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

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Australian Society of Anaesthetists®

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AUSTRALIAN
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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

Contents

Would you like to contribute to the next issue?

If you would like to contribute a feature or lifestyle piece for the March 2025 edition of Australian Anaesthetist, the following deadlines apply:

- Intention to contribute must be emailed by 10 January 2025.
- Final article is due no later than 17 January 2025.

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

FROM THE ASA PRESIDENT

DR MARK SINCLAIR
PRESIDENT

THE ASA WAS SADDENED TO HEAR OF THE PASSING OF RESPECTED SOUTH AUSTRALIAN ANAESTHETIST AND PAST PRESIDENT OF ANZCA, DR RICHARD WILLIS AM, IN OCTOBER. DR WILLIS WAS ALSO A 50-YEAR ASA MEMBER, AND A PAST CHAIR OF THE SA & NT COMMITTEE OF MANAGEMENT OF THE ASA. OUR CONDOLENCES GO TO HIS FAMILY, HIS COLLEAGUES, AND HIS MANY FRIENDS.

ASA Policy Manager Bernard Rupasinghe and I attended the American Society of Anesthesiologists' conference, 'Anesthesia 2024', in Philadelphia in October. As always, this was a huge meeting, with over 12,000 delegates, representing over 80 countries. We are most grateful to USA ASA for inviting us to their conference, and also attend their House of Delegates sessions, in which various groups and committees within the USA ASA present reports and lead discussions.

We also had the opportunity to chat with senior representatives of some of their individual state committees. A recurring theme, when comparing and contrasting the provision of anaesthesia services in Australia and the USA, was "you're doing well, so don't go down the path we have!".

Members are no doubt well aware of the situation in the USA, where certified registered nurse anesthetists (CRNAs) have been a part of the system for many years. Where CRNAs work as part of a doctor-led team, the system works well and patient outcomes are good. However there has been an ongoing push for CRNAs to work autonomously, and for them to be referred to as 'nurse anesthesiologists'. The USA ASA is leading the debate against these ideas. There is also of course the issue of USA-style managed care, whereby health insurance companies wield enormous influence over the provision of health care.

"Don't go down the path we have" is indeed good advice. No doubt we will continue to see efforts to move toward the USA-style system, by those with a vested interest in such outcomes. To quote one of our senior USA colleagues, "don't be naïve like we were, trying to play the nice guys while all this was going on". There is no evidence that lesser-trained health care workers are safe when working autonomously, only when they work in a doctor-led model. And we are all aware of the economics of the USA healthcare system, with enormous costs but poorer overall outcomes than countries such as Australia.

The 'expedited' pathway for the credentialling of specialist international medical graduates (SIMGs), initially in general practice but with anaesthesia, psychiatry and obstetrics and gynaecology set soon to follow, is well along the path to implementation at the time of writing. As members will be aware from previous communications, the plan by Health Ministers and the Australian Health Care Practitioner Regulation Agency (Ahpra) is to have Ahpra fast track' the registration of SIMGs, and largely bypass the proven system of having the Colleges supervising and overseeing the integration of SIMGs into our system. As previously noted, the ASA supports the idea of decreasing the red tape and costs faced by SIMGs wishing to join us in Australia, but ANZCA's processing and assessing of SIMGs is

There is also of course the issue of USA-style managed care, whereby health insurance companies wield enormous influence over the provision of health care. "Don't go down the path we have" is indeed good advice.

already very efficient when compared to many specialties. Any attempt to bypass ANZCA, with its proven track record in producing world-leading specialist anaesthetists, can only result in risks to patient safety. ANZCA has written to all Australian Health Ministers and senior departmental officials, and this letter along with its accompanying media release, and updates on ANZCA activity in this area, can be found on the ANZCA website (https://www.anzca.edu.au/news/anzca-warns-of-risks-in-fast-tracking-specialist-i).

No doubt we will continue to hear the argument from governments and others that more SIMGs are needed to help solve our current and predicted future workforce shortages. However, increasing the number of trainee specialist anaesthetists here in Australia is a potential solution we continue to highlight. During the October sitting of Parliament, our CEO, Dr. Matthew Fisher, Vice President Dr. Vida Viliunas OAM, and ACT Committee of Management Chair Dr. Girish Palnitkar (who also serves as anaesthesia craft group representative to the federal AMA) met with a series of federal MPs, Senators and their advisors over two days. This issue formed a major part of these discussions, along with issues such as the rural workforce. Generally, the idea of increasing our domestically trained workforce as opposed to importing more SIMGs was well received. Of course this will also require the co-operation of the state governments, and this is something we will continue to work on. Our thanks and congratulations go to Matt, Vida and Girish for their outstanding efforts over these two days, and to Leon Beswick and his team from the Civic Partnership (https://www.civicpartners.com.au/) for their ongoing assistance and advice in organising such meetings.

