovan@asa.org.au

Economic Advisory Committee

Professional Issues Advisory Committee

Public Practice Advisory Committee

Editorial Board of Anaesthesia & Intensive Care

Overseas Development and Education Committee

Trainee Members Group Committee

General Practitioner Anaesthetists Group

National Scientific Congress Committees

Communications Committee

Retired Anaesthetists Group

The History of Anaesthesia Library, Museum and Archives Committee

ASA State Committees of Management

Wellbeing Advocates Committee

Continued engagement with our public sector members and the health entities they are employed through, to enable us to influence planning and decisions.

oxide administration by anaesthetists has already been significantly reduced in recent decades, for medical reasons. We wish to ensure that infrastructure, supply, and industry issues are appropriately addressed whilst ensuring that clinical decision making is prioritised. Including, of course, by other specialty groups involved in the use of nitrous oxide in patient care. This will involve consultation and education'.

- Remaining engaged through the Economic Advisory Committee (EAC) and Professional Issues Advisory Committee (PIAC) with the Medical Services Advisory Committee (MSAC) and the Medicare Benefits Schedule (MBS), private health insurers, and also the Australian Health Practitioner Regulation Agency (Ahpra) to ensure that we not only understand their systems but that they also understand the specialty.
- Convening a parliamentary roundtable in Canberra early next year to focus the work we have been doing in relationship development and advocacy. More details will be made available as they are confirmed.
- Partnering with Doctor Portal Learning which owns cpdhome.org.au, enabling us to influence compliance support in CPD whilst focusing on our strengths of member engagement, collegiality, and provision of focussed CPD.

Finally, it continues to be a privilege to be the CEO of the ASA and assist with the future given the tremendous achievements of the past 90 years. I appreciate the Board, members and staff who have supported this journey over the past 18 months.

Matthew Fisher

PhD DHlthSt (honoris causa)

Contact

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

ASANSC

4–8 October
Melbourne 2023

NSC23 CONVENOR'S WRAP UP

THE WARMTH AND ENERGY OF A BUSY CONGRESS ASTOUNDS

Musings from two Congress convenors

IN MID 2021, AS BRISBANE WAS BUSILY CONVERTING ITS NATIONAL SCIENTIFIC CONGRESS (NSC) TO A FULLY VIRTUAL EVENT (WHICH HAD NOT BEEN THE PLAN!) WE HAD GREAT CAUSE TO CONTEMPLATE WHAT A CONFERENCE IN 2023 MIGHT LOOK LIKE. CREATIVELY, WE MAY EVEN HAVE HAD SEVERAL OF OUR PLANNING MEETINGS WHILST WALKING OUTSIDE, 'EXERCISING' DURING LOCKDOWN (NO RULES WERE BROKEN!).

Ideally, several years in the future we would be no longer locked down (although predictions to date had been famously unreliable and want to change at hyper-short notice), presumably state borders would be open. Beyond that: would we still want virtual meetings? Would in-person meetings of 1000+ people be an echo of the past? How does one plan a big event with a several-year lead time, with no guidance as to what the future would be likely to look like in this strange era? The only things that were obvious were that we would have to wait and see some more for any clear answers. And that we would need to be prepared to be flexible and take whatever new landscape we were dealt in our collective stride. A challenge accepted.

So let us meander back to basics for a moment. What is it that makes an NSC worthwhile we asked? What do doctors, what do anaesthetists crave from medical education and from conferences now and into the future?

We had some answers - and quite a few more questions. For example, why do people come to conferences? What do they value most? Do they want to come in person or keep the flexibility gifted to us during covid to attend virtually? What makes an NSC feel 'successful' and why are some major conferences more enjoyable than others? How will we prevent our team feeling burnt out? How do we give delegates the sense of connection that we suspect they are largely craving?

Two and a half years later in October 2023 thankfully our bold programming was well received!

If anaesthetists want to attend in person, we mused it's probably for the people: we get a sense that so many of us cherish that feeling of being part of a bigger, connected community. We want interaction and a sense of collegiality with our counterparts. We want informal conversations and to connect with speakers and to come away feeling optimistic, like our dogma has been challenged, or we've learned something to take away. Reflecting on this, workshops would need to be a shining light of our reimagined program.

We would need to provide opportunities for small group questioning and hands-on sessions. We would strive to build on the fact that anaesthetists have embraced online learning and value access from their homes, their cars, their workplaces. We would keep our familiar program elements of scientific sessions which would be largely concurrent (we ended up limiting this to three concurrent streams so there weren't as many sessions competing for brain real-estate).

Morning workshops and virtual live content

We would maximise space in our program for attendees to attend workshops, and add in masterclasses. We would change several elements: we would separate our workshops and emergency responses from the lecture program on all days so our delegates could do both without them clashing, and so that our facilitators would also have opportunity to attend the congress. We would build in choices so that anaesthetists could access learning that suited them. We would harness technology and bring some of our international speakers to the congress virtually. Offering virtual access to the program allowed education without flight time and carbon footprint, a more sustainable congress delivery model. Virtual access would allow those overseas, interstate, or in rural and regional areas to attend without travelling. We hoped this would meet a need for some of our delegates who have children or other responsibilities and want the flexibility of watching from home. Or they want to attend the congress in the mornings for workshops and then in the evenings have dinner with family then tune into a twilight session. Perhaps in the morning they want to sleep in or exercise or meet up with old friends and explore the city? This year we would offer that opportunity without missing core content, moving away from one-size-fits-all programming. We had also observed that participation in afterhours work meetings had increased since they had all been made virtual: apparently anaesthetists are great multitaskers. Should we adapt and plan to meet people where they are at?

Two and a half years later in October 2023 thankfully our bold programming was well received! When we ask our colleagues who reach out to say thank you for hosting, what their most enjoyable or valued aspects were their answers are varied, so let us explore some themes that resonated.

What we loved

Many delegates thank us for the live virtual access because it turns out they loved being able to attend some parts in person and then leave the venue (but not leave the Congress) and carried on watching or listening from elsewhere (even from their hotel).

Some people cherish the speakers: they loved the energy and enthusiasm brought by Professor Javier Garcia Fernandes and they were inspired by the big thinking and impact of Associate Professor Gunisha Kaur, Anesthesiologist, Director of the Human Rights Impact Lab and Medical Director of the Weill Cornell Center for Human Rights. They think differently about paediatric airway problems after listening to Dr Stefan Sabato in the paediatric session on Sunday. They valued the bariatric symposium. They were challenged and inspired to create change by the sustainability session on Thursday. They loved their workshop, or workshops, or emergency responses. The Gala Dinner. The Finger On the Pulse Sessions, kicking off with Obstetrics and Paediatrics on Wednesday were incredible (these were virtual).

Several people have told us that the most interesting talk they went to was that given by Professor Tim Entwisle, Director and Chief Executive at Royal Botanic Gardens Victoria in Melbourne. Did you know that the Botanic Gardens now considers future climate as an important variable in deciding what trees to replant in their gardens? Or that not only is time spent in nature good for us physically, mentally and emotionally, but that the psychological benefits gained by visiting urban green spaces increase with the levels of biodiversity?

Another favourite event during the NSC was the airway 'debate' (of sorts) on Friday featuring leaders from Airway Societies and expert groups across Australia and the UK, moderated by Louise Ellard, Adam Rehak and Linda Beckman. Is approaching from the patient's right and scalpel – finger – bougie – tube the likely frontrunner approach for front of neck emergency access in the future? For another

> We had also observed that participation in afterhours work meetings had increased since they had all been made virtual: apparently anaesthetists are great multitaskers. Should we adapt and plan to meet people where they are at?

delegate: seeing the quality of trainee research on show in the displayed posters and prize sessions.

On the topic of prizes, we were proud to offer the opportunity for young researchers to present work they've been involved in to international researchers. For those across the plains to share the small as well as big projects that they are beavering away at in their departments. As Associate Professor Alwin Chuan says, the ASA is proud to support these young researchers and their contributions to Australian academic anaesthesia. Prize winners included Dr Kwok Ho, Dr Sophie Meyerson, Dr Lachlan McLennan and Dr Misha Yadav: read about their research in Alwin's article as SPARC Chair in this edition. We encourage all anaesthetists and trainees to consider submitting their research or audit work as either a free poster or part of a prize category at one of the two major meetings in the yearly Australian calendar (the National Scientific Congress in September/October or Annual Scientific Meeting in May).

Some of our people

Workshops and the Practice Evaluation program ran Wednesday to Sunday and were curated by Dr Kaylee Jordan and Dr Lucky DeSilva (with help from some friends, especially Dr Michelle Chan and Dr Janette Wright) and what a program that was.

The vibrancy of the Melbourne NSC speaker cohort and program is thanks to the Special Interest Groups who hosted stimulating sessions and particularly to the brilliance of Professor Laurence Weinberg, ASA NSC 2023 Scientific Convenor - big thinker and consummate host. Catch Laurence's humorous and heart-warming final session/closing plenary with five of the NSC beloved international speakers on demand via the Congress platform or app.

Saturday evening welcomed Dr Mark Sinclair as the new ASA President after the traditional President's Oration by Dr Andrew Miller. His talk was authentic, thought provoking, honest and personal.

Now, since we don't want to be serious all the time, how lovely it was to flood the dancefloor with a flashmob at the Gala Dinner on Friday night with dynamic organising committee members, ASA State Chairs and even Board members. Such conviviality. Lighthearted and joyous entertainment by unexpectedly opera-singing chefs was a delight. Gastronomy highlights for the evening included an oyster bar pre-dinner, shared banquet tables, and for something fun, an after-dinner gelati cart.

Choice Challenge Change

Here are some Congress statistics: 19 Emergency Responses workshops; one SPANZA EPIC course; 13 virtual workshops or masterclasses; one Airway SIG satellite meeting; one CRASH course; over 80 poster submissions; one glorious Launch Party; 15 in-person Masterclasses; over 100 small group sessions in total; one well-used parents space; 1000s of barista coffees poured; eight prizes awarded; well over 1100 attendees; two busy Convenors; and over 200 watch-on-demand scientific sessions viewed in just the first two weeks post release.

Watch-on-demand content is accessible for three months post-Congress, via a delegate's personalised login to either the virtual platform or NSC Congress app.

We appreciated the practical and team-orientated attitude of so many people who came together to make a dynamic Melbourne Congress. Gratitude to our attendees; our amazing and spirited organising committee, ASA staff, speakers both international and local, our next generation speakers, judges, workshop facilitators, attendees and Convenors that came before and will come after us. What an event.

See you in Darwin, September 2024

Dr Grace Gunasegaram

Convenor

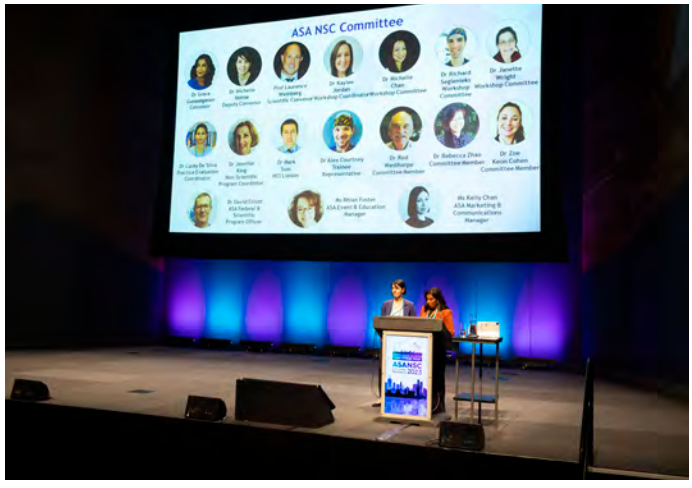
Dr Michelle Horne

Deputy Convenor

NSC SESSIONS & WORKSHOPS

Dr Vanessa Beavis, Prof Hilary Grocott, Prof Laurence Weinberg

Dr David Elliot, Dr Grace Gunasegaram, Dr Michelle Horne, Prof Laurence Weinberg



NSC23 Convenor, Dr Grace Gunasegaram & Deputy Convenor, Dr Michelle Horne

NSC23 Convenor, Dr Grace Gunasegaram

NSC23 Scientific Convenor, Prof Laurence Weinberg

NSC23 Workshop Convenor, Dr Kaylee Jordan

NSC SESSIONS & WORKSHOPS

A/Prof Gunisha Kaur

ASA President, Dr Mark Sinclair

A/Prof Gunisha Kaur

ASA Immediate Past President, Dr Andrew Miller

Launching NSC24 with Convenor, Dr Brigid Brown & Social Coordinator, Dr Tim Donaldson

President of the Pacific Society of Anaesthetists, Dr Lisepa Mila

NSC SESSIONS & WORKSHOPS

Welcome to Country with Elder Mandy Nicholson and the Djirri Djirri dance group

Chair of the ASA Professional Issues Advisory Committee, Dr Peter Waterhouse

Prof Hilary Grocott

Kester Brown Lecturer, Prof Tim Entwisle

ASA Immediate Past President, Dr Andrew Miller

Prof Jennifer Weller, Dr Grace Gunasegaram, A/Prof Gunisha Kaur, Dr Vanessa Beavis, Prof Laurence Weinberg, Dr David Elliot, Dr Michelle Horne

Prof Javier Fernandez

Dr Julia Dubowitz

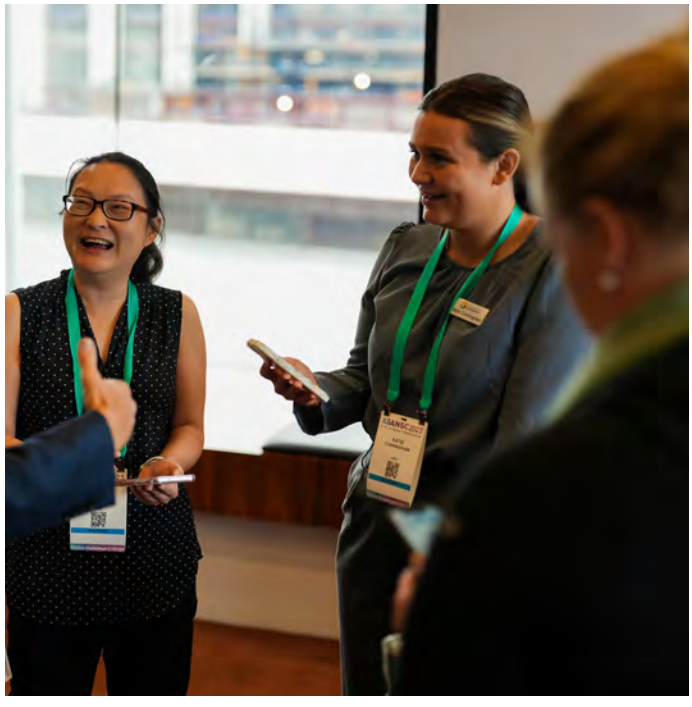
NSC23 Scientific Convenor, Prof Laurence Weinberg

EXHIBITION HALL & VENUE

ASA CEO, Dr Matthew Fisher & Dr Katherine Jeffrey

Australian Anaesthesia podcast host Dr Suzi Nou & Anaesthesia Coffee Break host Dr Lahiru Amaratunge recording at the ASA Booth

NSC23 Convenor, Dr Grace Gunasegaram, Deputy Convenor, Dr Michelle Horne & ASA Education & Events Manager, Rhian Foster



ASA Membership team, Natalie Sinn & Katie Cunningham

Melbourne Convention & Exhibition Centre

WELCOME DRINKS

Welcome drinks at the Ian Potter Queen's Hall, State Library of Victoria

Winner of the 2023 Gilbert Troup Prize, Dr Kwok-Ming Ho and A&IC Chief Editor, A/Prof John Loadsman

Dr Greg Deacon & Dr Rod Westhorpe

Prof Jennifer Weller, Dr David Elliot, ASA President Dr Mark Sinclair, Bel Simmons

ASA Vice President, Dr Vida Viliunas OAM & Dr Shrina Begg

ASA Vice President, Dr Vida Viliunas OAM & NSC23 Workshop Convenor, Dr Kaylee Jordan

GALA DINNER

A/Prof Gunisha Kaur & Immediate Past President, Dr Andrew Miller

Dr Alwin Chuan, announcing the winners of the NSC awards & prizes

Immediate Past President, Dr Andrew Miller & NSC Best Poster Prize winner, Dr Sophie Meyerson

ASA Federal & Scientific Program Officer, Dr David Elliot

When the chef's secret ingredient is a surprise opera performance

Dr Michelle Chan, Dr Grace Gunasegaram & Dr Vanessa Beavis

GALA DINNER

Dr Greg Deacon, Dr Anna Granger & Dr Mark Sinclair

NSC Best Poster Prize Runner-up, Dr Aquib Chowdury & Dr Andrew Walpole

NSC23 Convenor, Dr Grace Gunasegaram & Deputy Convenor, Dr Michelle Horne

NSC23 Organising Committee's Gala Dinner surprise: a dazzling flash mob

A/Prof Gunisha Kaur, Prof Laurence Weinberg, Prof Hilary Grocott

NSC23 Organising Committee

NSC23 SPEAKER SPOTLIGHT

Choice Challenge Change

ASANSC 4–8 October Melbourne 2023

This year's congress featured a diverse lineup of key figures in the field of anaesthesia from across the globe. From exploring safety in anaesthesia to unravelling airway challenges, discover the insights and wisdom shared by this year's speakers. We asked our keynotes to share what inspired their presentations and the key takeaways they hope to impart on delegates.

