AUSTRALIAN

Anaesthetist

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

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INSIDE ANAESTHESIA

A PARTNER'S PERSPECTIVE

MULTIDISCIPLINARY WORK BUILDS BETTER COMMUNITIES IN HEALTHCARE

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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.

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Australian Society of Anaesthetists®

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

Contents

Would you like to contribute to the next issue?

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

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

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


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DR MARK SINCLAIR
PRESIDENT

FROM THE ASA PRESIDENT

THE ASA BOARD AND COUNCIL HELD A STRATEGIC PLANNING MEETING IN LATE MARCH. AN ORGANISATION SUCH AS OURS, WHICH NEEDS TO ADAPT TO AN EVER-CHANGING ENVIRONMENT, MUST FORMALLY REVIEW ITS AIMS AND GOALS ON A REGULAR BASIS, AND OF COURSE REFLECT ON PAST EVENTS AND ISSUES.

I am grateful to all of our Councillors, Board members and ASA staff for their excellent input on the day. Also special thanks to Mr John Peacock AM (CEO, Associations Forum), who is an experienced advisor to associations and societies (particularly in the not-for-profit sector), and who led our discussions on that day. Our CEO Matthew Fisher reports in more detail, on page 6.

The Parliamentary Round-Table meeting referred to in the last edition of Australian Anaesthetist had to be postponed, as Parliament rose earlier than expected in March. The meeting has been shifted to August. One key point of discussion will be anaesthesia workforce issues as we move into the future. Members may well be aware from other ASA reports that we engaged Health Consult (healthconsult.com.au) to analyse and predict our future workforce requirements, given the ever-increasing demand for anaesthesia services. Again, our CEO provides detailed data in his report. We also thank ANZCA for providing some of their own workforce data. Clearly, we need to train more specialist anaesthetists and this will be a key message to governments across the country. This is no reflection on ANZCA, which does not set trainee numbers but rather has the role of ensuring training locations are providing the appropriate educational opportunities and resources. Governments across the country are responsible for employing trainee specialists. Producing more qualified anaesthetists takes time, and there may be a temptation for our leaders to engage in 'quick fix' remedies such as recruiting anaesthetists from overseas, or handing over anaesthesia care to lesser-trained healthcare professionals.

There is of course an argument for recruiting anaesthetists from other countries, and we all believe Australia is the best place to live and work! However, quality and safety are, as always, paramount. Overseas-trained anaesthetists must meet our requirements for training and experience. ANZCA must be the go-to body to assess our overseas colleagues' qualifications, not government bodies. We also need to take note of the fact that it is not just Australia facing a shortage of anaesthetists, and of many other healthcare professionals as well. So we

Governments across the country are responsible for employing trainee specialists. Producing more qualified anaesthetists takes time, and there may be a temptation for our leaders to engage in 'quick fix' remedies such as recruiting anaesthetists from overseas, or handing over anaesthesia care to lesser-trained healthcare professionals.

may well be creating further problems in other countries with this approach.

On the issue of task substitution, this is of course something that is not new. 'Conscious sedation' services are already provided by other healthcare professionals. But again, safety and quality are essential. The ASA continues to take the position that any 'sedation' level deeper than 'conscious sedation' is essentially anaesthesia, and must be provided by appropriately trained specialist doctors or recognised GP anaesthetists, in appropriately staffed and equipped facilities.

For this reason, the ASA continues to closely watch the Department of Health and Aged Care 'Scope of Practice' review. At the time of writing, the second discussion paper has just been released by this group. Members who would like further reading material can obtain updates online, at https://www.health.gov.au/our-work/scope-of-practice-review. The AMA has also given extensive feedback. The review continues to focus on primary care rather than other specialties, and the task will clearly require intensive work, and quite some time, to implement. However, it may well move on to consider specialties such as ours, and there is always the possibility that other authorities will consider the issue in the meantime.

ASA members from a number of Australian states have contacted the ASA with concerns regarding payroll tax liabilities, which are being considered by their state governments. As private practice anaesthetists are typically not employees, this is something which has not been seriously considered in the past. However, depending on the actual method by which funds are received by doctors in private practice, it is possible that payments could be seen as being 'wages' paid under a 'relevant contract', and therefore potentially liable for payroll tax. State AMA branches have been actively lobbying their local governments on the issue. It is essential that anaesthetists in private practice take independent legal and accounting advice on their own specific situation. At the time of writing, we are not aware of any anaesthesia practices being approached by their local taxation authorities (again, general practice has been the first area considered), but anaesthetists should certainly not wait until this happens before taking professional advice.

By the time of publication of this edition, the ASA National Scientific Congress (NSC) will be only a few short months away (6 to 9 September). This will be our third Darwin NSC, and we can again promise delegates an enjoyable educational experience in this excellent venue at Australia's 'Top End'. Visit www.asansc.com.au to register, and for the latest updates. I look forward to seeing you all there!

Dr Mark Sinclair

MB BS, GAICD, FANZCA

FROM THE CEO

DR MATTHEW FISHER
CHIEF EXECUTIVE OFFICER

CELEBRATING OUR 90TH YEAR SINCE FOUNDATION HAS ALLOWED US TIME TO LOOK IN THE REAR-VISION MIRROR WHILST FIRMLY LOOKING TO THE FUTURE. THIS IS A BALANCING ACT OF RESPECTING THE TRADITIONS YET ENABLING EVOLUTION TO ENSURE THAT WE ARE FIT FOR THE FUTURE.

In late March 2024, the ASA Board, Committee Chairs and Executive Team met to review the strategic direction of the past three years to determine what needs to evolve over the next three years to 2027. Our Vision for the specialty (aspiration for the future) remains 'anaesthetists practising optimally on behalf of patients, their safety and the health system', whilst our Vision for the ASA has evolved to embrace our intent on being an exemplary society that not only advances on behalf of anaesthetists but does so overtly in the interests of the Australian public. This balances the support we provide to you (so you practice optimally) and advocate for the specialty and your patients to ensure safe and high-quality care that is accessible and equitable for Australians.

You may ask "what is different to what we have done before?" Much of it is evolution within the context of the challenges to the health system, which include resourcing and rising costs, workforce, an ageing population and increasing demand on health services, increasing rates of chronic disease, costs of medical research and innovations, making the best use of emerging health technologies and making better use of health data. As an exemplary society we need to ensure we are effective and efficient in what we do.

What we intend to do to meet our goals (Mission) is to focus on the following six key areas:

- Represent the anaesthesia specialty to stakeholders.
- Advocate for patient and community access, equity, and patient education.
- Engage with anaesthetists and provide member services.
- Provide professional development activities and resources.
- Support the welfare and wellbeing of members.
- Ensure good governance and management.

With regards to the first two areas of representation and advocacy, we will continue to build the public profile of the ASA and increase the awareness of how the specialty acts not only at an individual patient, systems and policy level, but in the interests of advancing the health literacy of the community regarding anaesthesia. Our intent is to not only elevate the voice of members in our work but that of the public through our actions. We are acutely aware of groups and self-styled experts who purport to act in the public interest though often having an undeclared bias, whereas we are stating that our members and the ASA act in the public interest on a daily basis. In short, we are aiming to be the go-to society if you want to engage and understand anaesthesia and anaesthetists.

As part of this direction, our independent review of health workforce modelling was undertaken to estimate the demand for, and supply of, the anaesthetic workforce between 2022 and 2032.

As part of this direction, our independent review of health workforce modelling was undertaken to estimate the demand for, and supply of, the anaesthetic workforce between 2022 and 2032. The model will inform future planning for the anaesthetic workforce in Australia through its understanding of the current composition and trends in the workforce and its subsequent projections of the likely changes in the supply of anaesthetists needed over the next eight to ten years to meet future service demands.

From this modelling, the anaesthetist workforce in Australia is forecast to increase by 663 specialists (12.3%) between 2023 (5,392) and 2032 (6,055). However, despite this level of growth, there are predicted shortfalls in the supply of anaesthetists relative to future demand. This modelling is at a national level and from other data, we can make commentary on a regional basis. A key driver of this is that the demand for anaesthetic services is expected to increase by 35.7% between 2017 and 2032, or from 6,011,250 MBS services in 2017 to 8,157,510 in 2032.

One of the key findings that emerged from the project was that anaesthetists' working hours are increasingly unlikely to match the ever-increasing workload into the future. This compounds the predicted undersupply of anaesthetists by 2027 which widens by 2032. Even if workload was maintained at current participation, the workforce under-supply is significant and will worsen.

The primary solution to the undersupply relates to increasing the number of graduating Fellows entering the workforce on an annual basis, the majority of which is through the number of trainee positions set by States and Territories. This report will provide a foundational piece of research to inform our representation going forward and will be formally released later in 2024.

Given our understanding of the specialty and contribution to matters beneficial to the public, we are setting a key activity domain of advocating for patient and community access, equity, and public education. The ASA is a registered charity that reports to the Australian Charities and Not-for-profits Commission (ACNC) as the national regulator of charities. Our activities, both past and future, fulfil a 'charitable purpose' which has a special legal meaning, developed over the years by the courts and parliament. The courts have recognised many different charitable purposes, and as society changes new charitable purposes are accepted. The current Charities Act 2013 (Cth) lists twelve charitable purposes and the ASA acts decisively in many of them including those listed below:

- advancing health
- advancing education
- advancing the natural environment
- other similar purposes 'beneficial to the general public,' and
- promoting or opposing a change to any matter established by law, policy or practice in the Commonwealth, a state, a territory or another country (where that change furthers or opposes one or more of the purposes above).

The ASA was primarily formed as a medical society where the founders embedded public benefit within the Objects which demonstrated great foresight, and there have been amendments since foundation.

Our role as an exemplar society means that we will continue to and improve on how we engage with you and provide services to you, of which professional development, welfare and wellbeing support are critical investments for us. Our role in working with governments and health services assist you with focussing on the specialist care that you provide with the reassurance that we are there to support you no matter what stage your career is. This is where being accessible to and our understanding of you is an important goal for the ASA. Your feedback and engagement is important in maintaining this. To that end, we decided in early 2023 to implement a new association management system and web-based platform to serve our needs into the future. This went live in late May,

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

including our new web portal interface for members, the public and other stakeholders. We expect that your user experience with us will improve.

This exemplifies an underpinning strategy of ensuring good governance and management given we are a membership society. Some of the elements of this 'pillar' include:

- Encourage Board, Council, and Committees to reflect diversity of the specialty.
- Support diversity, equity, and inclusion in ASA activities and leadership.
- Monitor ASA organisational culture and values, including sustainability and support for first nations people.
- Support and encourage participation of members within ASA committees.
- Support States and Territories committees to ensure capacity for engagement and advocacy.
- Ensure appropriate financial management and investment policies.

On this last point, in late 2023, we concluded a shift of our investment portfolio to Morgan Stanley who have a leading reputation of supporting charities and the not-for-profit sector, particularly in healthcare. This new relationship is showing positive signs in how we best invest for the (perpetual) future and better understand responsible investing within our risk framework.

So, in summary, the ASA will keep evolving on behalf of past, current and future members and the specialty, whilst exercising a more overt role on behalf of the public in Australia.

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

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

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

GUARDIANS OF COMFORT AND SAFETY:

A Patient's Perspective on the Role of the Anaesthetist

I WAS 25 YEARS OLD WHEN I UNDERWENT MY FIRST SURGERY – JUST A ROUTINE WISDOM TEETH EXTRACTION FOR A HEALTHY YOUNG PERSON WITH NO OTHER COMPLICATIONS. AND, WHILST I WAS OLD ENOUGH TO COORDINATE UNDERGOING THE PROCEDURE MYSELF, AND UNFORTUNATELY OLD ENOUGH TO PAY FOR IT MYSELF TOO, IT WAS THE FIRST TIME I HAD EVER DONE ANYTHING LIKE IT.