Members will be aware of the ongoing challenges being faced by our private hospitals. Inflationary pressures, workforce challenges, and funding by private health insurers are just some of these. In May, the federal government directed the Department of Health to undertake a 'Financial Health Check' of the sector, and a report (https://www.health.gov.au/sites/default/files/2024-11/private-hospital-financial-viability-health-check-summary.pdf) was released in early November. As a result of the report's findings, the federal government will form a 'Private Health CEO Forum', with representatives from all stakeholder groups, to consider options for both the short- and long-term.

Maternity care in the private sector is facing its own specific challenges, and the National Association of Specialist Obstetricians and Gynaecologists (NASOG) has been holding meetings across Australia to discuss approaches to this. I was grateful to be invited to the Adelaide meeting on October 31, and by the time of publication, NSW Committee of Management Chair, Dr. Simon Martel, will have attended the Sydney meeting. The closures of a number of private maternity facilities due to financial challenges, particularly units outside our major cities, is a real concern. An audit of over 26,000 births in the private sector clearly showed that private maternity care is safe and effective when compared to public hospitals, and also very cost effective. It must remain accessible to Australian families. The ASA will continue to liaise with NASOG on this issue.

Dr Mark Sinclair

MB BS, GAICD, FANZCA

DR MATTHEW FISHER
CHIEF EXECUTIVE OFFICER

FROM THE CEO

You only Turn 90 once

GIVEN WE CELEBRATED OUR 90TH BIRTHDAY AT THE NATIONAL MUSEUM OF AUSTRALIA IN JUNE 2024, I THOUGHT THAT I WOULD LOOK AT TROVE ON THE NATIONAL LIBRARY OF AUSTRALIA WEBSITE FOR OTHER NOTABLE EVENTS IN 1934. BELOW ARE SOME THAT TOOK MY EYE, AND YOU CAN DRAW PARALLELS TO WHAT WE OBSERVE IN 2024.

There were low prices for some food commodities crippling farmers (but not price gouging nor Senate inquiries); Bradman was batting at number 3 and scoring runs at will; Richmond and Captain Blood were AFL premiers (yes, I am a Victorian by birth); floods, storms and bushfires caused death and damage; a caterpillar plague (not mice) was wreaking havoc; gold was rising in price; Kingsford-Smith flew across the Tasman (now there are 17 hour flights to many destinations); States sought Federal assistance and failed to reach agreement (!?); there was political unrest in many parts of the world; there were energy supply problems in Australia; there was a rise in the basic wage; there was a Federal surplus; and Dame Edna was born. Sadly, no mention of the formation meeting of the ASA in Hadley's Hotel in Hobart.

So, what will the next 90 hold and what parallels will there be? Safe to say I am not a futurist however I am confident that I will not be writing that article but hope that a human rather than AI may well be doing it.

Almost three years on in my tenure as CEO, I reflected on the past year, where we focused on our platform for the future from an infrastructure and capability perspective. Symbolically, we celebrated our 90th Birthday in Canberra which had broad attendance from the specialty and other medical organisations, politicians and senior health executives. In reviewing some of the achievements in no particular order, from a finance perspective, we reviewed and moved our investment portfolio to Morgan Stanley for future growth and appointed Nexia Australia as our auditors. Our investment in and delivery of a new association management system "front end" including a new website was a significant project that has delivered a leading-edge platform to take us into the future. We are currently planning for the implementation of a new accounting and audit system "backend" to conclude the project. As a future option for and to support members into the future, the ASA became a shareholder in CPDHome and has been populating content for anaesthetists to make it easy to fulfil the revised registration standard. Our advocacy and representation continued to be a priority which included convening the inaugural Australian Forum for Independent Medicine, contributing to various submissions including the National Climate & Health strategy and building our political and policy relationships both federally and jurisdictionally. Our investment in commissioning an independent report into the supply of, and demand for, anaesthetists projecting

to 2032 was a significant step that came to fruition in our 90th year. Internationally, the ASA was influential within the Common Issues Group comprising the USA, UK, New Zealand, Canada and South Africa with an improved agreement between the Societies in these countries. Additionally, our attendance at WFSA 2024 as one of the founding members was well received and the efforts of individuals and the Overseas Development and Education Committee recognized. Our NSC23 in Melbourne was convened in a new format and was successful which also triggered a review of how to embed a sustainable system that differentiates the engagement and experience offered by the ASA. The recently convened NSC24 in Darwin furthered this pursuit of delivering a highly regarded and informative experience. Finally, in 2024, we refreshed our Strategic Directions to guide the operations of the ASA to at least 2027 yet be responsive to change and emerging priorities.

This affirmed our Vision for the Specialty to remain, "Anaesthetists practising optimally on behalf of patients, their safety and the health system" whilst we strive to be "An exemplary society of anaesthetists advocating for the specialty, patients, patient safety and an accessible, equitable health system" to ensure that we "support members and advance their skills while advocating for the anaesthesia specialty to ensure safe and high-quality patient care for the Australian public". To achieve this, we will: 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; and Ensure good governance and management.

Thankyou for your support during 2024.