Professor Tim Entwisle

Director and Chief Executive of Royal Botanic Gardens

When I was invited to deliver the Kester Brown Lecture, I thought what could I talk about that would draw on my 30-years' experience running botanic gardens that would be of interest to Australia's top anaesthetists. Easy, I thought, the health-giving benefits of gardens. I had recently published a memoir that covered these very ideas, concluding that the original concept of a botanic garden as a 'physic' (medicinal) garden applied more than ever today.

My key message is that this new, or reimagined, physic garden is not just a collection of medicinal plants. Today we should view the whole (botanic) garden as a restorative place, alongside it's critical role in caring for the natural world in the same way the medical profession cares for us.

Associate Professor Gunisha Kaur

Professor of Anesthesiology and Medical Director of the Weill Cornell Center for Human Rights, United States

The idea is to bring global health and human rights work - through anesthesiology - to healthcare providers across the globe. We have an important and critical role to play. I hope that attendees see new possibilities in how they might contribute to global health and human rights issues. I hope each person will find a new way to utilise their skills and knowledge in healthcare to contribute to a cause greater than themselves. Carve out new pathways! Do something that has never been done before.

I hope that attendees see new possibilities in how they might contribute to global health and human rights issues. I hope each person will find a new way to utilise their skills and knowledge in healthcare to contribute to a cause greater than themselves.

Prof. André Y. Denault

Anesthesiologist to Intensivist, Montreal Heart Institute, Director of the Targeted Ultrasound Fellowship Program, Canada

It is so important to evaluate the right ventricle in cardiac and non-cardiac surgery. It is crucial to develop an approach to haemodynamic instability not limited to the heart only in theatre.

Get adequate training in whatever area you want to have expertise in and follow your passion for getting better in what you do on a daily basis.

Professor Elizabeth Malinzak

Professor at Duke University and Director of Medical Student Education for the Department of Anesthesiology, United States

My academic passion is advocating for equity and initially that was inspired by my experience becoming a mother as a trainee. I have spoken on this topic in many venues in the United States, but as this is an international conference, I am excited to bring my passion to this audience.

Key takeaways from the presentations include what women want: workplace respect without discrimination and harassment, systemic recognition of the value of caregiving, and investment in their careers and what women need: a new workplace culture, greater support for caregiving support, and recruitment, retainment, and representation.

Dr Vanessa Beavis

Immediate Past President of the Australian New Zealand College of Anaesthetists, New Zealand

I think the concept of periop medicine is the future of our speciality, and with our deep knowledge and expertise in looking after patients in the operating room, we are uniquely placed to lead care in this area and so demonstrate our value to the community, beyond just anaesthetic expertise.

You spend so much time at work, build strong relationships with your colleagues, so you know someone has your back. Be generous with your time and expertise for those coming up behind you.

Professor Javier Fernandez

Chairman of Anesthesia and Critical Care Department, Puerta de Hierro University Hospital, Spain

Talking about mechanical ventilation at the NSC23 deeply inspires and motivates me. Visualising mechanical ventilation, which has been my focus for the past 24 years of my professional life, serves two purposes: increasing the clinical safety of patients and helping my colleagues feel secure and calm in critical respiratory situations with patients. The main message for all my colleagues is that mechanical ventilation, although initially challenging to grasp, can be studied and easily understood with a visual approach using simulators and models of isolated lungs. These tools allow us to comprehend complex concepts at a glance, making what initially seems complicated much more manageable.

Professor Jennifer Weller

Head of the Centre for Medical and Health Sciences Education, University of Auckland

Associate Professor Lachlan Miles

Staff Anaesthetist, Austin Health

Professor Robert Hahn

Professor of Anaesthesia Karolinska Institute at Danderyd's Hospital (KIDS), Stockholm Sweden Department of Research, Södertälje Hospital; Södertälje

Associate Professor Jai Darvall

University of Melbourne in the Departments of Critical Care and Medical Education

Dr Julia Dubowitz

Staff Anaesthetist, Peter MacCallum Cancer Centre

Professor Ramani Moonesinghe

Professor of Perioperative Medicine, University College London Director of the Health Services Research Centre, Royal College of Anaesthetists

Professor Hilary Grocott

Professor, Department of Anesthesia & Perioperative Medicine University of Manitoba, Canada

NAVIGATING THE PATH TO BETTER PATIENT OUTCOMES

An Interview with Associate Professor Lachlan Miles

The emergence of prehabilitation introduces a fundamental shift in our approach to undergoing major surgery. Rather than expending all our efforts on post-surgery recovery, prehabilitation emphasises thorough preparation before the surgical journey, fostering swifter recuperation, enhanced results, and a faster return to regular life. Against the backdrop of a bustling National Scientific Congress (NSC), next generation speaker, Associate Professor Lachlan Miles shared insights into his career, perioperative medicine, prehabilitation and the importance of shared decision-making in achieving better patient outcomes.

Associate Professor Miles graduated from medical school at Monash University with first class honours in 2007 before completing basic and advanced anaesthetic training at the Alfred in Melbourne, a subsequent provisional fellowship at the Austin Hospital in cardiac, hepatobiliary, and liver transplant anaesthesia, and a further clinical fellowship in cardiothoracic anaesthesia and intensive care at Royal Papworth Hospital NHS Foundation Trust in the United Kingdom. He is currently a consultant anaesthetist in full-time public practice at Austin Health.

With specialist interests in the management of the critically ill surgical patient, before, during and after surgery, he shared his insights on improving patient outcomes through comprehensive perioperative care and the integration of shared decision-making.

Is there a key experience that led you to your current role?

"My father is a surgeon and I got into medical school, and I knew I wanted to be a doctor from a very young age… I'd gotten through two or three weeks of medical school and dad said to me "right, time to show the boy the family trade". He drags me into his private list, and he said, "alright son, stand there in the corner, don't touch anything unless somebody asks you to. If any of these staff ask you to do something, I want you to do it and I'm going to go scrub". The anaesthetist, who is an ASA member, looked over at me and asked, "Who are you?" I say "Oh, Doctor, I am Dad's, oh I mean Dr Miles' son, I'm Lachlan." He asked, "What are you doing here"? I said, "I'm a medical student" and he said, "How long have you been a medical student?", and I said, "Oh about two weeks", and he sort of stopped for a second and thought and then he said, "Have you ever intubated somebody before?"

From that moment on, I was sort of hooked. At that point I decided that I wanted to do something that involved critical care, whether it be anaesthetics or ICU. I realised I could get all the intellectual stimulation that I need in the operating theatre looking after a particular group of patients. And that's patients who are having major surgery who have multiple major medical comorbidities and trying to balance those two problems. So, most of my work now is a balance between perioperative medicine, cardiac anaesthesia, and anaesthesia for major intrabdominal procedures like liver transplantations but also major cancer, oncological surgery."

How do you approach achieving better patient outcomes?

"In the centre where I work, we run clinics twice a week, one is a high-risk anaesthetic assessment clinic where we're really able to spend a lot of time with patients, they get a slot of 45 minutes to an hour. If somebody presents with three volumes of history about themselves, you need time to assimilate all that information in order to be able to meet the person and have a good idea about what they're about and what their shared goals are, and then make a decision at the end of it. On top of that, for emergency surgery we've got a consultant every weekday who's dedicated to seeing patients for perioperative medicine reviews.

So, models of care are possible where you can deliver that individualised care, but it's got to be a whole-institution concept, and there's also got to be support from within your department and a group of individuals who are highly invested in it."

Why do you think prehabilitation is important in the context of major surgery?

"For the vast majority of the population, major surgery is the worst thing that will ever happen to them. And you can say that it's analogous to running a marathon or doing an iron man triathlon in terms of the physiological stress it puts on the body. When you think about an individual who would run a marathon or do an iron man triathlon that involves a substantial amount of training prior to that taking place. Now we expect our athletes to go through this, but we don't expect that patients presenting for major surgery are going to go through a degree of training of optimisation prior to surgery. And then add on top of that, patients that are elderly, sometimes frail, have multiple medical comorbidities, they might be diabetic, they might be obese, they might be smokers.

Up until recently we never really expected that a degree of optimisation would need to take place prior to surgery, to reduce the rate of postoperative complications… And that's kind of the idea of prehabilitation, it really suggests that rather than putting all of our effort into recovering from major surgery, perhaps we should put more effort into preparing for major surgery and then they can recover faster, better, stronger, with fewer complications, go home sooner and most importantly, return to what they were previously doing."

How do patients' priorities, like function or independence, influence the approach to prehabilitation?

"A lot of my older, wiser patients often say, "death is not the worst thing that can happen to me, loss of function is the worst thing that can happen to me", "loss of independence is the worst thing that can happen to me", inability to return home and being forced to go to a nursing home". These things really, really, REALLY matter to patients. And so, when we talk about prehabilitation, it's not just the idea of optimising or preparing patients prior to surgery, it's also for some patients, diverting them away from surgery to other modalities of treatment or care.

For every individual that discussion is different and the program of treatment we initiate whether that be prehabilitation or diversion to other modalities of care is different and very much tailored to the individuals and their goals in terms of what they want to achieve out of their course of treatment. Sometimes surgery is not the answer, sometimes it's something else. Chemotherapy, radiotherapy, palliative care, or other viable options."

Is there an ideal starting point for entering perioperative medicine?

"A really good way to start is to get a taste and to do something small. For example, the Monash Perioperative Medicine Short Course or the Masters of Perioperative Medicine. It's a great way to get a taste of what perioperative medicine is about and the information can be taken and applied to anaesthetic care day in and day out. If you like it, it's a good gateway to perioperative medicine as a speciality and from there you can start to invest a little bit more time. It's very different from the regular anaesthetic preadmission clinic where I have nine patients, three hours and every patient gets 15 minutes and the rest of the time I write the notes. It can be tremendously rewarding even if the patient doesn't go to surgery to know that you have listened to them, and you've worked with them to get an outcome they're happy with as opposed to an outcome they'll regret six months or a year down the track."

Kelly Chan

BSLS, BMus, MBA/LLM Candidate
Marketing & Communications Manager, Australian Society of Anaesthetists

FROM THE BRAIN TO THE HEART:

Exploring the Journey of a Leading Cardiothoracic Anaesthesiologist

AS THE CONGRESS BUZZED WITH ACTIVITY, I FOUND A QUIET CORNER TO SIT DOWN WITH KEYNOTE SPEAKER, PROFESSOR HILARY GROCOTT TO UNRAVEL THE CAREER PATH OF A LUMINARY IN THE FIELD OF CARDIOTHORACIC ANAESTHESIA. HAILING FROM THE UNIVERSITY OF BRITISH COLUMBIA, CANADA, PROFESSOR GROCOTT'S ILLUSTRIOUS CAREER, HIGHLIGHTED BY OVER 450 PEER-REVIEWED ARTICLES, ABSTRACTS, AND BOOK CHAPTERS, HAS SIGNIFICANTLY CONTRIBUTED TO THE FIELD OF CEREBRAL AND PERIOPERATIVE OUTCOMES FOLLOWING CARDIAC SURGERY.

What inspired you to pursue a career in cardiothoracic anaesthesiology and delve into the intricate relationship between the brain and cardiac surgery outcomes?

During my anaesthetic training, I had a great focus and interest in the brain, and actually intended to be a neuroanaesthesiologist. However, I found when I was subsequently exposed to clinical work in cardiac anaesthesia, I was suddenly drawn to the complexity and the dynamic situation of the cardiothoracic operating room and thought, "OK, I need to do this instead". My interest in the brain remained, and right around that time - this was the very early 1990s - papers started appearing in the literature describing some of the neurological, particularly cognitive, complications of cardiac surgery. I suddenly found that I could do both. I could be a cardiac anaesthesiologist, but I could also focus on the brain. As it was really in the relatively early days of this type of research, I cultivated that interest and sought out the people to study under who were really breaking ground in this area.

From a very personal perspective, I saw the consequences of brain dysfunction after cardiac surgery in my own family. My father had heart surgery twice and I was really struck by just what an impact it had on the brain. My earlier clinical observations became personal observations. It was an exciting and dynamic emerging field and I wanted to be part of the emerging cutting-edge research.

Were there any influential figures who helped you forge your career path?

I've had several influential mentors. When I was a trainee, I did six months of research in Canada with a very notable neuroanaesthesiologist who just happened to be developing an interest in spinal cord injury, particularly from cardiac surgery. Through his great intellect and interest, he showed me what a dynamic and interesting life one could have as a clinician and as a scientist. He was the first of several important mentors I had along my career path.

After early training in Canada, I spent 12 years in the United States, at Duke University that was well known to be the leading research centre in neurological injury after cardiac surgery. There I met two great mentors, Mark Newman, a cardiac anaesthesiologist, and David Warner, a neuroanaesthesiologist, both

who really taught me a great deal about scientific process.

I'm always keenly aware of serendipity in medicine, and how chance encounters can make major changes in the direction of your career, and I have countless examples of meeting the right person at the right time to point me in a direction that I otherwise might not have found.

What do you feel is your most significant contribution to the field of cardiothoracic anaesthesia?

I was quite fortunate to enter this field at a stage when major knowledge gaps were being identified and cutting-edge research was being done. Some of my early work came at a time when temperature during cardiac surgery was a hot topic and some of my work dealt with the impact of temperature on the brain, including how we warm and cool patients during surgery. As a result of that, we were able to identify that high temperature and the rapidity at which you rewarm patients during cardiac surgery had a major impact on neurological outcome.

While working at Duke University, I had an incredibly supportive department that gave me the resources to develop an idea and take a deep dive into it. We developed this unique experimental model using a miniaturised cardiopulmonary bypass circuit for small rodent. We were able to take these animals, cool and rewarm them at different rates and different temperatures, then subsequently recover them and examine their neurocognitive abilities using already well-established models of memory and learning. Thus, we were able to merge the clinical arena with the benchtop allowing us to develop this transformational work that subsequently led to some of the practice changes that persist today.

What are some of the most critical challenges you see in the development of the field of cardiothoracic anaesthesia?

The specialty of cardiothoracic anaesthesia itself is rapidly evolving in concert with the operations and other procedures being offered to patients. Not only are the procedures constantly changing, but the patients themselves are changing. We've seen over the last three decades that the patients presenting for these procedures are increasingly higher risk and older, which is matching known demographic trends. These patients are sicker now than they've ever been before. The constant challenge is that the field is moving so quickly that there's often not enough time to adequately study some of these new procedures. By the time you fully understand the consequences of these procedures on patient outcomes, the field has already moved on to the next development. I think that's always going to be a challenge.

Is there any advice you can give about the challenge of keeping up with the latest information?

I think one of the more destructive forces in academia and in science is in the failure to keeping an open mind. People can be quite dogmatic in their approaches to problems and reluctant to change. We need to constantly refine our thinking to move this field forward. I've always taken the perspective that when the data changes, you need to be prepared to change your mind. Sure, sometimes we'll make a few missteps, but if we don't try new things, we'll never advance our thinking. The resistance to change is one of the most difficult impediments in science and medicine today.

What is your current focus?

Over the most recent decade, my focus has really been on the dissemination of science through the medical publishing and editorial process. I just recently finished two terms as the Editor-in-Chief of the Canadian Journal of Anesthesia and in order to do that, I had to take a step back from active research. One can only do so many things and now that I've finished that work, and I've relocated to a new university, I have that unique opportunity to see how I can best use the skillsets and knowledge that I've acquired in research and medical publishing to help push the field forward in other ways. I see my role now as more of an advisor and a mentor to some of my junior colleagues. That in itself has always been a goal of mine and the shepherding of the next generation is really where my focus is now.

What advice would you give to the next generation of anaesthetists?

Medicine, anaesthesia, - whatever discipline you choose - is so interesting and multifaceted that often times when people start their careers, their focus is too dispersed because they're excited about so many things. In order to really move a field forward, I think focus is one of the things that's underachieved by many. I know for myself, it took a long time to develop that focus. I think getting distracted by the next exciting thing that someone throws your way needs to be resisted. One also needs to resist the negative comments perhaps about the lack of employment in your specialty interest area. Do what you love and the job will follow. If you're not doing what you love, that's just a recipe for unhappiness in your career and life. Making career decisions are always risky and fraught with uncertainty. You can alleviate this by simply making a decision, and when you do so, you make it the right decision.