I'd never required surgery whilst under my parents' care and I had never even spoken to a surgeon before, let alone an anaesthetist. I had no idea what to expect, no understanding of why I was paying two separate bills and casually inserted "I'm going under twilight" into conversations, without knowing what it meant. It wasn't until I met my anaesthetist, my surgery sherpa, that I began to grasp what was to come, what I would need to do, and what I would need others around me to do.

As anaesthetists, you play a crucial role in ensuring the comfort and safety of patients undergoing surgery. Whilst us patients may not fully understand the intricacies of anaesthesia, we greatly appreciate the efforts made to put us at ease and ensure a smooth surgical experience. My experience was just one of many that shows how anaesthetists, like the one who cared for me during my wisdom teeth extraction, can significantly enhance the surgical journey.

Preoperative Preparation

Before the extraction, I thought I was fine. But as the day approached, I found myself feeling increasingly anxious and unsure. When I spoke with my anaesthetist for the preoperative assessment, their thoroughness and attention to detail were a source of comfort. They meticulously reviewed my medical records and engaged in a detailed discussion with me about the procedure. Their careful consideration of my medical history and specific needs not only reassured me but also made me feel valued as a patient.

It was during this assessment that I realised anaesthetists don't just go through motions; they genuinely care about the wellbeing of patients and want to ensure that the anaesthetic plan is tailored to suit individual needs. Understanding the level of personalisation that goes into the plan helped alleviate my fears and instilled a sense of trust in my anaesthetist's abilities. I felt confident and reassured, knowing that I was in capable hands.

As the day of the extraction approached, I was filled with a mix of anticipation and anxiety. Before entering the operating room, my anaesthetist spent a few minutes to speak with me and simplify complex medical terms and concepts, ensuring that I was fully informed about what to expect. Whilst it may have only been a few minutes, this discussion not only alleviated anxiety but also made me feel more involved in my care. I felt empowered to ask questions and voice any concerns I had, knowing that my anaesthetist was there to support me every step of the way.

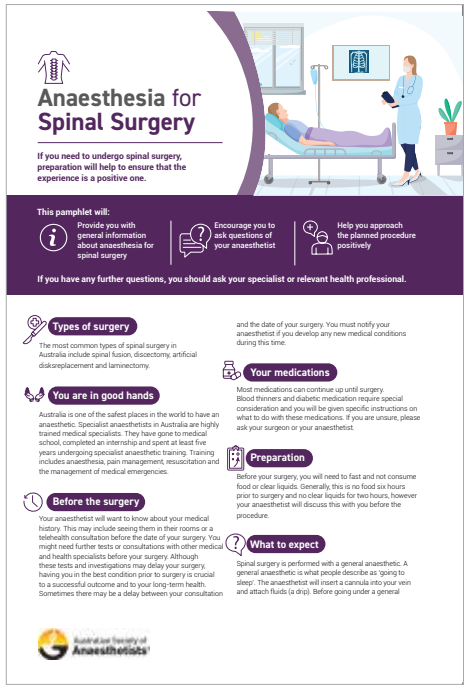
During Surgery

Entering the operating room, I felt like I was about to embark on a wild adventure. The room was bustling with activity, and I couldn't help but feel a bit like I was on a movie set. But then I saw my anaesthetist, who looked as cool as a cucumber.

Their calm and composed demeanour reminded me of a seasoned chef in a busy kitchen, effortlessly orchestrating a symphony of flavours. As they started the anaesthetic process, I remember joking that I'd never felt so popular with all the attention I was getting. The next thing I knew, I was waking up, feeling as though I'd just taken a quick nap. The entire surgery felt like a blur, but thanks to my anaesthetist's expertise and care, it was a smooth and uneventful experience.

Postoperative Care

Emerging from the haze of anaesthesia, I felt like I was waking from a deep, dreamless sleep. My anaesthetist was there, a reassuring presence at my side. They carefully monitored my vital signs, ensuring my stability and comfort as I slowly regained consciousness. They ensured my wellbeing, provided me with the necessary pain medication for my comfort at home, and offered emotional support to ensure I was feeling okay. I felt grateful, not just for their precision and skill, but also for their compassion.



The Australian Society of Anaesthetists has crafted a new suite of patient information pamphlets. These materials are designed to ease patient concerns and assist anaesthetists in educating their patients.

Communication and Support

Throughout the entire process, my anaesthetist, a type of doctor I had never really considered before, became a pillar of support and reassurance. They communicated with clarity and compassion, guiding me through each step of the process and addressing any concerns I had.

Effective communication and support are vital components of the patient experience. While direct communication with patients may not always be feasible, any form of interaction or information shared is immensely valued.

In an effort to enhance support and communication, the Australian Society of Anaesthetists has crafted a new suite of patient information pamphlets. These materials are designed to ease patient concerns and assist anaesthetists in educating their patients. The pamphlets provide general information about common procedures and anaesthesia, empowering patients with knowledge. They promote open dialogue between patients and anaesthetists, enriching the overall experience with a focus on informed and comfortable care. ASA members can access the complete range of pamphlets through the ASA website (https://asa.org.au/patient-information-pamphlets/).

Whilst us patients may not fully understand the complexities of all you do for us, I can safely say as you continue to provide exceptional care, know that your efforts make a significant difference in the lives of those you care for.

Kelly Chan

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

A PARTNER'S PERSPECTIVE:

Appreciating the Anaesthetic Journey

I MET MY PARTNER TOM DURING OUR UNDERGRADUATE YEARS AT UNIVERSITY, WHERE WE RAN SCIENCE WORKSHOPS IN PRIMARY SCHOOLS. FAST FORWARD NINE YEARS AND HE IS NOW IN HIS FIRST YEAR OF THE ANZCA ANAESTHESIA TRAINING PROGRAM.

Before we met, my exposure to anaesthetists had consisted of quick chats before going in for procedures, and being the last face I saw before fading into the best sleep I could ask for. That, and TV medical dramas where a dramatic tracheotomy is performed with a pocketknife when someone falls unconscious. If you had asked me a few years ago what an anaesthetist did outside of theatre, I wouldn't have been able to tell you. Since meeting Tom, my perceptions of the field have grown considerably, and I'm sure will continue to evolve as he progresses through his training.

Whether you are at the beginning of your anaesthetics journey or have been a consultant for years, you have likely encountered many conversations with patients, family, friends and strangers about your job. I have listened to Tom tackle some of these questions and comments several times over.

Explaining that anaesthesia involves a bit more than just putting someone to sleep and waking them up. Stepping through the complex training pathway when asked "So, are you actually a doctor now?". Laughing along with jokes about going off to do crosswords mid-surgery.

Reflecting on these conversations, a shift in my understanding of the field has highlighted that anaesthetists seem to be viewed as behind the scenes specialists, with much of the role remaining unknown to the public. While someone who has undergone a major surgery could probably tell you the name of the surgeon who led the case, that may not be the same for the anaesthetist who kept them alive. Two key aspects come to mind when I think about how my perceptions have changed- the immense investment required to become an anaesthetist and what their responsibilities are outside of theatre.

It's always a surprise to people when they find out that despite 3 years of undergraduate biomedicine, 4 years of medical school, 1 internship year, and 2 years as a resident, there is still a minimum of 5 years until Tom will be a fully qualified anaesthetist. That on top of long work hours, his training means finding time to fit in study, take extra courses, publish research, present at conferences, teach students and the list goes on. That getting onto the training program isn't a guaranteed acceptance in without passing yet more exams. Along with this comes the inevitable sacrifices that are made, whether it's having to do night shifts or missing birthdays and social gatherings. Every skipped event is met with mixed emotions from loved ones which I can empathise with- being proud of your achievements but also wishing that you were there. The stereotype that people choose this career for money has undoubtedly been challenged since knowing someone on this journey. Given the profound commitment required and the personal toll it can take (plus the mountains of student debt and ongoing costs), it's difficult to imagine anyone pursuing this profession without a genuine passion for what they do.

Given the profound commitment required and the personal toll it can take (plus the mountains of student debt and ongoing costs), it's difficult to imagine anyone pursuing this profession without a genuine passion for what they do.

Learning what the role of an anaesthetist has been eye-opening, and the simple "putting someone to sleep" has become infinitely more complex. So, it involves more than one drug? What do you mean you can give drugs to make someone lose their memory? Why are you doing so much math? What was more surprising is that it involves much more than giving anaesthesia during theatre. That anaesthetists are leaders in critical care, pain management and advanced life support. They are there early to set up equipment and check drugs. They are titrating drug doses and influencing subtle metrics based on a variety of factors. They will be the ones to give an epidural during labour, see you for pain after an operation and provide emergency airway management in the emergency department. They are all involved in continuing education in some form, whether that's teaching students and trainee doctors or getting involved in journal clubs and audits. Nevertheless, I think that the jokes about doing crosswords while a patient sleeps will stick around for some time.

Some of my perceptions haven't changed, but rather have been reinforced. Undergoing a procedure can be intimidating for many people, evoking worries about complications or pain. Having a specialist who is calm, collected and good at communication is invaluable. Anaesthetists fill this fundamental role with patients, and although these interactions can be quick, they are impactful. Assessing and educating a patient is just as important as reassuring them they are in safe hands. I'll never forget the one anaesthetist who smiled down at me and simply said "Goodnight" as I drifted off. There was something about his composed demeanour that eliminated any concerns I had, and I now realise he did a lot more than just push the drugs through that syringe.

Above all, if I have learnt anything it is that the career of an anaesthetist is a demanding but rewarding one. It is a true privilege, and a stressful one at that, to hold someone's life in your hands. For those of us who are along for the ride, although we may not be in your shoes, we do see you. Your parents who have seen you through years of study. Your partner who is there after late work finishes to debrief about your day. Your friend who helped you practise OSCEs in medical school. Your patient who puts their trust in you, sometimes reluctantly. Everyone who tries their best not to mispronounce anaesthetics. I feel incredibly lucky to have gained a small glimpse behind the curtain of your profession (and that I can now recognise when medical dramas get intubation wrong). Anyone who is supporting a loved one through their anaesthetics journey will have their own unique experiences and exposure to various perceptions of the field. While it comes with its challenges, I'm looking forward to seeing what comes next.

Stephanie Stylli

MULTIDISCIPLINARY WORK BUILDS BETTER COMMUNITIES IN HEALTHCARE:

a somewhat biased intensivist's perspective.

SO. WHY READ THIS? I'M NOT SURE. I'M ALSO NOT QUITE SURE WHY I HAVE THE PRIVILEGE OF WRITING THIS. CERTAINLY, I HAVE HAD AN EXTENSIVE AMOUNT OF IMPOSTOR SYNDROME MOMENTS OVER THE LAST FEW WEEKS. MAYBE IT'S BECAUSE MY WIFE IS AN ANAESTHETIST (I STILL FIND IT HARD SPELLING THAT WORD)? WE CERTAINLY DO SOME MULTIDISCIPLINARY WORK AT HOME. MAYBE IT'S BECAUSE I DON'T KNOW HOW TO SAY NO? OR MAYBE IT'S BECAUSE I'VE BEEN FORTUNATE ENOUGH TO HAVE EXPERIENCED SOME TRULY WONDERFUL MULTIDISCIPLINARY MOMENTS DURING MY CLINICAL AND EDUCATIONAL CAREER, ESPECIALLY WITH MY ANAESTHETIC FRIENDS AND COLLEAGUES.

