AUSTRALIAN

# Anaesthetist

THE MAGAZINE OF THE AUSTRALIAN SOCIETY OF ANAESTHETISTS • **MARCH 2024**

THE ANAESTHETIC PRIMARY EXAM: A JOURNEY OF PREPARATION

THE REAL WORLD ANAESTHESIA COURSE

THE RESEARCH DREAM

PREPARING FOR A FELLOWSHIP OVERSEAS

COVID PREPAREDNESS

Australian Society of Anaesthetists®

Australian Society of Anaesthetists®

# 2024 marks **90 years**

of the Australian Society of Anaesthetists.

Join us in honouring the **past,**
celebrating the **present**
and embracing the **future.**

Learn more about our first ninety:

www.ourfirst90.asa.org.au

**Our first** 90 **years** 1934-2024


# Cyber security 101 for businesses

Hack attacks, ransomware and phishing are just some of the cybercrimes against small businesses that can expose them to data theft, extortion or even business failure. There are many steps businesses can take to reduce these risks and potential damage in the event of an attack.

There are lots of different ways criminals attack businesses online. The Australian Cyber Security Centre (ACSC) has categorised the three main cyber threats small businesses face as malware, phishing scams, and ransomware.

## Top tips to stay safe online

Prevention is always the best form of protection. Here are some quick wins to help keep yourself and your business safe.

- Turn on automatic software updates – this helps to patch up vulnerabilities and the automatic updates mean you don't have to think about them.
- Cyber training – teach your team how to identify common cyber scams, such as phishing emails.
- Use anti-virus software – this helps protect your data from malware.
- Secure your devices – Use locks or encryption, and regularly back up your files.
- Avoid public wifi – use a secure connection, as information can be easily intercepted on public wifi.
- Regularly back up devices – recovering data can be expensive, so make sure you have your up-to-date documents backed up.
- Switch on multi-factor authentication – provide two or more proofs of identity for better security.
- Use passphrases rather than passwords – these are easier to remember and harder to crack.
- Create a Cyber Incident Response Plan – don't wait until it's too late to create a contingency plan for your business.

## Should your business consider cyber insurance?

Today, every business is supported by a digital backbone. Which means all Australian firms are at risk of criminal cyberattacks. Cyber insurance offers businesses a level of protection to mitigate the effects of a cyber breach or attack. So, while prevention and practicing cyber safety is crucial, it also pays to take out insurance, so your business can better restore its operations if it falls victim to an attack.

## Cyber cover in action: case study

A medical practice was the subject of a ransomware attack, in this hypothetical example. The criminals encrypted the network data, locking the business out of its system and disrupting normal operations. Sensitive client data was compromised in the process.

The medical practice had taken out cyber insurance, so it was covered for the cost to forensically investigate the breach, the legal costs associated with prosecuting the criminals, as well as paying for the funds to settle customers' claims. The insurance policy also met the costs associated with notifying government bodies and regulators of the breach.

While prevention is better than cure when it comes to cybercrime, having insurance cover in place meant the business was able to appropriately defend the attack and recover from it. ■

### YOUR BROKER CAN HELP

Don't risk waking up one morning to find cyber criminals have locked your business's IT systems. Talk to your broker today about how we can help mitigate the risk of cyberattacks stopping your business in its tracks. Contact AMA Insurance on **1800 262 346** or **insurance@amainsurance.com.au**.

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

## Contents



### Would you like to contribute to the next issue?

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

- Intention to contribute must be emailed by 20 April 2024
- Final article is due no later than 25 April 2024

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

# ASA ADVOCACY UPDATE

## Three new RVG items from 1 March 2024

As a result of ASA Advocacy to the Department of Health (the Department), three new Medicare Benefits Schedule (MBS) items 22052, 22053, and 22054 will be added into the Relative Value Guide (RVG) from 1 March 2024.

These new RVG items will allow patients to access MBS benefits for services they receive while under anaesthesia.

## ASA advocacy

Anaesthetists have been unable to co-claim items outside of the Anaesthesia Relative Value Guide Section of the MBS (Cat 3, Group T10, Subgroups 1-25) from mid-2022 because of amendments to MBS Note TN.10.8 which removed the following paragraph:

> **"Where an anaesthetist provides an additional (clinically relevant) service during anaesthesia that is not one listed in Subgroup 19 (excluding intravenous infusion or electrocardiographic monitoring) the relevant non-RVG item should be claimed."**

The Department referred to Section 16 of the Health Insurance Act which states: A Medicare benefit is not, except with the approval of the Minister, payable in respect of the administration of an anaesthetic in connexion with a professional service unless the anaesthetic is administered by a practitioner other than the practitioner who renders the professional service in connexion with which the anaesthetic is administered."

ASA made as submission to the Department to replicate 10 items that were identified as anaesthetists co-claiming with anaesthesia, but not contained within the Anaesthesia section of the RVG of the MBS (Category 3, Group T10, Subgroups 1-25.) The Department has now approved three items for replication in the RVG.

## What are the changes?

Effective 1 March 2024, there will be three new items added into group T10 subgroup 19 of the RVG. These three new RVG items replicate existing GMST items 13703, 40018 and 55135:

- Item 13703 (for blood transfusion services) will be replicated into the Anaesthesia RVG section as item 22052.
- Item 40018 (for the insertion of lumbar cerebrospinal fluid drain) will be replicated into the Anaesthesia RVG section as item 22053.
- Item 55135 (for real time transoesophageal echocardiograph) will be replicated into the Anaesthesia RVG section as item 22052 item 22054.

The MBS will be updated with co-claim restrictions being introduced into items 13703, 40018 and 55135 to prohibit them from being claimed together with items 22052, 22053 and 22054 respectively.

## How will these changes affect patients?

Anaesthetists have been unable to claim MBS items 13703, 40018, and 55135 since 1 March 2022. From 1 March 2024, anaesthetist can now claim for 22052, 22053 and 22054 and patients will receive a Medicare and Private Health Insurance rebate for these new services.

## New item descriptors (to take effect 1 March 2024)

**Category: 3. THERAPEUTIC PROCEDURES**

**Group: 10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service**
**Subgroup: 19. Therapeutic And Diagnostic Services**

**22052**

Transfusion of blood by an anaesthetist, including collection from donor, when used for intra-operative normovolaemic haemodilution, where the service is provided on the same occasion as the administration of anaesthesia by the same anaesthetist, other than a service associated with a service to which item 13703 applies
**(6 basic units)**
**Fee: $130.80 Benefit: 75% = $98.10 Benefit: 85% = $111.20**
**Private Health Insurance Classification:**
**Clinical category: Support List**
**Procedure type: Unlisted**

**22053**

Insertion of lumbar cerebrospinal fluid drain, by an anaesthetist at the request of the treating specialist, where the service is provided on the same occasion as the administration of anaesthesia by the same anaesthetist, other than a service associated with a service to which item 40018 applies
**(6 basic units)**
**Fee: $130.80 Benefit: 75% = $98.10**
**Private Health Insurance Classification:**
**Clinical category: Support List**
**Procedure type: Unlisted**

**22054**

Intraoperative two-dimensional or three-dimensional real time transoesophageal echocardiography by an anaesthetist, where the service:

a) is provided on the same day as a service to which item 38477, 38484, 38499, 38516 or 38517 applies; and
b) includes Doppler techniques with colour flow mapping and recordings on digital media; and
c) is performed during cardiac valve surgery (replacement or repair); and
d) incorporates sequential assessment of cardiac function and valve competence before and after the surgical procedure; and
e) is not associated with a service to which item 21936, 22051, 55118, 55130 or 55135 applies; and
f) is provided on the same occasion as the administration of anaesthesia by the same anaesthetist

**(18 basic units)**
**Fee: $392.40 Benefit: 75% = $294.30**
**Private Health Insurance Classification:**
**Clinical category: Support List**
**Procedure type: Unlisted**

DR MARK SINCLAIR
PRESIDENT

# FROM THE ASA PRESIDENT

**WELCOME TO THE FIRST EDITION OF *AUSTRALIAN ANAESTHETIST* FOR 2024, THE YEAR IN WHICH WE CELEBRATE THE 90TH ANNIVERSARY OF THE ASA, AFTER ITS FOUNDING IN HOBART ON 19 JANUARY 1934.**

You can keep up with our plans for celebrating our 90th at www.ourfirst90.asa.org.au. The 90th Anniversary Dinner will be held at the National Museum, Canberra, on Thursday June 27. Both Houses of Parliament will be sitting that week, and the week after, and we will be extending invitations to our representatives to attend. We also have a roundtable meeting booked in Canberra on Thursday March 28, which is at the end of the March sittings of both Houses. We are most grateful to Dr Mike Freelander MP (Paediatrician, Federal Member for Macarthur, NSW) for agreeing to host the event, which is intended to address Australia's health workforce needs, through the Parliamentary Friends of Medicine. This group aims to provide a non-partisan forum for parliamentarians to meet and interact with stakeholder groups on matters related to medicine. It is Co-Chaired by Dr Freelander and Dr David Gillespie MP (Gastroenterologist, also Diploma of Anaesthetics UK, Federal Member for Lyne, NSW). Representatives of other specialist medical societies and associations will also be present.

At the time of writing, the Australia Day 2024 Honours List has just been released. We warmly congratulate three ASA members who were recognised for their contributions to the Australian community.

At the time of writing, the Australia Day 2024 Honours List has just been released. We warmly congratulate three ASA members who were recognised for their contributions to the Australian community.

Dr Richard Bailey (NSW), after whom our Richard Bailey Library is named, has been appointed as a member of the Order of Australia (AM) in the General Division, for significant services to medicine in the field of anaesthesia, including his contributions to the ASA over more than four decades. Dr Bailey was awarded Life Membership of the ASA (our highest individual award) in 2009, for his many years of excellent service.

Dr Graham Grant (NSW) was appointed as an Officer of the Order of Australia (AO) in the General Division, for his distinguished contribution to biomedical engineering, and to medicine in general. Dr Grant is responsible for the development of numerous items of anaesthesia equipment over many years, including the Grant Humidifier and the Grant Respiration Assistor, as well as other healthcare devices and resources. He has also donated a number of items to our Harry Daly Museum (of which Dr Bailey was our Honorary Curator, 1990-2001).

The Honourable Dr Brian Pezzutti (NSW) was appointed as a Member of the Order of Australia (AM) in the General Division, for significant service to the Parliament of NSW, and to community health. Dr Pezzutti served in the NSW Legislative Council from 1988-2003. During that time, he served in numerous roles, including as a member of the Health Complaints Commission (1995-2002), the Mental Health Select Committee (2001-2002), the Hospital Waiting Lists Select Committee (1995-1997), and the Road Safety Standing Committee (1988-1991). He is a specialist anaesthetist and has been a member of the ASA for over 50 years.

The ASA also congratulates Dr Richard Harris on his appointment as Lieutenant Governor of South Australia. Dr Harris is well known for his amazing efforts in the rescue of 13 boys and young men trapped in a flooded cave in Thailand in 2018, and he was jointly awarded Australian of the Year along with his colleague Dr Craig Challen.

The theme of this edition of Australian Anaesthetist is "Preparedness". This is a concept with which we are all no doubt familiar, in a wide range of situations in our professional lives. As always, we are grateful to our members who have given up their valuable time to provide us with articles on this theme.

The theme of this edition of Australian Anaesthetist is "Preparedness". This is a concept with which we are all no doubt familiar, in a wide range of situations in our professional lives. As always, we are grateful to our members who have given up their valuable time to provide us with articles on this theme.

The ASA is very much looking forward to the 18th World Congress of Anaesthesiologists (WCA2024), being held in Singapore from March 3-7. I hope to see many of you there, supporting the organiser, the World Federation of Societies of Anaesthesiologists (WFSA), in its important work (www.wca2024.org). The Congress will be followed by a meeting of the Common Interest Group (CIG), which comprises the senior office bearers and executives of the anaesthesia societies and associations from the major English-speaking nations (Australia, Canada, New Zealand, South Africa, UK, USA). This meeting is held annually, rotating from country to country, and is typically attached to the major annual conference of the host society. This year it is the ASA's turn to act as host, and we decided to hold the meeting at the World Congress. As the name suggests, the purpose of the meeting is to discuss issues of common interest to anaesthesiologists from these nations, and it is certainly a valuable learning experience for all of us in attendance. Each nation has different health care systems, and many different issues can arise as a result. However, there are certainly many common issues faced, including what is currently being referred to here as enhancing the "scope of practice" of healthcare professionals, which may well be just another term for task substitution. I look forward to providing members with updates in the monthly e-news releases, as well as in future editions of Australian Anaesthetist.

Please enjoy your reading on the theme of "Preparedness" as well as our regular contributions from our hard-working ASA staff and committee chairs. Always keep in mind that this is, as ASA members, your magazine. We always welcome contributions from our members, be it letters, opinion pieces, or articles on any matter of interest to Australian anaesthetists.

**Dr Mark Sinclair**

MB BS, GAICD, FANZCA

# FROM THE CEO

DR MATTHEW FISHER
CHIEF EXECUTIVE OFFICER

# PREPAREDNESS FOR TRANSFORMATION AND ORGANISATIONAL EVOLUTION AS A CEO

The theme of this edition of the Australian Anaesthetist is preparedness. I will approach this from the perspective of a CEO coming into the ASA with its rich history of 90 years since 1934 and an article I was asked to write for other not-for-profit (NFP) leaders or aspiring leaders to consider.

So how do you prepare to be a CEO? Theoretically and practically, being a CEO is a demanding role that requires a wide range of skills and abilities to be successful particularly if you (and your family) want to remain sane and enjoy the ride. Some of the essential skills as part of a rounded skill set include strategic planning and execution, communication, leading and motivating a team, problem-solving and decision-making. These capabilities are common to many roles that have greater or lesser complexity and impacts, which we continually hone.

As John F Kennedy remarked in 1963, "Change is the law of life. And those who look only to the past or present are certain to miss the future". On reflection, I think that I have learnt more about myself and others in the almost 23 years as a CEO in three companies and as an on and off director at four organisations in a not dissimilar time frame. Who grows up wanting to be a CEO or director when considering life's journey? I didn't, but it has and continues to be a rewarding ride given there has always been a for purpose aspect of professional success and the organisations that I have had the privilege to be with. Those experiences, formed through successes and failures, have been the preparedness for my role with the ASA.

So, what are some of the reflections based on preparedness? My role with the ASA has become a match at many levels – values, contribution to the public, opportunity to develop and evolve a business, and the opportunity to influence performance into the future. Under the direction of the Board, we have embarked on a systems review to focus on your experience and engagement with the ASA and increasing the capability of the professional staff to act in your collective interests. This is a legacy perspective.

Transformation has many parts to it at the CEO level of a membership organisation and there is certainly a strong platform at the ASA and an organisational willingness to evolve. Preparedness to act effectively within agreed parameters has been based on being curious and asking a series of questions: Has the Board got a sense of where it wants to lead the organisation and membership to and does the governance structure enable that? What is the culture of the organisation and is it reflective of the role the members have in Society? What is the internal culture of the organisation? Do the staff share the same values and culture plus do they understand the shoes the member walks in? Is the organisation well-resourced and is the operational platform fit for purpose? Does the structure enable success to be achieved and do you have the right people with the rights skills and attitude?

Some of the essential skills as part of a rounded skill set include strategic planning and execution, communication, leading and motivating a team, problem-solving and decision-making.

Transformation has many parts to it at the CEO level of a membership organisation and there is certainly a strong platform at the ASA and an organisational willingness to evolve

What is the operational environment of the organisation and how expansive is the sphere of influence?

Transitioning into and transforming an organisation is an energising and consuming life event. Distilling this down further, it has been important for me to build relationships and gain context to determine how I can add the most value and what is the timeframe for achievements along the simple to complex continuum of achievement. Remaining open minded and reassessing direction and performance is essential in enabling informed decision making. Clear, consistent communication will help set the platform of expectation.

Our current preparation for 2024 began in late 2022 and has also responded to opportunities along the way. Some of the key initiatives include our efforts to anchor anaesthetists as a forethought in healthcare delivery rather than an afterthought in the minds of policy makers and service delivery planners is well advanced. The IT platform to take the operations of the ASA into the future and improve your interactions with us will go live in the first half of the year. Our engagement with governments and other environmental 'shapers' continues to advance as does our work with members in the public sector. As we progress through our 90th year, I hope that we can all reflect on the collective achievements of past and present to ensure that we are well prepared for the future.

**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

# 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 Operations Manager, Suzanne Bowyer at committees@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**

# THE ANAESTHETIC PRIMARY EXAM: A JOURNEY OF PREPARATION

I'M BEGINNING A JOURNEY THAT HAS BEEN DESCRIBED TO ME BY THOSE WHO'VE UNDERTAKEN IT AS HORRIBLE, INTIMIDATING, AND A BURDEN ON MYSELF AND MY LOVED ONES. AND THAT I'M ABOUT TO ENTER, AS MANY REGISTRARS HAVE DESCRIBED IT, 'THE SH*TTIEST YEAR OF MY LIFE': THE ANAESTHETIC PRIMARY EXAMINATIONS. WOW. WHAT A WAY TO SELL THE BEGINNING OF MY ANAESTHETIC JOURNEY!

**This article is on how I'm preparing for this intimidating hurdle which has tripped up many of my colleagues. It's purely an opinion piece, a reflection on how I plan to tackle the exam. It's certainly not a recommendation for my approach as I haven't sat the exam yet - I could do horribly!**

## Step one

is to seek advice from those around me. I've always found the best and most knowledgeable people to offer advice on a challenge are the ones who have just overcome it. It's illuminating to hear the different approaches people have taken; some used textbooks, others flashcards, some used online resources, and many used specialised computer programs. Seeking advice from a variety of sources provides an average – a median approach that seemed to be a recipe for success for most people, and one that I myself can utilise.

## Step two

on my journey has been planning, planning, and yet more planning. At present, I've allocated weekly topics for five months. I've done this utilising the advice of anaesthetic registrars and others' suggested schedules. It's a hefty plan, but it gives me a structure to work towards, and engages my sense of determination. It allows me to feel confident that, while this is a large undertaking, it can be overcome. If I stick to the schedule and cover the topics, then I'll finish the core content with enough time to revise it multiple times, allaying the fear I'll run out of time to cover everything. When my plan is on paper (or my laptop more accurately), it also provides something tangible to aim for rather than nebulous learning objectives provided.

I've always found the best and most knowledgeable people to offer advice on a challenge are the ones who have just overcome it.

## Step three

information gathering. Here an expression comes to mind: 'standing on the shoulders of giants'. I have been taken aback at the resources that are available for me to access. There's a plethora of websites, notes, and programs that people have put together. Many of these are significant undertakings that would have taken years of hard work and dedication to compile. And they come with regular updates to boot! While some are paid resources, the majority are free. This reflects the culture of generosity and 'passing it forward' that exists in many areas of medicine. Even at this early stage of my study, I know that if these resources didn't exist, as they don't for many other speciality examinations, then my journey would be significantly harder.

## Step four

is summarised in a phrase that I've heard frequently in the hospital environment: 'managing expectations'. For this exam it relates to two areas – my own expectations and the expectations of those around me. In regards to my own expectations, I am taking to heart that this is a difficult test. For many, it is the first major exam they fail. I have sat many tests, examinations, and interviews and done well in them. For the anaesthetic primary exam, I need to acknowledge there is a very real possibility of failure. Will I do everything in my power to prevent that? Yes. Does that mean it still won't happen? Unfortunately, no. Accepting this is part of my preparations. While I am aiming to not be disappointed, I must ensure that I keep myself sustainable, and realistic about the challenge ahead.

This ties in with managing the expectations of those around me. It's important to me that the people that are closest to me know that I'm sitting this exam and the time requirement it asks of me. This is particularly relevant because I'm in my late 20s, sitting an exam when most people my age have long left university and its associated tests. This can make it difficult for friends and family to appreciate my need to study. My plan is to address this issue early, so there's an understanding of why I may need to say no to some events.

## Step five

study group. Communal study is something that is new to me. While I enjoy the camaraderie of going through exams as a cohort, I've always been a solo studier. However, with strong advocacy for the benefits and with the enticement of joining a wonderful group of colleagues, I've joined a study group. And I've found it very rewarding. It's helped me identify areas I'm missing and where my deficits are. Most importantly, I'm enjoying sharing the experience with others. It's good to have people who can relate to the challenges and experiences I'm going through. The study group provides an important forum in which to express the shared frustrations, the trials and the tribulations.

## Step six

flexible attitude. When I was gathering advice, a common benchmark was espoused – it takes around 1000 hours to prepare for this exam. I found this time commitment very hard to appreciate, until I realised it was equal to more than six months' full-time work (with the traditional 40-hour Monday to Friday work week). This seems insane when every person sitting the exam will also be working full-time (with traditionally rostered registrar hours of 86 hours per fortnight). The maths doesn't appear to work out, and I began to understand the description 'the sh*ttiest year of your life'. How am I preparing for this onslaught of work? By being flexible and studying when I can. Nightshift can provide excellent study time. The hospital is quieter and there are generally less demands. This offers the opportunity to do a few hours of study. I myself am writing this article at 4am on a night shift at present. I'm a morning person, much preferring to wake up early, work, and have the evenings to myself. Acknowledging that this is not realistic for the commitments I'll have in the work/study year ahead is an adjustment I'm making, and trying to take on board.

Ultimately, studying for this exam, it's important for me to acknowledge to myself that I can't know everything. I can't predict everything. And most importantly I can't prepare for everything. But I'll do my best. I hope to overcome any hurdles the year throws at me and enjoy this first year of training, and to take this first step on my journey to being a specialist.