Thank you for sharing your expertise at this year's NSC. What were the highlights of the Congress for you?

There were a couple of highlights. When I came into this conference, I didn't know that much about the ASA per se, but I have been so impressed by the organisation, the depth of expertise and the bigger-picture perspectives being presented that you don't often see at scientific meetings. The opening plenary was remarkable, and hearing from Professor Entwisle made me think of how interests outside our own field of medicine are so important to our health. Associate Professor Kaur gave a remarkable and truly inspirational and humbling lecture on the influence that anaesthesiologists can have outside of the operating room. Finally, I thought that Dr Andrew Miller's final address as ASA President was an incredibly moving dissertation of history, philosophy, and medicine. One of the best addresses I've seen in recent memory.

Kelly Chan

BSLS, BMus, MBA/LLM Candidate
Marketing & Communications Manager, Australian Society of Anaesthetists

NSC Major Partners

AirLife · CSL Seqirus · Edwards · Medtronic

NSC 2023 Educational Partners

Masimo · mindray

NSC 2023 Congress Partners

3M
Adecco Aust Pty ltd trading as ADF Careers
AFT Pharmaceutical
AMBU
Avant
Bbraun
BD
Clarius Mobile Health
Credabl
DPM Financial Services
Fisher and Paykel
Fujifilm Sonosite
GE Healthcare
Haemonetics
Hosportal
Intersurgical Australia
Lateral Medical
LTR Medical
MDA National
Medical Business Systems
Medisecure
Meditrust
MIPS
Murray Medical
PEMDx Pty Ltd
Phebra
Priority Life
Royal Botanic Gardens Victoria
Solo Practice Management
Surimex
TCI Health
Trustmost
Ultrasound Education Group - University of Melbourne
Zeep Medical

In partnership with psychiatrists at Hand-n-Hand, the Australian Society of Anaesthetists proudly present

Australian Society of Anaesthetists®

members for members

Peer Support Programme

Simply put, peer support is a way of providing emotional and wellbeing assistance where both the facilitator and participant are equals. Through this, people can connect through shared experience. It's not mentorship or career guidance - your facilitators are peers you can relate to.

When you sign up, you're linked in with a facilitator from the same profession and similar level of training. Our facilitators are trained and experienced in providing peer support.

Benefits of peer support

- 1-on-1 or group support available.
- Meet as often or as little as you like, at times that suit your schedule.
- Withdraw at any time, for any reason.
- Involves no clinical psychiatric treatment.
- Supported by evidence as a pre-clinical mental health intervention.

Are you looking for peer support?

Are you a peer support facilitator, or interested in becoming a trained facilitator?

By volunteering as a peer support facilitator, you can help others in your position navigate the ups and downs of the health profession.

Our triage method is guided by Hand-n-Hand to best suit you
Contact the ASA Wellbeing Advocates Committee

ASApeersupport@asa.org.au

Applications are welcome at any time

ASA RESEARCH GRANTS AND SCHOLARSHIPS 2024

The ASA has expanded its Research Priority Program (RPP) with the creation of four new small grants of up to $3000 each per year, for original research into the current ASA Research Priority areas:

ENVIRONMENT & ANAESTHESIA
INNOVATION & ANAESTHESIA
SAFETY IN ANAESTHESIA

Eligibility: trainee members, and members within five years of full membership who have been financial members of the ASA for over 12 months. Applicants are welcome from research teams, but at least one member needs to meet the eligibility requirements.
There is a requirement to present work in a public forum eg a future NSC, publish in a peer review journal, Australian Anaesthetist or ASA podcast.

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

FOR FURTHER INFORMATION APPLICATION & FORMS LOG IN TO

asa.org.au/asa-awards-prizes-and-research-grants/
or contact sdonovan@asa.org.au

FROM THE SPARC CHAIR

ASSOCIATE PROFESSOR
ALWIN CHUAN

In a busy quarter for SPARC, the outcomes for the ASA's 2023 annual research grant round was finalised in late September to be followed immediately by adjudication for the four prize sessions during the very successful Melbourne NSC 2023.

We awarded the ASA Annual Research Grant, Jackson Rees Research Award, and the Kevin McCaul prize to the three deserving successful grant applicants.

The eight winners and runners-up of the ASA Gilbert Troup, ASA Best Poster, Trainee Member Group Best Poster, and the Trainee Member Group Audit/Survey Prizes were also announced during the NSC's Gala Dinner.

I am very pleased to bring you highlights of these 11 individuals and the research teams they represent: Strong female representation; a wide range of experience from novices, PhD candidates and experienced researchers; a wide mix of resident medical officers, anaesthesia trainees, fellows and consultants; representing 4 different states in Australia; presenting on topics of high relevance and direct interest to our community: regional anaesthesia, obstetrics, anaesthesia for high risk patients, smoking cessation, monitored anaesthesia care, workplace fatigue, environment and sustainability, and airway management. The ASA is proud to support these young researchers and their contributions to Australian academic anaesthesia.

Lastly, a reminder of the ASA's Small Grants scheme which provides $3000 for original research in anaesthesia, pain medicine, and intensive care. With quick turnaround, the Small Grants are ideal as seed money to help build larger research projects. The next deadline is March 2024.

Further information is available at the ASA website https://asa.org.au/asa-awards-prizes-and-research-grants/ and the NSC abstracts submission portal https://asansc.com.au/abstracts/

PRE-NATIONAL SCIENTIFIC CONGRESS (NSC) ADJUDICATED GRANTS

Annual Research Grant Award Winner

Dr Earlene Silvapulle

Dr Earlene Silvapulle is a staff specialist anaesthetist with Royal Melbourne Hospital's Department of Anaesthesia and Pain Management and a research fellow and PhD candidate with the University of Melbourne's Department of Critical Care.

Dr Earlene's project focuses on improving the detection of myocardial injury after noncardiac surgery (MINS) and postoperative myocardial infarction (MI). With 93% of MINS and 68% of postoperative MI being clinically silent, it is difficult to diagnose reliability without systematic troponin testing. Whilst international society guidelines recommend postoperative troponin surveillance in high-risk patients, a pressing knowledge gap is how preoperative assessment can accurately identify individuals at a high-risk of MINS and postoperative MI, who will benefit from postoperative troponin screening.

This feasibility study will examine how the combination of functional capacity (measured by the Duke Activity Status Index, DASI), frailty and other measures of health status predicts postoperative cardiac complications in older patients undergoing intermediate-to-major noncardiac surgery. Furthermore, this study will evaluate the costs and feasibility of a postoperative troponin screening program within Australia. Accurate identification of such high-risk individuals will enable initiation of appropriate postoperative surveillance and open potential avenues for secondary prevention therapy. Amongst our elderly surgical cohort, this will be expected to have a profound impact on postoperative cardiovascular complications, long-term patient health outcomes and quality of life

---

Jackson Rees Research Award Winner

Dr D-Yin (Indy) Lin

Dr D-Yin Indy Lin is an anaesthetist at Flinders Medical Centre. Dr Lin's project, *Efficacy of the PEricapsular Nerve Group (PENG) Block versus Intrathecal Morphine for Analgesia in Anterior Approach Total Hip Arthroplasty: A Multi-Centre Blinded Randomized Comparative Trial*, is a multi-centre blinded randomised comparative trial that will be conducted at two large teaching hospitals in South Australia, Noarlunga Health Services (NHS) and Flinders Medical Centre (FMC). Both centres are located in Adelaide, Australia.

In this study the PEricapsular Nerve Group (PENG) block shall be investigated for short term outcomes in elective anterior approach total hip arthroplasty (THA), as compared to low dose intrathecal morphine. In addition to standardised spinal anaesthesia and local infiltration analgesia (LIA), THA patients shall be randomised to receive either a PENG block or intrathecal morphine (ITM). Blinding is via a non-invasive sham version of the PENG block. This is a pragmatic study with short term pain as primary outcome.

Kevin McCaul Prize Winner

Dr Annie Xin

Dr Annie Xin is an anaesthetics registrar (advanced trainee) at Royal Melbourne Hospital and a research associate at Murdoch Children's Research Institute, Victoria.

Dr Xin's 'Narrative review on safe airway management in patients with preeclampsia' looks at preeclampsia, the most common serious complication of pregnancy and one of the top three causes of maternal death in Australia.

Patients with preeclampsia are frequently managed by anaesthetists in the perioperative period both for resuscitation and for the management of anaesthesia for caesarean delivery. Exaggerated hypertensive responses can commonly occur during general anaesthesia at times of tracheal intubation and extubation, and patients with severe preeclampsia are vulnerable during these time periods where life-threatening complications such as cerebral haemorrhage and pulmonary oedema may occur. Although much emphasis has been placed on preventing pressor response during laryngoscopy and tracheal intubation in patients with severe preeclampsia, there is relatively little consensus or guidance in the anaesthetic literature for safe tracheal extubation practice in this patient population. This narrative review summarises current evidence on pharmacological treatment of hypertensive responses during airway management in patients with preeclampsia. The aim of the review is to raise awareness on this important topic in our anaesthetic community and to provide evidence-based recommendations for providing safer anaesthesia in this high-risk obstetric population.

NATIONAL SCIENTIFIC CONGRESS (NSC) 2023 PRIZE WINNERS

Gilbert Troup Prize Winner

Dr Kwok-Ming Ho

Dr Ho's project looks at using biological age as a predictor of adverse patient-centred outcomes. Accelerated ageing is present when one's biological age is in excess of the corresponding chronological age, and this is increasingly recognised as an important predictor of long-term health outcomes.

Using the biological age data of 2950 patients admitted to the intensive care unit after major surgery or with acute illness, Dr Ho's team established that biological age was better than chronological age in predicting adverse patient-centred outcomes in a 'dose-related' fashion, even after adjusting for frailty, comorbidities, and severity of acute illness.

Gilbert Troup Prize Runner-up

Dr James Molloy

Dr James Molloy is a Registrar at Royal North Shore Hospital, New South Wales. Dr Molloy's study, conducted at Royal North Shore Hospital, assessed levels of fatigue in anaesthetic registrars during night shifts using actigraphy to provide accurate and objective levels of fatigue and associated impairment.

Dr Molloy and his team's study highlighted a high incidence of performing clinical duties whilst fatigued, with a specific window between 12am – 5am of significant and consistent impairment.

Additionally, one in three times driving home, registrars were impaired to a blood alcohol level of 0.05 or worse. This study provides the basis for accurate measurement of fatigue to help implement fatigue risk-mitigation strategies.

National Scientific Congress Best Poster Prize Winner

Dr Sophie Meyerson

Dr Sophie Meyerson is a Resident Medical Officer at Royal North Shore Hospital, New South Wales.

Dr Meyerson's retrospective cohort study examined the impact of introducing monitored anaesthetic care in the cardiac cath lab on patient outcomes. Dr Meyerson and her team found that patients who received monitored anaesthetic care had a significantly reduced rate of cardiac arrests and 24-hour post-procedure mortality compared to nurse-led sedation.

To the best of their knowledge, this is the first study to examine this issue in Australia or New Zealand, and they hope their findings encourage further, high-quality research in this area, potentially also covering questions of cost effectiveness and patient experience.

National Scientific Congress Best Poster Prize Runner-up

Dr Aquib Chowdury

Dr Aquib Chowdury is a Critical Care Resident Medical Officer at the University Hospital Geelong in Victoria. Dr Chowdury's project, Accidental Dural Puncture and Post-Dural Puncture Headache: Audit of a Victorian Tertiary Obstetric Service looked at characterising obstetric neuraxial complications at a Victorian Tertiary Obstetric Service.

The aim was to characterize obstetric neuraxial complications at the service. Dr Chowdury and his team found a 1.6% incidence of post-dural puncture headache at their service – which is higher than reported in other centres – most of which were secondary to accidental dural puncture from epidurals. In future, their findings can be used to advocate for routine electronic complication surveys for anaesthetists to use at their health service.

Trainee Members Group Best Poster Prize Winner

Dr Lachlan McLennan

Dr McLennan is an Advance Trainee 1 (AT1) at St George Hospital, New South Wales. With Dr Karen Joseph, Dr Boris Waldman and Dr Nathan Hewitt, Dr McLennan's presentation looked at inconsistencies in the advice given by anaesthetists to quit smoking preoperatively.

Current evidence suggests that anaesthetists are inconsistent with their advice and referrals to quit smoking preoperatively. Barriers to initiating interventions may include insufficient knowledge, time constraints, lack of multidisciplinary support and limited ability to provide follow-up.

Dr McLennan's team conducted an audit which demonstrated that a brief educational intervention given to anaesthetists improved their confidence in discussing NRT and ability to refer patients for ongoing smoking cessation support. Similar programs could be considered at other centres.

Trainee Members Group Best Poster Prize Runner-up

Dr Hayden Burch

Dr Hayden Burch is an Anaesthetic Resident at Austin Health and an Honorary Clinical Lecturer with the University of Melbourne's Department of Critical Care.

Dr Burch's study is a national cross-sectional audit of N2O procurement for all Australian public hospitals between 2017 – 2022. The annual N2O purchased by Australian public hospitals was equivalent to the annual carbon emissions of over 37,000 Australian cars on the road, with significant variation (up to three-fold) in annual N2O procurement per state/territory per number of hospital beds.

This study highlighted the significance of piped nitrous leak across national public hospital infrastructure and supports transitioning toward local cylinder supply where clinically appropriate, amongst other methods to reduce unnecessary procurement and use.

Trainee Members Group Audit/Survey Prize Winner

Dr Misha Yadav

Dr Misha Yadav is an Anaesthesia Fellow at Royal Adelaide Hospital, South Australia.

Dr Yadav and her team conducted an audit of mortality and morbidity among 745 patients who presented with femur fractures at Queen Elizabeth Hospital from June 2016 to September 2020. The 30-day mortality rate was 9.3%, while the one-year mortality rate was 26.5%. The team identified statistically significant associations between 30-day mortality and ASA grade (P-value = 0.0119), as well as between one-year mortality and age at admission (P-value = 0.0033) and ASA grade (P-value < 0.0001). The outcomes of patients presenting with hip fractures at the hospital were consistent with the normal variation observed in the Australia and New Zealand Hip Fracture Registry findings. However, the team identified a few areas for improvement, such as the provision of analgesia, the timing of orthogeriatric reviews, and the need for delirium prevention.

Trainee Members Group Audit/Survey Prize Runner-up

Dr Courtney Cini

Dr Courtney Cini is a Critical Care Resident at Eastern Health, Victoria.

Dr Cini and her team's study looked at failed intubations at Box Hill Hospital (Eastern Health, Victoria). The team conducted an audit on difficult and failed intubations at Box Hill Hospital and used the Victorian Admitted Episodes Dataset (VAED) registry to complete the audit, which identified the prevalence of difficult intubation to be nearly four per 1000 general anaesthesia procedures. Administrative data appeared to be reliable. Difficult (and failed) intubations are not currently reported as a hospital-acquired complication, highlighting the potential for the VAED to monitor for patient safety. Dr Cini and her team look forward to expanding this audit work to other hospitals and across the entire state.

SAVE MORE ON YOUR MORTGAGE WITH A TRUSTED & CERTIFIED BROKER

Sit back and relax while we do the legwork on the loan to secure your dream home.

At **AMA Wealth** our certified and trusted mortgage broking team will take the time to understand your individual goals and needs, and navigate you through the mortgage process, so you can choose the right loan to suit your needs.

Take advantage of our services and reap the rewards:

- We save you time & money
- We reduce your stress & anxiety
- We help with pre-approval
- We do all the leg-work to secure your home loan
- Work with one certified and trusted mortgage broker
- Get up to $2K cashback^ as an ASA member

BOOK A FREE ONLINE CONSULTATION OR CALL TO SPEAK TO A BROKER

AMA WEALTH

P: 1300 55 44 77

E: info@amawealth.com.au **www.amawealth.com.au**

FAILURE TO PREPARE, OR PREPARING TO FAIL: A SURGEON'S INITIATIVE

In 2017, during a late evening at my office, I met a 79-year-old lady diagnosed with bowel cancer. Living independently and appearing fit for her age, she seemed an apt candidate for surgery. As I outlined the procedure, risks and recovery expectations, her understandably anxious family sought an earlier surgical date, echoing a common sentiment to expedite cancer treatment. But given the average age of patients with bowel cancer, and the likely physiological consequences they face due to their disease such as malnourishment and de-conditioning, I pondered these questions: Is rushing to the operating table always in their best interest, and if not, what can we do whilst waiting for their operation?