By way of introduction, I'm Max. I'm an Intensivist and Clinical Educator. I've had several hats over the years – trainee, consultant, supervisor of training, deputy director, medical simulation lead. And that's just within medicine. I've a (relatively) young family, whom I am deeply passionate about and spend as much time with as I can. I love my kung fu, especially when my boys and I can do classes together. (Sidenote: when your six-year-old demonstrates their 'Bruce Lee one inch punch' on you, it can still hurt. A lot.)

What about multidisciplinary work? I'm not sure what that means to you. To me, I would often envisage it as a heterogeneric group of people (often quite eclectic) getting together to solve a particular problem. I would also often mix and match the terms 'multidisciplinary' with 'interdisciplinary' and even 'interprofessional', as concepts; the purists of you will probably tell me off for that. When asking my educator friends what it means to them, often the reply is that it is teaching more than one clinical group of trainees together, often even interprofessional (e.g. medical and nursing students). When I quizzed my clinical friends, many replied that it involved working closely with the nursing and/or allied health staff within ICU (e.g. on a ward round).

The answer that stuck with me though was the idea that multidisciplinary work in healthcare is a team continuing to collaborate and evolve together to achieve better outcomes, for their patients and their colleagues/selves. That it is dynamic, continuously developing, and able to change. To me this means that the group doesn't necessarily 'disband' once a particular challenge is solved.

> ...the idea that multidisciplinary work in healthcare is a team continuing to collaborate and evolve together to achieve better outcomes, for their patients and their colleagues/selves. That it is dynamic, continuously developing, and able to change.

This potentially leads into a community of practice (not mutually exclusive from a multidisciplinary team, and another cool phrase currently). This community can be influenced by each individual team member and the team members are in turn influenced by the community itself. And this community doesn't just disappear. It can continue to evolve and grow and support its constituent members. Importantly this development and growth can lead to better relationships between the members.

This concept particularly resonated with me when I reflected on much of my Covid experience. Covid has been a real tale of two cities for many of us. (Although, for myself, during the best and worst of times I sometimes wonder if there was more foolishness on my part rather than wisdom). At one point early on (somewhere in 2020, I forget exactly) I was lucky enough to collaborate in a small way with a neighbour. He has an orthotics manufacturing business and between us we were able to identify needs for PPE in some smaller hospitals. His business was able to adapt and start producing the PPE that was required, rather than the traditional inserts for shoes he had been working on up to that point. As an aside, I've not declared competing interests for this article, as I didn't make any financial gain out of this wonderful multidisciplinary get-together. What I gained was simply the joyous feeling of having collaborated with someone in a vastly different profession to address a need in healthcare. That, and I gained an improved understanding that red wines were more than just 'not white wine' (we had a number of 1.5m socially distanced glasses of red wine over our fence in the early months of Covid). But I digress. It really was a wonderful experience of two significantly diverse professions collaborating to address a challenge.

From an educational multidisciplinary point of view, I was lucky enough to be asked to help create a few resources on 'how to be an intensivist in just seven minutes a day'. (Ok that wasn't really the title but in retrospect I wish I had called it something like that). Once again there was a perceived need in the early stages of Covid, this time for the rapid expansion of our ICUs in size – especially staffing. For our colleagues in other specialties this meant the possibility of being required to step into an ICU to perform clinically for the first time in a while (for some, potentially a very long time). Not only that, but those with similar skill sets (that's you anaesthetic bunch) might be asked to step up into quite senior ICU roles. Knowing how I would feel if someone asked me to go and run a complex theatre list (terrified) I can imagine how this may have impacted some anaesthetists. So, to create something that had at least some educational value I necessarily had to employ a multidisciplinary approach. (And a special thanks to our physio staff and other allied specialties who were particularly patient with me when creating the resources). Without this diverse group the finished products would have been only one perspective, one set of tips, and no doubt failed to address many issues. Out of this as a group we got a sense of being helpful, useful; and as a group it helped build strong bonds during a stressful and at times, a despairing period.

Finally, the multidisciplinary moment that really sticks in my mind was the combination of intensivists and ICU nurses, with anaesthetists and registrars. It came during several clinical moments when a Covid patient's airway and breathing needed definitive management with intubation and ventilation. What I witnessed was at times chaotic, sometimes scary but always a diverse group of specialties and professions working together to overcome one of the big challenges that Covid threw at us. The sense of achievement at the time was almost physically palpable.

Overcoming a challenge together with a diverse group builds comradery like nothing else I have experienced in medicine. Working side by side in those scary or difficult moments, rising to meet and overcoming a challenge, has truly evolved and developed my community of practice and my group of friends to a new level. It doesn't mean that everything is roses and gumdrops. But it does mean that I know the person on the end of the phone just that much better. And they know me. We've achieved things together, because of each other and not despite each other. If this is sounding a little too much like singing Kumbaya together I apologise. And at the same time, I don't apologise. I think it is worth stating explicitly the huge benefit we as healthcare providers can obtain through working across specialties and professions. This benefit is for our patients and (?more importantly) for our colleagues and selves. I'm pretty sure that nothing I've written here is unique or eye opening, but I'd be genuinely interested to hear your thoughts on how multidisciplinary work can build and improve relationships and communities of practice. Does it? Should we invest more time and effort in our clinical and educational moments to work multidisciplinary style? If not, why not? What is stopping us?

Excuse me while I head off to sing Kumbaya...

Max Moser
Intensivist and Clinical Educator

MDT VIEW OF ANAESTHETICS

THIS IS A PERSONAL REFLECTION OF THE EVOLUTION OF MY RELATIONSHIP WITH ANAESTHETISTS IN TERTIARY PUBLIC HEALTH.

I set foot onto a surgical ward for the first time around 15 years ago as a junior physiotherapist in a large public hospital. My knowledge of the anaesthetic team was rudimentary, and I understood that anaesthetists were the people that put you to sleep for surgery, but that's about it. I recall seeing a pain management team visit the ward regularly, but I didn't appreciate that they were anaesthetists too! On reflection, I believe my limited understanding of the broad range of work done by anaesthetists is not uncommon for physiotherapists or other people who are new to working in hospitals and surgical wards. Since my career began, physiotherapy has largely been considered as a postoperative part of the surgical journey, and as such I did not have a strong a reason nor often a chance to interact with the anaesthetics department in a meaningful way.

The introduction of a multidisciplinary perioperative program (SurgFit) at my current workplace has changed that relationship, and I think for the better. As part of the clinical team working to set up the program, I have been afforded new opportunity to form a closer working relationship and understanding between our two professions as we work to improve our patient's journey and outcomes. From the early days of the project, it was obvious that the anaesthetic department was vital in driving the initiative from a theory to actual practice. Now that it is up and running, my anaesthetic colleagues continue to provide the push for

It has been apparent to me that there has grown a greater respect between 'anaesthetics' and 'physiotherapy' since the project has commenced as it has become more evident that in partnership we can provide positive outcomes in patient optimisation, reduce hospital acquired complications and generally provide a more positive surgical journey.

improving the systems we have in place. Always striving for excellence.

It has been apparent to me that there has grown a greater respect between 'anaesthetics' and 'physiotherapy' since the project has commenced as it has become more evident that in partnership we can provide positive outcomes in patient optimisation, reduce hospital acquired complications and generally provide a more positive surgical journey. In this sense, we have been able to collaborate on some important parts of the program and achieve some tangible products. These have included:

- creation of triage categories utilising a standardised outcome assessment for the patients at-risk of poor surgical recovery. These have enabled patients to be identified as benefiting from physiotherapy (and/or other health professional) intervention prior to surgery.
- developing referral pathways into physiotherapy-led optimisation pathways, including respiratory prehabilitation as well as bespoke physical prehabilitation programs. Such pathways have led to an increase in capacity for physiotherapy and more discussion between physiotherapy and anaesthetics about patient progress.
- creating video resources for preventing postoperative pulmonary complications.

From the early days of SurgFit, anaesthetics have supported physiotherapy to have a greater role in patient care, particularly as there is robust evidence that preoperative intervention should be the gold standard of care. The anaesthetic team I work with have been true to that and recognised our skill set in this space. As a physiotherapist, it is a privilege to be asked to collaborate on projects with the medical profession. In addition to the work outlined previously, I was excited to receive an invite from anaesthetics as the one non-medical presenter in a local symposium. Being invited to contribute to patient care in the anaesthetic clinics was another one of these moments. It was in these clinics that I first heard an anaesthetist tell a patient that "Surgery is like a marathon, and you don't just jump up off of the couch and run one of those". I now use this statement on an almost daily basis! Attending this clinic has provided me a newfound appreciation for and understanding of the role and scope of perioperative medicine. The breadth of assessment and education provided, as well as the consideration given by the perioperative medicine team to aspects of care I might once have considered 'non-surgical' such as cognition, smoking cessation, cardiovascular fitness and psychological well-being (to name but a few). This went far beyond my initial expectations, and in my opinion demonstrates a true sense of holistic care.

I hope to see a future of continued collaboration with anaesthetics in both clinical care and research. I think we have just scratched the surface of what is possible, as we all know that clinical processes and habits are hard to change! The anaesthetists that I have collaborated with have all been strong advocates for excellent patient care and drivers of change. They have recognised that physiotherapy is a profession well-placed to provide effective care for our patients at all parts of the surgical journey and have supported our role in that. This understanding is really very much appreciated, and I hope it will enable us to grow as a collaborative team to continue to add value to a patient's journey.

Paul Gittings
Physiotherapist

INSIDE ANAESTHESIA

Insights from an Anaesthetic Nurse

IN AUSTRALIA, ANAESTHETIC NURSES PLAY A CRUCIAL ROLE IN SUPPORTING ANAESTHETISTS TO ENSURE A SAFE AND COMFORTABLE EXPERIENCE FOR PATIENTS. THEIR ROLE IS NOT TO INDEPENDENTLY ADMINISTER ANAESTHESIA BUT TO SUPPORT THE ANAESTHETIST IN PREPARING AND MANAGING EQUIPMENT, ASSISTING IN ADMINISTERING ANAESTHESIA, MONITORING PATIENT CONDITIONS, AND PROVIDING PRE- AND POST-ANAESTHESIA CARE.

ANAESTHETIC NURSE, JENIEKA OAKES, INVITES US TO SEE THE WORLD OF ANAESTHESIA THROUGH THE EYES OF A NURSE, WHERE METICULOUS PREPARATION, QUICK THINKING, AND A FOCUS ON PATIENT SAFETY ARE PARAMOUNT.

THE DAY IN THE LIFE OF AN ANAESTHETIC NURSE ACTUALLY BEGINS THE DAY BEFORE, WHERE A GLIMPSE OF THE FOLLOWING DAY'S ALLOCATIONS ARE CHECKED, NOT UNLIKE CHECKING THE WEATHER FORECAST, BUT WITH GREATER RELEVANCE AS TEMPERATURE IS ONE FACTOR THAT WE HAVE CONTROL OF IN THEATRES.

Instead of sun, wind, or rain, it's a day forecasted to be mostly hernias, followed by an afternoon scattering of scopes, with a moderate chance of cancellations and add-ons. Amidst these anticipated events, there may exist a medium to high chance of moments that brighten the day – perhaps a thoughtful gesture from a colleague, the comforting rhythm of good music playing in the background, the exchange of engaging conversations and banter, or even the interludes of silence, sometimes serving as a welcome respite in a chaotic day. And this is largely dependent on one factor that can supersede all others – the anaesthetist.