**Dr Tom Neal-Williams**

# PREPARING FOR A FELLOWSHIP OVERSEAS

**SO, YOU'RE CONSIDERING THE HUGE IDEA OF MOVING OVERSEAS FOR A FELLOWSHIP? PRETTY DAUNTING DECISION FOR MOST! THE THEME OF THIS EDITION OF AUSTRALIAN ANAESTHETIST IS PREPAREDNESS, SO I AM GOING TO FRAME THIS ARTICLE WITH THAT IN MIND, AND I WILL TALK LARGELY ABOUT HOW I APPROACHED THIS DECISION.**

For some context, I was in my Provisional Fellowship year when I made the decision to do a second fellowship, specifically in cardiothoracic anaesthesia. I had managed to convince my wife to move across the country to Western Australia so I could complete an aeromedical retrieval fellowship with the Royal Flying Doctor Service. But, to my surprise, my wife was the one who suggested I contemplate an overseas fellowship.

First step, get your family on board! They're a big part of any decision making process.

I looked overseas for a cardiothoracic anaesthesia fellowship, because by volume, even Australia's busiest centre is small by comparison. Many overseas centres measure their (e.g.) CABG case numbers in the thousands. I was mainly considering Canada and the United Kingdom. Canada for the potential adventure, and the UK because I'm British and so it would make the administrative process much easier.

Therein lies step two, where? I think this is where the 'big picture' comes into it. You won't always be working, so what will your life look like? Also, see Step 1; your family needs to have adventures too.

Now the when: a number of colleagues went overseas for their provisional fellowship year. Great idea, have a year abroad and come back as a fully fledged consultant then straight into consultant life. I have decided to go post fellowship

and have heard from others who did the same. Having a FANZCA after your name makes some of the health regulatory paperwork much easier. Pre-letters, an applicant needs to supply their entire medical working career, broken down by months in some cases, along with evidence. It has taken some of my colleagues over 7 months to hear back from the GMC (UK).

Another consideration for overseas fellowships is the medical year varies by country. UK starts in July, as does most of North America from what I can tell. They don't quite understand the February vs August starts that we often talk in. But, for bigger centres at least, they are very flexible with start dates. Two of the fellowships I considered in the UK advised they can start a new position any time.

Another consideration for overseas fellowships is the medical year varies by country. UK starts in July, as does most of North America from what I can tell.

You've narrowed down the country, now which health service...? Google, talking to international colleagues, talking to other people who've done fellowships overseas in the past, Anaesthetic Fellowships (https://www.anaestheticfellowships.org/), and surprisingly, Facebook! The Fellowship Life Transplant group was an excellent resource. Researching your chosen institutions from both an anaesthetic and surgical perspective will help you to understand what the institution specialises in and whether it will suit your career plans.

Once you've identified a few health services, it's time to email. I cold emailed the department head, head of training/fellowships, or found the contact from the most recent fellowship job advert and emailed them. My initial contact didn't always get a response, but that seemed to be only when the contact was a different person. I got responses from all the places I emailed, which was quite reassuring. They were all very positive and very keen to have an Australian anaesthetist come and work with them.

Specific job applications vary by institution. When they get posted online also varies and many will advertise a few times a year. Most had an online form to complete with volume of information anywhere between your name and email address through to how many arterial lines, intubations and epidurals you had inserted. Be prepared for a reasonable amount of work. Interestingly enough, cover letters weren't as common as I expected, although I had written one for each of the places I applied. Equally, a number of the offers I received were just via reaching out with my resume and a brief cover letter. The job application component via the website was a "formality for HR".

In the UK there are two main websites, NHS Jobs and trac.jobs . I couldn't figure out which website would advertise which health trusts, so I set up alerts on both. If you don't have a GMC number when you apply if you're forced to enter one, the field doesn't seem to actually check it's real, I just put seven 1's and it would work.

In Canada, there was a requirement for a "Letter of Recommendation" which needed to be sent directly to the institution from your department director. There are some guides around about what these entail, but they're a bit more involved than "Dr so-and-so works with us as an anaesthetic trainee". Some oddities are: often need to include the amount of sick leave you've taken, what non-clinical roles you've had, and how much you contribute to the department in meetings.

I eventually picked the UK for my fellowship location, commencing later this year. I declined the Canadian offer because after speaking to some Canadian consultants I worked with (who emphatically steered me away) I decided it wouldn't be the best work-life balance. As a UK citizen, it would also be a lot easier to work over there.

If you have been following any of the current turmoil plaguing the NHS, you will know that the pay is in dispute. The NHS employs on a salary basis, not a wage. Overtime is rarely rewarded, but often expected. But, there are various loadings on the base salary that apply at all times which boost the base income. For example, the published 'base' rate for a fellow role is approximately 63,000 GBP, but after allowances it goes up to about 76,000 GBP. Obviously, a reasonable pay cut compared to most senior registrar/fellow positions in Australia, which when combined with the increased cost of living over there, begs a reasonable period of reflection.

In the end, my wife and I decided that a fellowship in the UK would be a bit of an adventure, good for my career and learning and it's probably the last time we'd seriously consider working overseas. Come August we'll be planning our first casual weekend trip to Europe.

This is obviously a very individual decision, that only you can make. My final recommendation is "Do your research!". For many of us, working overseas will be a significant challenge for many non-clinical reasons. Ultimately, no one I have met has ever regretted their decision. Make sure it's the right decision for you but also make sure your passport is ready.

**Dr Alexander Courtney**
FANZCA

# THE REAL WORLD ANAESTHESIA COURSE

*Imagine you live in a village in the foothills of a tropical country. Your husband works each day on the small family farm outside the village, and you manage the household and your six children. Your husband has a lump in his groin, which over the past few years has gotten bigger, and sometimes hurts when he carries heavy loads. One day he comes home from work early because the lump in his groin has become hard and very painful.*

*The next day he goes to visit the local healer, who gives him a herbal poultice to apply twice a day. Two days later the lump is still there, but now it is exquisitely tender to touch. You both set off in the bus for the six-hour journey to town where there is a hospital. Your husband is confused, pale, and sweaty, and he groans whenever the bus bumps on the uneven road.*

*At the hospital, the surgeon says your husband needs an operation to repair his hernia, but you must pay before he will operate. You give the hospital all your savings and some money you borrowed from family. After three hours the surgeon and anaesthesia provider come out to tell you that your husband is dead. Sobbing you ask what happened. The anaesthesia provider shrugs "Your husband was not strong enough for the surgery, his heart stopped".*

*Heartbroken you return home, but now you struggle to pay your debts. You take your oldest son of twelve out from school to help run the farm, and decide your eldest daughter must marry as soon as she is of age.*

In 2015 the Lancet Commission on Global Surgery found that over five billion people lacked access to safe, affordable, or timely surgical care. The scenario above is a composite of several real-life patient stories. Deaths attributable to surgical disease each year are greater than those due to HIV, TB and malaria combined, yet historically surgical disease as a global health issue has received much less funding and public attention. Safe surgery is an indispensable part of basic health care provision, and safe anaesthesia plays an integral part. Obstetric, Anaesthesia and Surgical providers are critically lacking in numbers worldwide to provide for the workload of procedures needed for basic lifesaving treatments such as caesarean section, laparotomy, and open fracture fixation. Moreover, in many low- and middle-income countries anaesthesia care is administered by non-physician anaesthesia providers, a significant proportion of whom do not have access to either standardised training or ongoing professional development and oversight.

The Real World Anaesthesia Course (RWAC) is a five-day program for anaesthetists held annually in either Australia or New Zealand. It was established in 2004 and is organised by a group of anaesthetists with a passion for global health and a wealth of experience of anaesthesia in the 'real world', that is to say the majority world. It recognises that the anaesthesia we perform in Australia and New Zealand with TIVA pumps, ultrasounds, unlimited oxygen supplies, highly trained physician providers and assistants, high tech anaesthesia machines, plenum vaporisers, TOE probes and such, is not the anaesthesia that most of the world has either training in or the resources to perform. As part of the global anaesthesia community we have a responsibility to support our colleagues in less resourced environments, whether through education and training or working alongside them, and the RWAC has the goal to educate, equip, and inspire the participants to this task.

And thus it was that I found myself waiting for the team bus just before 6.30am on a warm Darwin morning in October, surrounded by strangers – 16 participants from all over Australia and New Zealand, and teaching faculty from as far away as England and Nepal. Over the next five days we would become friends and share some inspiring and challenging conversations during the course and the social events that followed.

The course was held at the Royal Darwin Hospital, and convened by Dr Phil Blum. One particular strength of this course is the practical opportunity to learn drawover anaesthesia and provide anaesthesia to consenting patients in the operating theatres. I'd like to thank the staff and patients of the Royal Darwin Hospital for their generosity in allowing us to both observe and perform drawover anaesthesia for five sessions that week. We were thoroughly educated on the Diamedica DPA-02 system, from how to assemble it and troubleshoot common problems, to how to use it to safely provide anaesthesia. Benefits of this system are that it is compact, easy to understand and clean, and can be used with room air or low-flow oxygen to provide accurate dosing of volatile anaesthetic – a very important attribute in situations where oxygen supplies are limited or unreliable.

The course program provided a variety of lectures, discussion groups and practical sessions. In addition to the hands-on sessions in theatre, we had lectures on relevant topics such as paediatrics, blood supply, and electrical safety. Another strength of the course was the variety of faculty – as well as anaesthetists we also had two biomedical engineers who were able to share their wealth of knowledge with us, and somehow managed to make it both interesting and comprehensible to those of us for whom the Primary Examination equipment theory felt like a lifetime ago!

Interactive workshops on subjects such obstetrics or teaching were thought-provoking – in our problem-based discussions we had to take into consideration not only the resources we might have available and how they differed from our Australian practice, but it was incredibly helpful to also consider some of the ethical aspects of anaesthesia – should we work outside our usual scope of practice? What is an acceptable level of morbidity or mortality? And what message do our actions portray to the local anaesthetic providers? These big picture ethical questions were reinforced in a lecture on short-term medical trips – how do we steward the resources we bring or consume, how do we sensitively manage the cultural differences, and how do we invest in building the capacity of the local health care staff?

My favourite part of each day was the afternoon where we were treated to talks from each faculty member about their own personal stories and work in global health and anaesthesia. There were so many interesting journeys, from Dr Suzi Nou describing her experiences in positions of leadership and international training and navigating these as a female and mother, to Dr Wayne Morriss describing his path from local anaesthetist in Fiji to President of the WFSA. There were plenty of inspiring stories, of decades-long teaching and working relationships in Mongolia, Fiji, PNG and Nepal, of what successful short-term trips can accomplish with Ausmat and Interplast, and harrowing and moving accounts of serving in conflict areas with MSF and International Red Cross.

We enjoyed local Darwin hospitality throughout the week – with drinks watching the famous Darwin sunset at the Dripstone cliffs, a sunset harbour cruise and a course dinner on the Thursday night. The social events were an opportunity to get to know the other participants better, as many of them had their own fascinating personal journey to why they were on the course. We also had an opportunity to visit the National Critical Care and Trauma Response Centre, which was an eye-opening insight into the amazing logistics and preparations behind the Ausmat teams, which can deploy within hours of a disaster.

I left Darwin both exhausted and energised. The course had relatively long hours, and presented a lot of information, but at the same time I could feel the energy and enthusiasm amongst the participants and faculty. I'm so glad I had the opportunity to attend, and I plan to follow up on some of the possibilities presented. I would highly recommend the Real World Anaesthesia Course to any anaesthetist who has an interest in global health or is thinking of volunteering their expertise in a resource-limited overseas environment.

**Dr Ann Marie McCallum**
FANZCA

# THE RESEARCH DREAM

"The four pillars of academic life as a doctor - clinical care, research, education, and community service".

**BRIGHAM AND WOMEN'S HOSPITAL, BOSTON, MASSACHUSETTS, US**

The Macquarie Dictionary describes research as 'Diligent and systematic inquiry or investigation into a subject in order to discover facts or principles' and a dream as 'A hope that gives one inspiration'. Aside from dictionary definitions, what exactly is a research dream and are you prepared for it?

A research dream is about inspiration, aspiration, curiosity, critical thinking, intelligence, ethics, and a sustained commitment to the scientific truth. These might sound like lofty issues; they are. I make no apology for this. There are lines in research, like lines in clinical care, patient safety, and professional life, and life in general, that should not be crossed, and your moral compass must guide you through your journey.

There is no mandate to do research as part of being an anaesthetist, and the vast majority of anaesthetists do not publish any research work during their career. There are few people with PhDs and that is ok. It is in fact not something that is widely supported at a healthcare infrastructure level in Australia.

Although there is no mandate to undertake research, there is a requirement to be scholarly, to be a critical thinker and to uphold scientific principles, as these underpin our speciality and therefore the care we provide to people who entrust their lives to us.

The idea of doing research might captivate you and you think you might want to do it. You might be wondering what the next steps are. Take a moment to reflect on your motivations.

In my view, it has to be about the dream and a problem worth solving and a question requiring answering. It is the longest lead-time activity, of months to years, of all the activities one can undertake in anaesthesia, so patience, discipline and persistence are essential. This is the complete opposite of the time scale we are used to, of only seconds, for our clinical work. There will be roadblocks, adversity, and criticism, which can sometimes be extreme depending on the challenges to thinking you present to others, and sometimes, becoming political and promoting what you are doing is necessary. As too is developing an extensive protection and support network and safety net. Rarely does primacy - the right idea, at the right time, in the right place – come with being a researcher.

It is important to remember that our medical training and anaesthesia training did not train us specifically to be medical researchers. It is a mistake to assume that just because you are a doctor you are intrinsically able to do scientific research. It needs to be learnt and training, such as in working for a PhD, is an outstanding way to learn the scientific method. However smaller research projects with the right mentor, in a safe respectful environment, can introduce you to the essential ingredients to pursue high-quality research studies in your career.

When reflecting on your motivations to do research, consider whether future employment will depend on it. Undertaking research with this pragmatic motivation has different final goals. It is generally about the number of publications you need to have and the key co-authors who can strategically position you to optimise your chances of attaining a specific position or entry into a training program. This may be necessary in the short term and may on occasion translate to ongoing research and perhaps a passion for it, but more often than not, research is not likely to be sustained.

Another motivation might be what I describe as the 'little voice in my head' telling you to do a PhD, and that fulfillment of your person will not occur without research. This was my motivation and the path I travelled along that led me to a PhD.

Of course, there are motivations in between what I would describe as these two extremes. Yours may be very

It is important to remember that our medical training and anaesthesia training did not train us specifically to be medical researchers. It is a mistake to assume that just because you are a doctor you are intrinsically able to do scientific research.

different, but if you think you will be unfulfilled without undertaking research then I strongly encourage you to pursue your dream to satisfy self.

You might be thinking, I still want to perform research, what do I do next? There are many ways forward. If you can, find a mentor, a key advisor, a trusted and kind supervisor, and someone who gets it and takes you seriously. You may consider undertaking further study including a PhD. There are many pathways for additional study and for undertaking a PhD. These will unlikely be funded to the level that your clinical employment provides so any reduction in clinical employment work to pursue research will come with a pay reduction. It is almost certain that regardless of the amount of clinical work you are doing, you will be working afterhours, unfunded, undertaking research. This is almost ubiquitous in the research world regardless of profession, and we must remember that anaesthetists enjoy high salaries in comparison to other groups who are undertaking research, so there is some capacity for us to self-fund. This is not something I am necessarily advocating but if you are waiting to be funded at anaesthesia rates for all the research hours you will do before you start research, then you should stop reading this article now and pursue with vigour your beach house renovation!

Honing and upskilling your reading, analysing, critical thinking skills, and writing skills is part of the preparation. Don't expect to be excellent at this at the start. Remember research is a learnt process and not an intrinsic skill, nor is it explicitly taught in medical school. Try to be realistic and kind to yourself at all points. One of my mantras, which perhaps is a bit outdated now in the AI era (!) is "the paper won't write itself", so be prepared for lots of writing. Research writing and thinking is almost always a contemplative, iterative, quiet, and solo process seldom observed, and frequently misunderstood by others who have not engaged in the process themselves.

Understanding what the scientific method is, is core to preparing and participating in research. The scientific method is a beautiful method; a self-correcting and transparent method that over time reveals the scientific truth. This is why it makes no sense, from a scientific or in my view knowledge contribution point of view, to not strictly and deliberately adhere to the scientific method. In the end, over time, unless you have fluked it, what you have done will be shown to be predictably incorrect. Design a yes-no experiment, perform that experiment, and report the results without bias. It is as simple and as magnificent as that. The scientific method over time will sort out the truth.

You are still reading on and perhaps thinking more about undertaking research, so what might be your aims. I would suggest trying to enjoy the experience and the wins. Try to learn from your experiences, and to work as hard as you can when you are well enough to do so whilst balancing all the other activities in your life! There is also a time to just get it done, and at times simply and most importantly, to survive.

The methods that you use during your research journey could be anything from being structured and organised, being unplanned and disorganised, being on the verge of complete chaos, or being able to converge on a wonderful solution. Sometimes it's many of these at once. It's important to seek help and recognise those people who will support you. Knowing how to distinguish help and support from hindrance is an art, a skill and at times a complete stab in the dark. Preparing for the times when you need to energise, reflect and redirect is also important. Developing an individualised plan for this with trusted friends and family can help.

When you achieve your research results they could be Surprising, Confusing, Complicated, Disturbing, Eureka-y, and Engaging. They can also be Dangerous and Challenging. Prepare yourself for a roller-coaster ride, if at all possible. Prepare yourself for the unpredictable and the occurrence of Serendipity to guide you.

After undertaking some research your conclusions might be "I want to do more of this!", "I never want to do this again.", "I might have a little break and then get back into it.", "I wonder what will happen to my work – will people actually read it, will it change practice, or thinking?" "Is this just the beginning of the journey?" or a range of other thoughts. All are valid. Talking with a mentor or support person at any point in the journey can be a positive thing.

So where to from here? Do you have a research dream, and if so, will you pursue it? Will your research dreams be transformed into clinical reality? The answer is that being true to yourself and true to science will transform you; whether it transforms the world is for others to decide.


## Dr Alicia Dennis

Alicia Dennis is a Fulbright Scholar and Specialist Anaesthetist at Joan Kirner Women's and Children's Sunshine Hospital, Western Health, Victoria; Professor and Research Scholar Collaborator in the Department of Anesthesiology, Pain, and Perioperative Medicine, Division of Obstetric Anesthesia, at the Brigham and Women's' Hospital, Boston, US; and holds academic appointments at Deakin University, the University of Melbourne, and Peter McCallum Cancer Centre, Victoria, Australia.

adennis@unimelb.edu.au

# COVID PREPAREDNESS:

## COVID Safety for Schools Course launches in Australia

At the start of the pandemic, the Australian Society of Anaesthetists was active in introducing measures that protected health workers and reduced the transmission of COVID in hospitals. We recognised the airborne transmission of SARS-CoV-2, the virus that causes COVID, and the need for fit testing, having access to respiratory protection and the importance of air quality. We are now entering our fifth year of the pandemic and COVID continues to spread in hospitals and in the community. Immediate Past President Andrew Miller, Past President Suzi Nou and ASA member Pieter Peach remain active in efforts that seek to prevent COVID transmission in the community. In this article we share with you the latest resource they have been involved in and invite you to participate and share it with your colleagues, fellow parents and school teachers.

Schools remain a significant location for COVID transmission. Research has also shown that schools are a major source of COVID transmission in the community. According to a US study[1], around 70% of household COVID transmission starts with a school-aged child. That matches with the experience of many Australian families who have had COVID come into their home via an infection picked up at school – sometimes multiple times a year.

Over the last two years of the pandemic we've all been encouraged to believe that COVID is now unexceptional and can be treated like any other respiratory illness[2]. We've been told that getting infected is a good thing as it leads to "rich hybrid immunity"[3], that it's mild in children[4], and that getting infected is not just inevitable, but necessary[4].

None of these statements is true, but they have all come from political leaders or public health officials who appear to have opted for popular, soothing messages about COVID, instead of being candid with the facts about the long-term health risks from the virus.

Research over the last four years has shown that we should take COVID very seriously. There's now substantial evidence that even a 'mild' initial infection can lead to serious long-term health impacts – including cardiovascular disease, neurological conditions, immune system damage and Long COVID – even in otherwise healthy kids and adults.

The reality is that many schools are poorly informed about COVID and aren't taking steps to prevent COVID spreading. This is putting students, teachers, their families and the wider community at unnecessary risk – not just from the acute phase of COVID (which has caused over 28,000 excess deaths[5] in Australia so far), but also the many long-term health impacts.

None of this is the fault of schools or school staff. In most states, schools have been given very limited (and in some cases totally incorrect) guidance about how COVID spreads, what can be done to prevent it spreading, or even why they should care about it.

School staff and parents alike have been influenced by the 'COVID is mild'

Over the last two years of the pandemic we've all been encouraged to believe that COVID is now unexceptional and can be treated like any other respiratory illness

narrative. It has led many to think that it's no longer important to take precautions against catching or spreading the virus. Many Australians don't know that COVID is airborne and is spread mainly by inhaling virus particles breathed out by infected people, or that the majority of COVID infections come from people who are asymptomatic – they have COVID, and are infectious, but have no idea they are spreading it to others.

The COVID Safety for Schools Course is Australia's first online video-based course about COVID for schools. It sets out to give schools accurate information about COVID that is informed by the latest science and free from political influence. The course's creators hope that it will empower principals and teachers to implement evidence-based approaches to reduce the risk of COVID spreading, without disrupting the school's core role of giving kids a great education.

The course features some of Australia's leading scientific and medical experts in fields relevant to COVID. With the help of experienced science communicator Colin Kinner, they explain the realities of COVID in clear, easy-to-understand language and debunk common myths and misunderstandings.