Teamwork makes the dream work: The beginnings of prehabilitation at Concord Hospital

The inception of our prehabilitation program underscored the undeniable power of collaboration. Though increasing evidence since 2017 has hinted at the potential of prehabilitation, Australia lacked a comprehensive model to emulate. It became clear that a successful prehabilitation program would hinge on an orchestrated effort from a multidisciplinary team. In 2013, we laid the groundwork with our Enhanced Recovery After Surgery (ERAS) program at Concord Hospital, which, over a decade, demonstrated the merit of collaborative postoperative care. This initiative thrived due to the collaboration between dedicated surgeons, anaesthetists, nurses, and allied health professionals, each contributing unique expertise to advance patient care. Recognising that we had deficits in the preoperative phase of care, amplified by patients asking us 'What can we do to prepare before surgery?', we used the ERAS model as a template for our prehabilitation endeavour. Yet, one key piece of the puzzle remained: an outpatient exercise

physiologist to lead a structured exercise program. Our search culminated in a fruitful partnership with the Sydney Survivorship Centre, bringing our vision for a holistic, multimodal prehabilitation program to fruition at Concord.

The Concord Colorectal Preoperative Optimisation Program

The collaboration above led to a pilot research study; 'The Colorectal Preoperative Optimisation Program (CPOP) study', which was kindly funded by the Concord Cancer Centre Research Grant. The aims were to evaluate the feasibility of a short-term, multimodal, prehabilitation program and explore its ability to improve patients' functional capacity prior to surgery.

Over the 12-month study period, it was confirmed that CPOP was feasible and effective in improving patient's functional capacity preoperatively. Components of the exercise program were both aerobic and resistance training. Between baseline status and immediately preoperatively, participants reported a mean increase in weekly unsupervised moderate-intensity aerobic exercise from 17 (range 0-210) to 73 minutes (range 0–276). The mean increase in weekly vigorous-intensity aerobic exercise was from 0 to 24 minutes (range 0-300). Weekly resistance exercise increased from 0.6 to 2.6 sessions. Mean 6-minute walk test distances increased by 48 metres (435-483m) as did 30-second 'sit to stand', by 1.6 repetitions.

CPOP Outcomes: The patients' perspective

Empowering patients with a sense of autonomy was a cornerstone of the CPOP study. It was crucial for us to gauge patient perspectives, as their active participation would dictate the program's success. Contrary to initial concerns about whether patients would embrace the idea of a preparation phase before cancer surgery, feedback was overwhelmingly positive. Every participant in the study expressed satisfaction, with many strongly endorsing the program and recommending it to others. The prehabilitation program's reception was not just about preparing patients physically; it instilled a deep sense of ownership and empowerment. This autonomy allowed patients to actively influence their preoperative journey, shifting them from passive recipients of care to active collaborators. The result? An informed and engaged patient population better prepared for their surgical journey, both physically and mentally.

Expanding the service: The Prehab-GI study and the Agency of Clinical Innovation (ACI)

The success of the CPOP pilot study led to interest into prehabilitation with other surgical teams. This led to more research, in the form of the Prehab-GI study, where recruitment finished at the end of 2022, and outcome data are still being analysed. However, there were a number of challenges encountered during this endeavour. One of the biggest hurdles being participant recruitment during the COVID-19 pandemic. We adapted, and within our restricted scope and limited resources, were able to change the program delivery mode from a 'face-to-face' to a virtual model. During this time, in 2021, the Concord prehabilitation team was invited by ACI Surgical Task Force to be part of the prehabilitation working group. We found out we were not alone! We met clinicians from other units in NSW to share our prehabilitation experience which has now formed part of the ACI's published 'Prehabilitation Key Principles' document.

The role of the anaesthetist

The role of the anaesthetist within the prehabilitation team is pivotal. As expert collaborators, often at the forefront of coordinating preadmission clinic services, we have a privileged position whereby we interact frequently with different surgical teams, medical specialists, nursing staff and allied health. By being the conductor of the prehabilitation services, anaesthetists can help to proactively identify and mitigate risks, coordinating members of the team to ensure patients are in their best physical and mental condition before surgery.

The Future

Prehabilitation is still an emerging field, especially within the Australian medical landscape. Navigating challenges related to institutional backing, sustainable funding models, and measuring cost-effectiveness within traditional hospital systems is no easy feat. Furthermore, conventional metrics may not encompass the broader, yet crucial, benefits that prehabilitation offers. These benefits extend beyond the immediate postoperative period, encompassing enhanced functional capacities of patients, a quicker and more efficient return to work, and fostering long-lasting commitments to healthier lifestyles, including regular exercise and improved dietary habits. Our experiences underscore that prehabilitation is not just feasible, but a transformative asset in the perioperative journey. Recognising its potential, it becomes imperative to advocate for the establishment of long term prehabilitation programs. Such programs, desired by patients, founded by enthusiastic individuals and forged ahead by cross-disciplinary collaboration, holds the promise of amplifying these benefits, making a profound difference in the lives of an ever-expanding patient community.

Dr Amy Lawrence

Anaesthetist | Concord Repatriation General Hospital

A/Prof Michael Suen

Colorectal Surgeon | Concord Repatriation General Hospital

THE NORTHERN HOSPITAL'S JOURNEY

ENHANCING PERIOPERATIVE CARE THROUGH PREHABILITATION AND COLLABORATION

THE TERM 'PERIOPERATIVE CARE' ENCOMPASSES A PATIENT'S ENTIRE SURGICAL JOURNEY, FROM THE INITIAL REFERRAL BY THEIR FAMILY DOCTOR TO THE SURGEON, PREOPERATIVE PREPARATION, THE SURGERY, AND ULTIMATELY, A SAFE DISCHARGE BACK INTO THE COMMUNITY. AT THE CORE OF THIS MULTIFACETED JOURNEY LIES A CRITICAL ELEMENT: THE PERIOPERATIVE TEAM. THESE TEAMS PLAY A PIVOTAL ROLE IN PATIENT CARE, ENSURING THAT EACH STEP IN THE PROCESS IS SEAMLESSLY EXECUTED, ALL THE WHILE PROMOTING PATIENT WELLBEING.

Dr Amanda Baric, 2022 recipient of the ANZCA Robert Orton Medal for distinguished service to anaesthesia and perioperative medicine, and Dr Jamie Mackay, perioperative lead at Northern Health, shared their insights into perioperative care at Northern Health in Victoria, illuminating the indispensable role of the perioperative team in ensuring the wellbeing of patients throughout their surgical journey.

The Northern Hospital

Northern Health includes the Northern Hospital, a metropolitan university teaching hospital in Epping that handles both emergencies and planned surgical cases, and Broadmeadows Hospital that offers planned surgery to less complex patients. Annually, the health service conducts around 10,000 elective surgical procedures, covering various specialties except for cardiac and neurosurgery. This year we implemented a new preadmission service in response to the twin challenges of increasingly complex patients and large numbers of patients waiting for surgery for extended periods after the interruption of the pandemic.

The challenge

Over time, a recurring challenge has emerged for perioperative services. Patients frequently present for surgery with preventable health issues such as untreated iron deficiency and anaemia, smoking, malnutrition, heavy alcohol use, low functional capacity or poorly controlled chronic illness. Unfortunately, these patients are then at a higher risk of complications after surgery, which in turn can lead to delayed recovery and discharge, diminished independence, and even lead to regret over the initial decision to undergo surgery. Our challenge was to create a model that would identify and manage these health issues before surgery, providing high value care to our patients within the budgetary constraints common to all public hospitals.

The integration of multidisciplinary care and prehabilitation

Northern Health embarked on a transformative journey to address the challenges identified in perioperative care. Recognising the need to

Back row, left to right: Vivian Tsang (dietician), Megan Bunting (physiotherapist), Karen Boone (PAC Nurse), Ally Malloy (PAC Nurse), Sean Hui (geriatrician) Front row, left to right: Lauren Beard (pharmacist), Jamie Mackay (anaesthetist)

enhance preoperative preparation and optimisation, we implemented several fundamental changes.

In order to identify patients who would benefit from prehabilitation and optimisation earlier, we deployed an electronic system to stratify patients according to their risk of complications, based on their electronic health questionnaire responses. This estimated risk would then inform the patient's care pathway prior to surgery and allow the perioperative team to initiate optimisation strategies with more time before surgery.

We expanded the number of anaesthetist-led preadmission clinics while retaining the nurse assessment pathway for low-risk patients. We introduced a multidisciplinary high-risk clinic to facilitate more comprehensive optimisation and introduced a separate complex decision-making clinic for patients for whom the decision to operate is unclear.

Our high-risk clinic is staffed by a team that includes a geriatrician, anaesthetist, clinical nurse specialists, dietitian, physiotherapist, and pharmacist. Patients are triaged to this clinic if they are undergoing major or complex surgery or have complex medical problems. In general, these are the high-risk patients, who benefit from nutritional optimisation, medication management, geriatric assessment and extensive discussions around risk and a plan for postoperative critical care. Our prehabilitation pathway is still maturing after eight months of operation, but so far, we offer nutritional support, a smoking cessation program, education about increasing activity, pulmonary education and inspiratory muscle training, and optimisation of medical conditions including anaemia and complex pain with the support of our pain service. Our next challenge is to identify those who would benefit from a formal exercise program and to offer better psychological preparation.

The most novel addition to our service has been the development of the Complex Decision-Making clinic, where patients and their loved ones have multidisciplinary discussions with a geriatrician, intensive care specialist and anaesthetist when the decision to proceed to surgery is not straightforward. The clinic provides an opportunity to speak with patients in detail to better understand what a 'good' outcome means to them and ensure that we tailor our care plan to match. This team has had great success in helping patients with their decisions to proceed (or not) to surgery and reduce 'decision regret'. Our surgeons are embracing the opportunity to refer patients to this pathway and this team regularly meets with surgeons to discuss complex patients that are referred to this clinic.

Fostering a culture of collaboration and gaining executive support

Developing a model of care was a crucial starting point. Our lead perioperative anaesthetists shaped this model and, with the endorsement of the anaesthetic department Head, we garnered support

from the Head of Perioperative Services and the Director of Surgery. We collaborated with leaders from various disciplines including pharmacy, allied health and general medicine, and crafted a strong business case. This group then put the plan into action, which included drafting procedures, recruiting staff, advocating for clinic space, and ongoing education of staff.

The new model started operation in February 2023 and the hospital has already witnessed improvements in patient care. The hospital continues to actively collect data on outcomes to share with teams and sponsors. While change in a busy clinical environment presents its challenges, the hospital has an established culture of respect, and with regular opportunities for feedback and team planning sessions, all team members' contributions are valued and appreciated.

The benefits

Implementing a multidisciplinary care approach brings about many benefits including process-related, health-related, and patient-centred outcomes. We are looking forward to demonstrating benefits including improved efficiency of referrals, diminished day-of-surgery cancellations, lower unplanned admissions to intensive care, reduced hospital stays, lower unplanned readmissions, and increases in same-day surgeries for specific procedures. The potential benefits to health outcomes are reductions in adverse events including medication errors, postoperative pulmonary complications, major adverse cardiac events, postoperative delirium, and postoperative mortality. Most importantly, from a patient-centred perspective, this approach will likely see improved patient satisfaction, better quality of recovery, and improved measures of overall quality of life.

The future: integrating rehabilitation and enhanced recovery programs

The next steps for our service will including the introduction of better patient education prior to surgery to empower them to take ownership of their recovery. We are seeking to better align with enhanced recovery after surgery initiatives that are currently being rolled out and to develop formal physical training programs for our vulnerable patients undergoing surgery.

- **Dr Amanda Baric**
- **Dr Jamie Mackay**

PREHABILITATION: A NEUROPSYCHOLOGICAL PERSPECTIVE

As our population ages, the number of adults over the age of 65 years who are presenting for surgery is growing. These patients are at high risk of neurocognitive disorders and hence there is increasing recognition of the need to consider a patient's cognitive health during the prehabilitation processes.

Cognition comprises a range of different thinking skills including attention, processing speed, learning and memory, spatial functions, language abilities, and executive functions such as planning, reasoning, and judgement. A recent consensus paper[1] developed the nomenclature 'perioperative neurocognitive disorders' (PNDs) as an overarching term to describe cognitive dysfunction identified around the time of anaesthesia and surgery. Interestingly, recognition of the relationship between cognition and anaesthesia has a long history. In 1887 the British Medical Journal published a seminal paper by English psychiatrist George Savage, titled 'Insanity following the use of anaesthetics in operations',[2] which detailed a case series of patients who experienced deteriorations in mental state following anaesthesia. The body of literature has of course developed substantially since then, with advancements in both the field of anaesthetics and neuropsychological assessment allowing for a more nuanced understanding of PNDs.

Neuropsychological assessment is a comprehensive evaluation of a person's cognitive functioning. It involves a series of standardised tests designed to measure various cognitive domains. These tests have been administered to a representative sample of individuals from the general population to establish a set of normative data. This data creates a reference point that allow

Case Example One

Josh is a 65-year-old male who is preparing for elective spinal surgery. The treating team have concerns about his cognitive functioning, and he is referred for neuropsychological assessment. The assessment reveals that Josh has difficulties with memory and processing complex information. As part of the prehabilitation process, Josh needs to enhance his physical condition by engaging in a daily exercise regime. Adaptations to the delivery and implementation of his prehabilitation are made to cater to Josh's current level of cognitive functioning. Information about his exercise regimen is delivered slowly and in simple language, using visual aids, and demonstrations. Josh is also provided with written information he can refer to later and his family members participate in discussions to offer extra support. Because of Josh's memory challenges, strategies are implemented to help him engage in his exercises. These include keeping exercise pictures in a visible and frequently visited place at home (e.g., the fridge) and setting daily alarms on his phone to remind him to complete the exercises. He also has a checklist he uses. His family reviews this to see if he has completed his exercises that day so they can prompt him when he forgets.

Case Example Two

Bianca is a 70-year-old retired professor who was scheduled for hip replacement surgery due to severe osteoarthritis. Her family has observed mild memory concerns, but note she is functioning well in daily life. Given her age and family concerns, the treating team administer the MOCA. Bianca scores 29/30 which is not suggestive of cognitive impairment. However, based on her educational and occupational history it is likely that Bianca has a high premorbid intellectual baseline and good cognitive reserve. A neuropsychological assessment is conducted to assess how Bianca's performance compares to people of a similar background. The assessment reveals a frontosubcortical pattern of cognitive deficits consistent with vascular cognitive impairment (VCI). The treating team explain the diagnosis to Bianca and her family and discuss how patients with VCI are at increased risk of cognitive decline after undergoing surgery. Bianca and the family are educated about the importance of postoperative vigilance regarding cognitive function, and what changes to look out for. Bianca makes a more informed decision about the relative risks and benefits of the surgery based on this information. She proceeds with the hip replacement surgery, which goes smoothly. In the month following the procedure it becomes evident that Bianca's cognitive function has declined. She finds multitasking more difficult and has increasing issues with learning new processes on her computer. Considering these cognitive changes, a repeat neuropsychological assessment is conducted three months following the surgery. The results reveal an exacerbation of Bianca's pre-existing cognitive deficits, particularly in memory and executive functioning. It is concluded that her VCI has been exacerbated by the surgical procedure. However, being equipped with this knowledge before the surgery meant that Bianca was well informed and had greater mental preparedness. This reduced the anxiety and distress she experienced about these changes. The treating team provided recommendations to assist with her cognitive concerns, and Bianca continued to function well in her day-to-day activities.

neuropsychologists to compare an individual's test results to those of a similar group of people in terms of age, education, and other relevant demographic features. A patient's pattern of performance across various cognitive domains can help identify a patient's cognitive strengths and weaknesses, as well as the aetiology of cognitive impairment, given different neurocognitive disorders have unique cognitive characterisations.

PNDs include preoperative neurocognitive disorders (i.e. cognitive deficits that a patient has prior to their surgery). These are important to identify and evaluate in the prehabilitation process as they can impact a patient's adherence to prehabilitation recommendations. For example, receptive and expressive language difficulties may affect a patient's ability to understand a prehabilitation program's instructions, goals, and expectations. Memory impairment may manifest as forgetting to complete exercise regimens or attend important medical appointments. Patients with executive functioning deficits could struggle to effectively plan their meals and make judgements about which foods align with the dietary advice provided. In cases where there is concern about pre-existing cognitive deficits, a neuropsychological assessment can help comprehensively evaluate a patient's cognitive functioning. This can help anticipate potential barriers to engaging in prehabilitation and aid in the development of strategies to overcome them (see case example one).

Neuropsychological assessment is a comprehensive evaluation of a person's cognitive functioning. It involves a series of standardised tests designed to measure various cognitive domains.