Despite the prospect of endless vascular cases teeming with calcified arteries, VRE, and possible major blood loss, the anaesthetic team can transform such days into eagerly anticipated challenges. You might be wondering: what attributes elevate an anaesthetist to the status of a favoured colleague? (Yes, we do have favourites). Allow me to transport you back a couple of years to the beginning of my new grad year, where I divulge the qualities that earn an anaesthetist this esteemed position.

Beginning my new grad journey, I had high hopes that anaesthetics would live up to the image I had in mind. My interest was sparked by the early realisation that ward nursing wasn't for me, combined with the great care I had personally received from anaesthetic nurses and anaesthetists. I can particularly recall one lengthy wait in an anaesthetic bay with a broken wrist. Instead of feeling anxious, I found myself engaged in lively banter with the anaesthetic nurse and doctor. It opened my eyes to the idea of working in a non-ward setting with a diverse team. From the outside, it seemed as though they genuinely enjoyed their work, and it left a lasting impression on me. However, mere weeks into my grad year job, doubts began to creep in about whether

My interest was sparked by the early realisation that ward nursing wasn't for me, combined with the great care I had personally received from anaesthetic nurses and anaesthetists.

anaesthetics, and indeed nursing, were the right fit for me.

The relentless pressure of maintaining the flow of an operating theatre and juggling a multitude of tasks while giving time to my patients to calm their anxieties felt overwhelming. The moments of joy I had hoped for, the satisfaction of providing excellent care, and the camaraderie with my anaesthetic team seemed more like a false narrative. Alongside these challenges emerged a wave of self-doubt and dwindling confidence. I introduced myself as a new graduate anaesthetic nurse to the team for far longer than was necessary, pre-emptively acknowledging my lack of experience to brace them for any potential mistakes or delays in the theatre.

Before long, I realised that the majority of anaesthetists were understanding and happy to provide guidance, especially those who were extra self-sufficient and unbothered by my lack of experience. Whilst there may have been a consultant or two that were not thrilled about babysitting a rookie anaesthetic nurse, these experiences highlighted the importance of communication within the anaesthetic team and the small things an anaesthetist can do which can have a huge impact on a nurses' day.

Something as small as "good morning" instead of being greeted with "I'll need an art line, C-mac with a D blade, an ambu-

In the early stages of my training, I found gentle reminders and suggestions for seeking guidance from educators to be incredibly beneficial.

scope just in case, reinforced tube with stylet, a good ultrasound (no, not the iPad one!), a spinal pack, midaz, fentanyl five hundred and spinal morphine (adding 10 minutes to retrieve these specific drugs from the main registry), and make sure we have blood in the fridge!" made a world of difference. Instructions conveyed clearly and concisely, afforded me the opportunity to digest and even jot down the plan for reference or page an educator if needed. However, rapid-fire list of demands often left me unsure of where to begin or what to prioritise. While expressing any uncertainties caused me a lot of stress in the beginning (especially when met with displeasure), they taught me a valuable lesson in prioritising tasks, taking direction, and forming my own plan.

A simple "when you're ready" from the anaesthetist provided calm and reassurance in these moments. It's a subtle acknowledgement that such preparation takes time, and just because the patient has arrived doesn't mean everything must unfold in a rush! Bonus points are on offer for those that used my name at some time during the day, so I know that I am more than just a tape dispenser. Additional bonus points if this is later followed by "what's your coffee order?". Even more bonus points if my coffee order is not met with too much ridicule (a weak coffee is still a coffee!). While it's understandable that an anaesthetist might have some concern over being paired with a fresh-faced graduate nurse, especially when it comes to entrusting patient safety, a little patience and empathy went a long way.

As I progressed in my training, the tasks and skills involved in anaesthetic nursing became second nature and I built confidence to the point where I felt it was time to ditch the 'new grad' title when introducing myself. I found that working regularly with the same consultants and trainees allowed trust and rapport to build over time. This felt particularly effortless with anaesthetists who actively included me in clinical discussions, engaged in casual conversation, even just a brief exchange about the weekend, and showed some confidence in my abilities.

In the early stages of my training, I found gentle reminders and suggestions for seeking guidance from educators to be incredibly beneficial. These cues helped me navigate the complexities of anaesthetic nursing and ensured that I provided the best care possible to patients. As I progressed in my career, however, I began to feel a sense of pride in my abilities and knowledge. While I am grateful for the support and guidance I received early on, I have reached a stage where I no longer require a reminder to 'tape the eyes'. This shift reflects not only my personal growth but also highlights the continuous learning and development that is inherent in the field of anaesthetic nursing.

Over time, the initial vision that inspired my career in anaesthetic nursing has become a reality. Now, I find myself on the other side of those meaningful patient interactions in the anaesthetic bay with my team and I find fulfilment in offering the same calibre of care and genuine interest that I experienced as a patient. These moments, together with the excitement, challenges, and healthy dose of fun are what make me confidently say that I enjoy my job, strengthened by the bonds I have built with my colleagues over time.

At the risk of sounding cheesy, I must express my gratitude to the many incredible anaesthetic consultants, registrars, and residents I have worked with over the last couple of years. Yet, you may still be wondering, how one earns themselves the status of favoured colleague? In essence, I've come to understand that an anaesthetist who values the delicate balance between earnest work and enjoyment, while demonstrating respect for the profession of anaesthetic nursing and fostering a culture of learning with patience and guidance, inevitably rises to the top. And let's not forget, the occasional coffee treat never hurts! When respect, enjoyment, hard work, and dedication harmonise within the anaesthetic team, even the stormiest days can turn out to be the most enjoyable in the theatre's ever-changing forecast.

Jenieka Oakes
Anaesthetic Nurse
Prince of Wales Hospital

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

ENVIRONMENT & ANAESTHESIA
INNOVATION & ANAESTHESIA
SAFETY IN ANAESTHESIA

Eligibility:

Trainee members, and members within five years of full membership who have been financial members of the ASA for over 12 months. Applicants are welcome from research teams, but at least one member needs to meet the eligibility requirements.

Requirement to present work in a public forum eg a future NSC, publish in a peer review journal, Australian Anaesthetist or ASA podcast.

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

FOR FURTHER INFORMATION and APPLICATION FORMS LOG IN TO
asa.org.au/asa-awards-prizes-and-research-grants/
or contact sdonovan@asa.org.au.

Let's Chat CPD

with **Dr Vida Viliunas OAM**

According to the Medical Board of Australia

"Continued Professional Development (CPD) has been redesigned to support quality, lifelong learning for doctors that is relevant, effective and evidence-based" [1]

ASA and AMA CPD Home

From 1st January 2024, medical practitioners are required to be affiliated with an Australian Medical Council (AMC) approved **CPD home.** With this in mind the ASA partnered with AMA WA to provide members with a CPD Home.

HERE'S HOW I make sure I meet the medical board requirements in my practice using the AMA's CPD home.

Make a start

The first requirement for CPD is to create a **CPD Plan** (which contributes time as a reviewing performance activity). It involves setting a few goals for your learning for the year. That could be deep-diving into a subspecialty or niche area, developing communication or other skills and exploring leadership for clinicians. A handy feature of **CPD Home** is that it invites members to select focus areas from the Medical Board required core content areas of:

- Culturally safe practice
- Health inequities
- Professionalism
- Ethical practice

It's an **easy way** to shape your learning for the year and satisfy the regulator's requirements.

Enter activities as you go

The **CPD Home mobile app** makes it very easy to upload proof of participation and enter activities as you do them.

Educational activities

Educational activity hours are easy to acquire – reading **journals**, participating in **webinars**, listening to **podcasts** and watching **videos** can easily be achieved from the ASAEd website and the ASA events calender **www.asa.org.au/asaeducation/events**.

That is not to say that CPD should be a tick-box activity, only that the minimum requirements of the Medical Board are easy to incorporate into a busy clinician's working life.

1 (https://www.medicalboard.gov.au/Professional-Performance-Framework/CPD.aspx).

Practice Evaluation activities - find the opportunities

Practice evaluation hours are harder to notch up for clinicians – especially for those in private practice. A closer look reveals many opportunities to complete this domain.

Practice evaluation activities will be on offer at the **Darwin National Scientific meeting** **www.asansc.com.au** - see you there!

Measuring outcomes activities

- M&M meetings can occur with colleagues regularly via zoom for those anaesthetists who do not have access to hospital meetings.
- Incident reports and quality improvement projects are part of the work of medical advisory committees in private hospitals with which clinicians can be involved.

Reviewing performance activities

- Patient satisfaction surveys are usually a part of group or small and large institutional practices, and can also be conducted by individuals – this also counts as a high-level specialist requirement for anaesthetists.
- Multi-source feedback surveys can be handed out and collected at the beginning and end of a session – again, these count as a high-level specialist requirement.

Just do it

CPD does not stop when the minimum hour requirements are met – it's a part of lifelong professional learning. However, I set myself a target to complete as many of the 50 required minimum hours as I can, as early in the year as possible, to ensure that there is no rush when the end of the year is approaching.

A colleague was complaining to me about CPD requirements being burdensome and onerous. We got together and made a start by creating a CPD Plan and activities entering activities already completed. It's like all of the jobs that we put off for days and weeks – in the end, it actually **takes just a few minutes** to do.

The CPD Home makes creating a CPD Plan and entering activities easy. ASA members can choose from the broad range of ASA activities to satisfy all of their CPD requirements. **So don't wait - do it now and get ahead.**

WEBAIRS

Dr Phillip Quinn and the ANZTADC
Case Report Writing Group

OPERATING TABLE TUMBLES:

PATIENT SLIPS AND FALLS FROM OPERATING TABLES REPORTED TO WEBAIRS

Patient falls from operating room (OR) tables during anaesthesia are rare and preventable adverse events[1], although when they do occur, they may be associated with serious injury or even death. Risk factors for these events have been described in the literature including patient characteristics, surgical techniques and positioning, equipment failure or incorrect use, lack of safety restraints, and health provider inattention[1–6].

One frequently cited patient factor in the medical literature is obesity, which presents challenges related to positioning, and complications arising from upper weight limits for operating tables and the distribution of body habitus leading to an uneven spread of mass across supportive equipment[1,4–6]. Even within the established safe weight range, instances of tipping of OR tables have been documented in case reports. Contributing factors identified include the inadvertent unlocking of the OR table or extension in a reverse orientation, which often is unrecognised until a tipping event occurs[2,5]. The average size of operating tables has not increased despite the increase in the rates of obese patients undergoing surgery[7], some even have the same dimensions as OR tables from the 1920s![1]

The aim of this analysis was to review patient falls and slips from the OR table and to provide learning opportunities.

A narrative search across 11,000 reports was conducted within the webAIRS database. The search criteria were tailored to identify reports containing keywords such as "fall," "fell," "slip," "slid," "table," "bed," "slump," "tilt," or related terms. This search identified 46 reports of patients falling from or slipping off OR tables.

Among these incidents, 20 patients had a body mass index (BMI) exceeding 30 kg/m². Notably, 45 of the incidents occurred under general anaesthesia, with one case occurring pre-induction during the transfer of a patient from a ward bed to the operating table. A comprehensive analysis revealed nine reports documenting patients falling from the OR table, while 24 cases reported near-misses wherein patients began slipping off the table, but a fall was averted. Additionally, 13 cases recounted events where a single limb or the patient's head slid off the OR table.

Anaesthetists entering these cases were able to provide their reflection including contributing and alleviating factors leading to the incident. Many cases featured multiple contributing factors outlined in the analyses. Among the reported cases, identified causative factors included 19 instances attributed to the degree of bed tilt, eight cases involving the use of an inflatable transfer mat, six incidents associated with slide sheets positioned under the patient, four cases where a surgical beanbag

was utilised, five instances marked by the failure to employ restraints, six incidents stemming from equipment unfamiliarity, and 16 occurrences where patient BMI was deemed a likely causative factor.