The course is intended as a professional development activity for staff in Australian primary and secondary schools. It is also available for parents who want to know what they can do to keep their own family safe. Participants will learn about the health impacts of COVID, the science of how it spreads, how to assess and manage risk, and how to use layered protections (such as ventilation, CO2 monitoring, HEPA filters, masks and testing) to reduce COVID risk.

The COVID Safety for Schools Course is an initiative of not-for-profit organisation COVID Safety Australia, and is available free at www.covidsafetyforschools.org.

## Quotes attributable to contributors to the course

**Colin Kinner, course creator:**

- "A lot of schools are struggling to know what to do about COVID. Principals and teachers are already overloaded, so with this course we're hoping to take some of that burden away from them and provide factual, scientifically accurate information that schools can use to make informed decisions."
- "Schools have been let down by public health in most states in Australia. The information they've been given is grossly inadequate, and in some cases just plain wrong. It's no wonder schools are finding it difficult to prevent COVID spreading."
- "We know that schools are suffering from teacher shortages, and that teachers are leaving the profession due to concerns about COVID. By implementing the simple measures covered in this course, schools can reduce staff illness and provide a safer workplace."
- "By acting on what's covered in this course, principals and teachers can save lives and prevent serious illness. Not in some loose abstract sense, but in a very literal sense. By reducing the risk of COVID spreading at schools, teachers can prevent people from getting infected, from dying, from developing Long COVID and from suffering the many other long-term health impacts that we now know can follow a COVID infection."
- "Kids have their whole lives ahead of them. We should be doing everything possible to prevent them catching a disease that could cause lifelong harm and chronic illness."

**Full list of expert contributors: www.covidsafetyforschools.org/about**

- **Assoc Professor Suzi Nou**
- **Dr Andrew Miller**
- **Dr Pieter Peach**

### References


1 https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2805468
2 https://federation.gov.au/national-cabinet/media/2022-12-09-strategic-framework-transitioning-covid-19-measures
3 https://www.indaily.com.au/news/2022/10/11/in-a-very-good-place-spurrier-says-sa-ready-for-next-covid-wave
4 https://vimeo.com/737886395/1569719f63
5 https://www.abc.net.au/news/2024-01-21/covid-safe-strategies-australian-scientists-virus-infection/103335466

# FROM GAS TO GIGGLES:

## Practical Tips for Anaesthetists Preparing for Pregnancy, Parenthood, and Professional Life

**BALANCING THE DEMANDING WORLD OF ANAESTHESIA WITH THE TRANSFORMATIVE JOURNEY OF PREGNANCY IS A REALITY FOR MANY WOMEN IN THE FIELD.**

Approximately half of anaesthetic trainees and a significant number of anaesthetists navigate the unique intersection of their medical career and impending parenthood. Dr Suzi Nou, host of the Australian Anaesthesia podcast, delved into this this topic with five anaesthetists, Dr Rosmarin Zacher, Dr Isabelle Cooper, Dr Georgie Cameron, Dr Anna Pietszch and Dr Emilia Reece in episodes 28 and 29 of the Australian Anaesthesia podcast. Their experiences shed light on the delicate balance of work, pregnancy, and the preparations for returning to professional life. Summarising their top tips, this article provides insights into managing the complex phase of balancing anaesthesia, pregnancy and returning to work.

### Charting the Course: Proactive Planning for a Smooth Transition

Just like sitting the primaries, proactive planning is key for success. Consider what you may need to ensure a smooth transition, taking into consideration factors like paperwork, training requirements, part-time options, and financial implications well in advance. Familiarise yourself with departmental policies and explore resources such as 'Pregnancy and the Anaesthetist' and 'The Trainee Returning to Work' guides (linked at the end of this article), created by anaesthetists, specifically for navigating this transition.

Open communication with your employer is important so don't shy away from discussing your plans and needs with your supervisor, training coordinator or head of department early on. Be transparent about your concerns and ask for their support. Explore options provided by your employer, such as 'keep in touch days' to help you plan for the different stages of your journey. Empower yourself by knowing the options available to you such as part-time training, job sharing, or opting to return to a larger department with more flexible arrangements.

## The Balancing Act: Working During Pregnancy

Pregnancy adds a unique layer to an already demanding profession, but it is possible to work while ensuring your own wellbeing, and that of the baby, as well as maintaining the highest standards of patient safety. Dr Zacher and Dr Cooper, who connected via the ASA's Trainee Members Group (TMG) Committee, co-authored a document titled 'Pregnancy and the Anaesthetist', specifically addressing the intricacies of working during pregnancy. In this balancing act of career and impending parenthood, the document serves as a practical guide, offering tips and insights for anaesthetists navigating the challenges of pregnancy in the workplace, from seeking support within the profession to understanding maternity leave entitlements.

## The Leave Leap: Managing Maternity and Family Time

Taking time off during maternity leave is not just a necessity but a strategic move that can enhance your long-term productivity and personal wellbeing. The duration of maternity leave can vary, and it's essential for anaesthetists to be informed about their rights under the Fair Work Act in Australia. Individuals are entitled to take up to twelve months off for parental leave. Note however, that while the leave duration is protected, it doesn't necessarily guarantee paid leave.

Open communication with your employer is important so don't shy away from discussing your plans and needs with your supervisor, training coordinator or head of department early on.

Pressure to return to work often arises due to financial considerations, and individuals may feel compelled to resume duties prematurely. To address this concern, individuals can explore alternatives, such as opting for half-pay for an extended period or considering other types of leave, like long service leave, to prolong their absence. Notably, the Fair Work Act protects the right to take the full twelve months, ensuring that no one can be forced to return earlier unless they voluntarily choose to do so.

Another provision within the Fair Work Act allows individuals to negotiate a second year of parental leave if they wish to extend their time away from work. However, this extension is at the discretion of the employer and necessitates mutual agreement. Individuals considering this option should discuss it with their Human Resources (HR) department, ensuring alignment with organisational policies and obtaining clarity on potential implications for medical registration.

Parental leave is a crucial aspect of an anaesthetist's journey, requiring informed decision-making. By understanding legal provisions, negotiating extended leave when needed, and tapping into available resources, anaesthetists can confidently manage their parental leave while safeguarding their wellbeing and professional interests.

## The Return: Transitioning Back to Work

For anaesthetists contemplating their return to work after maternity leave, there are a range of courses that can help facilitate the transition, such as the Critical Care, Resuscitation and Airway Skills in High Fidelity Simulation (CRASH) Course. Courses such as CRASH focus on facilitating the return-to-work journey for anaesthetists, through the relearning of practical skills and exposure to simulated critical events, instilling confidence tailored to an individual's specific needs.

The ASA recognises the importance of ensuring anaesthetists return to work after a period away with confidence and offers scholarships for members looking to attend the CRASH course. You can find out more here: https://asa.org.au/membership-benefits/membership-crash/. Alongside education, there are a series of steps you can take to help yourself feel better prepared.

**1. Build your support system:** Returning to work after leave, especially to a smaller hospital, can feel isolating. Seek out communities like the ASA's TMG Committee or social media groups, where you can connect with others who understand your unique challenges. Share experiences, learn from each other, and build a network of support.

**2. Advocate for yourself:** Don't be afraid to be your own champion. Pregnancy is a natural part of life, and you deserve understanding and support. Remember, open communication and clear expectations are key to navigating potential hurdles like part-time work arrangements or departmental limitations.

**3. Prioritise mental wellbeing:** Be mindful of the potential for increased stress and mental health concerns like postnatal depression. Remember, seeking help is a sign of strength, not weakness. Numerous resources are available to support you. The ASA's Wellbeing Advocates Committee is also available to provide support and guidance tailored to the unique needs of anaesthetists.

**4. Embrace the journey:** While demanding, this journey can be incredibly rewarding. Focus on enjoying the experience and creating a work-life balance that works for you. Remember, there's no one-size-fits-all approach. Embrace the unique joys and challenges of this exciting phase and prioritise your and your family's wellbeing alongside your professional aspirations.

Remember, you are not embarking on this journey alone. Numerous resources and support systems are available, from informative documents to supportive communities. By planning effectively, advocating for yourself, and building a network of understanding, you can navigate this exciting chapter in your life with confidence. So, take a deep breath, adjust your scope, and remember, you've got this, mama anaesthetist!

## Practical Toolkit

Discover the resources mentioned in this article below. While not an exhaustive list, it serves as a solid foundation to support your journey. Tailor your approach by exploring these resources and consider additional resources that resonate with your unique needs. Building a personalised toolkit is key to navigating the challenges of balancing anaesthesia and parenthood successfully.

- **Pregnancy and the Anaesthetist:** An informative guide tailored for anaesthetists navigating pregnancy (https://libguides.anzca.edu.au/ld.php?content_id=48309025)
- **The Trainee Returning to Work:** A comprehensive guide assisting trainees in their return-to-work journey (https://libguides.anzca.edu.au/ld.php?content_id=48309022)
- **Australian Anaesthesia Podcast Episode 28:** Pregnancy and the Anaesthetist with Drs Rosmarin Zacher and Isabelle Cooper (https://podcasts.apple.com/au/podcast/ep28-pregnancy-and-the-anaesthetist-with-drs/id1530484641?i=1000512037722)
- **Australian Anaesthesia Podcast Episode 29:** The Trainee Returning to Work with Drs Georgie Cameron, Anna Pietszch and Emilia Reece (https://podcasts.apple.com/au/podcast/the-trainee-returning-to-work-with-drs-georgie/id1530484641?i=1000512037723)

**Kelly Chan**
MBA/LLM Candidate
Marketing & Communications Manager, Australian Society of Anaesthetists


**This article is based on episodes 28 and 29 of the Australian Anaesthesia Podcast, a regular podcast hosted by Dr Suzi Nou, ASA Past President, that discusses the latest developments in anaesthesia and the issues impacting anaesthetists.**

**ASA members have access to the complete podcast library, while a series of episodes are publicly available on Apple Podcasts, Spotify, and Google Play.**

**We thank Dr Nou and Dr Zacher, Dr Cooper, Dr Cameron, Dr Pietszch and Dr Reece for their insightful discussions on pregnancy, anaesthesia and returning to work.**


# PREPAREDNESS:

## From over-prepared to under

**LATE DECEMBER- MESSAGE FROM SUZI NOU: "HEY JEN, I SAW RECENTLY THAT YOU COMPLETED THE GREAT VIC BIKE RIDE. WELL DONE! I'M WRITING WITH MY COMMS COMMITTEE HAT ON- THE THEME FOR THE MARCH EDITION IS PREPAREDNESS. I THOUGHT YOU COULD SHARE WHAT YOU DID TO PREPARE FOR THE GVB RIDE- WOULD YOU BE INTERESTED IN CONTRIBUTING AN ARTICLE?"**

**ME: "WHAT, YOU MEAN THE BIKE RIDE I WAS SO PREPARED FOR I FORGOT TO SEND IN MY LEAVE FORM AND HAD TO COME BACK FROM LAKES ENTRANCE TO MELBOURNE FOR A SINGLE DAY'S WORK AND THEN DRIVE 240 KM BACK TO A COUNTRY TOWN THE SAME NIGHT? THAT RIDE? THAT PREPAREDNESS? LOL".**

**SUZI: "YOU HAVE FREE LICENSE TO WRITE AS YOU WISH…"**

Well, that's a tale. I've had my coffee(s), so, put your helmet on, slather yourself in sunscreen, and clip in.

But I had prepared, hadn't I? Hundreds of kilometres, probably hundreds of hours on the bike, dodging magpies and pursuing dogs, working hard to build up my distance fitness. Hours and hours of physio- at least 20 minutes every night, repairing injuries and treating new ones, my physiotherapist shaking his head at yet another injury and commenting:

"Jen, you have the heart and soul of a teenage boy trapped inside the body of a …"

– he paused, unsure how to complete that sentence -politely-

"…middle aged woman", I completed for him.

Ok, well, 100% honesty, the ride preparation had been for the Around the Bay- a 135km ride from Geelong to Melbourne (with the Queenscliff to Sorrento ferry in between) in early October. My first long, long group ride. I'd have to do some 'centenary' rides to prepare, but I could do it. Cycling long distances had become my new thing: all carbon gravel bike*, fancy lycra jerseys, bidons** and clippy shoes. Which was itself a compromise: you see, I'd signed up for the Melbourne Marathon, only for my physio to have let me down gently earlier in the year; "Perhaps running just isn't in your future anymore".

Running. My true exercise love. In December 2019 I signed up for my first ever full marathon, aiming for the Melbourne Marathon: 7am, 4th October 2020. And then, of course, the world went to custard. Preparation turned into therapy- a way of dealing with the endless lockdowns. Up before dawn, in the chill of winter and with the mist rising of Merri creek, one foot after another. Ever increasing distances. Preparing. "Effort is more important than pace" was my mantra- who cares if I wasn't the fastest, I was determined, and, dammit, I wasn't going in unprepared. Even within a 5km bubble, I had my route mapped out. Be patient. Be prepared.

Great Vic Bike Ride: please note double bidon, all carbon bike with tubeless wheels, Di2 (IYKYK), steely expression and Lycra. Not shown: leave form.

The October date looked ambitious. By July it looked improbable. "We hope to have an answer by 21st September". I kept running. September 9th: the 2020 Melbourne Marathon has been cancelled. I was automatically transferred to the 2021 date. Scared I would lose all my gains I kept running at the same intensity. Then the date was pushed back again: October became December. I kept running, longer and longer distances. Anything under 20km was "a short run". I was so, so ready.

And the day came and it was glorious. I ran faster than I had anticipated, finishing ahead of the median for my age/gender group! I had done it! My 18 months of preparing had paid off…

Turns out, too much prepared can be a bad thing: overused and overstretched by the delays and my fears of losing my fitness, I developed first plantar fasciitis, swiftly followed by Achilles tendonitis, and then this combined to a stress fracture of my calcaneus. I had missed the sweet spot and gone straight to over-use. Little did I know I had also worn down the cartilage of my left knee joint in the process, and after 9 long months of no running, after getting the go ahead to start running again (another marathon! 2023!), I was back at the physio with a knee like an overstretched water balloon. And then, the gentle let down: another marathon is likely never happening.

Many will be familiar with the satirical "CracOn" paper[1]- the idea that sometimes you just must gird your loins and just get on with it. Whilst it is satire, there is sometimes some truth within: sometimes there truly is nothing more you can optimise. We know that delaying fractured neck of femur surgery can actually cause more harm, in an effort to prepare. My own over-preparedness for my marathon led me to a stress fracture, and I'll probably never run that distance (in one race) again. (Depressing research: only 11.8 % of long-distance runners return to long distance running after a TKR[2]).

But here's the thing - the night before the Great Vic Bike Ride, the night I discovered that whilst I'd completed a leave form but had never sent it in, and, yes, I would have to return to Melbourne to work, I swung into action. I Googled car hire, I booked a motel. I thought about options: would I leave my bike behind or take it with me? What would I do with my luggage? How would I rejoin the ride? I made a plan. I prepared for an unexpected detour. Preparedness is not only preparing for the expected- it's the unexpected that tests your true measure of responsiveness. Its being flexible enough to pivot (gah) to another form of exercise when you can no longer do what you love.

We're all too familiar with the "hours of boredom, moments of thrill, seconds of terror" model of anaesthesia***.

And it's here that being prepared is best demonstrated. We "expect the unexpected". You can only prepare so much: it's the sudden hypotension and flushing in an otherwise routine case in a healthy adult that demonstrates your absolute preparedness, swings you into action. It's Donald Rumsfeld's "Unknown unknowns" that demonstrate our ability to be flexible and ready to respond. It's not the straight road, but the hairy patch of potholes and debris on the shoulder when a passing B-double flings you off course that you need to be ready for.

Preparedness is not just the hours spent running: it's the ability to respond to the unknown. It's being flexible enough to cope with what is flung your way, be it your ageing joints or forgetfulness in hitting 'send'. It's also learning via your failures, and to adapt and change.

(And do I now have a spreadsheet with leave dates and leave approvals on my wall? You bet I do!)


**Dr Jennifer Dixon**
Sci, M.B.B.S Hons, FANZCA


* Gravel bike: a compromise between a road bike and a mountain bike. It looks like a road bike- that is, bent handlebars and an aerodynamic riding posture, but has wide, grippier tyres and a frame built to contend with, well, gravel roads. Otherwise known as a mid-life crisis on (tubeless, carbon fibre) wheels.

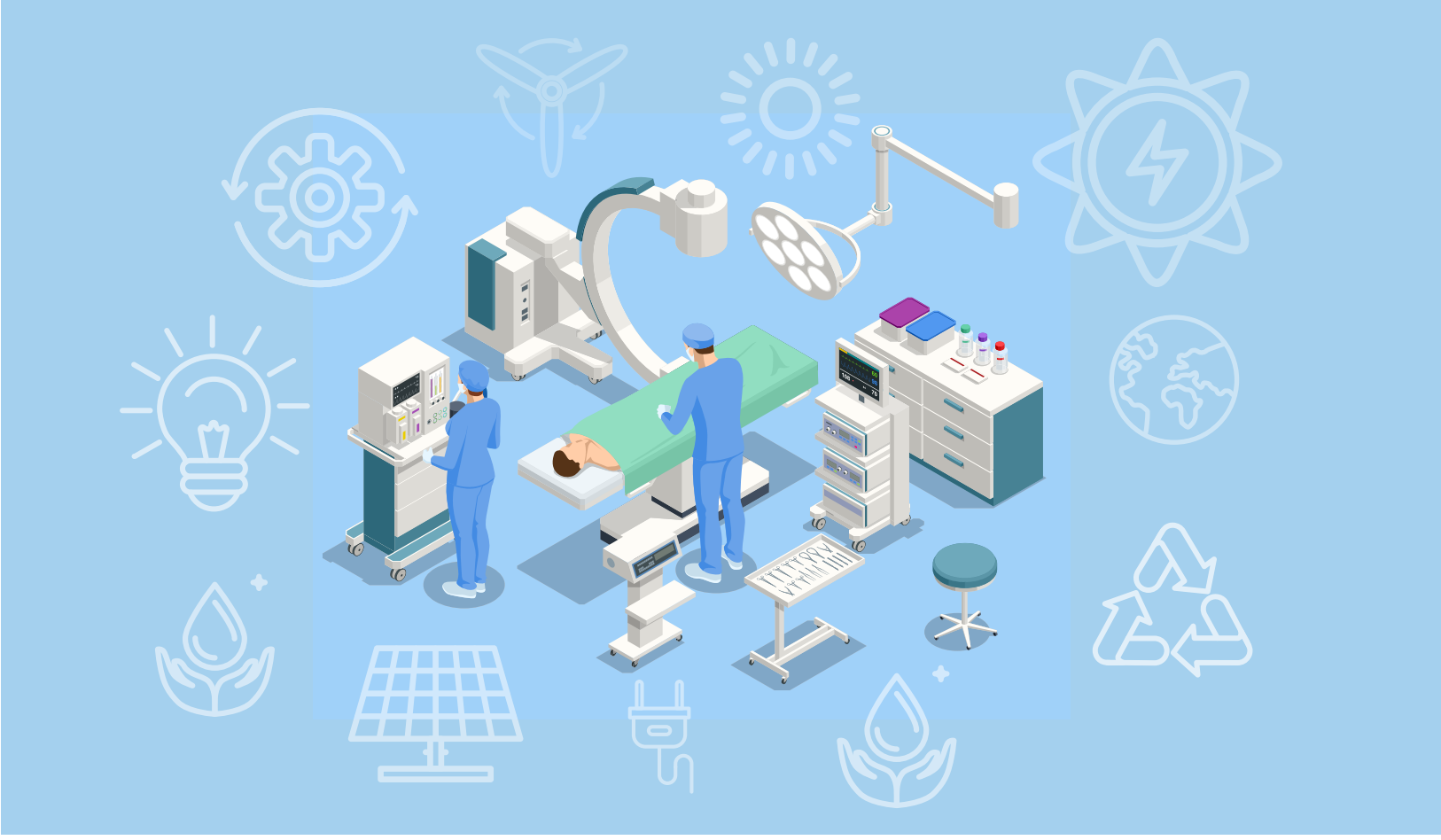
** bidon: what a MAMIL**** calls a bike bottle.

*** (Side note: stripped of your smartphone for Covid cases, did anyone else take to bringing in photocopied crosswords and sudoku to keep them occupied? [Careful, Jen, your age may be showing…])

**** MAMIL: Middle Aged Man in Lycra. Or in my case, Middle Aged Mum in Lycra. By the way, don't get me started on the ridiculous sizing in women's cycling gear, or we'll be here all night.

### References


1. Chrimes, N. Complete relinquishing of anaesthetic conscientiousness, optimisation and nuance (CRAC-ON) trial. Anaesthesia 71(12) Dec 2016 1408-1409
2. Antonelli B, Teng R, Breslow RG, Jamison M, Hepinstall M, Schwarzkopf R, Moschetti WE, Chen AF. Few Runners Return to Running after Total Joint Arthroplasty, While Others Initiate Running. J Am Acad Orthop Surg Glob Res Rev. 2023 Apr 19;7(4): e23.00019. doi: 10.5435/JAAOSGlobal-D-23-00019. PMCID: PMC10118379.