Preoperative neurocognitive disorders are also important to evaluate because they place patients at risk for developing PNDs after surgery. These include postoperative delirium, delayed neurocognitive recovery (cognitive decline diagnosed up to 30 days post-procedure), and postoperative neurocognitive disorders (cognitive decline diagnosed between 30 days and 12-months post-procedure). Other risk factors for PNDs include advanced age, lower educational attainment, medical comorbidities such as depression and cerebrovascular disease, alcohol abuse, and nutritional status.[3] As part of the prehabilitation process, cognitive assessment of older adults and other populations at greater risk of PND should be routine. This serves as a baseline for postsurgical cognitive assessment, so that any cognitive changes resultant from the procedure are objectively quantified.

A cognitive assessment can be conducted using cognitive screening tools which have the advantage of being brief and easy to administer. They can be performed by anaesthetists or other members of the treating team depending on the nature of the preoperative setting. Commonly used cognitive screening tasks include the Montreal Cognitive Assessment (MOCA), Mini-Mental State Examination (MMSE), and Addenbrooke's Cognitive Exam-III (ACE-III). For patients with culturally and linguistically diverse backgrounds the use of cognitive screens that are less culturally biased

A cognitive assessment can be conducted using cognitive screening tools which have the advantage of being brief and easy to administer. They can be performed by anaesthetists or other members of the treating team depending on the nature of the preoperative setting.

is necessary, such as the Rowland Universal Dementia Assessment Scale. It is important to note that cognitive screening tools are not as sensitive for eliciting evidence of cognitive deficit compared to neuropsychological assessments. Patients with high levels of cognitive reserve may perform relatively well on cognitive screening but poorly on neuropsychological assessment. Therefore, neuropsychological evaluation may be helpful in cases where performance on cognitive screening does not highlight impairment, but there remain concerns about cognitive functioning, or the patient is otherwise at high risk of developing a PND.

In terms of cognitive prehabilitation, there is emerging literature examining the efficacy of cognitive interventions for reducing the risk of PNDs. A recent prospective single-blinded randomised control trial examined whether one-hour of cognitive training for ten consecutive days pre-surgery reduced the incidence of postoperative delirium in older adults undergoing non-cardiac and non-neurological surgery under general anaesthesia. While the findings did not reach statistical significance, those who received cognitive training had lower incidence rates of post-operative delirium (14.4%) compared to controls (23.0%).[4] Another randomised control trial of older adults undergoing gastrointestinal surgery found that those who received three one-hour sessions of cognitive mnemonic skills training had significantly lower incidence of delayed neurocognitive recovery (15.9%) compared to controls (36.1%).[5] There is also a multidisciplinary and multicomponent perioperative intervention currently underway, which seeks to reduce the risk of PNDs.[6] Overall these preliminary findings are promising, though further trials will be helpful in validating these results and elucidating the optimal type of activities, dosage, and timing of cognitive interventions.

Until then, cognitive prehabilitation (at least from a non-pharmacological perspective) should largely focus on providing education to patients and their families to assist with mental preparedness, which may help alleviate psychological distress caused by any postoperative cognitive changes (see case example two). Anaesthetists are key members in the multidisciplinary perioperative care team who can play an important role in providing such education. Coordination with other doctors, nurses, and allied health professionals is also important, particularly in settings where limited time is afforded for anaesthetists to consult with patients prior to surgery. A handout for anaesthetists and surgeons has been designed by the American Society of Anesthesiologists Perioperative Brain Health Initiative in conjunction with the American Geriatric Society. It provides a brief overview of perioperative brain health to patients and can be downloaded online.[7]

In summary, cognitive health is an important consideration in prehabilitation. Evaluating a patient's cognitive functioning can be useful for devising prehabilitation programs that are more likely to be adhered to and therefore more efficacious. Evaluation of cognitive functioning can also help identify and manage a patient's risk of PNDs, with the view of improving their readiness for surgery and recovery from it. Communication is a crucial element in prehabilitation, and this is particularly the case for patients with a pre-existing neurocognitive disorder and those who are at greater risk of developing PNDs. A multidisciplinary approach incorporating anaesthetists, other doctors, nurses, and allied health professionals can ensure that prehabilitation programs effectively evaluate and manage a patient's cognitive health.

Karina Chan

BPsych(Hons), MClinNeuro, MAPS, FCCN

References

1. Evered et al. (2018). Recommendations for the Nomenclature of Cognitive Change Associated with Anaesthesia and Surgery-2018. Anesthesiology, 129(5), 872-879. https://doi.org/10.1097/ALN.0000000000002334.
2. Savage G.H. (1887). Insanity following the Use of Anæsthetics in Operations. British Medical Journal, 2(1405), 1199–1200.
3. Kong et al. (2022). Perioperative neurocognitive disorders: A narrative review focusing on diagnosis, prevention, and treatment. CNS Neuroscience and Therapeutics, 28(8), 1147-1167. https://doi.org/10.1111/cns.13873.
4. Humeidan et al. (2021). Effect of cognitive prehabilitation on the incidence of postoperative delirium among older adults undergoing major noncardiac surgery: The neurobics randomized clinical trial. JAMA Surgery, 156(2), 148-156. https://doi.org/10.1001/jamasurg.2020.4371.
5. Saleh et al. (2015). Preoperative cognitive intervention reduces cognitive dysfunction in elderly patients after gastrointestinal surgery: A randomized controlled trial. Medical Science Monitor, 21, 798-805. https://doi.org/10.12659/MSM.893359
6. Atkins et al. (2021). Preventing delirium and promoting long-term brain health: A clinical trial design for the perioperative cognitive enhancement (PROTECT) trial. Journal of Alzheimer's Disease, 83(4), 1637-1649. https://doi.org/10.3233/JAD-210438.
7. https://www.asahq.org/brainhealthinitiative/

ANAESTHESIA, PERIOPERATIVE CARE, EARLY RECOVERY AFTER BARIATRIC SURGERY AND PREHABILITATION

THE XXVI IFSO WORLD CONGRESS OF BARIATRIC & METABOLIC SURGERY

The International Federation for the Surgery of Obesity and Metabolic Disorders (IFSO) hosted the World Congress of Bariatric and Metabolic Surgery in the beautiful city of Naples, Italy, on the 30th August to the 1st September 2023.

Anaesthetists contributed to the Annual World Congress of the IFSO, which includes both the American Society of Metabolic Surgery (ASMBS) and the Australian and New Zealand Metabolic and Obesity Surgery Society (ANZMOSS). As the President of the International Society for the Perioperative Care of Patients with Obesity (ISPCOP), I curated the anaesthesia component under the auspices of the ISPCOP.

Our session was entitled 'Anaesthesia for bariatric surgery, robots, early recovery after bariatric surgery (ERABS) and all you need to know to update your practise in 2023' and was chaired by Professor Anu Wadhwa MBBS FASA (Texas), the immediate past president of ISPCOP.

This anaesthesia stand-alone session included presentations from myself, Professor Rainer Lenhardt MD FASA (Louisville) and Professor Jan Mulier MD PhD (Bruges) that respectively addressed the current literature in bariatric anaesthesia, robotic anaesthesia in high BMI patients, and the state of the art in ERABS. ISPCOP member, Dr Faruq Badiuddin MBBS FRCS (ENG.), bariatric surgeon, then presented his work on the role of surgeon applied perioperative analgesic blocks in bariatric surgery.

Later that day I chaired the abstract session on early recovery after metabolic and bariatric surgery (ERAMBS) management and innovation.

Professor Anu Wadhwa, Dr Adrian Sultana, Professor Rainer Lenhardt

Co- presenter Dr Faruq Badiuddin, provided an early release of the results of a survey of ERAS peri-operative practices among Bariatric Surgeons and anaesthesiologists conducted by the IFSO ERAMBS Taskforce.

Highlights from the anaesthesiology responses included:

- 67.12% of anaesthetists request no specific respiratory test or preparation prior to bariatric surgery.
- Approximately 50% of anaesthetists prescribe a preoperative anti-emetic regime with the NK-1 receptor antagonists (Aprepitant) starting to make an appearance (5.5%).
- 38.36% use a standardised anaesthetic for all bariatric patients
- 30% of anaesthetists use an intraoperative opioid free technique
- 52.05% of anaesthetists measure neuromuscular transmission (NMT) objectively (TOF or PTC) during induction, maintenance and after reversal (all 3 phases).
- 41-42.5 % of anaesthetists use processed EEG monitoring as a standard technique in every bariatric procedure and also adopt 'active depth adaptation' to avoid awareness (BIS or entropy >70) together with active depth adaptation to avoid deep anaesthesia (BIS or entropy < 40)

During the same abstract session, 12 bariatric units from ten different countries presented their original research on topics ranging from preoperative preparation to novel surgical techniques and fast-track protocols to achieve early recovery. Of notable interest to anaesthetists two presentations from the USA - one focused on aggressive postoperative thromboprophylaxis, while the other was regarding the management of GLP-1 agonists perioperativwely.

Early recovery after bariatric surgery and prehabilitation

These were overarching themes of the meeting and many surgical units worldwide were practising day case bariatric surgery based on rigorous preparation of patients and the skill and protocol-driven achievements of their anaesthesia colleagues.

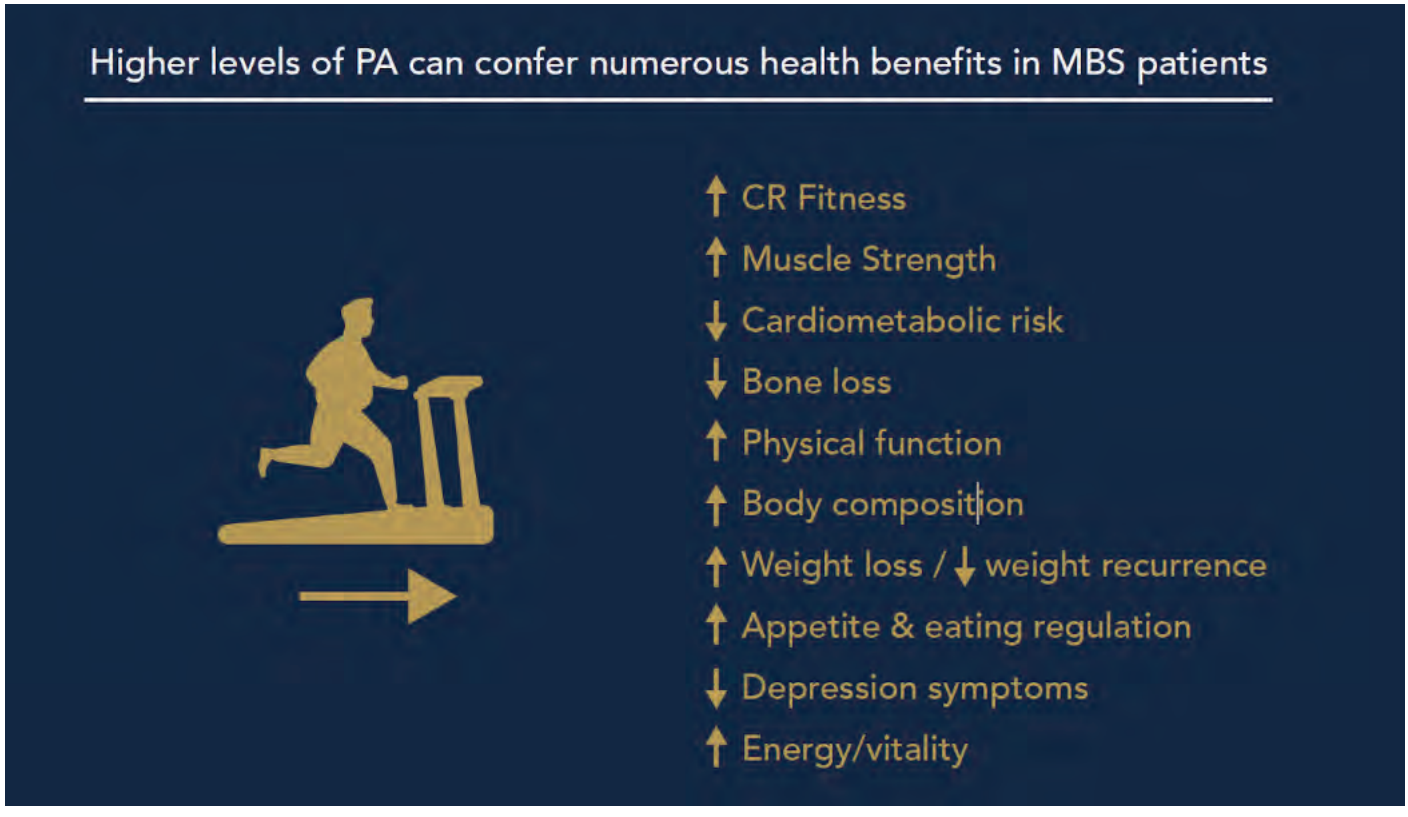
Alongside Professor Mulier, I was one of two anaesthetists who presented in the multi-disciplinary session: 'ambulatory bariatric surgery: the future or not worth it?'. This session culminated with a debate whose outcome was quite evenly matched but the 'pros' narrowly edged ahead.

Proceedings of the conference and a consensus book have been published[1]. Of special interest to anaesthetists are the following conclusions:

Diet, lifestyle and exercise

Surgical weight loss programs require dietary, lifestyle and exercise changes to achieve sustainable success. Education to guide patients' dietary practices, physical activity, and other influential lifestyle behaviours should be provided both prior to and after metabolic and bariatric surgery (MBS). Goal-directed guidance in line with patient values, and online sessions using videos with interactive activities, are additional innovations currently being suggested.

Figure 1*: Benefits of increased level of physical activity (PA) in MBS patients



Medical treatment of obesity

Weight management pharmacotherapy intersects with surgical weight loss programs before and after surgery and anaesthetists will need to be across this topic in some detail[2]. Recently the American Society of Anesthesiologists has published guidelines pertaining to the cessation of GLP-1 agonists and revised fasting guidelines for surgical patients on these medications prior to any form of surgery and anaesthesia given their well-known effects on gastric emptying[3].

In summary for elective surgery the guidelines recommend:

- Interrupting the dosing schedule by one unit (one day for daily drugs one week for weekly drugs)
- Postponing surgery if the patient has upper GI symptoms.
- Treating the patients as a full-stomach risk if they present for emergency surgery or if the drugs have not been withheld.
- If the elective surgery guidelines have been followed the (American) ASA recommends defaulting to routine fasting guidelines.

As this area remains relatively unclear I put forward my view that any patient that has undergone medical or surgical intervention that delays gastric emptying could perhaps be considered for a fasting regime that includes 24 hours of clear fluids (caloric or non-caloric) prior to surgery.

Our practice adopts this regime when patients present for secondary bariatric procedures or when laparoscopic surgery follows an endoscopic weight loss intervention.

There may also be a role for preoperative gastric ultrasound and medical management of the stomach and oesophagus with prokinetics and proton pump inhibitors.

Venous thromboembolism (VTE) prophylaxis in bariatric surgery

The evidence-based conclusions from this contribution by Dr Ashraf Haddad, are reproduced below as anaesthetists in Australia tend to run the VTE management in private practice.

- Mechanical prophylaxis is low risk and potentially of benefit and, therefore, should be used in all MBS patients.
- The use of mechanical prophylaxis alone is associated with higher VTE rates than mechanical combined with pharmacological prophylaxis.
- Low Molecular Weight Heparins (LMWH) is the most commonly used agent. However, LMWH and fondaparinux may be equally effective at reducing VTE and both are associated with lower VTE rates than unfractionated heparin (UFH).
- There is little to no published evidence supporting the use of augmented doses for reducing either VTE or major bleeding.
- Very low-quality and inconclusive data exist regarding the routine use of extended prophylaxis, in terms of VTE or major bleeding.
- The importance of extended prophylaxis arises when applied selectively to high-risk patients identified using risk assessment tools.
- There is no published evidence supporting the routine use of IVC filters.

I was honoured to contribute to the 2023 Annual Congress of the IFSO and I thank the secretariat for their invitation to ISPCOP to curate the anaesthesia component for the third congress in a row. The congress together with its ensuing proceedings and guidelines provided an exceptional educational opportunity for clinicians and I hope that I have brought some of this to the readership of Australian Anaesthetist.

The next IFSO world congress will take place in Melbourne in September 2024 and will feature an anaesthesia sub-meeting.

Dr Adrian Sultana

MD FRCP FANZCZ

References

1. American Society of Anesthesiologists Consensus-Based Guidance on Preoperative Management of Patients (Adults and Children) on Glucagon-Like Peptide-1 (GLP-1) Receptor Agonists. https://www.asahq.org/about-asa/newsroom/news-releases/2023/06/american-society-of-anesthesiologists-consensus-based-guidance-on-preoperative
2. Hulst AH, Polderman JAW, Siegelaar SE, van Raalte DH, DeVries JH, Preckel B, Hermanides J. Preoperative considerations of new long-acting glucagon-like peptide-1 receptor agonists in diabetes mellitus. Br J Anaesth. 2021 Mar;126(3):567-571. doi: 10.1016/j.bja.2020.10.023. Epub 2020 Dec 17. PMID: 33341227

webAIRS
Anaesthetic Incident Reporting System from ANZTADC

WEBAIRS

Dr Anna Steer and ANZTADC Case Report Writing Group

BURNS IN THE OPERATING THEATRE!