Case Examples

Patient falls from OR table

Case 1
A patient was anaesthetised and positioned on a traction table when the patient started sliding off the table. The surgeon just managed to catch the upper half of the patient before they hit the floor. There was no harm reported. One contributing factor mentioned was that a slide sheet had been left under the patient, causing sliding during traction.

Case 8
During surgery the patient was positioned head up and left side down. Midway through the procedure, the patient slid off the bed and hit the floor. Investigation after the surgery showed no injuries. Contributing factors reported were the tilt of the bed, the lack of safety straps, and that there were two sheets positioned under the patient.

Case 23
A patient was anaesthetised on an OR table which had a function that allowed it to be unlocked and swung 180 degrees, with the base remaining stationary. Partway through this rotation, the OR table tipped over and the patient fell on the floor. The surgery was aborted and the patient woken up, without any injury found during subsequent radiologic investigation. The OR table had been positioned off-centre from the pedestal for the previous procedure, which was not recognised at the beginning of the case. The change in weight distribution over the uncentred pedestal was assumed to lead to the incident.

Slips and slides

Case 11
During surgery, the table was left tilted, and the patient began to slide off the table before being stabilisied by the surgeon. No harm occurred.

Contributing factors mentioned included the bed tilt, high BMI and the use of a new patient underblanket. Alleviating factors reported included the surgeon in a position to identify patient movement and being able to provide immediate support.

Case 28
Patient was positioned in Trendelenburg. During surgery the patient started to slide and consequently invasive surgical equipment became dislodged. A postoperative debrief identified patient BMI and body shape, the degree of head down tilt, the use of an inflatable transfer mat and plastic over the leg mattress as contributing factors.

Case 40
A patient with a BMI above 40 kg/m^2 was positioned in a left-sided tilt, when midway during the surgery the patient started to slide. Contributing factors again were identified as improper use of an inflatable transfer mat and insufficient securing of the patient to the bed.

Limb or head sliding

Case 2
During a surgical procedure requiring significant traction, the patient's head slid caudally off the pillow ending in an extended one-sided position. Postoperatively, the patient described arm weakness and numbness on the contralateral side, likely from a brachial plexus stretch. Contributing factors reported were a difficult procedure requiring a lot of force, resulting in an unsupported head position.

Case 26
An arm support fell off the table during surgery, leading to patient's arm being unsupported. The anaesthetist quickly reacted to support the arm, and in the process incurred an accidental sharps injury to themselves.

Thankfully this case series of 46 reports was associated with little patient harm but nevertheless provides a valuable learning opportunity.

Contributing factors described by the reporters:

Patient factors
- Increased BMI was mentioned in 41%
- Body shape or habitus were also mentioned independent of BMI

Surgical factors
- General and orthopaedic surgeries made up over 80% of the reports
- Most general surgery procedures were minimally invasive, requiring tilting
- Surgical drapes caused delayed recognition of patient movement

Equipment factors
- Unfamiliarity with the OR table function
- Inadvertent breaching of safe OR table load limits
- Inadvertent release of arm boards
- Lack of a safety restraints
- Notably, OR table malfunction was not mentioned in the reports

Learning points and recommendations:

Inflatable transfer mats and slide sheets
The use of inflatable transfer mats and slide sheets likely reduce friction, thereby contributing to patient falls and slides off the OR table. While their use to transfer patients is recommended to maintain occupational health and safety, they may increase the risk of patient sliding during the surgical procedure, so should be removed after the patient's positioning is completed.

OR table tilt

The degree of tilt that will cause sliding seems to be affected by patient factors, the use of safety bolsters or restraints, and the friction between the patient and mattress.

OR tables

Knowledge of the safe weight limits and awareness that these limits may change, depending on the orientation of the table or if the OR table is positioned off-centre. Increased vigilance is required when unlocking the OR table when a patient is positioned on it, as, on some models, unlocking may shift the fulcrum by nearly 20 cm.

Patient attributes

Increased vigilance is required in patients with a high BMI or unusual body habitus.

Safety measures

Consider safety strapping all patients who may require changes of OR table positioning or will be in a position other than supine.

Consider removing the inflatable transfer mat if patient position will be different to supine.

Always remove the slide sheet after positioning the patient.

Be aware of bean bag reinflation, which might lead to patients slipping.

It has been recommended that patients have safety straps in place for laparoscopic procedures, as well as a foot plate if anticipating the reverse Trendelenburg position[9].

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DR MICHAEL LUMSDEN-STEEL
EAC CHAIR

ECONOMIC ADVISORY COMMITTEE

May Update

New MBS Items

Members would be aware that, from 1 March 2024, three new items were added into group T10 subgroup 19 of the RVG. This followed an ASA submission to the Medical Services Advisory Committee (MSAC) Executive seeking the replication of 10 procedural items into the RVG.

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 since March 2022. Following consideration by MSAC, three of the original 10 items were recommended for replication. The three new RVG items are:

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

These changes allow anaesthetists to bill for these services when performed in association with the administration of anaesthesia. Anaesthetists are not able to claim for an MBS item in association with providing anaesthesia that are not within Category 3, Group T10 of the MBS. We will continue our advocacy in this area.

Clarification on new item 22052 and Cell Salvage

On 1 March this year item 13703 (for blood transfusion services) was replicated into the Anaesthesia RVG section as item 22052. Many members have asked whether the new item number covers the collection and return to patients via cell salvage system? The short answer to this question is no.

There are no MBS item numbers currently for an anaesthetist working with a procedural team who collects red cells, puts it through a cell salvage system, and returns the red cells to the patient. 22052 is used only for hemodilution, most commonly for cardiac surgery. The ASA has raised this matter with the appropriate Medicare Policy team, and we are hoping to see a MBS item number for cell salvage red transfusion soon.

ASA members can listen as I discuss item 22052 with Dr Suzi Nou towards the end of her Talking Money podcast (Episode TM15, published 4 April 2024) which you can access in the members area of the website at https://asa.org.au/asaeducation/.

Recent ASA meetings

MBS Policy and Reviews Branch

We recently met with staff in Canberra from the MBS Policy and Reviews Branch of the Department of Health and Aged Care (DoHAC) who have responsibility for anaesthesia. One item for discussion was the progress of the ASA's MSAC application for a regional nerve catheter item number in association with anaesthesia. We remain hopeful that there will be a public announcement on the approval and funding of a new regional nerve catheter for post operative analgesia in the next few weeks.

Also discussed on the day were several areas where, due to the evolution of medical practice, and in particular interventional techniques, there are no clear MBS items for these services.

We were able to point to several ASA item numbers for services that were introduced into the 2024 version of the RVG that have no clear MBS item.

Department of Veterans' Affairs

While in Canberra, we also met with the DVA Chief Health Officer, Prof. Jenny Firman AM. Also in attendance at this meeting was Deputy Chief Health Officer, Dr. Anna Colwell, and senior DVA staff.

The main concern that we raised was DVA's grossly inadequate unit value indexation. The DVA Anaesthesia unit value is now $36.10, or just 36.1% of the AMA Unit Value, which increased to $100 in November 2023.

DVA noted that a health care provider may request prior financial authorisation from DVA for a service above the scheduled fee, in situations where that service is clinically justified and the impact on patient care justifies a higher fee being charged.

The pre-approval process can be sought for multiple doctors involved in an episode of care at the same time – for example, a surgeon is also able to seek pre-approval for surgical assistants and an anaesthetist.

We were able to point out to DVA that increasingly some specialists are choosing to no longer accept the DVA scheduled fee, and with IFC, are billing the patient as a private patient, noting that the patient will then have to contact DVA to confirm what rebate DVA may provide, if any.

The ASA will keep advocating on this issue with DVA and we intend requesting future meetings with the Department and also the current Minister for Veterans' Affairs, the Hon Matt Keogh MP.

Medical Costs Finder website

The Medical Costs Finder is a website created by the Australian Government to help patients 'find and understand costs for GP and medical specialist services across Australia'. Patients are able to search for a procedure or service (including appointments), browse by category or enter an MBS item number, to explore typical costs for these services across Australia, including the indicative fees and costs of participating specialists.

The site is run and managed by the Department of Health and Aged Care which recently provided us with an update on the Medical Costs Finder. Various Specialist craft groups have provided information and feedback about 'common procedures' performed, and item numbers for these procedures. The Medical Costs Finder provides an indication of costs, including out of pocket costs, based on data collected and reported for medical services.

By way of example, searching MBS item 17610 (first appointment with an anaesthetist which is no more than 15 minutes) brings up the following information, as set out in the image below.

The ASA notes that any participation in the medical costs finder site is voluntary, and any information that a specialist doctor chooses to upload is controlled by the doctor.

The site can be accessed at https://medicalcostsfinder.health.gov.au/.

EAC member enquires

The ASA would like to reinforce the provision of informed financial consent (IFC). In particular, where patients are required to prepay for anaesthesia services, the anaesthetist should provide the appropriate itemised receipt to facilitate the patient being able to access their Medicare rebate. We have received enquiries from patients who have been struggling to get this from their anaesthetist weeks after the provision of anaesthesia services. In situations such as this patients should be provided with their final invoice or account as soon as reasonably practicable after the service has been provided.

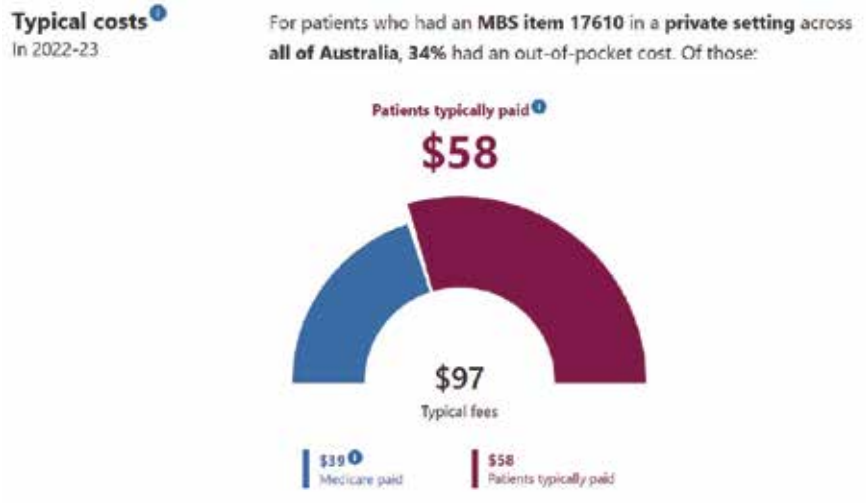


Image source: https://medicalcostsfinder.health.gov.au/services/Q17610/oh?term=anaesthetist&specialty=022001.

ASA RVG Review

Ongoing maintenance of the ASA RVG – as a contemporary, comprehensive, and accurate guide to billing for anaesthetic services – is a core responsibility within the ASA's purview. This year, the Economics Advisory Committee (EAC) will be undertaking a comprehensive review of the Anaesthesia RVG to identify areas where there is ambiguity, or no clear initiation of anaesthesia MBS number. We would like to work through these issues with Medicare Anaesthesia Policy Team to hopefully see this addressed with either new MBS items, or amendments to existing MBS items.

As part of this process the ASA will be seeking member feedback, and any Anaesthesia RVG item issues can be sent to policy@asa.org.au.