# GUARDIANS OF SUSTAINABILITY IN THE OPERATING THEATRE

**I GOT TWO ANAESTHETISTS TOGETHER TO EXPLORE COMMON GROUND ON THE TOPIC OF ANAESTHETIC GASES, SUSTAINABILITY AND OUR COLLECTIVE PREPAREDNESS FOR CHANGE. HERE, I'M HAVING A CONVERSATION WITH PIERRE BRADLEY AND JUSTIN SKOWNO. READ ON FOR A LIGHT-HEARTED EXPLORATION OF SOME OF THE ISSUES FACING ANAESTHETISTS IN 2024 AND BEYOND.**

I invited both today's guests into a conversation about their approaches to sustainability in anaesthesia broadly, and specifically with respect to the ongoing usage of desflurane which has produced quite some animated dialogue in many an anaesthetic corridor recently. Far from it being a cut and dried pro- or anti-des situation, I have found that the nuances of the conversation are important and most anaesthetists in Australia have a lot of common ground here. Most anaesthetists want to move forward in a way that is in harmony with sustainability principles, that provides excellent, individualised care for their patients, and that can preserve their clinical autonomy. Do we care? Yes. Can we do more? Yes. Do we have a lot of common ground? Absolutely!

Read ahead for a tongue in cheek, Mitchell and Webb* - skit style take on some of the hottest issues being discussed in hospital corridors and operating theatres.

**Dr Michelle Horne**
Chair, ASA Victoria; ASA Board Member; Deputy Convenor ASA NSC 2023

* Mitchell and Webb: British comedy double act: sketch comedy


**Pierre:** "Oh, Justin, here we go, another TIVA crusader in the OR. I'm all for the green anaesthesia movement, but desflurane is still my go-to. I get the eco-conscious vibe, but as a neuro-anaesthetist knee-deep in bariatrics, desflurane has its perks. It's like my secret sauce in there! Why don't you admit it, Justin, gas is where it's at! That nothing beats the classics.

**Pierre:** "So, let's not close the door on it entirely; perhaps there's a time and place for desflurane and focussing on the bigger picture is the way to go.

**Justin:** "Pierre, you old-fashioned fossil! Gas is so last century. It's all about Total Intravenous Anaesthesia now. It's like comparing a horse-drawn carriage to a sleek spaceship."

**Pierre:**"Oh, please! Gas has that nostalgia factor, and your TIVA obsession is like trying to anesthetise patients with unicorn dreams. It's not practical!"

**Justin:** "Your love for gas is like clinging to a typewriter in the age of computers. Times have changed! It's TIVA for precision and control, my friend."

**Pierre:** You and your fancy TIVA. What's next, organic anaesthesia? I bet you want to grow your own sedatives."

**Justin:** "Actually, Pierre, that's not a bad idea. Environmentally conscious anaesthesia is a thing, you know. It's called 'Green Sedation.'"

**Pierre:**"Green Sedation? What's that supposed to be?"

**Justin:** "It's all about reducing the carbon footprint of anaesthesia. Anaesthesia's footprint is a lot bigger than you think "

**Pierre:** "Oh, come on, Justin! I understand the Montreal and Kyoto Protocol and the more recent Paris Agreement to limit global warming, and I appreciate that sustainable anaesthetic practice is about reducing the carbon footprint of your anaesthesia, and I hope this isn't going to be a TIVA good, volatile bad type of discussion. Have you heard about this report from Dame Julia Slingo on environmental sustainability in anaesthesia? It questions the impact of volatile anaesthetics on climate change and suggests we should focus on reducing $CO_2$ emissions rather than eliminating desflurane. She mentions that concentrations of the fluoridated anaesthetics are in parts per trillion, while $CO_2$ is in parts per million. It's quite a difference in scale. And let's not forget the concentrations of these gases are tiny compared to major greenhouse gases. And their short lifetimes mean they have minimal impact on the Earth's energy budget.

**Justin:** " I appreciate your awareness of the Paris Agreement. It's evident that significant changes are necessary at both governmental and societal levels to enact substantial transformations. As anaesthetists, we can indeed make an impact. And yes, Pierre, Dame Slingo's report is generating considerable discussion. The response highlights the debate around inhaled anaesthetic agents and climate change. Her argument is that the minuscule quantity of desflurane in the atmosphere should not be overstated, especially compared to major greenhouse gases like $CO_2$. However, there are thousands of different areas of "carbon intensity" across the globe, and one of them is the inefficient use of volatile anaesthetics, and another is the use of nitrous oxide in anaesthesia, which we anaesthetists have direct control over.

**Pierre:** "Really, Justin, you know Dame Slingo is an extremely prominent and high-level figure in British climate science during an era when female role models were scarce. To make it to the top in that era meant she was exceptionally skilled and informed, so for her opinion to be brushed aside as being nothing new by anaesthetists with an interest in global climate change is kind of like surgeons giving their views on how to do an anaesthetic to an anaesthetist. She points out that it is easy to express it in simple terms as the equivalent emissions of $CO_2$ and not consider the effects of the translation of emissions into radiation forcing, followed by the translation of radiation forcing into an impact on the climate. And as she states, for anaesthetic gases, any impact of its tiny emissions and radiative forcing on our climate system will, quite frankly, be "lost in translation".

**Justin:** "Pierre, I'm well aware of radiation forcing, which is the difference between the radiation energy received from the sun and the radiation emitted back. The incoming radiation energy typically falls within the wavelength range of 0.1-2.0 micrometres, while the wavelength of outgoing radiation is generally longer. This distinction is crucial because certain gases, known as Greenhouse gases, can absorb the outgoing radiation. Among these gases, the most noteworthy include carbon dioxide, methane, nitrous oxide, and fluorocarbons. Greenhouse gas emissions of all sorts need drastic reduction if we are to avoid the worst consequences of climate disruption. Sum all these small areas of carbon pollution together, and you get the global problem itself. No one area is too small to matter. By simple changes in our practice, we can have a marked impact on our professional carbon footprint with minimal risk to our patients. The atmospheric life of sevoflurane are 1.1 years, isoflurane 3.2 years, desflurane 14 years, and nitrous oxide 114 years. The global warming potential (GWP) can be used to compare gases and is defined by its half-life and radiation absorption capacity. The comparisons of GWP100 values where carbon dioxide is the comparator are methane 25, sevoflurane 130, nitrous oxide 298, isoflurane 510 and desflurane 2540. Desflurane has a high GWP and is comparable in some ways to other greenhouse gases or in other words, it means that 1 kg of this gas captures the same amount of heat over a period of 100 years as 2540 kg of $CO_2$. Nitrous oxide is worse because of its high consumption amounts, leakage from pipelines, use in the wards and extremely long lifetime. Medical nitrous use and wastage account for 4% of all nitrous emissions, and a lot of that may not be directly attributable to anaesthesia, but we can advocate to change its use pattern. So, if we can choose alternatives, it will make a significant step and positive impact."

> "…. Environmentally conscious anaesthesia is a thing, you know. It's called 'Green Sedation.'"…..
>
> "It's all about reducing the carbon footprint of anaesthesia. Anaesthesia's footprint is a lot bigger than you think "

**Pierre:** "Hmmm.. whilst I agree nitrous oxide should be avoided because it has a high radiation forcing value and it adds little or nothing to a sevoflurane or desflurane anaesthetic technique even as a second gas effect to speed up a gas induction but appreciate as a neuro-anaesthetist I might be biased against nitrous oxide. However, I think this might be one of those circular arguments that use different measures to inform us and to quote Benjamin Disraeli, "There are three types of lies: lies, damn lies and statistics". Dame Slingo pointed out that GWP fails to adequately differentiate between the climate impacts of long-lived pollutants like $CO_2$ and short-lived pollutants like volatile anaesthetic gases. While a potent greenhouse gas with a brief lifespan might share the same GWP as a weaker gas with a longer lifespan, their identical mass emissions have different effects on global surface temperature change. She categorically states that though mathematically correct, a pulse emission of 1 kg of desflurane does not equal the climate impacts of a pulse emission of 2540 kg of $CO_2$. Current concentration-based radiative forcing offers a fairer comparison, avoiding the complexities of varying lifetimes and relying solely on the present-day accumulation of anthropogenic greenhouse gases measured by atmospheric concentrations. This approach is favoured by the Intergovernmental Panel on Climate Change (IPCC) for assessing the potential impacts of different gases on the climate system. Radiation forcing values for carbon dioxide are 1.68 W m-2, nitrous oxide 0.17 W m-2, desflurane 0.00014 W m-2 and sevoflurane 0.00005 W m-2. And perversely transitioning from inhalational anaesthesia to TIVA might contribute to a rise in long-lived carbon emissions due to the substantial amount of plastic needed. And while you're off on the anti-desflurane crusade, I've got another ace up my sleeve: patient safety. Rapid wake-up with desflurane, my friend! It's a game-changer, like an anaesthetic magic trick! Patients go to sleep, and poof, they're awake in no time, especially for high-risk groups such as the super morbidly obese and neurosurgical patients."

**Justin:** "Pierre, rapid wake-up is like an anaesthesia express train, but it also comes with a higher risk of post-op nausea. That's a rollercoaster no one wants to be on."

**Pierre:** "Nausea? Well, I suppose that's the price of a speedy recovery. But let's talk about something serious for a change. I appreciate that TIVA is all eco-conscious if you ignore the vast number of consumables that require incineration for disposable, but it's a risky business when it comes to intraoperative awareness. It's like a tightrope walk without a safety net! Now that's a horror show."

**Justin:** "Pierre, don't be such a gasbag. The small increase in plastic waste is nothing compared to what we routinely use in many other areas of healthcare. And it's been published as a head to head

with volatiles. Intraoperative awareness can also happen with any anaesthesia method. It's not exclusive to TIVA! "

**Pierre:** "Well, it is certainly more common, especially when you can't see or get access to the cannula. Anyway, Justin, it appears we're stuck in this debate. Gas or TIVA, it's like arguing over how to brew the perfect cuppa. Moreover, there's the issue of drug disposal. Approximately 50% of propofol in an operating suite can go unused. Incorrect drug disposal can contribute to water contamination and toxicity, adding another layer of environmental concern. It's essential for healthcare facilities to adopt proper waste management practices, including safe drug disposal methods, to minimize the ecological impact. Balancing the need for a green approach with patient safety is indeed a delicate matter that requires careful consideration."

Balancing the need for a green approach with patient safety is indeed a delicate matter that requires careful consideration."

**Justin:** "Ah, Pierre, it's like debating rugby tactics—everyone has their strategy, but in the end, it's the winning team that matters!"

**Pierre:** "True, Justin. Just like a crucial referee decision in the Rugby World Cup—sometimes it's the unexpected factors that influence the game, and all comes down to a single point again. In our case, an unexpected factor will be the EU's decision on whether to ban desflurane, and I know Scotland has already banned it".

**Justin:** "Okay, so it's not a simple black-and-white issue. We must balance our anaesthetic responsibility with the broader climate challenge we face".

**Pierre:** "Justin, I've realized it's a complex issue, but I want to stress one thing: it's not just about anaesthesia; it's about the bigger picture, patient safety, economic responsibility, and environmental benefits that must be considered. I fully imagine I'm going to have to adapt as I think we are going to ultimately lose desflurane in our armament because of market forces, much like methohexitone and, to a lesser degree, thiopentone, due to increasing expense, reduced use, ongoing campaigning against it and niche benefit to certain patient groups like bariatric and neurosurgery, rather than the larger population. Personally, I wish for a more balanced evidence-based approach, considering all sides of the argument and would be very disappointed if its use was banned. I think desflurane has some very specific indications and that its removal will have unintended consequences and create a more superficial one-size-fits-all approach rather than tailoring anaesthesia to the specific patient. Also, imagine if we had a propofol shortage, like what happened in some parts of the world during the COVID-19 pandemic; alternatives are required".

**Pierre:** " Hey Pierre, I totally get your love for desflurane and the comfort that routine brings. I know change isn't your favourite and embracing the change from desflurane to sevoflurane or TIVA might feel like a shift, but it doesn't make that much of a practical difference. I appreciate your point of view, and you highlight one of the anaesthetist's greatest strengths: adaptability. Our primary aim is to do no harm, both in the short term for the patient and the long term for our planet."

**Pierre:** "Certainly, Justin, I believe a comprehensive strategy is imperative. When addressing the intricacies of volatile anaesthesia, we can find common ground on several fronts. Firstly, steering clear of nitrous oxide seems prudent, given its adverse effects across various scientific metrics. Additionally, when employing volatile agents, adhering to a low flow rate—specifically, less than 1 l/min, ideally—is paramount. It is crucial to avoid using desflurane with a supraglottic airway or in unselected patient groups, as its benefits are negligible in such scenarios.

Furthermore, opting for local or regional anaesthetic alternatives where viable presents a sensible approach. For instance, choosing an epidural for analgesia over nitrous for labouring mothers can be a more judicious choice. In my perspective, a more significant impact on environmental sustainability can be achieved by instituting a structured anaesthetic waste management hierarchy plan at both local and regional levels. This approach aims to curtail carbon dioxide emissions, thereby contributing to the broader goal of environmental responsibility.

**Justin:** Oh, Pierre, you're bang on there! I mean, let's not just focus on the small details, right? It's all about the grand scheme of things. Take, for instance, this waste hierarchy business in Australia. They've got this whole system, ranking waste management strategies from the creme de la creme of avoiding waste creation down to the absolute last resort of disposal. You've got your Reduce, Reuse, Recycle, Refuse, Rethink, and Repair – the six golden rules of waste management, mate!

And yeah, incorporating environmental life cycle assessments is crucial. Check this out: decommissioning those nitrous

pipelines to cut down on leakage and wastage, opting for cylinders instead. The UK nitrous oxide project dropped a bomb, saying the environmental emissions from anaesthetic nitrous oxide across the NHS are like the carbon dioxide released by a whopping 135,000 flights from Frankfurt to New York. That's no small potatoes, my friend.

Then there's the 'Gloves Off' campaign, aligning with infection prevention and control recommendations, promoting reserving those examination gloves for the real messy situations. Rapidly transitioning to full electrification for new hospital builds is a no-brainer. And hey, us anaesthetists are all in on the eco-train too – slashing unnecessary plastic, pushing hospitals to up their recycling game for packaging and equipment.

And let's not forget the personal touch, mate. We're all about educating ourselves on climate change, its health perks, and the urgency to act. We're not just about putting patients under; we're also giving them lifestyle advice for a healthier life and a lighter carbon footprint. Plus, saving energy and money at home – insulate that place, turn off those appliances, and cut down on unnecessary goods and services.

But back to the medical turf, those plastic syringes – less is more, my friend. Draw up only what you need, leave emergency stuff unopened but ready to roll. It's all about being smart and savvy, Pierre. We're not just doctors; we're the guardians of sustainability in the operating room, blending medical acumen with environmental responsibility!

**Pierre:** "Well, Justin, mate, you've just orchestrated a symphony of environmentally conscious anaesthesia advice that rivals a Wagner opera! I half-expected the curtain to fall, and us all to break into applause. But hey, I'm all in for being the eco-Mozart of the operating room, composing harmonies of low-flow rates and recycling rhythms. While there isn't a universally standardized set of ABCDE for environmental considerations in anaesthesia, perhaps we should have one, such as

A - Awareness of environmental impact, aiming to minimize the ecological footprint.
B - Best practices in waste reduction and management.
C - Conscious choices in the selection and use of anaesthesia agents, considering their environmental effects.
D - Dedication to energy efficiency and reduced resource consumption in the operating room.
E - Education and advocacy for sustainable practices within the anaesthesia community and healthcare at large.

**Justin:** "Absolutely, Pierre! Couldn't agree more. Recognising the global health emergency that is the environmental crisis is paramount. As healthcare professionals, we stand at the forefront not just for patient care but also for the well-being of our planet. It's time to be potent advocates, addressing not only the threats posed to health by the planetary crisis but also championing the health benefits that can emerge from taking meaningful action. Let's weave environmental responsibility into our commitment to patient well-being and a healthier planet. Anaesthetists and healthcare workers can play a pivotal role in curbing healthcare-related carbon emissions, minimising waste anaesthetic gases, and actively engaging in public discourse. It's not just about our ABCs in anaesthesia; it's about embodying an E for Environmental stewardship in our professional ethos.

**Pierre:** Now back to desflurane....

**Justin:** Oh, fantastic, just when I thought we were agreeing you're being a typical Taurean sticking with desflurane like it's the eighth wonder of the world! Who needs change anyway? It's not like adapting could ever be a thing.

## Associate Professor Justin Skowno

A/Prof Skowno completed his anaesthesia training in Cape Town, South Africa in 2005. He subspecialised in paediatric anaesthesia at Red Cross War Memorial Children's Hospital in Cape Town, and Great Ormond Street Hospital for Children in London. In 2008 he moved to the Children's Hospital at Westmead, NSW, where he works as a full-time senior staff specialist.

His clinical subspecialty expertise includes paediatric cardio-thoracic anaesthesia, major neonatal anaesthesia and major paediatric oncological surgery. Other areas of expertise include intraoperative physiological monitoring, total intravenous anaesthesia, regional anaesthesia and vascular access. A/Prof Skowno was a speaker at the recent ASA NSC Sustainability session in October 2023.

## Associate Professor Pierre Bradley

A/Prof Pierre Bradley is a Specialist Anaesthetist at The Alfred Hospital and an Adjunct Associate Professor at Monash University in the Department of Anaesthesiology and Perioperative Medicine. He is a past Chair of the Australia and New Zealand Airway Management Special Interest Group, was the State airway lead for Victoria and Tasmania and involved in ANZCA Professional Document Development. Originally from the UK, Pierre completed his undergraduate training at the University of Dundee and started on physician training before finding anaesthesia. He is currently on the Anaesthetic Subcommittee of the Perioperative Consultative Council, Safer Care Victoria, ANZCA Victoria Regional Committee and a British Journal of Anaesthesia article reviewer. His areas of interest are neurosurgery, vascular and anaesthesia for the high perioperative risk patient in both the public and private system. He has a case series about the surgical management of spine trauma in the morbidly obese patient and did not envisage this as his particular area of interest when starting anaesthesia and thought his ideal patient was going to be ASA 1.

# INTERNATIONAL WOMEN'S DAY

## MARCH 8 #INSPIREINCLUSION

**Creating a world that is free from bias, stereotypes and discrimination is a shared vision that resonates with many. The theme for this year's International Women's Day on March 8, #InspireInclusion, aligns with the goals of the Women's Empowerment and Leadership Initiative (WELI). AUS/NZ WELI empowers highly productive women and non-binary anaesthetists and pain medicine specialists to achieve equity, promotion and leadership.**

The support from the ASA, ANZCA and SPANZA underscores the importance of collaborative efforts in achieving gender equity and promoting diversity and inclusion. WELI's workshop series, networking events and access to resources such as the advisor/protégé program, offer valuable opportunities for professional growth and community building. For those interested in learning more about WELI and getting involved, please reach out to info@ausnzWELI.org or register your interest at https://ausnzweli.org/.

International Women's Day is a fantastic occasion to celebrate the achievements of women in anaesthesia and pain medicine and to inspire everyone to continue working towards a more equitable and inclusive future.

**Dr Maryann Turner, Assoc Professor Suzi Nou, Dr Tanya Farrell**

The Advisory Board of WELI

ASSOCIATE PROFESSOR
ALWIN CHUAN
CHAIR, SCIENCE PRIZES AND
RESEARCH COMMITTEE

# FROM THE SPARC CHAIR

**I invite members to apply for the multiple ASA research grants and prizes that are available in 2024.**

The ASA is committed to supporting and funding researchers and their research in anaesthesia, intensive care medicine, and pain medicine in Australia. In particular, as part of the ASA's Research Priority Program to grow our specialty's future research leaders, we actively encourage applications from early career researchers, applicants within five years of full membership, and trainee members.

The ASA will consider all applications, with emphasis on three priority themes:

**ENVIRONMENT & ANAESTHESIA**

**INNOVATION & ANAESTHESIA**

**SAFETY IN ANAESTHESIA**

**FOR FULL INFORMATION ON ELIGIBILITY, GUIDELINES AND APPLICATION FORMS, LOG IN TO**

**asa.org.au/asa-awards-prizes-and-research-grants/**

**Darwin 2024 NSC abstracts submission portal https://asansc.com.au/call-for-abstracts/ or contact sdonovan@asa.org.au.**

## Research Grants and Prizes for 2024

Applications are open only to full and trainee financial members of the ASA for over 12 months. Applications from teams of researchers are also welcome, but at least one member of the research team needs to meet the eligibility requirements.

### (1) ASA Small Grants – deadline April 30

These grants are to support early or small research projects, or from early career researchers and trainee members. They provide funding for important topics that may not be justified under larger grant schemes, or to obtain pilot results that helps researchers design larger projects.

**$3000 for each successful grant**

### (2) ASA Annual Research Grant and scholarship – deadline June 30

These grants are to support a substantial research program in anaesthesia, perioperative medicine, intensive care medicine, or pain medicine. Trainee member applicants must have a suitable supervisor who is also full member of the ASA. Preference will be given to applicants enrolled in a higher degree research (PhD or Masters equivalent) or an emerging post-doctoral researcher (NHMRC guidelines, less than ten years full time equivalent after conferral of PhD), although all members are eligible to apply.

**Up to $75,000 over two years**

### (3) Kevin McCaul Prize – deadline June 30

This prize commemorates the late Dr Kevin McCaul who was, for many years, the Director of Obstetric Anaesthesia at the Royal Women's Hospital, Melbourne. The Kevin McCaul Prize is awarded to an application for a research project, publishable critical review/essay (as determined by the editors of the *Anaesthesia and Intensive Care* journal or *Australian Anaesthesia*) on any aspect of anaesthesia, pain relief, physiology, or pharmacology relevant to the female reproductive system.

Eligible applicants are ASA members who are trainees or specialists within two years of obtaining a higher qualification in anaesthesia.