A WEBAIRS REVIEW

Despite significant efforts to improve the safety of the operating theatre environment, burns to patients under anaesthetic care still occur. Burns may be caused by thermal energy from fire or heat, or chemical reactions, potentially causing serious and permanent physical and psychological harm to the patient.

Advancements in technology for surgery and anaesthesia have contributed to the rise in intraoperative fires and consequently thermal injury to patients. Electrocautery is the most commonly reported ignition source of fire in the operating theatre.

Increased utilisation of high flow nasal oxygen devices, providing supplemental oxygen ranging from FiO2 30% to 100% during the concurrent use of electrocautery has become a dangerous oxidiser completing the 'triangle of fire' in the operating theatre.

Several case reports of fire in the operating theatre in Australia and New Zealand have been published over recent years.

This analysis of incidents causing thermal and chemical burns reported to webAIRS aims to raise awareness of the possibility of these events and to examine the contributing factors.

Results

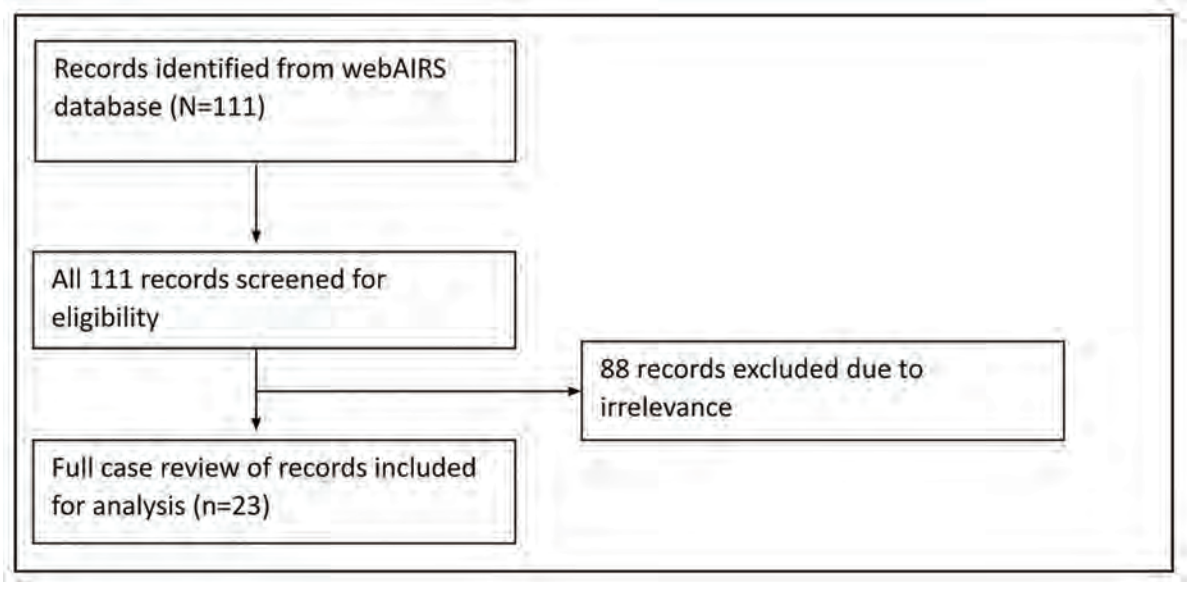


Figure 1.

Summary of Results

CHARACTERISTIC		N=23	%
Burn type	Thermal	20	87%
	Chemical	3	13%
Oxygen source	Nil supplemental O2	13	57%
	Simple face mask (i.e Hudson)	5	22%
	High Flow Nasal Prongs	4	17%
	Low Flow Nasal Prongs	1	4%
Ignition source	Electrocautery	13	57%
	Light source	2	9%
	Other	4	17%
	NA	4	17%
Fuel or heat source	Tissue/Hair	9	39%
	Drapes	7	30%
	Chlorhexidine/alcohol	5	22%
	Body warming devices	3	13%
	Oxygen delivery device	1	4%
Site of injury	Face	6	26%
	Periocular (incl. Lid & brow)	5	22%
	Lower body	4	17%
	Upper body	2	9%
	Airway	2	9%
	No injury	3	13%
	Unspecified	1	4%
Depth of injury	Superficial	14	61%
	Partial	7	30%
	No injury	2	9%
	Full	0	0%
ASA	1	6	26%
	2	7	30%
	3	6	26%
	4	2	9%
	Not specified	2	9%
Urgency	Elective	16	70%
	Emergency	6	26%
	Not specified	1	4%
Sex	Female	11	48%
	Male	10	43%
	Not specified	2	9%
Grade of anaesthetist	Specialist Anaesthetist	19	83%
	Trainee	2	9%
	Not specified	2	9%
Type of anaesthetist	GA	11	48%
	Sedation	10	43%
	Regional	1	4%
	Not specified	1	4%

Table 1.

ASA = American Society of Anaesthesiology; GA = general anaesthesia

Advancements in technology for surgery and anaesthesia have contributed to the rise in intraoperative fires and consequently thermal injury to patients.

A narrative search using Structure Query Language (SQL) searching for incidents where the words or parts of the words "burn" and "fire" was used across all incidents reported to webAIRS. One hundred and eleven records were identified of which 88 records were excluded due to irrelevance. A total of 23 records were included for analysis (Figure 1).

The highest incidence of thermal injuries occurred during superficial surgery to the head and neck region under monitored anaesthesia care, during plastics, vascular and cardiology procedures. These accounted for half of all thermal injuries reported. Ten cases were associated with delivery of supplemental oxygen via an open system, nine of which resulted in patient harm to the face and airway (six superficial burns, two partial thickness, two inhalational). Oxygen delivery devices implicated in the thermal injuries included simple face mask (n=5), low-flow nasal prongs (n=1) and high-flow nasal prong devices with humidification (n=4). Variable oxygen concentrations were delivered by these devices ranging from approximately FiO2 30% up to 100% at variable flow rates between 3L/min up to 70L/min.

Fuel sources included facial hair (eyelashes, eyebrows, and nasal hair), surgical drapes and one incident involving the plastic of the oxygen delivery device. Alcoholic skin preparation was implicated in two of the nine cases. The most common ignition source was electrocautery (57%).

Two cases of operative room fire occurred from the laparoscopic light source in general surgical procedures, one of which resulted in a superficial thermal burn to the patient's inferior eyelid. In both incidents the laparoscopic light source was placed on the surgical drapes, which subsequently became ignited.

Chemical injuries accounted for three cases, two involving the eye (partial thickness injury to the cornea) from inadvertent contamination with alcoholic chlorhexidine. In both cases the eyes were protected, one with Micropore ™ tape and one with Tegaderm ™ dressing. No cases reported ongoing sight-threatening injury. All were managed with ophthalmology follow-up. Recommendations from the reporting anaesthetists in both cases included vigilance both when securing eye protection and at the time of surgical preparation in addition to timely ophthalmological assessment. The third case also was due to alcoholic chlorhexidine preparation with likely prolonged contact with the wet solution resulting in a superficial chemical burn to the lower back region of the patient.

Thermal and chemical injury to patients undergoing procedures in the operating theatre continue to occur despite an abundance of published literature on the issue over the years, particularly since the introduction of electrocautery and LASER surgical techniques in addition to the advancement in high flow nasal oxygen delivery devices. Whilst the reported annual incidence of operating room fires across Australia & New Zealand averages one to two cases per year, slightly below published rates from other countries (~4-5 cases per year); it is important to highlight that underreporting of such events is an inherent limitation to the webAIRS system and hence it is likely that the numbers presented in this analysis are underrepresenting the actual incidence. Data published from the United States of America in 2009 estimated 200-350 operating theatre fire cases per year, 20-30 resulting in serious disabling or disfiguring harm to the patient and 1-5 deaths per year. The webAIRS data is comparable to the published literature where approximately half of the reported thermal injuries occurred in the head and neck regions and over 70% are related to electrocautery as the ignition source across similar surgical specialties (otolaryngology, vascular and plastic surgery) in patient's receiving monitored anaesthesia care.

Patient harm from burns injuries due to the combination of electrocautery and open system delivery of supplemental oxygen whilst receiving monitored anaesthesia care is well established in the literature. These injuries are considered reasonably foreseeable and preventable. It is imperative that risk reduction strategies are employed to mitigate harm from occurring in these seemingly innocuous settings. The ANZTAD committee strongly encourages the reporting of any thermal or chemical injury cases to the webAIRS database to improve our understanding of how these incidents occur and provide targeted recommendations for future prevention strategies.

Anaesthesia and Intensive Care

ANAESTHESIA AND INTENSIVE CARE EDITORIAL FELLOW

Dear Colleagues,

Applications are invited from ASA, NZSA, or ANZICS members within their final year of specialty training or within two years of obtaining their specialist qualification for the position of Anaesthesia and Intensive Care Editorial Fellow, 2024.

As with our current editorial positions, the position would be honorary and would be undertaken alongside the applicant's usual employment or training. The term would be for 12 months commencing February 2024.

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

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

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

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

Applications should be addressed to the Chief Editor, Anaesthesia and Intensive Care via email aic@asa.org.au by 31 December 2023.

Applicants will be notified of the outcome of their application by mid-January 2024.

Kind regards,

A/Prof John Loadsman

Chief Editor, Anaesthesia and Intensive Care

cpd home | AMA

2024 REGISTRATION CHANGES

From 1 January, for ongoing medical registration, doctors must join an Australian Medical Council (AMC) approved CPD home.

Are you ready to subscribe?

- medical specialists
- IMGs not on a specialist pathway, with limited or provisional registration
- PGY3+ doctors not in a specialty training program
- all other general registration doctors including non-vocationally registered medical practitioners

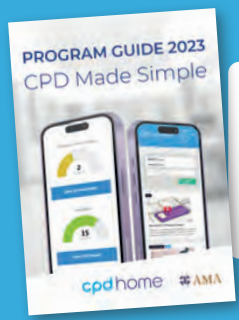
Mandatory CPD requirements

To meet the Standard, doctors are required to:

1. write a **CPD plan**
2. meet the **minimum hour requirements** across the two domains of learning, including high-level CPD requirements set by some specialist colleges where relevant to your registered scope
3. reflect on your **planned learning goals** at the end of the CPD year.

Your **CPD home will submit** your CPD compliance to the Australian Health Practitioner Regulation Agency (Ahpra).

Download the CPD Home Program Guide to find out more about accepted CPD activities



Join CPD Home Today!

Achieve your CPD compliance with ease.

At CPD Home, **we understand** the new Standard and how best to support you to stay compliant each year.

ASA Members
$440
Non-ASA Members
$880 full-time | **$660** part-time

Junior Doctors
ASA Members
$220
Non-ASA Members
$440 full-time | **$330** part-time

CPD Made Simple

Engage
Search our catalogue and complete evidence-based, relevant, timely accredited CPD activities.

Plan
Write your CPD plan, identify your learning goals and tag your focus topics.

Join
Getting started is easy by creating your learning profile.

Track
Complete 50hrs of CPD, including high-level CPD requirements for some specialities.

Reflect
At the end of the CPD year, reflect upon your learning goals.

Report
We automatically notify Ahpra of your compliance status.

Trust the AMA's CPD Home to guide your CPD journey. Find out more today.

cpdhome.org.au

cpd home | AMA

FIRST IMPRESSIONS

ASAED WITH DR VIDA VILIUNAS OAM

You've Got Seven Seconds!

Whether you are rehearsing for vivas, preparing for a job interview, giving a presentation, or consulting with patients or colleagues; verbal and non-technical skills are vital for positive and authoritative communication. Aside from content and knowledge that you impart, the impression you leave depends considerably on those other skills. There is inconsistent research on the number of seconds it takes to create an impression. There is agreement that it doesn't take very long and that longer exposures don't significantly alter those impressions[1].

Those candidates who have attended the ASA exam preparation sessions know my tirade about first impressions and how to make a good one. Whether it's for a viva examination, a job interview, a patient or other consultation, a good first impression improves credibility and all chances of success, however that is measured.


INSIDE YOUR SOCIETY

TIPS FOR JOB INTERVIEWS

DR VIDA VILIUNAS AND DR AARON PYM

FIRST IMPRESSIONS

LOGISTICS AND INTERVIEW PREPARATION

So much is free

There are a number of things that you can access for free – verbal and non-technical skills amongst them.

As I wrote in 'Tips for Job Interviews' (Australian Anaesthetist June 2021), studies claim that nonverbal communication contributes a great deal to positive elements such as ratings for charisma and intelligence. Grooming, eye-contact and smiling all make a difference.

The ASA has hosted several presentations with Dr Andrea Wojnicki, executive communication and personal branding coach, and creator of the 'Talk about Talk'[2] podcast. Andrea is the author of 'A simple way to introduce yourself' published in the Harvard Business Review. We are often asked to introduce ourselves at meetings and conferences. Being prepared rather than surprised for such a common request decreases the associated awkwardness.

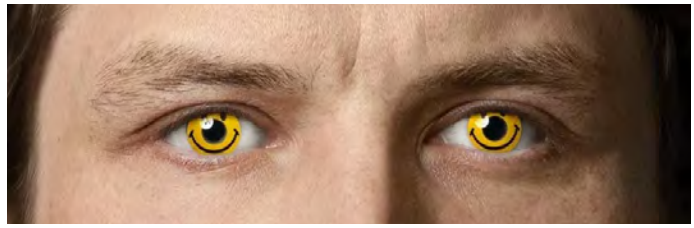
Wardrobe – dress the part

There are often no specific dress-codes advertised for life interactions. However, when considering your exam or job interview outfit, choose something businesslike, comfortable, and flattering. When you are comfortable, you will shine. The exam or high stakes interview is not the time to try out a new haircut, perfume/cologne, or flashy jewellery. Make it look as though you have made an effort, but keep it understated. Similarly, when meeting a patient out of scrubs it is important to convey an image of professionalism.

Body Language

Attending to your body language is another free element that can improve the impression you give during encounters with examiners, interviewers, colleagues, or patients. Nonverbal cues can have a significant subconscious impact on your audience.

- Keep an open posture and have a positive affect
- Keep extravagant hand gestures to a minimum
- Don't fidget with any part of your body



Eye Contact

Strong eye contact contributes to confidence. Too much eye contact makes your audience uncomfortable. The right amount confers likeability and credibility. Obviously cultural norms and your own comfort level play into making this look natural and not forced.

Words Matter

It requires conscious practice to delete or minimise filler words and informal, colloquial language from speech. There are many internet advisers on how to eliminate filler words from speech. Opening with 'So…', 'Um…', 'Like' or 'Good Question' impairs credibility, suggests a lack of authority and sounds unprofessional. Those perceptions are reinforced every time you repeat a filler word or expression. Advice on measuring the problem ranges from practicing out loud and videoing to performing in front of a critical audience. Treating the problem might involve managing anxiety or pausing instead of dropping a 'you know' bomb. Research data shows that most speakers do not pause enough. There is a sweet spot: 'pause, think, reply' is the mantra that allows good pacing.

My favourite internet experts in this area are Riaz Meghji from 'Every Conversation Counts' and Communication Coach Alex Lyon.

Voice

Varying pace and emphasis are where a face-to-face interaction has an advantage over written exchange. Thinking of the spoken word in bold or italics and pronouncing it with that emphasis is a recommended technique[3].

Listen

Listening is not just waiting for your turn to talk. Make sure that you have heard the question or scenario and answer the precise question asked, by patient, examiner, interviewer, or colleague. If you are unsure, ask for explanation. In the exam setting, it is not the role of the candidate to ask questions beyond a request for clarification. Wait until the end of your job interview to be invited to ask the panel any questions.

Managing Anxiety

Managing distress and anxiety should take place well before any high stakes interactions and correlates with reduced stress and improved performance. Techniques range from repetition, to meditations, mindfulness, psychological and pharmacological support[4].

If this occurs in the context of an exam, prepare a strategy for when you reach the limit of your knowledge, have an attack of 'viva brain' or cannot think of a response to an unusual question. That strategy should include the words (simple phrases such as 'I don't know' for example) as well as a way to manage the anxiety that can accompany that point in an exchange.

Photography

Headshots, other photography, and avatars deserve attention. These can serve as online introductions whether via LinkedIn or other internet references. Make them count.

No matter what the interaction, whether at an exam, job interview, professional interaction or at a cocktail party, think about your first impression.