Dr Michael Lumsden-Steel

EAC Chair

DR PETER WATERHOUSE
PIAC CHAIR

PROFESSIONAL ISSUES ADVISORY COMMITTEE

Controlling the agenda in public discussions about healthcare

A RECENT EPISODE OF THE AUSTRALIAN BROADCASTING COMMISSION'S FLAGSHIP FOR INVESTIGATIVE REPORTING, *FOUR CORNERS*, RAISES SEVERAL IMPORTANT ISSUES.

Pain Factory told the stories of four patients whose treatment for chronic pain did more harm than good. It was a heart-breaking reminder that doing something is not always better than doing nothing. It left viewers in no doubt of the high stakes accompanying procedural medicine.

Debate about interventional pain medicine is neither new nor undesirable. There are real issues to confront, from resource allocation to efficacy and risk.

However, beyond the human stories told in this episode, the ABC presented uninformed speculation about medical billing. The program asserted that it had obtained a very large database of private health insurance medical bills for spinal surgery. It was alleged that analysis of this data suggested widespread fraud. More recently, an ABC News online article alleged that anaesthetists were deliberately overbilling for certain procedures performed on patients with chronic pain in the private hospital system.

The ABC's suggestion of widespread Medicare rorting by anaesthetists would have been easily dismissed, had it bothered to ask a clinician for an explanation of anaesthesia billing. Attempting to reconstruct an episode of medical care from Medicare claims is an inexact business at best, especially when those attempting this analysis have no experience of the clinical environment.

Worse than this, the ABC gave the stage to Australia's private health insurers, who were quick to take the high moral ground. There was an implicit suggestion that non-medical oversight of clinical decision making was desirable, at least for expensive procedures.

Perhaps the ABC is simply guilty of poor fact-checking and unbalanced reporting. The effect, though, is to undermine confidence in the broader medical profession, assigning virtue instead to our private health insurers, whose motivation is far from altruistic.

Why are the health insurers making any comments at all?

Against the objections of the health insurance industry, Australia maintains a community-rated system for health insurance. This rule ensures that all Australians have access to affordable cover, regardless of their medical needs.

In such a system, the cost and value of care are naturally debated, as expenses incurred by individuals are subsidised by the entire pool of policy holders. Of course, from a purely actuarial perspective, the elimination of expensive therapies eases pressure on the whole system.

This is precisely why selection of medical therapies should remain in medical hands.

Of course, contentious therapies should be subjected to scrutiny and debate. Medical care should be guided by the best available evidence. But medical care is between an individual patient and a doctor. Final decisions regarding treatment are ultimately clinical.

At the individual level, there is no room for third parties in a therapeutic relationship.

Unfortunately, Australia's biggest insurers are successfully inserting themselves between doctors and patients. This is because they have a duty to return a profit to shareholders. Paying rebates is not good for the bottom line. Fortunately, our insurers are not permitted to insist on pre-authorisation of medical expenses. So alternative strategies to bolster returns have been implemented.

Currently the strategy enjoying the greatest success is hollowing out the product sold to patients. See Figure 1.

At the turn of the century it was fairly safe to assume that health insurance covered a broad range of medical treatments. By contrast it is now more common to hold a policy with exclusions than a comprehensive one.

This is perhaps not surprising when one considers the inflation in the price of top-cover policies. Choice magazine recently conducted an investigation revealing surprising increases in the price of the most inclusive cover:

"When CHOICE compared Gold Hospital policies at the five biggest funds available to new customers in February 2021 with those available in 2024, we found prices had skyrocketed:

- *HBF's Gold cover jumped by 46.9%*
- *Medibank's Gold cover jumped by 43%*
- *NIB's Qantas Gold cover jumped by 36.4%*
- *Bupa's Gold cover jumped by 35.3%*
- *HCF's Gold cover jumped by 34.4%"*

The above statistics reveal increasing cost and decreasing value, a clear win for the private health insurers. Patients, on the other hand, might discover that their health cover is not as useful to them as previously.

How does Medicare compare to the private insurers?

In contrast to the private health insurers, the Australian Government does not have to navigate a direct conflict of interest between patients and shareholders. However, budgetary constraints have led to a similar weakening of the financial support provided to patients.

Medicare, the Commonwealth Government's universal health insurance scheme, began in 1984. Since then, the value of Medicare to patients has declined considerably, as Figure 2 demonstrates.

The graph compares inflation with Medicare rebates, illustrating the widening gulf between rebates and medical expenses.

Far from being a rich trough, full of the snouts of greedy doctors, Medicare rebates fund a shrinking minority of the true cost of medical services.

Anaesthesia rebates are a case in point. At the time of writing, the Medicare Benefits Schedule unit value is less than 22% of the ASA RVG unit value, which increased to $100 in November 2023. *[Relative Value Guide, 25th edition]*

Figure 3 shows the declining proportion of anaesthesia accounts funded by Medicare since its inception. The Medicare portion has fallen below 40%.

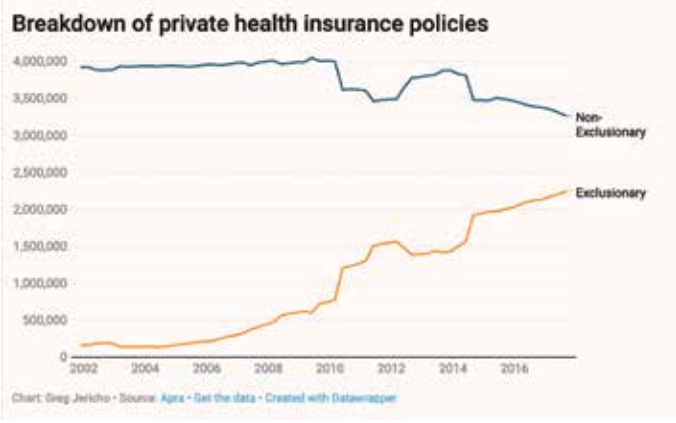


Figure 1: Source: https://www.theguardian.com/business/grogonomics/2018/feb/06/is-private-health-insurance-a-con-the-answer-is-in-the-graphs

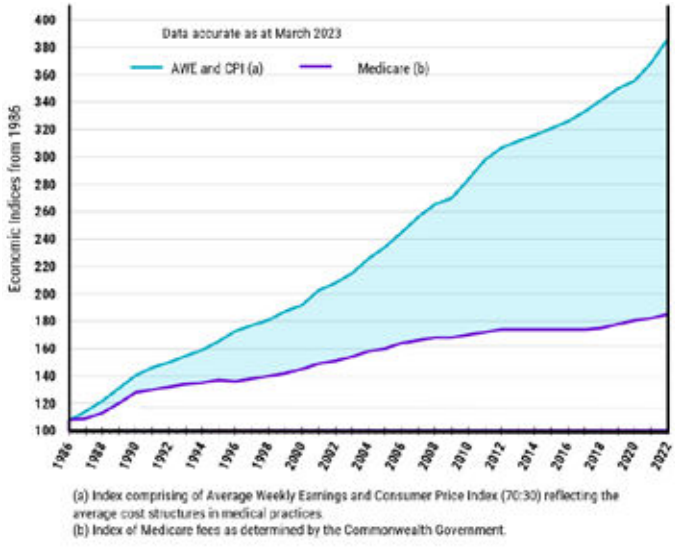


Figure 2: Source: AMA Gaps Poster 2023 available at https://feeslist.ama.com.au/file/download/fees-gaps-poster-2023.pdf

Where is this path leading?

These simple statistics demonstrate an upward trend in the proportion of healthcare expenditure met by individual patients. As the contributions of Medicare and health insurers decline, the patient must meet the shortfall.

In the private healthcare market, patients are the consumers. They have the right to choose their healthcare, and the responsibility to pay for it.

This libertarian sentiment is fine to a point. But compassionate societies like ours share the burden of life's more expensive necessities. At what point should society's generosity start contributing to individual health care?

For the time being, the system is apparently holding up. Australian patients are receiving high-quality treatment in a hybrid, public-private system. But there are risks on the horizon. The declining relevance of Medicare and the rising assertiveness of private health insurers pose a threat to the truly universal provision of medical services.

Unfortunately, this message is not breaking through into the popular media. For the moment, the public narrative is controlled by those who have their own reasons for undermining the system.

Note: The ASA has written to Private Healthcare Australia, the private health insurance industry's peak representative body, requesting to review the data referenced in the *Four Corners* program and follow up ABC online article

Dr Peter Waterhouse
PIAC Chair

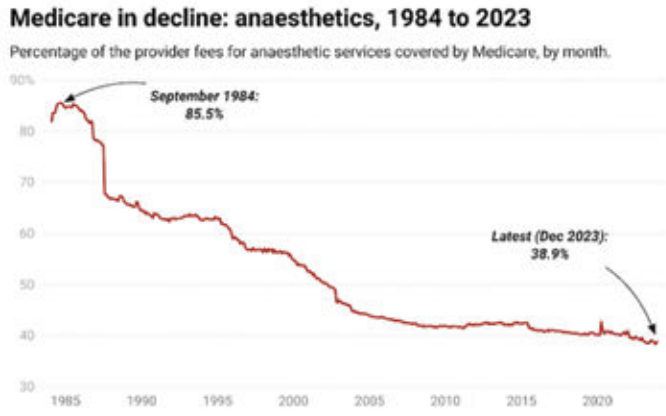


Figure 3: Source: http://www.thepolicypost.net/2024/02/normal-0-false-false-false-en-au-x-none_16.html

DR JULIA ROUSE
TMG CHAIR

TRAINEE MEMBERS GROUP COMMITTEE

Giving and receiving feedback well in anaesthesia: An evidence and feedback literacy-based approach

"Feedback is a process in which learners make sense of information about their performance in order to compare it with appropriate standards, used to enhance the quality of their work or learning strategies[1]."

ANAESTHETIC TRAINEES YEARN TO RECEIVE CONSTRUCTIVE FEEDBACK AND IMPROVE. IN ANAESTHESIA, CONSULTANTS, FELLOWS AND REGISTRARS, AT DIFFERING LEVELS OF SENIORITY, GIVE AND RECEIVE FEEDBACK ON A DAILY BASIS. THIS MAY BE FORMAL OR INFORMAL. WE HAVE A RESPONSIBILITY TO OUR PATIENTS AND OUR PROFESSION TO SHARE OUR KNOWLEDGE AND SKILLS WITH TRAINEES, VIA TEACHING AND EFFECTIVE FEEDBACK[2].

Nevertheless, despite feedback being critical to anaesthesia training, feedback does not always improve learning and performance[3]. In fact, studies suggest one third of feedback episodes lead to decreased performance[4]. Effective feedback requires both giving and receiving feedback well, by incorporating evidence-based practices and improving feedback literacy.

Giving feedback well

- **Creating a safe learning environment**

Historically, in medicine there has been an archaic approach to learning and feedback which involved purposefully using fear and intimidation to motivate learning. There was a belief that such a traumatic approach to learning and feedback would enhance retention of information and skills. In stark contrast, there is now evidence that fostering a positive, safe learning environment leads to more creative problem-solving and deeper learning, especially when we are training in teams[5,6]. Fortunately, this antiquated approach to learning and feedback is predominately - and ought to be - a thing of the past in anaesthesia. The focus now should be on providing regular and meaningful constructive feedback in a psychologically safe learning environment.

- **Encouraging engagement and trust**

Evidence suggests that teacher-centred or unidirectional approaches to feedback are much less effective than dialogic and learner-centred feedback[1,7]. The ANZCA Educators Program astutely suggests a 'feedback conversation'. Ideally, feedback recipients should feel as though they are establishing a trusted 'educational alliance' with the feedback provider[8,9], rather than being subjected to a censorious feedback process passively. With such an alliance, feedback recipients should feel that they can be vulnerable and openly discuss feedback goals and areas for improvement without judgement.