**$11,000 for the successful applicant**

### (4) National Scientific Congress (NSC) Darwin 2024 Presentation Prizes – deadline May 31

Five different prizes are awarded for the most highly ranked oral presentations at the NSC in the following categories:

- **Gilbert Troup Prize ($10,000 for winner, $3000 for runner-up)**
- **ASA Best Poster Prize ($5000 for winner, $2000 for runner-up)**
- **Trainee Member Group Best Poster Prize (complimentary registration to future NSC, approx. $2000 value)**
- **ASA Trainee Member Best Audit/ Survey Prize (complimentary registration to future NSC, approx. $2000 value)**
- **Rupert Hornabrook Prize for Day Surgery (complimentary registration to future NSC, approx. $2000 value)**

Please go to the Darwin 2024 NSC abstracts website for more information.

# CPD that won't put you to sleep

Take control of your CPD today!

## Join CPD Home and get up to 50% off!

Since 1 January, all doctors who require a CPD home must comply with the Medical Board of Australia's (MBA) Registration Standard: *Continuing Professional Development* (the Standard).

Achieve your CPD compliance with ease. Trust the ASA's CPD Home, accredited by the Australian Medical Council (AMC), to guide your CPD journey! We offer CPD activities for all specialties, including Anesthetists.

**Choose a subscription to suit your career stage** and budget from as little as $220! Plus we have a **6 month money back guarentee** - what do you have to loose?*

Find out more at **cpdhome.org.au**

> *I signed up to the CPD Home program starting in 2023.*
>
> *The CPD Home program has a very wide range of accepted activities for the all domains of learning: educational activities, reviewing performance, and measuring outcomes.*
>
> *It's especially easy to identify the mandatory elements required by the Medical Board: culturally safe practice, addressing health Inequities, professionalism, and ethical practice.*
>
> *All the hours count, and they quickly add up to the 50 required per year!*
>
> - Dr Vida Viliunas OAM

## The new CPD Home Mobile App!

CPD made simple. With access anytime, anywhere, CPD has never been easier. Our new ad-free mobile app is now available, so you can have all your most important CPD Home features right at your fingertips.

**Download the CPD Home Mobile App** by searching CPD Home on Google Play or Apple's App Store.

GET IT ON Google Play

Download on the App Store

| | ASA Members | Non-Members | |
|---|---|---|---|
| | 50% OFF PAY ONLY $440 (full-time or part-time) | 20% OFF PAY ONLY $528 (part-time) | 30% OFF PAY ONLY $616 (full-time) |
| Junior Doctors | 50% OFF PAY ONLY $220 (full-time or part-time) | 20% OFF PAY ONLY $264 (part-time) | 30% OFF PAY ONLY $308 (full-time) |

100% MONEY BACK GUARANTEE

*For money-back guarantee T&C's, see the website.

cpd home | AMA

# New CPD year, new opportunities for development

CPD Home has devised an easy Stepwise Plan to support you in meeting your annual CPD requirements.

**Complete the `Planning for Learning in 2024'** online learning module (optional)

**Write your CPD Plan**

- Determine your CPD goals for the 2024 CPD year.
- Select your three focus topic areas.
- Identify the CPD activities you are considering engaging in that align with your registered scope of practice.

**Look through our CPD Home Catalogue** for a wide range of Domains 1 and 2 accredited activities

**Keep an eye on your progress** relevant to your scope of practice

**Reflect** on your completed CPD activities

**Complete CPD activities** addressing the CAPE aspects

**Self-record externally** completed CPD activities and uploading your supporting evidence

**Watch your CPD hours grow** on the CPD Tracker

## Need assistance or an extension?

As a CPD Home subscriber, if you were unable to meet your CPD requirements by the end of the 2023 CPD year, there is no need to panic. It is not too late to seek an extension, which you can do so by getting in touch with us: **enquiries@cpdhome.org.au** | All extensions are valid until **31 March 2024**.


# ASSOCIATION OF ANAESTHETISTS TRAINEE CONFERENCE

## LEEDS, UK | 6-7TH JULY 2023

**I WAS VERY SURPRISED AND HUMBLED TO RECEIVE A PHONE CALL FROM THE ASA INFORMING ME THAT I HAD BEEN AWARDED THE COMMON INTEREST GROUP SCHOLARSHIP, WHICH ALLOWED ME TO ATTEND THE ASSOCIATION OF ANAESTHETISTS (AOA) TRAINEE CONFERENCE IN LEEDS THIS YEAR.**

This was to be somewhat of a homecoming for me, as I grew up until the age of 16 in the nearby city of Sheffield before emigrating to the sunnier shores of Brisbane with my family. Despite this upbringing, I have never trained or worked in the NHS and so I was keen to understand more about the opportunities and challenges facing the profession in the UK and the learning points there might be for Australian anaesthetists.

Leeds is a city of half a million people located in the North of England, nearby to Manchester, Sheffield and York. It was a prosperous market town in the Middle Ages and then became a major centre for textiles, milling and engineering during the Industrial Revolution. After the decline of the textiles industry in the mid-20th century, Leeds became a northern hub for the corporate and legal sectors. Although not a traditional tourist location for a conference, Leeds is located in 'God's Own Country' of Yorkshire, with its stunning countryside, idyllic villages and stately homes. I was fortunate to be able to do some hiking in the Peak District National Park and visited Chatsworth House, home of the Cavendish family since the 16th century.

I had a very warm welcome to Leeds by members of the AoA Trainee Committee, particularly the Chair, Dr Naomi Freeman and Vice Chair, Dr Stuart Edwardson. Indeed, a lot of attendees at the conference were keen to welcome and chat to the 'Australian', both about the practice of Australian anaesthesia and the concurrent Ashes test match at the nearby Headingley Cricket Ground. Although the conference was primarily a trainee event, it was very well attended by consultant anaesthetists, including the President of the AoA and Vice President of the Royal College of Anaesthetists (RCoA).

The conference is a major event in the AoA's calendar and was very professionally organised and executed. Over two days the sessions and workshops covered a wide variety of topics from paediatric TIVA to assisted dying, perioperative medicine and obstetric anaesthesia. I particularly enjoyed the session on extreme physiology, which included an update on high-altitude physiology, the expanding area of space medicine and a discussion of the often-missed condition of haemophagocytic lymphohistiocytosis. The fantastic presentation on high-altitude medicine was by Professor Daniel Martin, who holds the impressive record of the lowest measured arterial pO2 in a living human (19mmHg!), taken near the summit of Everest in 2007.

After listening to the varied sessions and attending several workshops, I was left with the impression that our Australian practice of anaesthesia is a modern interpretation of the art and is at the forefront of change. For example, a session covering TIVA for Category 1 GA caesarean sections discussed the potential advantages of this technique, but accepted it was not yet common practice and faced several barriers to implementation. However, my experience of training in South East Queensland has been quite the opposite; TIVA is routinely used by many anaesthetists due to the benefits for uterine tone and haemorrhage mitigation.

Where I feel the UK does lead the profession is in the areas of equality, diversity and inclusion, which had an entire session at the conference. There was a particularly moving lecture on transgender obstetrics care and an interesting presentation on inaccurate pulse oximetry readings in non-Caucasian patients. The results of a recent British Medical Association nation-wide survey were also presented, which showed persistent homophobic behaviour towards staff in the NHS.

There were two important topics raised during the conference that I feel are very important to be understood by Australian anaesthetists. Although these issues do not currently affect our specialty in this country, problems faced in the UK do tend to arise here several years later.

The first concerns the expansion of Anaesthesia Associates (AAs) in the recently released NHS Long Term Workforce Plan. The expansion is to help the NHS fill the predicted shortage of 11,000 anaesthetic staff by 2040. Nurses, Operating Department Practitioners (similar to our theatre nurses) or graduates with a Bachelor of Science (but no clinical experience) can apply to train on a paid, two-year clinical placement university program to become an AA. Once qualified, they are paid at the level of a registrar and are able to practice anaesthesia independently, under the local (ANZCA Level III) supervision of a consultant anaesthetist. The idea is to free up consultants to perform higher level tasks with their time. Generally, AAs are allocated to elective lists and do not work out of hours or weekends currently. The RCoA has embraced the change and has formulated a training curriculum, integration pathway and faculty for AAs.

The panel discussion session on AAs was the most well attended and contentious of the conference. Emotions were high and trainees raised numerous concerns to the panel: training spots were foregone in favour of AA positions; lists with regional anaesthesia opportunities were given in preference to AAs; lost case exposure; trainees were shifted to more service provision and after hours shifts; and unclear lines of supervision. Consultants raised concerns regarding a reduction in clinical exposure, unclear AA scope of practice and being expected to supervise multiple AAs (up to four) in multiple theatres simultaneously.

The concern over the expansion in AA numbers is so great that an independent group known as 'Anaesthetists United' gathered enough signatures to force the RCoA to hold an Extraordinary General Meeting on October 17th, 2023 to address these concerns. All six motions regarding AA expansion and anaesthesia training were passed with an overwhelming majority vote and the College must now respond to these concerns. On a wider scale, most medical Royal Colleges are facing increasing discontent from their members about scope creep and role substitution by other 'medical associate' roles such as Physician Associates and Surgical Care Practitioners.

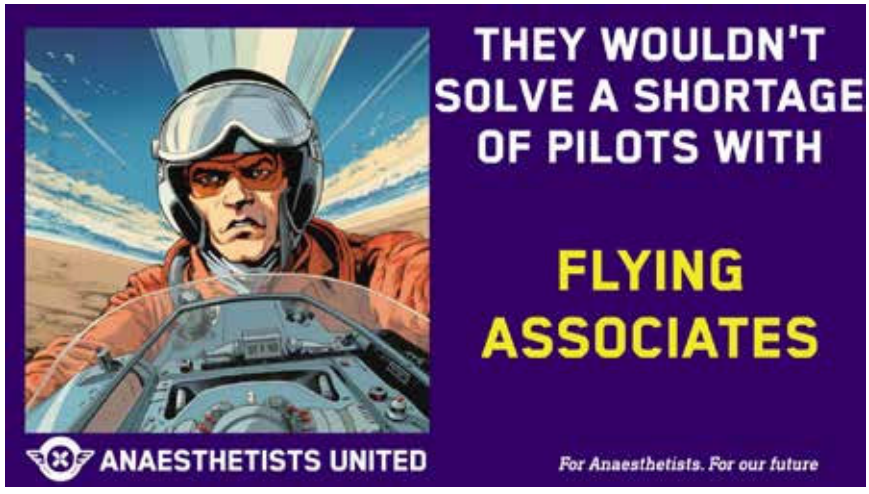
The ASA has a robust Position Statement (PS10, last revised 2019) that reinforces



the safety and high standards of anaesthesia as a medical role in Australia, supported by highly valued perioperative nurses and technicians. ANZCA has produced a similar Position Statement (PS59, last revised 2015), which also states that "innovation should be based on delegation, not substitution, of roles".

The second issue on everyone's minds at the conference was the ongoing strike action by anaesthetists and other medical staff in the NHS. This unprecedented action by junior medical officers and consultant grades is regarding pay and conditions. Junior doctors' pay has decreased by 26% in real terms since 2008. For consultants this reduction is 35% since 2008, with a compounded impact on pension schemes. Significant coordinated strike action at the start of January 2024 reduced NHS medical cover to Christmas Day levels of care for six days. The NHS estimates that over a million episodes of care have been cancelled or rescheduled since the strikes began in March 2022. The general mood at the conferences was one of resignation, with both trainees and consultants explaining that they did not want to go on strike but felt compelled to do so in order to force the government to listen to their concerns.

I feel very fortunate that we are not facing the same situation at home in Australia. I am cognisant of the fact that this is a position that has been hard won over many years by those before me and it is a reminder of the importance of being a member of a professional organisation such as the ASA.




Overall, my experience at the Trainee Conference has been enlightening, educational and rewarding and I am very grateful to the ASA for awarding me the Common Interest Group Scholarship. I hope that I have shed some light on the issues facing our British colleagues and the learning points that we can take from this for the future of the profession in Australia.

**Dr Ben Cahill**

Provisional Fellow
Gold Coast University Hospital

# WEBAIRS

Dr Yasmin Endlich, Dr Heather Reynolds and the ANZTADC Case Report Writing Group

# EMPOWERING PREPAREDNESS:

## THE CRUCIAL ROLE OF INCIDENT REPORTING IN ANAESTHETIC PRACTICE


**In his recent editorial, Gibbs beautifully described the role of incident reporting in anaesthetic practice. He states that learning from personal experiences and clinical incidents is crucial for anaesthetists, as it profoundly impacts future behaviour. However, relying solely on personal experience is a process that is too slow to cover the extensive range of potential adverse clinical events. The next level is sharing experiences with colleagues in informal settings or departmental meetings, providing valuable insights into adverse events. Local reporting and discussion are deemed the most meaningful, allowing for immediate insights, identifying system factors and providing an opportunity for feedback. Nevertheless, even local reporting at a departmental level may not encompass the full spectrum of incidents or provide insights into their relative frequency, precipitating factors, management strategies, and outcomes. This is where nationwide anaesthetic incident reporting fits in.**[1]

WebAIRS is the web-based anaesthetic incident reporting system available to all anaesthetists in Australia and New Zealand (www.anztadc.net). WebAIRS was established in 2009 by a tripartite alliance of the Australian and New Zealand College of Anaesthetists (ANZCA), the Australian Society of Anaesthetists (ASA), and the New Zealand Society of Anaesthetists (NZSA). The Australian and New Zealand Tripartite Anaesthesia Data Committee (ANZTADC) classifies incidents into nine main categories: assessment/documentation, cardiovascular, infrastructure/system, medical devices/equipment, medication, miscellaneous/other, neurological, other organ, and respiratory/airway. The webAIRS bi-national database now includes details of over 11,200 clinical incidents across more than 243 sites across Australia and New Zealand.

By providing a platform to collect, analyse and distribute the findings of near misses and adverse events in anaesthetic practice across Australia and New Zealand, webAIRS contributes to continuous safety improvements. Four publications of

webAIRS data discuss incidents from its start in 2009 to 2022.[2-5] These include Eley et al, 469 Caesarean-related incidents; Bright et al, 684 adult cardiac arrests; Mistry and Endlich's discussion, drawing from the first 8000 webAIRS reports, about 26 incidents related to paediatric regional anaesthesia; and Pattullo et al reporting 13 cases of perioperative hypercarbia, two involving high-flow nasal oxygen. These four publications are just the tip of the iceberg and since its inception, there are now 30 publications listed and available on the webAIRS webpage (https://www.anztadc.net/Publications/News.aspx?T=Publications). Analyses address incidents reported in airway management, medication errors, awareness, and introduction of incident assessment and management tools, like the Bowtie analysis.

Advisory notices, accessible only to registered users, provide snapshots of cases reported to webAIRS. These incidents include various possible events and provide lessons learned and references for further detailed reading. The advisory notices report about real anaesthetic events. Registered anaesthetists have the opportunity to read advisory notices, search within them for specific themes and topics and use these for case discussions and learning opportunities.

Incident reporting in anaesthetic practice is a multifaceted tool for enhancing patient safety and preparedness. By identifying systemic issues, anaesthesia teams can implement targeted improvements and preventive measures to address recurring patterns. The analysis of near misses provides valuable insights into potential vulnerabilities, allowing practitioners to proactively address issues before they potentially escalate. Serving as a cornerstone for continuous quality improvement, incident reporting enables departments to refine protocols, update guidelines, and foster a culture of ongoing enhancement. Beyond procedural aspects, it promotes open communication and teamwork, contributing to a collaborative effort in issue resolution. Incident reports also guide tailored education and training, addressing specific areas for improvement and enhancing preparedness for diverse scenarios. Moreover, incident reporting helps anaesthetists adapt to evolving challenges in healthcare environments, fostering a safety-conscious culture and contributing to benchmarking and the adoption of best practices across institutions.

Reports to webAIRS provide an overview of the characteristic problems in anaesthesia in our region. With the unpredictability of healthcare, improving safety in the complex activity of anaesthesia needs a long-term commitment. WebAIRS and other international databases and their review mechanisms provide a means for anaesthetists in Australia, New Zealand, and other international locations to achieve gradual gains in patient safety. Keeping up to date with these gains will contribute to improved preparedness for practice in the daily care of perioperative patients.

## Dr Martin Culwick

### Inaugural Medical Director for the ANZTADC

As the new year commences, we see a change in medical directorship following the retirement of Dr Martin Culwick as the inaugural Medical Director for the ANZTADC and webAIRS. Like many landmark projects that ANZCA has undertaken, ANZTADC was born out of one of the taskforces set up by Professor Michael Cousins in 2005. Dr Martin Culwick contributed to the ANZCA Quality and Safety Taskforce and to the ANZCA Data Taskforce. Through these processes a decision was made to establish a tripartite committee from ANZCA, the Australian Society of Anaesthetists and the New Zealand Society of Anaesthetists to improve the safety and quality of anaesthesia for patients by providing an enduring capability to capture, analyse and disseminate information about incidents (de-identified). Dr Culwick was appointed medical director of ANZTADC in November 2007 and contributed to the design and programming of the webAIRS website as a craft group-specific anaesthesia incident reporting system for Australia and New Zealand. His clinical expertise, extensive knowledge of information technology and tireless dedication to anaesthesia incident reporting is evident in the world-leading database that is webAIRS, with over 5000 registered users. While Dr Culwick will maintain an interest and involvement in conducting analyses of the webAIRS database, we wish him well in his retirement from the medical director role. May the coming years provide him more opportunities to enjoy his love of sailing and guitar and to see his beloved Brisbane Lions win another flag!

### References


(1) Gibbs NM. Clinical incident reporting: Extending the learning opportunities through webAIRS. Anaesth Intensive Care. 2023;51(6):372-374. doi:10.1177/0310057X231200508

(2) Eley VA, Culwick MD, Dennis AT. Analysis of anaesthesia incidents during caesarean section reported to webAIRS between 2009 and 2022. Anaesth Intensive Care. 2023; Nov;51(6):391-399. doi: 10.1177/0310057X231196915

(3) Bright MR, White LD, Concha Blamey SI, Endlich Y, Culwick MD. Perioperative corneal abrasions: A report of 42 cases from the webAIRS database. Anaesth Intensive Care. 2023 Jan;51(1):63-71. doi: 10.1177/0310057X221099032.

(4) Mistry MM, Endlich Y. Incidents relating to paediatric regional anaesthesia in the first 8000 cases reported to webAIRS. Anaesth Intensive Care. 2023 Nov;51(6):408-421. doi: 10.1177/0310057X231198255.

(5) Pattullo GG, Culwick MD, Endlich Y, MacPherson RD. Hypercarbia and high-flow nasal oxygen use during anaesthesia - risking a failure to thrive? Anaesth Intensive Care. 2023 Nov;51(6):400-407. doi: 10.1177/0310057X231198257

DR MICHAEL
LUMSDEN-STEEL
EAC CHAIR

# ECONOMIC ADVISORY COMMITTEE

## The transition from trainee to specialist anaesthetist

**ANAESTHESIA TRAINING AND BECOMING A FELLOW OF THE AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS (FANZCA) IS AN INCREDIBLE JOURNEY OF PERSONAL GROWTH, AND THE TRANSITION FROM BEING AN ANZCA TRAINEE TO A SPECIALIST ANAESTHETIST HAS MANY PATHWAYS. IT IS INVALUABLE TO START THINKING ABOUT THIS SOONER RATHER THAN LATER, AS THE PATHWAY TAKEN TO FELLOWSHIP CAN ALSO STRATEGICALLY POSITION FUTURE WORK OPPORTUNITIES AT THE END OF THE ANAESTHESIA TRAINEE JOURNEY.**

### What does a new specialist anaesthetist look like in 2024?

Increasingly diverse and hybridised. As anaesthetists seek work-life balance, they are exploring their options and discovering novel combinations of employment, balancing public and private practice, locum and volunteer work. General and sub-specialty anaesthesia interests may be combined with public hospital anaesthesia (fixed term appointment, casual contract, and permanent employment up to 1.0 full-time equivalent) and private anaesthesia, or some other combination, rather than exclusively one or the other. Time is the most precious commodity we have.

Out-of-theatre work also forms part of the professional activity and identity of the anaesthetist (retrieval services, clinical research, education, simulation, university lecturing, locum work, volunteer aid work, participation in professional association and medical college committees and boards). Some new specialists undertake a period of work as a specialist within Australia (locum anaesthetist, fixed-term employment etc.) to bridge the time while saving to 'self-fund' further sub-specialty anaesthesia training. Salary (and overall remuneration package) can be significantly less than a Provisional Fellowship package in Australia. Regardless of the pathway, this key checklist needs to be completed.

### ☐ Admission to Fellowship and specialist registration

The specialist registration (Specialty of Anaesthesia) allows the term 'specialist anaesthetist' to be used.

For ANZCA Trainees, completion of training and eligibility for Fellowship is the step required to be registered by the Medical Board of Australia (as required by Sections 57 and 58 of the Health Practitioner Regulation National Law). This process is outlined on the ANZCA website. Trainees are required to pay a full annual trainee fee for ANZCA Fellowship, which is then credited to the annual Fellow Membership fee.

ANZCA advises Medicare when trainees have been admitted as a specialist anaesthetist, and the Trainee then applies to the Australian Health Practitioner Regulation Agency (AHPRA) for specialist registration with the provisional certificate of Fellowship.

AHPRA processes the application for specialist recognition (currently a $490 fee) – which undergoes preliminary assessment and if the application is complete, it proceeds to a full and detailed assessment against the Medical Board's registration standards (this can take up to ten days to complete, or longer for complex applications, overseas applications, or where there is a high volume of applications received) and the applicant is advised when specialist registration is finalised, with a PDF certificate uploaded on the AHPRA website. Fortunately, AHPRA is aware and geared up for the College Fellowship assessment timings, and the process is generally seamless, but it will take 10 or more working days and will therefore be a period of "unemployment" unless the doctor has overlapping employment as registrar.