Dr Vida Viliunas

Dr Kaylee Jordan

Dr Vida Viliunas OAM

Vice President

References

1. Willis J, Todorov A. First impressions: making up your mind after a 100-ms exposure to a face. Psychol Sci. 2006 Jul;17(7):592-8. doi: 10.1111/j.1467-9280.2006.01750.x. PMID: 16866745
2. talkabouttalk.com
3. Selzer R, Ellen S, Rotstein L, Roseby R. Twelve tips for performing well in vivas. Med Teach. 2015 May;37(5):428-32. doi: 10.3109/0142159X.2014.959909. Epub 2014 Sep 26. PMID: 25259738.
4. Hearn, J.H., Stocker, C.J. Mindfulness practice correlates with reduced exam-induced stress and improved exam performance in preclinical medical students with the "acting with awareness", "non-judging" and "non-reacting" facets of mindfulness particularly associated with improved exam performance. BMC Psychol 10, 41 (2022). https://doi.org/10.1186/s40359-022-00754-3

DR PETER WATERHOUSE
PIAC CHAIR

PROFESSIONAL ISSUES ADVISORY COMMITTEE

2023 IN REVIEW

THE ASA HAS BEEN BUSY PROVIDING PROFESSIONAL REPRESENTATION TO MEMBERS AND THE WIDER ANAESTHETIC COMMUNITY. THIS REPRESENTATION TAKES PLACE ON TWO LEVELS: PERSONAL AND PROFESSION-WIDE.

Individual member enquiries

Members contact the ASA for assistance with a wide variety of challenges, but there are a small number of issues which account for a large proportion of all enquiries. These are roster disputes, hospital accreditation issues and impairment in a colleague.

Roster disputes

After-hours rosters are required by all inpatient facilities to ensure safe delivery of acute medical care. Beyond this universal requirement for emergency cover, there is wide variation in the requirements of individual facilities.

Given that each hospital has unique requirements, rosters are impossible to standardise. Many models exist. Some cities provide after-hours cover on a group practice basis, with each group covering its regular surgeons. This system provides surgeons, hospitals and fellow anaesthetists with a degree of extra support, as several people will be on call at the same time for each hospital. In other places, an individual anaesthetist is on call for each facility. This system ensures that somebody is exclusively available but does not guarantee that the doctor on call will be willing to provide anaesthesia for all surgical specialties or for small children.

The age at which it is permissible to retire from the roster is also variable. In many cities, senior colleagues are able to taper and conclude their after-hours commitment, while maintaining a busy practice. This reflects the natural narrowing of one's practice over time. It also acknowledges the increasing impact of anti-social working hours with age.

Special mention must be given to obstetric rosters, which consistently generate the highest number of enquiries and disputes. The unfortunate combination of limited elective work with a requirement for 24 hour emergency cover creates challenges for those administering the roster.

These challenges can only be overcome by close collaboration between doctors and hospital managers.

Hospital accreditation

In order to practice medicine, all doctors must maintain registration with the Medical Board of Australia (MBA) and its close cousin, the Australian Health Practitioner Regulation Agency (Ahpra). Complaints and notifications to MBA and Ahpra are handled by experienced administrative officers and medical peers. While subject to any investigation, doctors and their legal representatives are kept informed.

After-hours rosters are required by all inpatient facilities to ensure safe delivery of acute medical care. Beyond this universal requirement for emergency cover, there is wide variation in the requirements of individual facilities.

The same cannot be said for hospital accreditation processes.

Although the consequences of loss of accreditation at one's workplace are comparable to loss of medical registration, processes and governance are less well defined. Complaints and notifications in this environment are handled by hospital management, perhaps in collaboration with medical heads of department or craft group. Few guidelines exist, because of the low number of notifications in each institution.

In comparison to MBA and Ahpra systems, hospital processes can be opaque and open-ended. Decisions are practically incontestable, given the absolute discretion of the hospital when it comes to the accreditation of medical practitioners.

This is not to say that hospital accreditation could be administered fundamentally differently. After all, accredited practitioners are either guests or employees of the hospital. Who else could take charge of this process? However it is apparent that doctors who find themselves subject to a hospital complaints process do not have recourse to any external arbiter and can only hope for procedural fairness.

The Impaired Colleague

Impairment refers to a physical or mental condition adversely affecting the ability of a doctor to function safely.

Impairment of anaesthetists is sadly often related to the abuse of narcotic or sedative medications taken from the workplace.

There are two moments in the journey of an impaired doctor at which his or her colleagues are directly involved. One is near the beginning of the process, one is towards the end.

The first moment is the point at which a reasonable suspicion of impairment is entertained by a colleague. There is no retreat from this moment, because it is accompanied by a moral obligation to the impaired doctor and his/her patients. Strong and conflicting emotions characterise this unpleasant episode, and collegiate support is essential for both the impaired doctor and the colleagues taking responsibility for intervening.

The second moment, if it arrives, follows a period of suspended or restricted practice managed by Ahpra and the Medical Board. If re-entry to clinical practice is deemed appropriate, the impaired doctor's colleagues are again required to step up in order to facilitate his/her return to practice.

The ASA maintains close contact with Ahpra and MBA, in order to provide support to members who find themselves involved in the management of an impaired colleague.

Profession-wide advocacy

In addition to ongoing liaison with the Australian and New Zealand College of Anaesthetists (ANZCA), the ASA is in regular contact with other medical societies and private hospital operators. This latter group are united by their growing unease about the expanding role of health insurers in the provision of clinical patient care.

Rather than acting as a simple provider of patient rebates for medical services, insurers are actively cultivating greater control over the practical provision of treatment. This American model of insurer control improves the profitability of insurers.

Current insurer activity includes ownership of hospitals and attempts to enter into contracts with doctors. Both activities erode the independence of hospital and doctors. This in turn adversely affects patients, whose treatment is now more dependent on what the insurer will pay for.

Encouragingly, the ASA and Australian Medical Association (AMA) are both hard at work to raise awareness of the risk of insurer dominance in our health system.

The ASA has created a forum for all parties in favour of strong and independent hospitals and doctors. Its second meeting will take place as this magazine goes to print.

The AMA is lobbying the government for the creation of a statutory body to act as an umpire for the private health industry.

Neither of these new bodies are likely to achieve prohibition of contracts between payers and providers. This is the only guaranteed way to limit the influence of insurers. However they may succeed in introducing greater scrutiny of health insurers and awareness of the conflict of interest between their shareholders and customers. In this way it may be possible to moderate insurer behaviour in favour of patients.

Happy Holidays!

As the year draws to a close, I would like to thank the readers of our magazine for their indulgence and support. I wish you a peaceful festive season.

Dr Peter Waterhouse

PIAC Chair

DR MICHAEL LUMSDEN-STEEL
EAC CHAIR

ECONOMIC ADVISORY COMMITTEE

Prehabilitation and enhanced recovery after surgery: Will the benefits be funded

PUBLIC HEALTHCARE SYSTEMS IN AUSTRALIA WERE ALREADY STRUGGLING TO KEEP UP WITH DEMAND PRIOR TO COVID-19 AND, ANECDOTALLY, FRUSTRATION THAT THE INCREASING BURDEN OF EMERGENCY ADMISSIONS WAS NOT BEING MATCHED BY AN INCREASE IN RESOURCES WAS ALSO GROWING.

Complex, multidisciplinary care procedures are for the most part undertaken in larger public hospitals, often tertiary centres, and, to a much lesser degree, in well-resourced private hospitals. Winter 'flu seasons' often hit surgical operating lists just as the medical inpatient load expands to fill surgical beds, and when health practitioner sick leave reduces elective surgical capacity (theatre, ward beds, ICU and HDU capacity etc) at those tertiary centres undertaking complex, 'super-specialised' work.

Every time an elective procedure is rescheduled due to insufficient ICU/HDU or surgical ward bed capacity, this lost opportunity delays the next patient in the queue. A day case procedure that unexpectedly requires overnight admission postoperatively will often impact negatively on another patient's procedure.

Internationally, both during the initial peaks of the Covid-19 pandemic and since, healthcare systems have seen procedural backlog pressures generated by periods of reduced procedural activity, the lack of prepandemic surge capacity (especially for 'medical beds'), the impacts of insufficient subacute and rehabilitation capacity, and a health workforce shortage. These have all impacted on surgical bed access largely within the public healthcare system. Public hospital waiting lists are managed by a number of different strategies, including the various attempts at outsourcing ASA 1 and 2 patients to private hospitals. Unfortunately, this often means the public healthcare system carries a higher load of complex patients with a higher incidence of chronic disease, who have waited longer for their surgery. These patients have varying degrees of preparation and prehabilitation while waiting for an undefined surgical date and, when they do have their surgery, may require a longer length of stay (LOS). Wait times in excess of 12 months, if not 24 months, are not uncommon unfortunately.

How can we do more, with the same level of resources (or less), is a question repeatedly asked of us when working in elective surgery. How can we reduce the wait list? How can we reduce LOS? Surely that patient doesn't need an overnight bed. Do we really need a close observation after surgery bed? Do we really need an ICU bed for that patient?

An increasing number of studies are signaling that prehabilitated patients can recover quicker, have less complications,

Every time an elective procedure is rescheduled due to insufficient ICU/ HDU or surgical ward bed capacity, this lost opportunity delays the next patient in the queue.

use less resources, with reduced LOS. How is success measured? Is this reduced mortality at 30 days, three months, or 12 months? All of these are a win for both the patient and the healthcare system. The savings from reduced complications can be difficult to quantify, but measuring our interventions, outcomes, and savings drives the investment to reducing expenses in the future. Where emergency admission patients have little to no opportunity for prehabilitation before procedure, those waiting for elective surgery do. How can we make the most use of the one resource on our wait list most often neglected – time? Patients on elective surgical wait lists have time to be identified and prehabilitated.

Within the public healthcare system, with its mix of state and federal funding, prehabilitation pioneers have been able to set up complex, high-risk patient preadmission clinics and explore multidisciplinary prehabilitation clinics. The purpose of these clinics is to prepare and optimise patients pre-surgery to:

- reduce the likelihood of complications,
- reduce LOS for admission,
- reduce the length (or even requirement for) critical care unit admission post op,
- reduce postoperative rehabilitation requirements,
- facilitate early discharge, and
- enable earlier return to pretreatment function.

Where this has been funded by activity-based funding (ABF), limiting factors have included:

- evidence,
- where to target resources,
- obtaining the critical funding from the hospital / health network to establish the services,
- ability to recruit the allied health, nursing, and medical staff to drive the prehabilitation services, and
- implementation.

Where care has generated savings and/or reduced inpatient length of stay, this should translate to increased capacity within the healthcare system and hopefully enable more patients to have their procedure undertaken. Somehow, all this will be performed within the ABF cap, which during the Covid-19 pandemic was funded 50:50 between the State and the Federal Governments, up from 45% to 55% (which it may return to in the near future). The challenge of course is seeing this translated to appropriately funded, sustainable increases in activity, surgical bed availability, and increased surgical bed capacity not being filled with long stay, complex sub-acute medical patients.

The most significant challenge facing prehabilitation services is how will they be appropriately resourced? How is outpatient prehabilitation in the public and the private sectors going to be funded? Will it be new funding, or a redistribution of existing funding? Many of the existing MBS items for these services are not currently available to anaesthetists. The MBS item rules for anaesthetists are limited to face-to-face preanaesthesia consultations (17610 to 17625), or the use of AMA and ASA item numbers for which there is no Medicare patient rebate. Where preanaesthesia consultations are undertaken in rooms, for a preanaesthesia

consultation 17615 and above, MBS item 17690 may be also be claimed if the 17690 criteria are met. The MBS has only one preanaesthesia telehealth item (92701) that must be by video and not over the telephone and be at least a 17615 equivalent (time and complexity).

There are no MBS items for postanaesthesia telehealth follow-up. Currently, attendance at multidisciplinary meetings by anaesthetists is largely unsupported. Follow-up consultations that may be required for prehabilitation coordination and telehealth telephone calls have limited MBS item for anaesthetists, other than face-to-face specialist consultation numbers (17640 to 17655). Postprocedural follow up care has been built into the procedural item numbers. Growing prehabilitation capacity in the private sector will free up public hospital capacity, but this is largely outpatient services where allied health may be covered by health insurance, while nursing staff and specialist consultations, within the MBS items, have a Medicare patient rebate of 85% of the MBS item fee, where there is an appropriate MBS item. This means many patients are likely to incur out-of-pocket expenses for private outpatient prehabilitation services from allied health and for specialist consultations.

The PREHABIL Trial is one of many prehabilitation trials that have been undertaken or are currently underway. The PREHABIL Trial focuses on frail, elderly patients undergoing major surgery with a proven low functional capacity using cardiopulmonary exercise testing. The hypothesis for this trial being 'that the implementation of a multimodal, multidisciplinary prehabilitation program over two-four weeks, consisting of physical exercise, nutrition, anaemia correction, and smoking cessation, will result in Lower CCI (Comprehensive Complication Index) within 30 days after major surgery in elderly patients. This, and other trials, will guide patient selection for prehabilitation, and help the economic arguments for funding prehabilitation services.

Better still would be a population with a healthy baseline, and where there is a need for preprocedural patient optimisation, being initiated at the time of specialist referral by the general practitioner. In the not-too-distant future, it may be that intraoperative artificial intelligence polyp detection at colonoscopy, or an AI health screening tool at the time of referral for a review and possible procedure may see a preemptive recommendation to commence prehabilitation on the likelihood of needing a major surgical procedure. A patient referred for consideration for joint replacement undergoes assessment at the time of referral, commences a GP-led multidisciplinary prehabilitation program, which is then reviewed and optimised by the perioperative team at the time of the booking/ request for admission for surgery. The targeted early commencement of prehabilitation has the patient optimised for surgery, and ready for care, avoiding preventable delays in patient preparation.

Better still would be a population with a healthy baseline, and where there is a need for preprocedural patient optimisation, being initiated at the time of specialist referral by the general practitioner.

Dr Michael Lumsden-Steel

EAC Chair

Australian Society of Anaesthetists®

On the road to becoming an anaesthetist? The ASA is here to support you at every step of your journey.

Join Now

www.asa.org.au

Contact the Membership Team 1800 806 654 membership@asa.org.au

TRAINEE MEMBERS GROUP COMMITTEE

NSC UPDATE AND PREHABILITATION

DR JASON KONG
TMG CHAIR

The ASA National Scientific Conference was recently run in October. Our trainee lunch was attended by a vast array of international leaders in anaesthesia, and this was a fantastic opportunity to learn and network with our colleagues from here and abroad. We hope that the trainee members that attended had a great time, and we encourage you all to attend next year. Within the scientific program, there were a couple of sessions on perioperative medicine and prehabilitation which is something I'm quite passionate about and happens to also to be the focus of this edition of this magazine.

Prehabilitation isn't something we get exposed to all that much as trainees. A lot of our training focuses on the technical aspects – how to give the anaesthetic, how to manage the crisis, and how to assess and optimise a patient's medical co-morbidities perioperatively. The breadth of the curriculum can seem so expansive as you're going through training, and we focus so much on learning how to give the anaesthetic, it can be hard to spend any time thinking about the role that our allied health colleagues can play in patient outcomes, and even harder to accept that perhaps, just maybe they could play an even more important role in long-term outcomes than we do. Let me explain.

There is a common misconception amongst patients that when they are about to have surgery, they need to rest. We recently had a 60-year-old patient having an Ultra Low Anterior Resection (ULAR) and transverse colectomy, which was going to take eight hours. He was smoking 15 cigarettes a day, drinking six standard drinks a day, eating a carb-heavy, protein-poor diet, and also very anxious about his surgery. Since finding out about his surgery, he had been 'actively resting' to prepare for his surgery and had avoided physical exertion for about two weeks. Now imagine an identical patient but were able to get to him a couple of weeks earlier, get him to cut down on smoking and alcohol, get him to do some good physical training, get him on a protein rich diet, and educate him on the journey we expect him to take, and get him into a clear and determined mindset.

You might reasonably expect that these two patients would take very different clinical trajectories. The motivated and well-trained patient is more likely to get out of bed more, be more active, and get back to daily activities faster. A patient that is engaged and educated is also more likely to be satisfied with the clinical journey. The clinical and health economic benefits have been observed in a number of Australian public hospitals which have embedded prehabilitation and Enhanced Recovery After Surgery (ERAS) into their clinical armamentarium.

Health economics aside, we see an ever-aging population of patients, and the issue of long-term functional outcomes in the context of advancing age is another issue. We expect most of our elective patients to maintain independence, and to be able to walk after their surgery. But what about running, jumping, or lifting? What about being able to play the sport that they love? I recently met a 70-year-old man, five years post radical prostatectomy for prostate cancer. Prior to diagnosis at 65, he was an ironman competitor. Now, he was ambulating with a walking stick. A successful cancer treatment, but less than ideal functional outcome. Patients will often tell you (the ones that have had a major surgery), that it was a major life-changing event. To me, the biggest potential for prehab and ERAS relates to long-term functional outcomes and quality of life. Maybe we can set the bar for recovery high, and help people who were running, jumping, and lifting before their operations to do this again after their surgery.