It is important to note feedback recipients may take time to 'unlearn' their previous knowledge and skills, and feedback providers must show patience and understanding. This may occur more frequently with

- **Active feedback and follow up**

The feedback provider has a responsibility to be actively involved in and oversee improvement in the knowledge and skills critiqued. This increases the likelihood of improvement, the development of a trusted educational dialogue and satisfaction for both parties when improvement is achieved.

- **Limit and prioritise specific feedback**

Cognitive load theory suggests the human brain can only process a certain amount of information at one time[10,11]. Limiting feedback to two to three key points allows the feedback recipient to focus on specific areas for improvement rather than experiencing information overload.

- **Timely feedback**

Feedback should be provided in close proximity to the knowledge or skill demonstrated by the feedback recipient. This allows self-reflection, two-way dialogue and targeted plans for improvement to be established, whilst ephemeral details are still fresh in the trainee's mind[12].

It is important to note feedback recipients may take time to 'unlearn' their previous knowledge and skills, and feedback providers must show patience and understanding. This may occur more frequently with experienced trainees when compared to more junior trainees.

- **Accurate and objective**

Effective feedback should be factual and clear. Effective feedback should also be unbiased and focused on behaviour, not the individual[13].

- **Employ structured, learner-centred feedback models**

There are multiple evidence-based, learner-centred feedback models available which may be employed by feedback providers. Each focus on positive or effective aspects of performance as well as areas for improvement, encourage a feedback dialogue and feedback recipient reflection.

1) Pendleton's framework
   - Learner identifies what went well/ what was effective
   - Teacher adds observations about effective behaviours/performance
   - Learner identifies what could be done differently next time
   - Teacher adds observations of what was less effective and offers strategies and recommendations

2) AERO model
   - Affective – How does the trainee feel about their performance?
   - Effective – The trainees identifies what was effective
   - Reflection – On reflection, what would the trainee do differently next time?
   - Observations – With permission, the teacher offers some observations about the observed task or activity

3) Plus/Delta model
   - Plus: What went well and why?
   - Delta: What would you do differently next time and why?

Receiving feedback well

Receiving feedback well in anaesthesia can be enhanced by feedback literacy. Feedback literacy is defined as the feedback recipient's ability to understand the purpose and processes of feedback, to accurately self-evaluate their work and through collaboration with others, generate and enact a plan for improvement[14]. As conveniently outlined by David Carless and David Boud, the four inter-related features of feedback literacy include appreciating the purpose of feedback, making judgments, managing affect and taking action.

- **Appreciating the purpose of feedback**

As most anaesthetic trainees are high achievers aiming for perfection, the thought of negative feedback often inspires trepidation and may result in the avoidance of seeking feedback. Refocusing feedback from 'negative' or 'positive' towards ways to 'optimise' or 'finesse' may assist trainees overcoming this cultural dogma.

Appreciating the enormous value that effective feedback can have on learning and development throughout training is vital for promoting feedback. Moreover, highlighting the active role that the feedback recipient should have in setting goals, reflection and a two-way, judgement-free dialogue is crucial for dispelling fears surrounding feedback.

- **Making judgements**

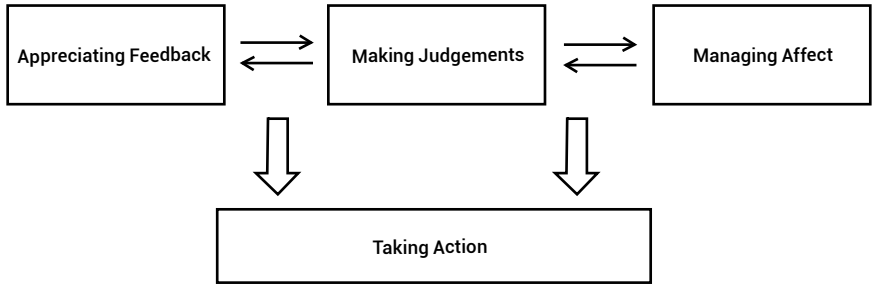
To take on feedback and move towards improvement, trainees must develop the ability to self-reflect and evaluate their own as well as their peers' performance[15].

- **Managing affect**

It is important to maintain emotional equilibrium and avoid defensiveness when receiving feedback. Enhanced feedback literacy enables trainees to better navigate the emotional turmoil in receiving feedback[16]. The focus should be on being proactive lifelong learners, aiming for continual improvement rather than perceiving feedback as a threat.

- **Taking action**

Trainees must be motivated to improve and should act on the feedback they have received. As feedback literacy improves, trainees should also aim to seek out and ask for specific feedback-related opportunities. Empowering trainees with the feedback literacy will help to facilitate this process.



Conclusion

Feedback is essential throughout anaesthetic training and into consultancy. Education on giving and receiving feedback well during anaesthetic training is lacking despite its importance. College and departmental initiatives to educate feedback recipients and providers will undoubtedly allay the fear surrounding feedback and reduce the damage caused by ineffective feedback. With improved feedback literacy, recipients will be more engaged and focused on ongoing learning and development. By fostering a positive and fertile feedback environment, ultimately our patients and our profession will be the beneficiaries.

Practical tip for feedback providers

Before tomorrow's list, ask your junior one or two things they would like to work on. Create a safe learning environment, apply one of the learner-centred feedback models and share your own experiences on how you gained that knowledge or those skills.

Dr Julia Rouse

TMG Chair

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AROUND AUSTRALIA

Western Australia

Dr Archana Shrivathsa

Chair of the Western Australian Committee of Management

CPD in Western Australia

In response to member feedback, the WA Anaesthetic Continuing Education (ACE) Committee has decided to alter the format of the CME program this year, moving to an evening lecture and workshop series tailored to assist members to complete the new CPD program requirements and to accommodate increasing requests for virtual options. The Autumn Scientific Meeting will not be held in 2024. In its place, a lecture series will be held once a month in the ANZCA WA office. This format will be trialled for 2024 to determine its viability for the future.

This change allows for topics and meetings to be scheduled as issues arise within certain areas throughout the year. It also allows us to record the sessions using the Zoom room and make them available online.

The first meeting was held on the 13 March with a Perioperative Practice Evaluation evening from the WA State Burns Service. Presenters included burns surgeons Dr Helen Douglas and Major Rachel Howes, and anaesthetist Dr Kristine Owen.

Other events for 2024 are listed on the ANZCA events page: WA ACE Lecture Series 2024

WA State Burns Service Perioperative Practice Evaluation evening

Wally Thompson Prize

Congratulations to Alex Majri who was presented the Dr Wally Thompson Prize in Anaesthetics by Dr Wally Thompson. This prize is sponsored by ANZCA and the ASA in collaboration with The University of Notre Dame.

Alex Majri - Dr Wally Thompson Prize

Introduction to Anaesthesia course

The Introduction to Anaesthesia course is run yearly in all regions and New Zealand to welcome new trainees into the ANZCA training program. This year, WA invited 18 new trainees to the course which was held on 9 February at the ANZCA WA Office. We once again welcomed guest speakers including trainees, Supervisors of Training and consultants to discuss professionalism and performance, ANZCA resources, the Trainee Portfolio System, welfare, mentoring and training, as well as the ASA and benefits for trainees.

The ASA WA sponsored the post-IAT networking drinks, organised by our TMG representative Dr Merredith Cully. Introductory Trainees and the SOT group were invited to enjoy a relaxed evening at P&M café in Wembley.

WA 2024 IAT participants

Australian Capital Territory

Dr Girish Palnitkar

Chair of the ACT Committee of Management

Registrar Welcome Event

2024 began well with a welcome drinks event for registrars at The Realm Hotel. We had an excellent turnout of registrars and consultants. It was a great way to get to know those new to the ACT training scheme and explain to them the benefits of joining the ASA from a trainee stage.

Registrar Welcome Event

Cancellation of this year's Scan and Ski

Unfortunately this year, due to sponsorship issues and logistics, we have regretfully had to cancel this year's Scan & Ski event. The Scan and Ski meeting has been a biannual fixture for a number of years now and has always been ever popular due to the hands on nature of the course, internationally recognised lecturers/demonstrators ... and of course, the skiing! Dr Ross Peake has tirelessly run this course since it started and we hope that he can organise one in the future.

Art of Anaesthesia

This year, our annual scientific meeting will have a new look. The Art of Anaesthesia, will now be run in November rather than September and will have a CPD based programme. It will be a great opportunity for everyone to get those last minute CPD points before the end of the year. In addition, Drs Adam Eslick & Bibhuti Thakur have stepped down as co-convenors for the event - we thank them for their efforts over the last few years. Taking over from them are Drs Niketh Kuruvilla and Michael Li - and we congratulate and thank them for accepting this role.

NSC planning

The 2025 NSC planning is well under way. We have approached a number of world renowned anaesthetists who have in principle agreed to attend. Naturally, it's all under lock and key at this stage but expect more exciting news to follow in the coming month.

Preferred Medibank Private Endoscopy

One of the private endoscopy centres in the ACT is attempting to commence a MBP preferred no gap service. The aim was to assess the willingness of anaesthetists and GP sedationists to sign up to such a contract. At present, it is our understanding that all the specialist anaesthetists have resisted this move towards managed care. The policy, however, is aimed squarely at GP sedationists who provide a large volume of the care for endoscopy in the territory. At present only one has signed to this contract. Evidently, resistance to agreeing to managed care models is high, with many constituents worried about coercion and detrimental patient outcomes.

South Australia / Northern Territory

Dr Sophia Bermingham

Chair of the South Australia / Northern Territory Committee of Management

Support

As we go to print with this AA edition, we are halfway through our 90th Anniversary celebrations. The SA/NT Committee are excited to announce that we will be hosting our own event in Adelaide on Saturday August 3rd at Victoria Park Social Club. Our thanks go to Dr Bec Madigan, Dr Cheryl Chooi and Dr Nicole Diakomichalis for organising this. More details will follow shortly and we look forward to seeing you all there!.

Represent

Thank you to all those South Australian members who have taken the time to complete the surveys we have distributed over the past several months. Your participation and feedback have greatly contributed to the ASA being able to provide sound and considered submissions on issues affecting our profession.

As such, the SA/NT Committee are currently working with the Policy Team to provide a submission on the Consultation of draft Clinical Prioritisation Criteria (CPC) and Respiratory and Sleep Medicine (Paediatrics), and Rheumatology (Adults and Paediatrics), to SA Health. We will keep members informed and updated.

We continue to work with the AMA and Return to Work SA to address the currently lamentable rates for this work. My sincere thanks to Dr Louis Papillion, Dr Tim Donaldson, Dr Tristan Adams, and the AMA for their hard work in this area. We are hoping to make some more progress in June of this year and will keep you updated accordingly.

Educate

This year we are proud to host the ASA National Scientific Congress In Darwin September 6 to 9. With over 200 participants registering within the first week, I encourage you to register (https://asansc.com.au/) and organise flights and accommodation ASAP before it is all booked out! There is an incredible line up of speakers including Dr Glaucomflecken, Professor Anthony Fauci (virtual) and Professor Daniel Sessler amongst many others. I wish the Convenor Dr Brigid Brown, Scientific Convenor Dr Indy Lin and the whole committee all the best for the event (which I'm hoping to fly to from Singapore)!

Farewell

This will be my last contribution to Around Australia as I pack my bags for Singapore in June. I wanted to take this opportunity to thank the SA/NT Committee for their support and hard work over the past year. I am proud of the fabulous advocacy work we have done on behalf of our members. In particular I wish to acknowledge Dr Tim Donaldson and Dr Brigid Brown for their kind words and sage advice. I'm confident that they will do an outstanding job as co-chairs in my absence. I also want to thank the ASA Council members, ASA CEO Dr Matt Fisher and the federal office staff for their assistance and guidance. I have enjoyed getting to know you and will miss the spirited discussions and festive ASA dinners!