## Specialist credentialing: clinical privileges to work as an anaesthetist

Public and Private hospitals have a credentialing process that must be completed (specialist international medical graduates [SIMGs] may have a separate approval and credentialing process) to work at the hospital as a specialist anaesthetist. The application process (now increasingly online) requires certified copies of original medical and specialist qualifications (university medical degree, specialist qualifications, medical registration) to be uploaded, usually along with a minimum of three referees, an up-to-date CV, and can also require immunisation details. Private hospitals require evidence of current private medical indemnity insurance. Private hospitals may also require a nominated back-up credentialed anaesthetist to be contacted should you be uncontactable for a clinical call regarding a patient you have provided care for (e.g. advice, take back to theatre, clinical deterioration). Each private hospital has its own credentialing requirements, which are likely to include a few of the public hospital mandatory training requirements (for example hand hygiene).

Some new specialists undertake a period of work as a specialist within Australia (locum anaesthetist, fixed-term employment etc.) to bridge the time while saving to 'self-fund' further sub-specialty anaesthesia training.

A useful tip is to investigate what is required by the private hospital you will be applying to and ensure any required courses or modules have recently been completed at the end of training. Frustratingly, the same details are often required with each hospital that requires credentialing, and there is currently no single credentialing body for all private hospitals.

## Medicare requirements

A Medicare provider number is required at each hospital location where a provider will be working. Anaesthetists may also have a specialist provider number for the location of their anaesthesia practice/group. Anaesthetists should consider the need to write/issue prescriptions for post-discharge analgesia - by physical PBS prescription pad or by specific electronic prescribing software. Specialist registration and Medicare provider numbers are required for patients to access MBS rebates for eligible MBS item services that you undertake for those patients. Specialist anaesthetists via the SIMG pathway, or who have worked and trained overseas (excluding New Zealand) will have Medicare 19AB eligibility criteria that need to be considered, which may restrict patient access to a Medicare rebate. One way to obtain a 19AB Medicare exemption is by working in designated areas of specialist workforce shortage, or by writing to Medicare seeking an exemption.

## Public hospital doctors

Specialist anaesthetists working in public hospitals (as staff specialists/salaried specialists) or as visiting medical practitioners are employed under State/Territory industrial instruments (usually Awards – and Agreements, with supporting policy), negotiated by the registered doctors' industrial union or equivalent. Registered Industrial Organisations vary around the country and include the Australian Salaried Medical Officers Federation (ASMOF) and state Australian Medical Associations (AMA). Work at public hospitals may also be undertaken as a 'locum' which may have alternative remuneration arrangements.

Employment security, retention of sick leave, annual leave, CPD leave, long service leave, parental leave and other leave entitlements accrued during employment as a 'public servant' as a junior doctor and anaesthetic registrar with ongoing employment as a specialist anaesthetist needs to also be considered by each individual when planning for the future. Long service leave will usually be recognised and transferable where there has been continuous service between public service organisations, but can require communication and chasing up to ensure this occurs. Otherwise, not all forms of leave are transferable or paid out when ceasing employment. Approved 'leave without pay' may be an option that enables trainees to retain accrued leave benefits to allow completion of subspecialty work or work in other jurisdictions for up to 12 months.

Remuneration is largely an hours-based wage, plus allowances with specified on-call payments, callbacks etc. In Victoria, after-hours remuneration for anaesthetists is commonly calculated and paid by the hospital using the Anaesthesia Relative Value Guide (RVG) fee-for-service model, using Medicare Benefits Schedule (MBS) items (some locations use ASA items), at variously negotiated RVG unit values.

### Private anaesthesia

There are many ways to start working in the private sector, driven largely by supply and demand, and the 'A' factors – being affable, available, and being a specialist anaesthetist! Working relationships based on mutual respect and shared clinical outcomes between proceduralists and anaesthetists may evolve from medical student days, from working together as junior doctors/registrars in the public system, or from a random list worked together. It is useful to be aware that on the completion of training, the procedural specialists and registrars from the public may well be the procedural colleagues we are working with in private in the future. List allocation may be well organised and on a template within a 'group,' or at the other spectrum, more random, ad hoc – filling in on an 'as needed to cover' basis when starting out. Senior trainees and junior specialists might be quietly invited to have a chat with a private group, they might approach anaesthesia groups directly, make contacts at networking opportunities through local ASA events and meetings, or commence work as a solo practitioner, or a group of anaesthetists might even set up their own group.

Anaesthetists working in the private sector need a system to provide some introduction to the anaesthetist – organising lists, pre-anaesthetic screening assessments, pre-anaesthetic consultations, medication and fasting advice, the provision of informed financial consent, and billing. This could be undertaken by the individual, by joining an anaesthesia group practice, by outsourcing this to online support and billing services, and the use of evolving anaesthesia apps. How the information is presented and transmitted to the patient can be the initial and/or only contact that the patient has with the anaesthetist prior to meeting the patient on the day of surgery: remember that first impressions matter.

The ASA runs a one-day Practice Managers Conference every year to provide an update to ASA Practice Managers, as well as communicating regularly with Practice Managers to resolve billing enquiries and issues with Services Australia, Medicare, health insurers, hospital groups, and other stakeholders.

As part of being credentialed at a private hospital, anaesthetists may be required to participate in an 'on-call' system, which is highly variable depending on the work undertaken at the hospital (whether it has an emergency department, maternity unit, etc.). Recent difficulties maintaining on-call rosters is generating significant discussion: these can generate significant tensions between anaesthetists, and anaesthetists and the hospital, particularly on-call coverage and appropriate clinical scope of practice. The volume of elective and emergency after-hours work (weekday and weekend) can be highly variable depending on local workforce factors, surgeon availability, theatre availability, list distribution and access in hours versus out of hours, and hospital culture. The on-call roster may be hospital-run, provided by anaesthesia groups, or through some other system. All anaesthetists may be expected to contribute on an equal basis, there may be a specific obstetric/maternity roster and general rosters, and there may be some financial payment/incentive for availability when on the on-call roster. Some arrangements have allowed for 'age milestones' to no longer require on-call roster participation for anaesthetists over a certain age, and as an anaesthetist comes off the after-hours roster how this may impact on in hours availability and/or capacity to participate in late finishing lists and work distribution needs consideration. Other on-call systems for cases can be via messaging and chat groups. Day hospitals/procedural units may have no after-hours capacity for care, and patients might be referred to a nearby private hospital emergency department for any postoperative concerns.

There are many ways to start working in the private sector, driven largely by supply and demand, and the 'A' factors – being affable, available, and an anaesthetist.

## Locum anaesthesia

Working as a locum anaesthetist requires specialists' registration, and signing up to a locum agency, who then guides the anaesthetist through the requirements. Locum pay varies greatly depending on the location, time of year, and urgency to provide the anaesthesia services (i.e. cover work). Locum pay ranges from $2000-$4500 per day. The locum agency is likely to organise the flights, car hire and accommodation as well, and the work requirements may or may not include on-call, and other emergency response expectations at the hospital.

## Understanding Medicare and anaesthesia billing- what is the *Anaesthesia Relative Value Guide*?

It is beyond the scope of this article to explain the MBS/RVG, other than to reinforce the necessity to invest the time to gain a clear understanding of principles of 'business and billings' for anaesthesia. It is important to understand how the RVG is used to determine units for anaesthesia services as a fee for service, and the requirement to provide informed financial consent. The key components for all anaesthesia episodes are the (i) base unit allocation (the initiation of anaesthesia item), (ii) the time units, and (iii) modifying units. Additional units, where clinically required (such as pre-anaesthetic consultation, invasive arterial catheter insertion and invasive arterial blood pressure monitoring etc.), can also be claimed.

Complexity of the procedure being performed determines the relative value for the Initiation of the Anaesthesia (the Base Item). For example, CA216 (or MBS equivalent 20216) is allocated 20 units, whereas CQ700 (or 21700) is allocated 3 units.

The ASA RVG resources include the ASA RVG Book available in hard copy, the ASA RVG Book online, the ASA RVG smartphone app, and the many ASA Talking Money Podcasts presented by Dr Suzi Nou. Within the ASA RVG Book there is a quick guide to commonly used obstetric MBS items.

**The Fundamental Medicare Rule** is: anaesthetists, when "anaesthetising" can only use numbers contained within the anaesthesia section of the Medicare Benefits Schedule (MBS). These items are located in Category 3, Group T10, Subgroups 1-26.

- Items outside of Category 3, Group T10 **cannot** be claimed in association with initiation of anaesthesia base items.
- Items within Subgroup 19 **can** be claimed in association with the initiation of anaesthesia base items. Anaesthetists should always be aware that maxillofacial surgeons may not always use MBS items when performing dental procedures, they may use dental schedules. Anaesthetists are recommended to use 22900 and or 22905 for all dental extractions or restorations as anaesthesia services are only claimable where an eligible Medicare service has been undertaken.
- Anaesthesia consultation items in the MBS and PHI fee schedules attract a flat rebate not calculated on unit value.

MBS items for pain management (not in association with anaesthesia) and pain consultations are separate from the RVG for Anaesthesia Section and are contained in:

- MBS Category 3 - Therapeutic Procedures, Group T7 - Regional or Field nerve Blocks, and
- MBS Category 1 - Professional Attendances, Group A24 - Pain and Palliative Medicine

| Item | Units | Description |
|---|---|---|
| **CA216 / 20216** | 20 | INITIATION OF MANAGEMENT OF ANAESTHESIA for intracranial vascular procedures including those for aneurysms or arterio-venous abnormalities |

| Item | Units | Description |
|---|---|---|
| **CQ700 / 21700** | 3 | INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous tissue of the upper arm or elbow (3 basic units) |

| Category 3 | Therapeutic Procedures |
|---|---|
| **Group T10 (20100-25205)** | Relative Value Guide for Anaesthesia<br>- Medicare Benefits are only Payable for Anaesthesia Performed in Association with an Eligible Service |
| **Subgroups 1-18 (20100-21997)** | Organised by Anatomical Region<br>(base initiation of anaesthesia items) |
| **Subgroup 19 (22002-22075)** | Therapeutic and diagnostic services<br>(can be claimed in addition to base initiation of anaesthesia items |
| **Subgroup 20 (22900-22905)** | Administration of Anaesthesia in Connection with a Dental service |
| **Subgroup 21 (23010-24136)** | Anaesthesia/Perfusion Time Units<br>(a component of the anaesthetic fee is based on time taken for the procedure) |
| **Subgroup 22-25 (25000-25025)** | Anaesthesia/Perfusion Modifying Units<br>(various modifiers for patient risk, after hours, etc.) |
| **Subgroup 19 (22002-22075)** | Therapeutic and diagnostic services<br>(can be claimed in addition to base initiation of anaesthesia items |
| **Subgroup 26 (25200-25205)** | Assistance at Anaesthesia |

**Figure 1 Excerpt from MBS structure (MBS Online, 2024)**

| Category 1 | Professional Attendances |
|---|---|
| **Group A24 (2801-3093)** | Pain and Palliative Medicine |
| **Subgroup 1 (2801-2840)** | Pain Medicine Attendances |
| **Subgroup 2 (2946-3000)** | Pain Medicine Case Conferences |
| **Subgroup 3 (3005-3028)** | Palliative Medicine Attendances |
| **Subgroup 4 (3032-3093)** | Palliative Medicine Case Conferences |

**Figure 2 Excerpt from MBS structure (MBS Online, 2024)**

A useful task to undertake is to read the relevant sections of the MBS that outline the rules for billing regarding anaesthesia:

1. MBS Category 3 - Therapeutic Procedures, Group T10 - Relative Value Guide for Anaesthetics- Notes TN.10.1- TN.10.30.

**TN.10.1 Relative Value Guide for Anaesthetics - (Group T10) Overview of the RVG**

The RVG groups anaesthesia services within anatomical regions. These items are listed in the MBS under Group T10, Subgroups 1-16. Anaesthesia for radiological and other therapeutic and diagnostic services are grouped separately under Subgroup 17. Also included in the RVG format are certain additional monitoring and therapeutic services. Read More on the MBS Online Website | (https://www.mbsonline.gov.au)

2. Notes TN.6.1- TN.6.3

**TN.6.1 Pre-anaesthesia Consultations by an Anaesthetist - (Items 17610 to 17625)**

Pre-anaesthesia consultations are covered by items in the range 17610 - 17625.

Pre-anaesthesia consultations comprise four time-based items utilising 15-minute increments up to and exceeding 45 minutes, in conjunction with content-based descriptors. A pre-anaesthesia consultation will attract benefits under the appropriate items based on BOTH the duration of the consultation AND the complexity. Read More on the MBS Online Website | (https://www.mbsonline.gov.au)

All anaesthetists must be aware that Medicare does not check that every submitted claim is correct, i.e. it assumes that the provider has made a correct claim. Where errors are made, the incorrect items fees need to be repaid, the correct items claimed for, and appropriate parties advised (Medicare, private health insurer [PHI], patient etc.). This process is extremely time and resource consuming, and it can be very stressful and costly. All ASA members are advised to contact the ASA should a billing enquiry, audit or compliance activity be initiated.

Due to the inadequacies of the MBS, there are ASA and AMA items where there are no appropriate MBS items for anaesthesia services. AMA items do not typically have an MBS or PHI patient rebate. AMA items are paid by some workers compensation insurers and motor vehicle accident insurers.

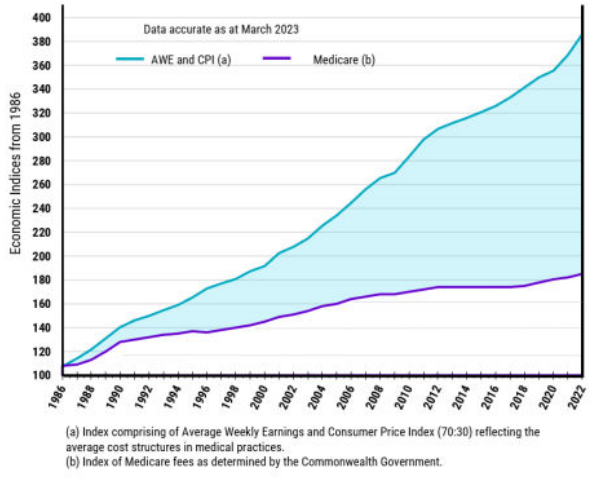



**Figure 3 AMA Fees Gaps Poster**

## Individual RVG Unit Value

Each anaesthetist should take the time to set **their own unit value**, and at least annually, review indexation of **their unit value**. As of January 2024, the MBS unit value is $21.80, the Australian Health Service Alliance average value is $36.53, and the ASA/AMA recommended unit value is $100.00. As shown in Figure 3, AMA Fees Gaps Poster, The Australian Government's indexation of Medicare rebates has not kept pace with the rising cost of medical practice, leading to increased out-of-pocket expenses (gaps) for patients.

## Indemnity Insurance

Indemnity insurance is required for private practice, and the indemnity providers also provide options for specialists working in public hospitals. Medical indemnity coverage ensures that you have access to medicolegal experts to advise and represent you, should a situation arise between you and any other party (patient, employer, HCW) in the course of your employment.

## Private Health Insurers

The majority of specialists will register with the various PHIs (also known as health funds), to be able to (i) lodge and receive payments electronically, AND (ii) for patients to be able to access the health fund benefits schedule that is above the MBS. PHIs are only legally required to top up the remaining 25% of the MBS fee from the 75% paid by Medicare. If a specialist does not register with the health funds as a provider (or provide services prior to being a registered provider with the health fund), the patient will only receive from the PHI the 25% MBS top-up amount. The ASA RVG Book and ASA RVG APP contain the PHI RVG Unit values.

By registering with the PHI, providers also agree to abide by the rules of the PHI, as outlined in the terms and conditions of each PHI.

The payment process for registered providers

- The PHI electronically transfers the total patient rebate into the provider's designated bank account which includes:
  - the Medicare contribution (which is 75% of the MBS fee for each eligible MBS service - the health fund collects that from Medicare)
  - PHI contribution (25% top of MBS Fee, plus PHI loading) determined by the PHI rules.
- All PHIs have their own fee schedule. These schedules are what the health funds have determined they will rebate the patient for each MBS service, and the PHI may offer a No Gap and/or a Known Gap Fee schedule (which may have another name).
- Some funds allow doctors to choose between both options, others require an election for one or the other (e.g. HBF in WA requires specialist anaesthetists to elect to be Provider Choice or Fully Covered Fee schedule)
- Where the PHI provides for a Known Gap:
  - The PHI higher patient rebate is unchanged where the providers fee is up to and including the maximum Known Gap allowed per episode of service (this includes all services provided per episode)
  - Where the providers fee is higher than the Known Gap, the PHI reduces the patient benefit, and only rebates the minimum required (the 25% MBS top up). This is a reduction in the patients rebate, and increases the contribution required to be paid by the patient. The PHI saves money, and the patient pays more.
  - Most Known Gaps are $500.00. This amount has not been indexed since inception of the Known Gap, and where previously the Known Gaps was for each item, it is now applied to all items for the episode of care from each provider (anaesthetists being separate to surgeon for example).
  - Long, complex cases which generate many units are very likely to end up exceeding the Known Gap limit where the anaesthetists unit value is greater than the health fund RVG unit value. The impact of this is:
    - Where the anaesthetist caps their gap at the Known Gap limit: this reduces the unit value you receive
    - Where the anaesthetist does not reduce their unit value and the fee exceeds the Known Gap limit: the PHI will reduce the patient rebate to the 25% MBS top, and the patient has a larger out of pocket due to this benefit reduction.
- Where the PHI is a No Gap schedule:
  - Some No Gap schemes are opting in/opt out (choice to provider), others are no choice.
  - OPT in scheme:
    - The PHI will only reimburse at the No Gap Schedule rebate if the provider agrees to the No Gap fee schedule for all cases.
    - The PHI terms of the scheme may contractually prohibit the provider from charging a higher fee for patients insured by that PHI.
    - An example is HBF's Fully Covered Specialist Anaesthesia Schedule for WA Anaesthetists
  - Some No Gap schemes allow the provider to opt-in/opt-out on a case-by-case basis:
  - The PHI will cover expenses up to the No Gap Schedule Fee, ensuring the patient incurs no out-of-pocket costs, as long as the provider's fee does not exceed the No Gap fee schedule.
  - If the provider's fee surpasses the No Gap fee schedule:
    - The PHI reverts to reimbursing the minimum legally required (the 25% MBS top-up).
    - This reduction in PHI contribution to the patient rebate results in cost savings for the PHI, and out-of-pockets (gaps) for the patient.
    - The patient's fee equals the provider's fee minus 100% of the MBS fee.

Ultimately, each anaesthetist needs to set their own RVG unit value and provide IFC, especially where the patient will have an out of pocket experience. There is no requirement for anaesthetists to participate in the PHI fee schedules, and while there are logistical advantages with doing so (electronic funds transfer etc.), the PHI rules and PHI fee schedules do determine what the final fee is where the anaesthetist accepts health fund fee schedules and/or cap fees to known gap limits.

## Australian Business Number (ABN)

Most anaesthetists working in private, as a sole trader, or company structure, will need to apply for an ABN, and this is compulsory if the business has an annual turnover of $75,000 or more. Provision of services that attract GST (cosmetic surgery etc.) also need consideration, and anaesthetists should discuss this with their accountant.

## Rights of Private Practice (RoPP) in public hospitals

Staff specialists and VMP anaesthetists are likely needed to be registered with the PHI in order to access and/or bill privately insured patients under Rights of Private Practice (RoPP) arrangements (known by various terms around the country including private patient schemes etc.). Public hospital doctors may receive additional income generated from RoPP, which may have been built into the salary, or be a separate RoPP arrangement. Specialists should familiarise themselves with what the RoPP may be.

## ASA support preparing for life as a specialist anaesthetist

The transition to work as a specialist anaesthetist is highly rewarding professionally, but also has many layers of financial complexity. Understanding public hospital remuneration and entitlements can be complex, the requirements to undertake any work in private, Medicare rules, private health insurer rules, obtaining Informed Financial Consent (IFC) billing, how to collect fees, and providing a service to patients who are paying for their procedure is complex. All anaesthetic trainees, new fellows and anaesthetists who have moved to Australia are encouraged to attend local ASA events, including local ASA Business and Billing events (commonly referred to as the 'ASA Part 3 Course'), which are held face-to-face and/or online. The ASA has been trialing ASA Business and Billing events that are designed to provide ASA members (trainees and specialists) with a local update, MBS and PHI updates, and networking opportunities. These events are run by the State/Territory ASA Chair and other ASA committee members. ASA members are encouraged to explore the vast range of ASA resources available through the ASA website, listen to Dr Suzi Nou on the ASA *Australian Anaesthesia* Podcast, and check out the ASA RVG App (and as a bonus the ASA podcasts can now be accessed from the ASA RVG app from the Rebates Table tab, selecting RVG Unit Value and Indexation table, selecting Notes and scrolling down.