For those that question whether this is possible in an elderly population, it may amaze you to discover the world of Masters Athletics. The men's marathon record for the 80-85 age group is three hours 15 minutes and 54 seconds, and the record for the 10 kilometre is 42 minutes and 39 seconds. There are also events in the over 80 age group in long jump, hurdles, and a number of strength sports as well, and these records are comparable to the kinds of numbers that I can lift. I'm also reminded of the Japanese Masters Sprinter, Hidekichi Miyazaki, who (according to some admittedly unreliable sources) started training for running at the age of 90, after falling ill with pneumonia and becoming reliant on a wheelchair for mobility. At the age of 105, he ran a 100-metre sprint in 42.22 seconds. At 108 years old, he died quickly of a subarachnoid haemorrhage.

I'm not saying all of our 80-year-old patients are capable of running a marathon, but the point I'm trying to make is that as perioperative physicians, for us to be doing right by our patients, we should also be thinking about the kind of function our patients want to maintain (or obtain, for that matter), and help them navigate a path towards that. I hope that by reading this article, this might inspire you as trainees to start thinking about your patient's long-term functional outcomes, and not just how to give the anaesthetic and manage pain postoperatively.

Dr Jason Kong

TMG Chair

Australian Society of Anaesthetists®

ASA Trainee Members

Apply for our 2024 international scholarships

A great opportunity for our Trainee members…

$5K*

CANADIAN ANESTHESIOLOGISTS' SOCIETY

Destination

VICTORIA, BC

Date

7–10 JUNE 2024

ASSOCIATION OF ANAESTHETISTS

Destination

GLASGOW, SCOTLAND

Date

27–28 JUNE 2024

AMERICAN SOCIETY OF ANESTHESIOLOGISTS

Destination

PHILADELPHIA, PENNYSLVANIA

Date

18–22 OCTOBER 2024

Attending an overseas conference may seem out of reach for some, but what an amazing opportunity! Each year the ASA awards a scholarship to three ASA Trainee Members to attend the annual meeting/ conference at one of our participating overseas Societies.

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

Available exclusively to ASA Trainee Members who have been financial members for 12 months prior to their CIG application. Each scholarship is valued at $5,000 to cover cost of airfares and accommodation.

AROUND AUSTRALIA

New South Wales

Dr Simon Martel

Chair of the New South Wales Committee of Management

The NSW Committee has made a submission to the Special Inquiry into Health Care Funding. Thank you to those members who submitted feedback via our survey. The ASA remains concerned with the origins of the inquiry, and possible risks it presents given the attacks in the media on our profession by other groups such as the Health Services Union and the NSW Treasurer. We have taken the opportunity to correct those misrepresentations and provide solutions to improving health care funding in NSW and await the next phase of the inquiry.

In late August, we held a meeting involving the Australian Medical Association (AMA) and various professional societies. The discussion revolved around the Special Commission and the ongoing issues with Public in Private healthcare. These collaborative meetings are important to sharing and hearing the various specialties' opinions on current issues in healthcare and informing our own decisions.

We have also successfully submitted our input to the Operating Theatre Efficiency Clinical Practice Guide Consultation. We provided feedback on several issues, including our concern regarding the emphasis on improving efficiency using anaesthetic bays to induce patients whilst another patient is anaesthetised in the theatre and comments regarding the cost of building anaesthetic bays into a theatre footprint, and the wording of some metrics which were unfriendly to anaesthetists. Early input in these processes is important to ensure guidelines don't adversely affect the safe and efficient practice of anaesthetists.

Further, in improving patient care and anaesthetic outcomes in public hospitals, I'd like to acknowledge the unwavering support of our CEO, Dr Matthew Fisher, and the secretariat team, for our staff specialists at the Children's Hospital Westmead (CHW). The ASA has been supporting the advocacy of its members at the CHW to ensure that there is sustainability of staffing and the ability to continue to provide the great, complex care required by the community. The ASA is committed to assisting both staff specialist and VMO anaesthetists. If you have specific inquiries or need further details, don't hesitate to reach out to ASA's policy team at policy@asa.org.au.

Finally, the ASA held another successful ACT/NSW Virtual Part Three Course on the 25th of November. Designed for trainees who have completed their Part Two exam and are soon transitioning to consultant practice, this course offers non-clinical advice and guidance in commencing a career in anaesthesia. Congratulations to those members who will soon be finishing training. Remember the ASA is a fantastic resource for your ongoing professional work, both in public and private practice.

Queensland

Dr Graham Mapp

Queensland Committee of Management

Great catching up with all Queenslander Fellows and Trainees at the National Scientific Congress and having the opportunity to discuss issues affecting Queensland anaesthetic life. Health funds, hospital accreditation, workforce, and anaesthetic alternate providers i.e., nurse practitioners, inflationary pressures on practice and payroll tax.

The QLD Revenue Office (QRO) has released an updated payroll tax public ruling for medical centres that clarifies financial entities that could be liable for payroll tax. Of course, seek legal advice for your individual practices.

By the time this report is published, Queensland Health may have provided an update to QScript and the desired exemption for in hospital prescribing. The QScript login experience has been updated and is outlined on the QScript website.

The Queensland Committee of Management supported trainees by sponsoring exam viva nights at Princess Alexandra Hospital and Sunshine Coast University Hospital in October. The Part Zero date for 2024 will be 10 February. We will host a social event to follow so wait for details but mark it in your calendars.

The Queensland Committee is always happy to discuss issues affecting members so please contact us via the ASA HQ. We hope you have a wonderful Christmas/holiday and happy 2024. Stay safe!

Australian Capital Territory

Dr Vida Viliunas OAM

Immediate Past Chair of the Australian Capital Territory Committee of Management and ASA Vice President

North Canberra Public Hospital

The most disruptive event for anaesthesia and hospital services in the ACT was the compulsory acquisition of the North Canberra Public Hospital (the hospital previously known as Calvary Bruce) in July 2023. Most anaesthetists' concerns relating to working conditions, benefits, indemnity, and other uncertainties have now been settled.

Full services in the North Canberra hospital have still not resumed after the fire in one of the operating theatres in December 2022.

Digital Health Record

The introduction of the Digital Health Record in the public hospital system in 2023 was not without teething problems. Though many initial difficulties have been sorted, the training remains onerous, particularly for locum service providers.

Public in Private

Public in private work has been managed reasonably well in the ACT relative to conditions in other jurisdictions.

Canberra

Successful registrar welcomes, social gatherings and committee meetings remain part of our successful calendar of activities. The Art of Anaesthesia conference was a standout this year – with record attendance, happy trade and delegates who got the opportunity to meet with colleagues. Plans are well underway for the Canberra NSC in 2025!

New leadership team

From the ACT ASA AGM in November, I have handed over to a new leadership team. Congratulations to Dr Girish Palnitkar, Chair and Dr Valerie Quah, Deputy Chair.

South Australia / Northern Territory

Dr Sophia Bermingham

Chair of the South Australia / Northern Territory Committee of Management

I am pleased to introduce myself as the Chair of the South Australia and Northern Territory Committee. I'd like to take this opportunity to thank the outgoing Chair, Dr Tim Donaldson, for the leadership and hard work he displayed during his tenure. For background, I graduated from the University of Melbourne and completed my anaesthesia training at Alfred Health in Melbourne. In 2016 I returned to my hometown of Adelaide, and I now enjoy working in public at SALHN and in private as a Pulse Anaesthetics associate. I enjoy a wide range of clinical anaesthesia, and I have particular interests in healthcare leadership and wellbeing.

Support

One issue I wish to draw your attention to is the ongoing challenge that is public in private (PIP) work. We have recently been notified of a communique from Calvary Care regarding a significant reduction in remuneration rates for PIP work (down to BUPA rates). The ASA has been clear in our support of appropriate and safe care for these patients. We have offered guidance regarding the perioperative journey, sharing of information and remuneration for PIP work. Unfortunately, our offers of assistance have largely been declined in South Australia. We have met with the chairs of the private practice groups in Adelaide and have plans to further represent your interests with relevant stakeholders. This situation presents a real opportunity for our membership and committee to set an appropriately remunerated, clinically safe, and administratively secure PIP program going forward.

Social Event

My sincere gratitude to Dr Bec Madigan for organising our fabulous annual Bright Young Things social event at Whistle and Flute on Saturday 21 October. It was great to see lots of familiar and new faces at our event. It also provided attendees with the opportunity to speak to the new Federal ASA President, Dr Mark Sinclair who outlined all the important work the ASA is doing to look after anaesthetists!

Represent

Alongside the Australian Medical Association (AMA), the SA/NT ASA Committee are investigating and speaking with those who set the Return-to-Work SA rates which have not been indexed in almost 15 years. Thanks to Dr Tim Donaldson, Dr Tristan Adams, and the AMA for their hard work in this area. We will keep you updated on any progress.

Educate

We direct you to the ASA PIP guideline that can be found on our website (ASA PS23 - Anaesthetists and Public-in-Private Surgery). For those of your colleagues who aren't members this is a good time to refer them for ASA membership so they can be included in our discussions and ACCC collective bargaining exemption.

I am also in awe of our senior and junior trainee representatives, Dr Julia Rouse, and Dr Mila Sterbova respectively, who have been tirelessly organising both our Part Zero and Part Three courses for trainees. I am looking forward to attending the next Part Three Course in Adelaide on Saturday January 20, 2024. I also want to say thank you to Dr Rouse as she steps away from being a trainee representative and wish her all the best for her Fellowship in Sydney. It also gives me pleasure to welcome Dr Evelyn Timpani to our team as the Junior ASA Trainee Representative.

Next year the ASA National Scientific Congress will be held in the beautiful city of Darwin from September 6-9. I want to encourage everyone to start booking flights and annual leave, as it is bound to be a spectacular event! I wish the Convenor Dr Brigid Brown, Scientific Convenor Dr Indy Lin, and the whole committee all the best for the coming months of meticulous planning.

PATRICIA COYLE

RSCJ, AO, BSC (MED) 1959, MB, BS 1960, DIP MED TROP (ANTWERP), DIP PAST THEO (CANADA), FANZA, FRCA

27/10/1929 - 3/10/2023

Patricia was born in Sydney on 27 October 1929, the only daughter of Charles and Hazel Coyle, and sister to Geoffrey and Dennis. Her schooling was in Bondi Beach and Woollahra Public Schools for primary, and Sydney Girls High for secondary. She left school aged 15 and worked at the Peters Ice Cream factory in the office. She became interested in laboratory work and after some training at Sydney Technical College, moved into the factory's laboratory for about three years and then to the Royal North Shore Hospital Pathology Department in 1950. Being attracted to medicine as a career she studied privately for the Leaving Certificate and matriculated on her second attempt.

She enrolled at Sydney University in 1953, gaining her B Sc (Med) in 1959 followed by her MBBS in 1960. During some of her years as a medical student, she was a resident at Sancta Sophia College which was possibly her first contact with the Society of the Sacred Heart. Following her internship at Royal Prince Alfred Hospital, she did a few GP locum jobs. Patricia then entered an international Catholic religious order, the Society of the Sacred Heart of Jesus. Patricia was a woman of few words, particularly about herself, so we know nothing about how she was drawn to religious life nor of her decision to enter the Society of the Sacred Heart. She enjoyed teaching Science in the Congregation's schools in Australia and New Zealand.

In 1961 she travelled to England to join the novices at Woldingham. She had to find her own way there, so went as a ship's doctor. She returned to Sydney to continue her noviceship at Rose Bay making her first vows in 1963. At that time in the Society practising as a doctor was not possible and Patricia spent three years teaching science at Rose Bay, then another couple of years teaching at Baradene College in Auckland. She then travelled to Rome in preparation for her Final Vows. After final profession at the Society's HQ in Rome in 1969, she studied pastoral theology at the University of Montreal 1969-70.

In 1971, following Vatican II, which relaxed the rules on religious orders, she was allowed to resume medical practice. Several updating hospital jobs in Auckland changed her plans from a possible vocation in Psychiatry to one in Intensive Care. She trained in anaesthesia in hospitals in Auckland and in Sydney, including terms at Royal Alexandra Hospital for Children, St Vincent's Hospital and Lidcombe Hospital, qualifying for the F.F.A.R.A.C.S. in 1977. She became a Staff Specialist at Lidcombe Hospital and was involved in their ICU.

Patricia was asked by the congregation to work in Africa. She prepared for this with study at the Institute of Tropical Medicine in Antwerp, Belgium, gaining the Diploma of Tropical Medicine in 1981. She was sent to work in Uganda which was under the leadership of Idi Amin. She worked for the Ministry of Health and Makerere University. She established a University Diploma in Anaesthesia and a Master of Medicine (Anaesthesia). She left Uganda after the first Ugandan specialists graduated in 1989. (There were two further visits to Uganda in 1992 and 1997 as a lecturer and anaesthetist.) Six months were spent in London studying philosophy and African medical anthropology before returning to medical practice in Sydney.

Patricia died on 3 October 2023 at Mount St Joseph's Home, Randwick, aged 93. Her career and life is held in awe by those who knew her.

In 1991 she went again to Africa, to Ethiopia this time, at the Black Lion Hospital in Addis Ababa as a specialist anaesthetist and spent six months training post-graduates. This was followed by two three-month tours of duty with the International Red Cross in war surgery teams – at Khao-I-Dang on the Thai-Cambodian border and at Quetta in Pakistan in 1993. These experiences initiated her commitment to the International Campaign to Ban Landmines. Her last overseas work was as a specialist anaesthetist with Medicins-Sans-Frontiers in East Timor for three months in 1999. On return to Sydney, the last six years of her practice saw a gradual transition from anaesthesia to emergency medicine, mainly at Lidcombe Hospital. She also spent some years as a tutor at the University of Sydney in the Medical post-graduate program and teaching undergraduates an elective course in Hospital Practice in the Developing World which proved very popular.

Patricia's work was recognised by the award of the Pask Certificate of Honour by the Association of Anaesthetists of Great Britain and Ireland in 1984. She was granted Fellowship of the Faculty of Anaesthetists of the Royal College of Surgeons (now the Royal College of Anaesthetists) in 1988. In 2001 she was appointed Officer of the Order of Australia for her service to the community, particularly humanitarian aid overseas.

In retirement from clinical work, Patricia maintained an active interest in appropriate medical technology and in other aspects of medical practice in the developing world. She used the gifts she had been given for the service of those in need. She remained involved with the Australian Network of the International Campaign to Ban Landmines. She was awarded honorary membership of the ASA in 2001. She also served on its History of Anaesthesia Library, Museum and Archives (HALMA) Committee in 2009. Her last few years were marked by the development of dementia which required nursing home care. She died on 3 October 2023 at Mount St Joseph's Home, Randwick, aged 93. Her career and life is held in awe by those who knew her.

Dr William Herlihy

References:

1. Eulogy. Sister Diana Hayes RSCJ, personal communication
2. UniversityofSydneyOnlineMuseum: https://www.sydney.edu.au/medicine/museum/mwmuseum/index.php/Coyle,_Patricia_Margaret
3. ASA Audio Archives: Patricia Coyle interviewed by Dr Ross Holland (2000)

IN MEMORIAM

The ASA regrets to announce the passing of ASA members Dr Michael Kister, Dr Daryl Salmon, Dr Peter Beahan and Dr John Henry Williamson, AM, OS&J.

Australian Society of Anaesthetists®

ASAEd

Learning Resource Hub

GET INSPIRED | GET INFORMED | GET EDUCATED

About ASAEd

ASAEd is a place where ASA's Fellow and Trainee members can find professional resources for all facets of anaesthetic learning.

Here you have access to quality resources wherever and whenever you need it.

WEBINARS

Access our past webinars focusing on topical anaesthetic issues.

NEW FELLOW

Resources to support transition from trainee to specialist anaesthetic practice.

TRAINEE

Resources to support ASA Trainee Members in their anaesthetic training.

PODCAST

Find up-to-date educational podcasts recorded by Dr Suzi Nou.

www.asa.org.au/asaeducation

YOUR DESTINATION FOR YOUR EDUCATIONAL RESOURCES

ASA NSC 24 DARWIN

6 – 9 SEPTEMBER

Engaging Enhancing Evolving

#NSC24

SAVE THE DATE

6-9 September 2024

Key Dates of Congress

Call for Abstracts Launch
Monday 4 December 2023

Deadline for Submission of Abstracts
Friday 31 May 2024

Authors Advised of Submission Result
Friday 12 July 2024

Darwin NSC Congress Dates 2024
Friday 6 September – Monday 9 September

www.asansc.com.au/2024

Darwin Convention Centre
Darwin, Australia

Australian Society of Anaesthetists®