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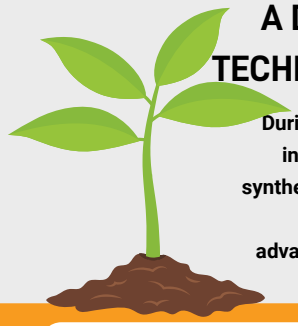
1954 - 1963



A DECADE OF HUGE ADVANCES IN ANAESTHETIC DRUGS, TECHNOLOGY & EQUIPMENT AFFECTING MEMBERS' PRACTICES

During this decade, there were numerous major advances in both anaesthetic pharmacology and instrumentation, influencing the practices of ASA members. Key developments included the synthesis and introduction of various drugs such as warfarin (Coumadin) in 1954, povidone-iodine in 1955, in 1956 and bupivacaine (Marcain) in 1957, alongside many others. Additionally, advancements in laryngoscope blades and endotracheal tubes were notable, with various designs being introduced throughout the decade.

Adoption of the Definition of a Specialist

In 1954, the ASA adopted the definition of a specialist as defined by the Federal Council of the then British Medical Association in Australia. This definition outlined the qualifications and criteria for practitioners to be recognised as specialists in a particular branch of medicine or surgery.

First Proposal for a Journal of Anaesthesia

In 1954, ASA President James Fishbourne McCulloch suggested the production of a Journal of Anaesthesia. This proposal marked the beginning of efforts to establish a publication dedicated to anaesthesia within the ASA.

ASA Relocates Its Melbourne-Based HQ

In 1955, Dr Geoffrey Kaye, the ASA Secretary, terminated his agreement with the ASA to house their headquarters, library, and museum at his home in Mathoura Road, Melbourne. As a result, the ASA offered the library and museum collection to the Faculty of Anaesthetists of the Royal Australasian College of Surgeons. The ASA offered to contribute to the upkeep of those two facilities.

ASA Forms a Standards Committee

In 1956, the ASA established a Standards Committee to cover the increasing introduction of new anaesthetic equipment and devices. This move was essential to ensure the safe and effective adoption of new technologies in anaesthesia practices.

Adoption of a "Crest" & Movement to Be More Independent

In 1958, the ASA Federal Executive chose a crest following a competition. This comprised an almost circular logo with a kangaroo leaping over a small map of Australia with the words "Australian Society of Anaesthetists" in a band around the picture; the motto "Vigila et Ventila" appeared curved below. This crest was changed to the current logo in 1978.

Establishment of a Government Liaison Committee

In 1961, the ASA formed a special sub-committee to liaise with the Federal Government concerning Commonwealth Medical Benefits for anaesthesia. This initiative was crucial as it aimed to address and advocate for fair and adequate compensation for anaesthetists, highlighting the importance of their role in the healthcare system and ensuring their financial stability.

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

Looking to learn more?

Discover more about the evolution of the Australian Society of Anaesthetists across 1954 - 1963.

1964 - 1973

The decade from 1964 to 1973 marked significant changes and advancements within the Australian Society of Anaesthetists (ASA) and the field of World Anaesthesia, coinciding with the Vietnam War era.

Australian Society of Anaesthetists

In 1969, Dr Ben Barry proposed the appointment of a full-time secretary and the establishment of a secretariat in the state where the Honorary Federal Secretary resided. This proposal received unanimous support. In 1970, Miss Suzanne G Butterworth was appointed to the position at 86 Elizabeth Bay Road in Sydney, NSW, thanks to a space offered by a private practice anaesthetic group.

By 1972, the ASA AGM agreed to establish a permanent secretariat in Sydney, making 86 Elizabeth Bay Road the second Headquarters and the first permanent secretariat for the ASA. This location was pivotal, with seven dedicated, dynamic and productive Federal Presidents emerging from this group.

World Federation of Societies of Anaesthesiologists (WFSA)

On the global front, the WFSA (of which the ASA had been a founding member in 1955) played a significant role. The 1964 World Congress in Sao Paulo, Brazil, saw official Australian delegates Drs Roger Bennet and Graham Cumpston in attendance. Dr Bennett, elected Vice President of the ASA, sadly passed away in 1967 while still in office. In 1968, Professor Douglas Joseph was elected to the Executive Committee of the WFSA and later as Vice President. The 1970 World Congress in Canberra, Australia, marked a major milestone with 700 attendees, including 253 visitors from 32 countries, showcasing the ASA's global standing.

Anaesthesia and Intensive Care Journal

In the realm of scholarly communication, the ASA took a significant step with the launch of the "Anaesthesia and Intensive Care" journal in 1972, under the leadership of Dr Ben Barry. The editorial committee consisted of distinguished professionals such as Allan Bond (Hobart), Teresa O'Rourke-Brophy (Brisbane), Kester Brown (Melbourne), Noel Cass (Melbourne), Brian Dwyer (Sydney), Graham Fisk (Sydney), Miller Forbes (Perth), Don Harrison (Sydney), Douglas Joseph (Sydney), James Loughman (Sydney), John Mainland (Melbourne), and Maurice Sando (Adelaide). The journal's inception marked a significant milestone in advancing anaesthesia research and practice.

Vietnam War

The Vietnam War era presented unique challenges and opportunities for anaesthesia practices. Beginning in 1963, Australian and New Zealand civilian surgical teams entered South Vietnam, caring for the civilian population amidst infectious diseases, chronic conditions, and war-related injuries. The Australian team operated at Long Xuyen Hospital, while the New Zealand team was stationed at Qui Nhon Hospital. Anaesthesia was provided by local medics and technicians, many of whom were trained and supervised under Australian anaesthetists. The EMO (Epstein-Mackintosh-Oxford) Vaporizer emerged as a crucial anaesthetic machine, known for its ease of use, accuracy, robustness, and portability, basically requiring only air, ether and water to operate – ideal for situations such as war zones

Qui Nhon Hospital Lambretta Ambulance, Vietnam 1967

Looking to learn more?

Discover more about the evolution of the Australian Society of Anaesthetists across 1964 - 1973.

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

1974 - 1983

A DECADE OF ADVANCES

This decade saw significant changes in anaesthesia practices, marked by the evolution of anaesthetic agents, equipment sterilisation practices, technological advancements, and shifts in the profession's demographics and focus.

Guiding Best Practice

The ASA played a crucial role across this decade, guiding anaesthesia practices in Australia. The Society emphasised peer review, continuing education, and professionalism, with a focus on international conferences and subspecialties. This shift in focus helped elevate anaesthesia from being seen as subordinate to surgeons to establishing its influence in areas such as Intensive Care Units and Retrieval Medicine.

Anaesthetic Agents and Induction Practices

During this decade, the standard "GOH" (Gas, Oxygen, Halothane) was replaced by Enflurane due to halothane's hepatotoxicity concerns. However, Enflurane had drawbacks like EEG epileptiform activity. Isoflurane, introduced in the early 1980s, was seen as an ideal replacement. Thiopentone was the primary induction agent, while Althesin, promising for day surgery, fell out of use due to severe reactions. These changes underscored the need for ongoing research and innovation in anaesthetic practices.

Equipment and Technological Advancements

This decade saw a shift towards disposable equipment. While tubings, masks, endotracheal tubes, and epidural needles were initially cleaned and resterilised, disposable options became increasingly available. However, economic considerations led to the continued reuse of certain items, such as endotracheal tubes in paediatrics. Simultaneously, the evolution of computers began to impact anaesthesia, with computers being used for monitoring, auditing, education, and billing purposes. This technological shift was highlighted in an editorial in Anaesthesia and Intensive Care in 1982, noting the increasing accessibility of computers to anaesthetists.

Anaesthetist and ASA NSW Committee Chair Dr Daryl Salmon (right) in Operating Theatres at Liverpool Hospital Sydney 1981 with anaesthetic technician Cyril Huggins (left).

Anaesthetist Dr Jane McDonald at Liverpool Hospital in 1982.

Demographic Changes

With a fervent focus on education, the number of women in medicine and anaesthesia increased during this period. Australia had a tradition of high-achieving women in anaesthesia, having had Mary Burnell and Patricia McKay as outstanding female anaesthetists, further highlighting the profession's diversity and excellence.

Looking to learn more?

Discover more about the evolution of the Australian Society of Anaesthetists across 1974 - 1983.

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

LETTER TO THE EDITOR

Please note that letters to the editor may be edited for clarity, style and adherence to publication guidelines.

Dear Editor,

I write in response to the article The Guardians of Sustainability in the Operating Theatre in the March edition of Australian Anaesthetist.

The issue of sustainability is vitally import and I would like to make some comments.

On page 25 Pierre states that "...whilst I agree that 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..." this ignores the fact that using a 50% nitrous oxide in the carrying gas reduces exponentially the severe cardiac and circulatory effects of the volatile agents and significantly reduces the opioid requirements during anaesthesia.

I remind readers that ANZCA took the unusual step of writing to all members after the release of "Enigma 2" to assure members of the continuing safety of nitrous oxide. Not just last century but in use for 180 years.

The "judicious choice" of regional anaesthesia substitution for nitrous oxide for all labouring mothers is both resisted by the midwives and would require huge manpower upgrades. Published figures for epidural complications far outweigh those for the use of nitrous oxide. Incidentally, a woman in strong labour will uses more nitrous oxide in a single contraction than would be used for one hour of nitrous oxide/sevoflurane anaesthesia at 750 ml/min fresh gas flows.

Further, it escaped this chat to mention that there are commercially available, point-of-use scavenged gas destruction methods for the elimination of nitrous oxide into the atmosphere. Google Medclair .... you will be amazed!

Using lower than 1 L/min flows is welcomed and it is time to reinforce that message.

We have been scavenging anaesthesia gasses in operating theatres since at least 1972 . It must be time for the Guardians to take advantage of that and require all scavenged gasses to pass through an activated charcoal medium to remove the volatiles, or use the available technology to reduce the amount of volatiles added to the circuit. That allows the volatiles to be recovered or moved to join propofol at the high-temperature incinerator.

Propofol kills fish and other aquatic animals and uses as a carrier soybean oil. To grow soybean much fertiliser is used and the nitrates remaining are turned into nitrous oxide by clever microbes in the soil!! This nitrate/microbe interaction is the single biggest cause of the rise in environmental levels of nitrous oxide (a side-effect of the need to feed an exploding worldwide population).

The proponents of sevoflurane and propofol will not discuss the potential renal damage and other impacts of the use of metaraminol infusions to support the circulation that can, for the most part, be avoided by using nitrous oxide with both techniques.

Having just completed the rigorous commissioning of the gas delivery system in a major hospital, I am concerned about the ability to check for leaks in these systems after hospital opening. Widely published information supports such audits.

About time to stop nitrous bashing and promote real, available solutions for environmental sustainability of appropriate anaesthesia agent usage.

Regards

Brian Pezzutti

FFARACS 1975 FANZCA 1992

Response to Letter to the Editor March Edition

I thank Dr. George for taking the time to write to us. Similar responses have been regularly received at the ASA, while others quite supportive of the removal of desflurane have also been received.

To me, this simply supports what the ASA has been saying in recent months. Eminent climate scientists have been in disagreement as to the significance of the effect of desflurane on the environment. Many clinicians at the coalface still attest to the benefits of desflurane. So while the experts continue to remain in disagreement, we feel it is inappropriate to make the agent unavailable to clinicians, without adequate consultation.

Dr Mark Sinclair

President

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