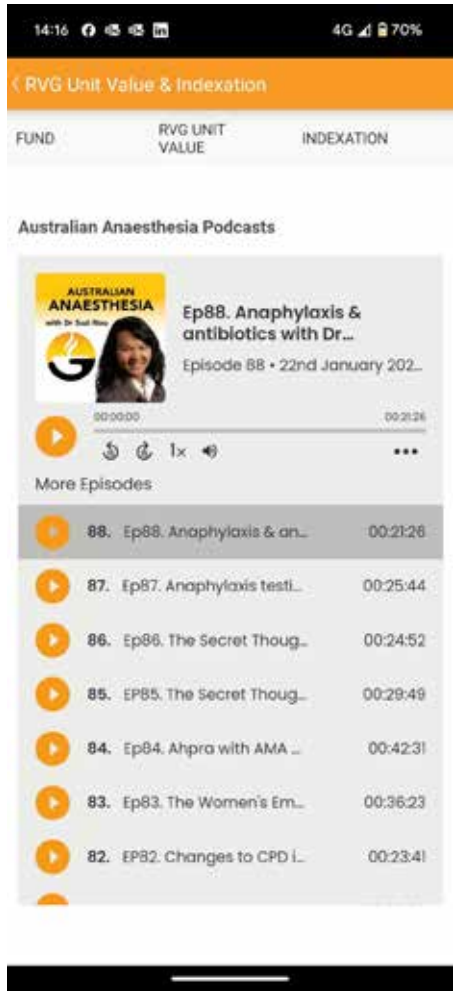

## Dr Michael Lumsden-Steel

EAC Chair



**References**

AMA Fees List (2023). Available at: https://feeslist.ama.com.au/resources-ama-gaps-poster

DR PETER WATERHOUSE
PIAC CHAIR

# PROFESSIONAL ISSUES ADVISORY COMMITTEE

JANUARY 2024

**MUCH OF THE ASA'S WORK IS REACTIVE. WE SERVE MEMBERS COLLECTIVELY BY REACTING TO GOVERNMENTS, MEDICARE, HEALTH INSURERS, REGULATORS AND MEDICAL INDEMNITY FIRMS, AMONGST AN EXPANDING CAST OF OTHER ORGANISATIONS.**

On a personal level, we react to member requests for assistance with a broad spectrum of professional challenges. These range from medicolegal issues to accreditation and roster disputes.

It can sometimes appear that planning and preparation take a back seat at the Society, as all hands rush to plug the latest breach in the hull. Recent examples include our responses to the Medicare Benefits Schedule review, and the entry into the Australian health insurance market of American giant Cigna through local subsidiary Honeysuckle Health.

Fortunately this is not entirely true. In fact, because we spend so much time reacting, we can be confident that at least some of the future's dilemmas will look fairly similar to those of the recent past.

The predictability of a proportion of the profession's challenges enables the use of a consistent, if not identical, approach to repeated dilemmas. For example, the ACCC exemption for collective negotiation has been employed by a growing number of groups around the country. Similarly, public-in-private surgery encounters foreseeable problems wherever it is attempted, enabling the creation of broad guidelines to assist those anaesthetists invited to participate in these schemes.

When contemporary issues are of widespread interest, a professional document is produced. Recent examples include PS 25 on rest facilities in hospitals, and PS 26 on deep sedation. The COVID pandemic similarly resulted in the publication of guidelines by the ASA.

Other issues have led to the creation of new pages on the ASA website, amassing the accumulated resources relating to a particular theme. These include public-in-private surgery and managed care.

## Corporate Knowledge

Over the years our Society has benefitted from the special talents and interests of individual committee members. The creation of professional documents has made their expertise readily accessible to the wider membership. Not all anaesthetists are well-versed in medicolegal proceedings, for example, but ASA PS09 is available to guide members called to act as medical experts in court.

Similarly, PS17 provides an overview of the My Health Record for the benefit of the technologically less-informed

It can sometimes appear that planning and preparation take a back seat at the Society, as all hands rush to plug the latest breach in the hull. Recent examples include our responses to the Medicare Benefits Schedule review...

## Patient Information

The ASA website hosts a collection of patient information brochures pertaining to common procedures. These are freely available for download to help patients prepare for upcoming surgery. The publicly accessible pages of the ASA website also contain general information about clinical and financial aspects of anaesthesia.

## Information Format

Technological change has led to greater choice with respect to the presentation of information. Podcasts in particular have found a sizeable audience. Our resident super-podcaster and Past President, Dr Suzi Nou, has recorded interviews and updates on a broad range of topics. In the Society's 90th year, Suzi's podcast output is fast approaching 90.

## Updated Information

All publications require periodic evaluation to ensure their ongoing relevance and accuracy, although 'shelf-life' varies according to content. For this reason, the entire ASA catalogue of professional literature is reviewed by our Professional Issues Advisory and Communications Committees on a cyclical basis.

## Suggestions please!

Is there an issue you think the ASA should have a public position on?

Perhaps you would like a patient information brochure for a specific operation?

Do you have a story to tell on a podcast?

Get in touch! We would love to expand and improve the information available to members, their patients and practice managers. Better still, join a committee or send us a draft document. PIAC will meet five times this year, and our new website will be able to ensure ready access to useful information.

## Reactive and Proactive

So while it is true that your Society is here to respond to challenges as they emerge, resources are being created in the background.

We aim to be prepared for predictable challenges and head off some problems before they arise.

Happy New Year!

**Dr Peter Waterhouse**

PIAC Chair

DR JASON KONG
IMMEDIATE PAST CHAIR
OF TMG COMMITTEE

# TRAINEE MEMBERS GROUP COMMITTEE

## PREPAREDNESS

**A FEW YEARS AGO, BEFORE SITTING MY PART 2 EXAMS, I ATTENDED AN EFFECTIVE MANAGEMENT OF ANAESTHETIC CRISES (EMAC) COURSE. I'VE ALWAYS WONDERED ABOUT THE GROUP DISCUSSION AFTER SIMULATION. WE SIT AROUND TALKING ABOUT HOW WE FELT STRESSED, AND HOW IT'S SO HARD TO PERFORM UNDER STRESS. BUT THERE WAS ONE PERSON AT THIS COURSE WHO, WHEN ASKED HOW THEY FELT, JUST SAID "YEP. FINE." AND THAT WAS IT. BRILLIANT. IT GOT ME THINKING – HOW SHOULD I FEEL IN A CRISIS? WHAT DOES IT MEAN TO BE PREPARED?**

I'm not an effusive person. Indeed, if you picked me from a room of people at random, there would be a decent chance you would have picked the most boring person with the flattest energy in the room… Or at least I try to be. In a world where metaemotional intelligence seems to hold just as much importance as technical and intellectual competence, I often get lost. I often get asked how I'm feeling, like how I felt after a simulation exercise, or how I performed over the year. I know what I'm supposed to say – that I felt 'something'. Is it weird to feel nothing? Is it weird for everything to just be neutral?

Athletes often talk about being in the zone. In sport, it's a level of peak performance where the senses are perfectly alert, the athlete makes decisive and effective decisions, and interestingly, where 'feelings' seem to disappear. There is no emotion. Just an overall feeling of calm and focus. Energy levels are flat, no peaks and troughs. There is no stress, and celebrations don't feel necessary either.

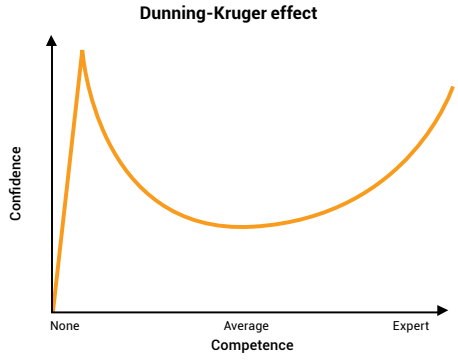
Kobe Bryant explained in an interview that he used to listen to the Michael Myers Halloween[1] theme song to try to get in the zone. He explained the meaningfulness of the mask being 'void of emotion', a place where there were no distractions, only focus. He described being in the zone as a feeling of "supreme confidence, and complete belief in one's ability to execute a plan".

Underpinning his ability to perform under pressure was something he called his "mamba mentality". A dedication to practice and repetition, to technical mastery. He would consider himself ready when execution of a move no longer required any thought. Reflecting on my own life, I thought back to my high-school years, when I was playing violin at a high level. I took a similar approach to practice – playing the same thing over and over and over again. While preparing for a competition, I would set myself the goal of being able to do 20 'reps' of the music without making a mistake. If I did, I would reset the counter, and start again. When I was able to do this, I found that stepping on that stage, I felt no fear, no anxiety and I could focus on producing the music. When I couldn't, I knew I was underprepared, and the emotions crept in.

So, what do I think is missing from simulation? Well, where is the opportunity to practice? I wonder if it would be more beneficial sometimes to run the same simulation 20 times in a row rather than change scenarios and rotating roles to 'give everyone a go'. Like watching the same movie over and over again, you are more likely to pick up on the small details when repeating something, as opposed to doing it once and moving on. I'm going to guess that most simulation experts would disagree with me here and say that the improved performance with repetition simply reflects participants learning the scenario, rather than implementing the underlying learning objectives, and improvements in performance would not translate into real-world anaesthesia where every situation is different. I would be very happy to be corrected on this, but I could not find any research to confirm or refute this claim. What I do know is that, when I learned a piece of music well, my ability to sight-read a new piece of music with a similar motif or technique was much better. I don't think it's that far-fetched that repeating simulations (in the way you might do drills in a sport) will improve your performance in real life more than if you do many different simulations once each. In the words of Bruce Lee, "I fear not the man who has practiced 10,000 kicks once, but I fear the man who has practiced one kick 10,000 times."

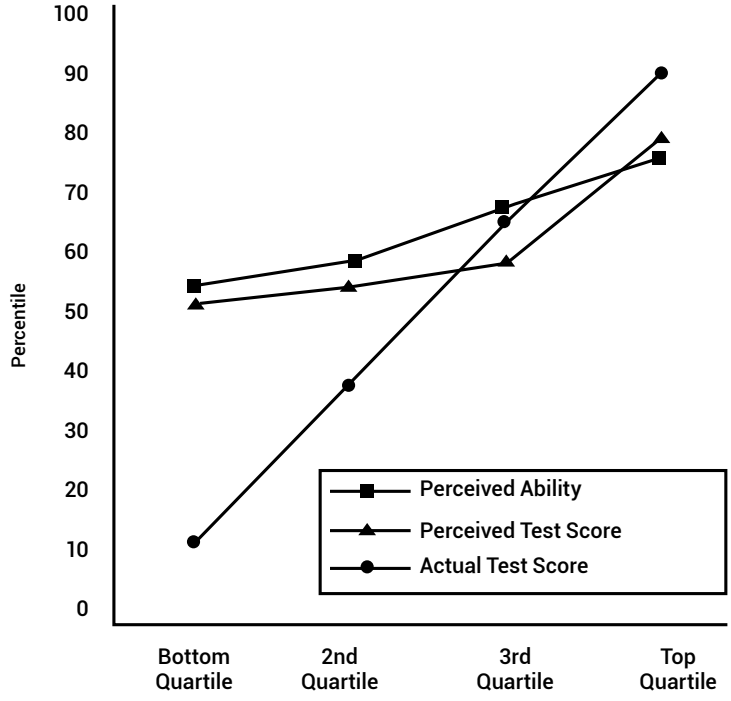
## The Dunning-Kruger Effect

Ahh the famous Dunning-Kruger effect. The observed tendency that people who perform poorly compared to their peers tend to over-estimate their performance, and those who perform favourably tend to under-estimate their performance. Everyone recognises this graph.[2]




This is so engrained and well accepted, there is a reflexive tendency to think that confident trainees (who by definition can't be experts due to lack of experience) lack insight and are dangerously overconfident. We encourage these trainees to 'chill out' and warn them to be more careful. In contrast, we reflexively think that underconfident trainees are probably being overly humble, are probably better than they let on, and we encourage these trainees to relax, be more proactive, and to have more confidence. Well, here are the original results from the original study.[2]

Many other subsequent studies of the Dunning-Kruger effect replicate similar-looking results. It is easy to see how the Dunning-Kruger effect in its current form may have been concluded – that poorer performers are frequently overconfident and lack insight, and higher-performing people tend to be more humble in their self-assessment. However, the truth is more complicated than that.




**Perceived logical resoning ability and test performance as a function of actual test performance**

Table 2

Bottom and Top Performers' Average Actual Score, Estimated Raw Score and Estimates of the Average Raw Score Achieved By Other Participants.

| | Bottom Performer Estimates | | | Top Performer Estimates | | | |
|---|---|---|---|---|---|---|---|
| Study | Self | Other | Actual | Self | Other | Actual | Average Performance |
| Logic I | 70.9 | 72.7 | 48.2 | 70.0 | 63.7 | 79.6 | 64.7 |
| Grammar | 64.7 | 68.8 | 45.9 | 84.7 | 77.2 | 82.1 | 66.4 |
| Logic II | 55.3 | 62.7 | 3.2 | 88.9 | 73.9 | 100.0 | 49.1 |
| Exam | 76.0 | 77.6 | 55.5 | 82.3 | 78.8 | 87.0 | 71.2 |
| Overall | 65.7 | 69.9 | 33.3 | 83.1 | 74.4 | 89.0 | 61.2 |

Open in a separate window

Note: Raw Scores are expressed as a percentage of total score possible in each study.

Take a look at the raw data from some of these follow-up studies.[3] The poor performers overestimated their raw mark, but still reported that they were doing below average, just not as much as they were, and the top performers still do think they're doing better than average, just not as much as they actually are. Presumably then people who did 'average' thought they did average. It's just hard to be less average than you already are (regression to the mean). Interestingly, both high and low performing groups thought that the average performance of participants was better than it actually was over multiple domains, and interestingly poor performers seemed to be more accurate in their assessment of the group.

The reason this distinction is important is that the opposite (deducing someone's performance based on their level of confidence, in particular judging all confidence as overconfidence, and all insecurity as humility) is actually entirely unreliable, and the Dunning-Kruger effect was not designed to support this kind of analysis. Indeed, if anything, based on the experimental data, you should actually reach the opposite conclusion. Here, confidence likely reflected a high level of performance, and insecurity likely reflected a poor level of performance. Indeed, those that were self-confident were more likely to be humble, and those who were insecure were more likely to be arrogant. The problem is telling confidence and arrogance apart, and humility and insecurity apart. This can be nearly impossible.

The reason this distinction is important is that the opposite (deducing someone's performance based on their level of confidence, in particular judging all confidence as overconfidence, and all insecurity as humility) is actually entirely unreliable, and the Dunning-Kruger effect was not designed to support this kind of analysis.

## Conclusion

So, what do I want you to take away from these ramblings? Firstly, repetitive, and deliberate practice are highly effective ways to improve your performance (at least in simulation), and I believe that it is highly likely that this will cross over into real-life performance. Secondly, repetitive rehearsal is more likely to lead to performing 'in the zone' during a crisis, where negative emotion is less likely to affect how you perform. The confidence and belief in your ability to execute a plan is extremely important during an anaesthetic crisis. As a follow on from this, we shouldn't rush to label all confidence as arrogance, and all insecurity as humility. Confidence or lack thereof should not cloud your assessment of a person's ability.

As the exiting TMG chair, I would like to end my final AA article by welcoming our new incoming TMG Chair, Dr Julia Rouse. The TMG is committed to continuing our support to make things better for all trainee members by addressing issues that cover the whole breadth of trainee experiences from those that are struggling, to those that are thriving. The importance of continual presence, activity and counterpressure cannot be understated in the adversarial system that determines our enterprise bargaining agreement which if left unchecked will cause us a death by 1000 cuts. It is therefore doubly important that you make sure to stay engaged with us and encourage your non-member colleagues to become members. There is a certain strength in solidarity.

**Dr Jason Kong**

Immediate Past Chair of TMG Committee

### References

1 Halloween 2007; Dimension Films.

2 Kruger J, Dunning D. Unskilled and unaware of it: How difficulties in recognizing one's own incompetence lead to inflated self-assessments. Journal of Personality and Social Psychology. 1999; 77(6), 1121–1134. https://doi.org/10.1037/0022-3514.77.6.1121

3 Ehrlinger J, Johnson K, Banner M, Dunning D, Kruger J. Why the unskilled are unaware: Further explorations of (absent) self-insight among the incompetent. Organizational Behavior and Human Decision Processes. 2008; 105(1), 98–121.

# AROUND AUSTRALIA

## Victoria

### Dr Michelle Horne

*Chair of the Victorian Committee of Management*

I am pleased to bring you updates from Victoria, following the hosting of the 2023 National Scientific Congress (NSC) in Melbourne last October (read all about it in the December AA article). The NSC was warmly received by so many, which is a real compliment to the effort of the 2023 NSC committee. I am especially pleased with the enthusiasm for sharing smaller and bigger research works via posters and the significant prize sessions. Thank you to the Airway Management SIG for running a satellite meeting to lead us in. We have a debt of gratitude to the Victorian members who brought the NSC to you (many of whom are also committee members): Dr Grace Gunasegaram, Professor Laurence Weinberg, Dr Kaylee Jordan, Dr Michelle Chan, Dr Richard Seglenieks, Dr Janette Wright, Dr Lucky De Silva, Dr Jennifer King, Dr Mark Suss, Dr Rod Westhorpe, Dr Alex Courtney, Dr Rebecca Zhao and Dr Zoe Keon-Cohen.

The NSC was followed by an ASA Victorian AGM & Forum on the 26th of November 2023. Recent topics of irritation amongst the anaesthetic community were aired and we have been able to follow up on some of these issues. Additionally, as Chair I am a member of various working groups and committees representing the ASA. One such body is the Victorian Surgical Recovery and Reform Taskforce, as a voice for anaesthetists. The Taskforce has varied representation and was established in response to the developing crisis related to planned surgery waitlists and access to surgical care for Victorians over the last few years, a concern shared by many across the country. The 'Planned Surgery Reform Blueprint' as an output of that Taskforce was released on the 25th of October 2023 and was virtually launched on the 1st of November. This blueprint outlines ten interrelated areas of focus, some underway and some more aspirational by the Department of Health. Additional information can be accessed on the Department of Health website: https://health.vic.gov.au/planned-surgery-reform-blueprint.

The ANZCA Part Zero course, assisted by ASA contributions was held on February 23. In other news, we thank Dr Jason Kong who has now concluded his time as Trainee Member Group Chair and Dr Pieter Peach who reaches the end of his six year term as ASA Representative and Chair of ANZTADC.

Save the date: July 27-28 2024 Melbourne Winter Anaesthetic Meeting. Once again, we will run a scientific program followed by a Practice Evaluation session.

## Queensland

### Dr Graham Mapp

*Chair of the Queensland Committee of Management*

We have some exciting plans for our Queensland members this year! We held the Part Zero course in February, followed by a social gathering at the wonderful Covent Gardens for our new registrars. We are also looking forward to hosting the ANZCA Annual Scientific Meeting in Brisbane in May. A gala evening to celebrate the Australian Society of Anaesthetists' 90 years later in the year is also being considered, and we'd love to hear our members' thoughts on this. Please reach out to any of your Queensland Committee members to share your thoughts.

## Western Australia

### Dr Archana Shrivathsa

*Chair of the Western Australian Committee of Management*

The WA Part 3 course was a highlight of 2023, held at the Westin Perth on December 15th, and meticulously organized by our trainee representatives Dr Merredith Cully and Dr Rebecca Wood. In addition to the excellent speakers, attendees had the opportunity to meet and discuss issues of life as a consultant anaesthetist in public and private with representatives from the major anaesthetic groups and public and private hospital Heads of Department. The Part 3 course was followed by our annual cocktail evening in the stunning surrounds of Hearth Lounge.

Congratulations to Dr Cully and Dr Wood on an exceptional event!

2024 brings ongoing and fresh challenges for anaesthetists in WA which the ASA Committee is well prepared to tackle.

I'm very pleased to introduce myself as the incoming Chair of the ASA WA

Committee. I'm a WA-trained anaesthetist working in public and private practice across the metropolitan area. My interests are in perioperative medicine, the environmental and financial impacts and sustainability of perioperative care, and maintaining the high standards of anaesthesia training and practice in Australia.

I would like to thank our immediate past chair Dr David Kingsbury and our State Committee for their work and advocacy for all anaesthetists in WA.

## Australian Capital Territory

**Dr Girish Palnitkar**

*Chair of the ACT Committee of Management*

Greetings from the ACT!

My name is Girish Palnitkar. I am the new Chair of the ACT Committee of Management. It is clear I am stepping into a role with great responsibility and a dedication to serving the anaesthetists of the ACT. I'd like to take this opportunity to thank the magnificent Dr Vida Viliunas for her years of service and commitment to our Territory and wish her well on her next journey on the ASA Board. I certainly have big shoes to fill!

A little about me - I am a full-time VMO with a mixed private-public practice with a focus on cardiothoracics, orthopaedics, ENT and upper GI surgery. I also consult as a health economist and actively participate on the EAC of the ASA.

2024 is shaping to be an exciting and productive year in the ACT. We are facing several challenges, including issues with public in the private, DVA, and the implementation of managed care models. This highlights the importance of the ASA's involvement in advocating for the interests of anaesthetists and the ACT Committee will continue to contribute and play our role in this advocacy.

From an education perspective, the Art of Anaesthesia meeting will take on a different look this year with a focus on CPD. We are also excited to be hosting the ever-popular Scan and Ski event at Thredbo. Watch this space for more information on both!

Another focus for the ACT Committee will be the planning of the 2025 NSC, which is to be held in Canberra. Planning has already begun in earnest with an exciting programme being developed by the team led by myself as Convenor, Adam Eslick as our Scientific Convenor and Julia Hoy as our Social Convenor. We look forward to sharing more details with you as we get closer to the event.

Finally, a reminder that your ACT Committee is here to support and represent YOU! I encourage you to reach out to me or any committee member, if you have any concerns, issues, or feedback. I look forward to an exciting year ahead as your Chair.

## South Australia / Northern Territory

**Dr Sophia Bermingham**

*Chair of the South Australia / Northern Territory Committee of Management*

**Support**

One issue I wish to draw your attention to is the ongoing challenge that is public-in-private (PIP) work. Since our last report, we have had very successful meetings with both Calvary Care and ACHA regarding PIP work. The ASA has been clear in our support of appropriate and safe care for these patients. We have offered education and guidance regarding the perioperative journey, sharing of information and remuneration for PIP work.

Furthermore, we met with SA Health Chief Medical Officer Dr Michael Cusack and his team this week regarding issues such as workforce shortages and PIP work.

SA/NT Part 3 Course attendees enjoying post course drinks.

ASA President, Dr Mark Sinclair presenting at the SA/NT Part 3 Course in January.

It was a very productive discussion and an opportunity to both advocate for our members and establish rapport for any future issues that might arise.

**Represent**

Alongside the AMA, the SA/NT ASA committee are investigating and speaking with those who set the Return to Work SA rate ('WorkCover') which has not been indexed in almost 15 years and currently sits at just over 50% rates nationwide. We recently conducted a survey of our membership which revealed that many members were unaware of this discrepancy and were keen for us to advocate on their behalf for appropriate remuneration levels and indexation. My sincere thanks to Dr Louis Papillion, Dr Tim Donaldson, Dr Tristan Adams, and the AMA for their hard work in this area. We will keep you updated on any further progress that is made.

**Educate**

We direct you to the ASA PIP guideline that can be found on our website (https://asa.org.au/policy/position-statements-3/asa-ps23-anaesthetists-and-public-in-private-surgery-pip/?_zs=i38Pl&_zl=RIfj2). 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.

My sincere gratitude to Dr Jarmila Sterbova, Dr Julia Rouse and Dr Evelyn Timpani for organising our fabulous Part 3 Course in January this year. It was great to see lots of familiar and new faces at our event, we were fortunate to have a very strong list of presenters. It provided attendees with the opportunity to speak to the new ASA President, Dr Mark Sinclair, who outlined all the important work the ASA is doing to look after anaesthetists!

This year we are proud to host the ASA National Scientific Congress in Darwin from September 6th-9th. I want to encourage everyone to register and confirm flights, accommodation 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.

## Tasmania

As members may be aware Dr Simon Morphett stepped down as Tasmanian Committee of Management Chair following the AGM last month. Dr Morphett has contributed to this committee for four years and we thank him for his dedication to the profession and look forward to him continuing with the Committee as Immediate Past Chair. We are now seeking expressions of interest to join the Tasmanian Committee of Management. This is a fantastic opportunity to engage and learn from some of the most outstanding contributors in our profession. If you are interested in joining the committee, please email your CV and letter of interest to committees@asa.org.au.

Dr Neil Street AM – inventor of the MH machine

# NEW TO THE MUSEUM: HYPERTHERMIA TESTING UNIT

**AS CURATOR OF THE HARRY DALY MUSEUM, ONE QUESTION I'M OFTEN ASKED IS HOW DANGEROUS IS MODERN ANAESTHESIA? FOR THE NON-MEDICAL, NON-ANAESTHETIST VISITOR IT IS A QUESTION WHISPERED WITH THE SCARED CURIOSITY, AKIN TO WATCHING A HORROR MOVIE THROUGH YOUR FINGERS.**

Thankfully, there is often visible relief in the visitor when I explain that in Australia, having an anaesthetic is extremely safe, and indeed is so safe due to our standards, intensive training and ever evolving clinical practices.

However, it remains high risk for patients with Malignant Hyperthermia Susceptibility (MHS) – a rare pharmacogenetic disorder, characterised by reactions to certain drugs used commonly in anaesthesia. It can be fatal without prompt treatment. It induces a hypercatabolic state with symptoms including dangerously high body temperature, muscle spasms, rapid heart rate and increased cardon dioxide production. The syndrome is caused by a defect in the ryanodine receptor, with the characteristic pathophysiologic changes of malignant hyperthermia occurring due to uncontrolled rise of myoplasmic calcium. Diagnostic testing relies on assessing the in vitro contracture response of biopsied muscle to halothane, caffeine, and other drugs.

Diagnostic testing relies on assessing the in vitro contracture response of biopsied muscle to halothane, caffeine, and other drugs.

The incidence of Malignant Hyperthermia (MH) reactions ranges from 1:5,000 to 1:50,000–100,000, but the prevalence of the genetic abnormalities may be as great as 1 in 3,000 individuals. Generally, patients will not be aware if they have MHS, unless they have a known family history to fatal or near fatal anaesthetic reactions.

One of our latest donations to the Museum is an original MH testing machine from The Children's Hospital at Westmead (CHW), Sydney. This unique and custom-built unit was developed and designed by the late Dr Neil Street AM, a pioneer in MH research and testing.

The machine for in vitro contracture testing (IVCT) of muscle samples was decommissioned in 2022, as the MH Unit at CHW is being upgraded, twenty years after Drs Street, David Baines AM, Margaret Perry and Mark Lovell founded the team in 2002. The MH Unit was one of only four of its kind across Australia and New Zealand. Staff tested patients from across New South Wales, Queensland, and Canberra through genetic analysis or muscle biopsy. Dr Gail Wong noted during the donation that it is thought to be the first IVCT testing set up accredited outside of Europe by the European Malignant Hyperthermia Group, whose testing protocol remains the standard for IVCT (accredited circa May 2006).

Dr Wong further described the machine as "not having been altered from its original condition when I had taken over the IVCT testing. At a pinch, it may well still work! The main components – the tissue baths, transducer set-up and heating system – were designed and created by Neil Street with his biomedical engineering colleagues at Children's Hospital Westmead, and are very elegant and well thought-out. He had factored in some measure of portability in its design as he had considered taking it to country NSW (Central West region) where MH susceptibility ran in a large family. He thought to take his machine to the patients rather than the other way around and to test the family members *en masse* whilst visiting from time to time."

This object represents the engineering, drive and passion of a great Australian anaesthetist. It will be a key part of communicating to a general audience the risks, and risk minimisation, of contemporary anaesthetic practices – emphasising of course, how rare these genetic risk factors are. In fact, with recent research in understanding the clinical manifestation and pathophysiology of MHS, the mortality rate from MH complications has dropped from over 80% thirty years ago to less than 5% today.

Thanks to Dr Gail Wong and Dr Justin Skowno for the donation, and for Dr Michael Cooper for assisting with the acquisition process.

## Celebrating 90 years of ASA

To mark the ASA's milestone 90th anniversary, the HALMA committee have plumbed the archives (and their own memories) to create ten posters exploring the history, developments, changes and innovations of the Society during the past century. You can peruse the first three of these posters in the following pages. Many thanks to Dr Richard Bailey and Dr Don Maxwell for their research into the first three posters, covering the first two decades of the Society, and the beginnings of the 20th century leading to that pivotal meeting on 19 January 1934 at Hadley's Hotel in Hobart which founded the ASA.

Over the course of 2024, the remaining decades will be published here in the magazine, as well as online (and keep an eye out for them at the forthcoming Darwin NSC!).

**Kate Pentecost**

ASA Museum Curator, Archivist and Librarian.

# TOWARDS FOUNDATION

**Step into the historical roots preceding the establishment of the Australian Society of Anaesthetists (ASA) that laid the foundation for 90 years of the ASA's enduring contributions to the field of anaesthesia.**

## Birth of Anaesthesia

On October 16, 1846, the medical landscape witnessed a groundbreaking moment with the first public demonstration of ether anaesthesia in Boston. This event marked the inception of a revolutionary approach to medical practices, paving the way for the transformative role of anaesthesia in healthcare.

Robert Hinckley, "The First Operation Under Ether," Harvard Countway Library.

## Ether Arrives in Australia

News of ether-induced 'painless surgery' reached Australia in 1847. This was soon followed by the first administration of ether anaesthetics in the country on June 7, 1847, carried out by Drs Charles Nathan, John Belisario, and William Russ Pugh. Together, these events laid the initial groundwork for the practice of anaesthesia in Australia.

## Full-Time Anaesthetist Emerges

In 1909, Dr R W Hornabrook assumed the role of the first full-time anaesthetist in Australia. This marked a crucial moment in the professionalisation of anaesthetic care, showcasing the emergence of dedicated experts in the field.

## The Vision for a Society

The visionary Dr Hornabrook, in 1913, made the first suggestion to form a society dedicated to anaesthesia. This forward-thinking proposal laid the groundwork for the eventual establishment of the ASA.

## Contributions of Dr Geoffrey Kaye

In 1927 a pioneer in the fields of Australian anaesthetics and anaesthetic apparatus design entered the scene, Dr Geoffrey Kaye. As Australia's second full-time anaesthetist, Dr Kaye's contributions were instrumental in shaping the trajectory of anaesthetic practices in Australia.

Dr Hornabrook administering ethyl chloride on a light honeycomb towel to a nine-year-old girl at the Melbourne Dental Hospital, May 8, 1915.

*Anaesthesia and Intensive Care, Vol. 27, No. 5, October 1999*

## Formal Recognition by BMA

The year 1929 witnessed a pivotal moment with the establishment of the first Section of Anaesthetics within the British Medical Association (BMA) in Australia. This formal recognition marked a significant step in acknowledging anaesthesia as a specialised field within the broader medical community in the country.

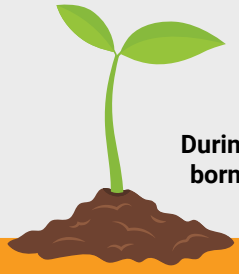
## Looking to learn more?

Discover more about the evolution of the Australian Society of Anaesthetists.

This poster was developed by the History of Anaesthesia Library, Museum and Archives Committee (HALMA) of the Australian Society of Anaesthetists

# 1934 - 1943

## THE FOUNDING DECADE



**During this formative decade, the Australian Society of Anaesthetists (ASA) was born, setting the stage for a path of advancement, cooperation, and excellence that would profoundly influence Australian anaesthesia.**

### Australasian Medical Congress

In January 1934, at the British Medical Association (BMA) Congress in Hobart, Dr George Leonard Lillies took charge of the Section of Anaesthesia, orchestrating three sessions dedicated to exploring diverse facets of this burgeoning specialty. This marked a significant acknowledgment of anaesthesia as an independent and vital field, laying the foundation for subsequent pivotal advancements.

### Foundation Meeting at Hadley's Hotel

On January 19, 1934, after the final anaesthesia session of the BMA Congress, an informal gathering at Hadley's Hotel in Hobart marked the foundational meeting of the ASA. This meeting brought together seven visionary doctors, shaping the nascent stages of the ASA.

### Founders of ASA

The visionary septet, comprised of Geoffrey Kaye, Gilbert Brown, Gilbert Troup, Harry Daly, Ivor Hotten, George Lillies, and Cedric Duncombe. This group not only founded the ASA but also laid the essential groundwork that propelled the ASA towards growth and success.

### ASA's Mission Declaration

On January 20, 1934, the ASA solidified its mission with a Statement of Aims, outlining objectives such as enhancing the status of anaesthesia in Australia, fostering international collaboration, encouraging research, and promoting the publication of anaesthesia-related articles.

### The Inaugural Annual General Meeting

The inaugural Annual General Meeting (AGM) of the ASA took place in Melbourne from September 16-18 in 1935. Dr Zebulon Mennell from St Thomas' Hospital, London, graced the event as the first Guest of the Society. This gathering marked a crucial step in the formalisation of the ASA.

Dr. Geoffrey Kaye

### Formation of Museum & Library

In 1939, during the third AGM in Melbourne, the ASA turned its attention to preserving its history and knowledge by establishing a Museum and Library. This initiative, led by Gilbert Brown's Presidential Address, aimed to safeguard the rich heritage and advancements in anaesthesia.

### Looking to learn more?

Discover more about the evolution of the Australian Society of Anaesthetists across 1934 - 1943.

This poster was developed by the History of Anaesthesia Library, Museum and Archives Committee (HALMA) of the Australian Society of Anaesthetists

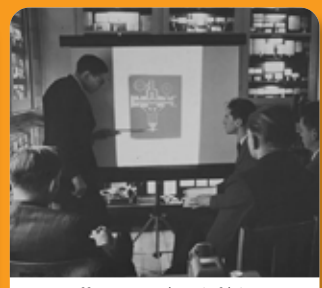
# 1944 - 1953

## A DECADE OF RESURGENCE AND RESILIENCE

**This was a dynamic decade, shaped by dedicated leaders and a collective commitment to excellence. This propelled the Australian Society of Anaesthetists (ASA) to consolidate its position, elevate standards, and champion the welfare of anaesthetists nationwide.**

### Forging a New Era

In the aftermath of World War II, anaesthetists recognised the necessity for organisation and education, navigating challenges and embracing new advancements. The ASA and anaesthetists played a vital role during the war, contributing expertise to the medical efforts and fostering valuable skills that would later shape the post-war regeneration of anaesthesia practices.



Dr. Geoffrey Kaye (top left) lecturing in the 1950s. Image courtesy of the Geoffrey Kaye Museum of Anaesthetic History.

### Overcoming the Tyranny of Distance

In an era marked by the vastness of Australia and limited connectivity, the ASA faced the challenges posed by the 'tyranny of distance'. Communication hurdles were overcome as the Society, led by dedicated individuals, sought innovative ways to connect anaesthetists across the expansive landscape.

### Crafting a New Structural Identity

In the post-War years (1945-1950), the ASA experienced a resurgence, reviving Annual General Meetings after a hiatus during the conflict. Dr Geoffrey Kaye, demobilised in 1943, played a pivotal role in revitalising the Society. New agents, techniques, faces, and voices emerged, propelling membership from 53 in 1946 to 108 by 1950.

### Establishing State Autonomy

A landmark decision during the 1948 Annual General Meeting in Perth saw the ASA constitutionally establish State Sections, granting autonomy to individual states. This move proved crucial, decentralising administration, empowering states to address local issues, negotiate with governments, and contribute to the national agenda.

### Growing Membership

With a fervent focus on education, the ASA passionately pursued higher standards for anaesthetists. Membership tripled from the initial 34 members in the previous decade, with an increasing number seeking diplomas in anaesthetics. The Society's dedication to quality education laid the foundation for professional excellence.

Oxygen & nitrous oxide cylinders made by Commonwealth Industrial Gases Ltd. CIG was a key manufacturer and developer of anaesthetic equipment in Australia until the 1990s. Image courtesy of the State Library of Western Australia.

### Navigating the Space Challenge

Navigating the complexities of securing a headquarters, the Society initially found its home this decade at 49 Mathoura Rd Toorak, Melbourne. This marked the hub for meetings, lectures, and the Museum of anaesthetic equipment. Under Dr Geoffrey Kaye's leadership, centralising in Melbourne marked a pivotal phase, cementing the Society's structure and presence.

### Looking to learn more?

Discover more about the evolution of the Australian Society of Anaesthetists across 1944 - 1953.

This poster was developed by the History of Anaesthesia Library, Museum and Archives Committee (HALMA) of the Australian Society of Anaesthetists

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

# DAVID HENRY MCCONNEL

OAM

22/04/1939 – 4/11/2023

David Henry McConnel was born in Toowoomba on 22nd April 1939. He had a state school education before enrolling in medicine at the University of Queensland (UQ) in 1957. He met Audrey Edwards at a friend's wedding four years later and renewed the friendship when completing a surgical term at Princess Alexandra Hospital as a final year student. She was the surgical registrar and in spite of him being dispatched to Cairns as a resident, the romance flourished, and they were married in 1964.

He returned to Brisbane taking up a position as an anaesthetic registrar at the Royal Brisbane Hospital which he occupied for two years. Although this was a training position there were no structured courses for the primary examination, so he was advised to enrol in the course at the Royal College of surgeons in London. He passed the primary in May 1968 and with references from anaesthetists who had worked in England was able to obtain a registrar opposition at the London Hospital. He enjoyed the London with its long history, strict hierarchical tradition, and the fact that you had to wear a suit to lunch and sit at the correct table. He passed the English Fellowship in the following January.

While in London he received an invitation to join Dan Hogg's practice in Brisbane in July 1970. To fill in time he took up a Staff Anaesthetist position at Grotte Schurr Hospital in Cape Town. In correspondence he advised that the work was interesting, and he was being well treated but as usual expenditure exceeded income. Although the English fellowship afforded specialist registration, he successfully took the Australian fellowship on his return.

He was extravagant and throughout his life he had a different appreciation of money. Not long after starting practice he purchased a yellow Fiat 124 and had driving gloves, dark glasses, and cap similar to Sterling Moss. Driving with him was an experience best avoided. Appearance was important to him, and he had all his clothes tailored and had a silk handkerchief 'vomiting' out of the breast pocket of his jacket.

The ethos of the practice he joined was that as well as working in private practice, time should be given to the administration of the specialty, teaching and returning time to the public system in which you were educated. He was appointed Visiting Specialist to the Royal Brisbane Hospital, a position he occupied for over 20 years. In 1974 he became a member of the regional committee of the Faculty, Continuing Education Officer from 1975 to 1980 and Chairman from 1980 to 1982. In 1976 he was appointed Examiner for the Final Examination and was elected to the Board in 1984. He spent 12 years on the Board of Faculty and later occupied many positions on the Board including Protocol Officer which he enjoyed.

In 1976 he was Chairman of the regional committee of the Australian Society of Anaesthetists (ASA) which was staging the National Scientific Congress at the Gold Coast, where he was part of the organising committee, when he was elected Vice President. This meant he was President from 1978 to 1980. During his time The ASA purchased its first freehold property at Gurner Street, and he was part of the committee which designed the ASA

The ethos of the practice he joined was that as well as working in private practice, time should be given to the administration of the specialty, teaching and returning time to the public system in which you were educated

logo. Until this time the ASA had been reliant on the generosity of the Elizabeth Bay Gas Company for office space.

He developed an interest in The Medical Defence Society, became a member of the Cases Committee and ultimately President of the Queensland Medico Legal Society.

Jazz music entertained him, and he had his own double bass and would try to play with the band at ASA meetings. He was a regular attender of the opera and with Audrey developed a collection of contemporary art and enjoyed lunching at the Queensland Club. He had a wine cellar next to his office under his house. At an ASA meeting in Adelaide, he bought so much wine that the cases had to be delivered before they returned home and they had trouble getting in the front door.

He began to receive recognition for his efforts and was awarded the Australian and New Zealand College of Anaesthetists (ANZCA) Medal and Citation in 2003 and the Order of Australia Medal in 2012 for service to medicine, particularly as an anaesthetist. He retired from practice in 2013.

He enjoyed his retirement spending time at his beach house and having lunch with his friends at the Queensland Club even though, with time, this was becoming more difficult due to deterioration in his physical condition.

He is survived by Audrey and their children, Anthony, Phillipa and Victoria and three grandchildren.

He was extraverted, extravagant, hardworking and enjoyed life to the full. We will miss him.

**Dr John Hains**

Past President Australian Society of Anaesthetists

# LETTER TO THE EDITOR

Dear Editor,

It is disturbing that the NSW Health Department has announced that Desflurane will be removed from the public hospital formulary effective March 1.

The reasons for this decision have been outlined by the Formulary Committee after discussion with the NSW Health Net Zero Team and are based on:

1. Cost
2. Environmental concerns
3. Availability of clinically equivalent alternatives

I strongly believe that none of the above reasons justify the action taken.

### Cost

We calculated that using a low flow modality at an end tidal concentration of 6.6% (above MAC) that the cost of running desflurane is $7 per hour. This was based on the cost of a bottle of $196 which is the price at our hospital. This calculation was confirmed by the anaesthetic machine which calculates hourly cost during maintenance mode.

### Environmental Concerns

The impact of this agent on the environment is a subject of controversy. A review article published in *Anaesthesia* this year by Slingo and Slingo describes the effects of desflurane on the environment as vanishingly small. While these findings have been questioned it at least casts enough doubt given the credentials of these authors that a decision to remove a therapeutic agent based on questionable science is indeed that, questionable. Of far greater concern is the unchecked leakage of nitrous oxide from fractures in piping caused by the agent. It has been shown in the UK that up to ten times the amount of nitrous is lost through pipe leaks than is used clinically. It beggars the question why this hasn't been pursued with the same vigour that the elimination of desflurane has by those practitioners who don't even use the agent?

### Availability of clinically equivalent alternatives

To state that the pharmacological profiles of both TCI and sevoflurane are clinically equivalent to desflurane simplifies our specialty and appears to be an attempt to create a one size fits all formula for providing anaesthesia. To leave us with essentially a choice of one volatile agent and discard an agent with significantly superior washout characteristics especially in the bariatric population is in my opinion a severe restriction on our ability to provide what the individual decides is the highest quality of care.

When a move as significant as this is taken by a bureaucratic body with limited consultation with the specialty it signals a dangerous precedent for us as clinicians who expect to be able to make therapeutic decisions based on our training and experience. What happens in the future when we receive notice that there is a worldwide shortage of sevoflurane or that propofol production has been interrupted by unforeseen circumstances. Reduction of options is unwise and I feel strongly that our clinical independence has been undermined.

Of far greater concern is the unchecked leakage of nitrous oxide from fractures in piping caused by the agent

Yours Sincerely,

**Dr Louis George**

VMO Anaesthetist and Deputy Director Gosford Hospital Department of Anaesthesia and Pain Management

# Join now and connect with your community

Australian Society of Anaesthetists®

Dr Lan-Hoa Lê
ASA Member since 2016

- EDUCATION
- ADVOCACY
- SCHOLARSHIPS AND GRANTS*
- EVENTS
- PUBLICATIONS
- RESOURCES
- FORUMS

**The ASA represents and advises Anaesthetists and is a peak body organisation that is respected and consulted by government, hospital management, local health districts and health insurers.**

**www.asa.org.au | 1800 806 654 | membership@asa.org.au**

*Applicants require a minimum of 12 months ASA membership to be eligible.

# 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®