Matthew Fisher

PhD DHlthSt (honoris causa)

Contact

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

Get involved in your ASA ...

Seeking new members

The Communications Committee is seeking new members who are passionate about effective communication. If you are interested in enhancing the communication strategies of the ASA please send an email to Senior Communications Coordinator, Brittney Beynon bbeynon@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**

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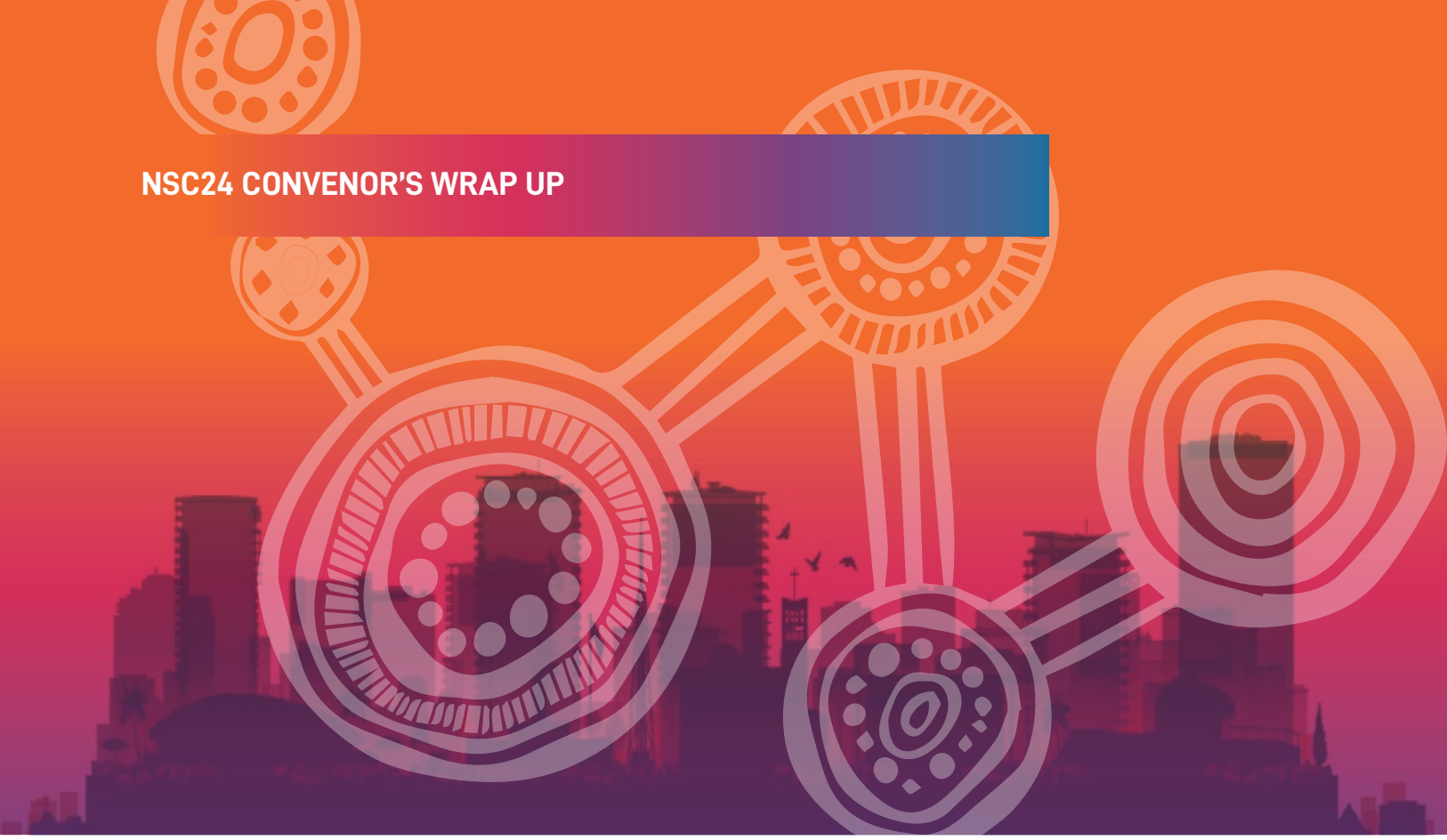

NSC24 CONVENOR'S WRAP UP

DARWIN NATIONAL SCIENTIFIC CONGRESS

WE CAN CONFIDENTLY SAY THAT THE 2024 DARWIN ASA NATIONAL SCIENTIFIC CONGRESS EXCEEDED ALL EXPECTATIONS. FROM THE MOMENT WE WELCOMED YOU WITH THE PROMISE OF "ENGAGING, ENHANCING, AND EVOLVING" TOGETHER, TO THE FINAL MOMENTS OF CONNECTION AND REFLECTION, THIS CONGRESS HAS TRULY BEEN A CELEBRATION OF ANAESTHESIA'S DYNAMIC NATURE.

The weather in Darwin was nothing short of spectacular, providing the perfect backdrop for our time there. We certainly took advantage of the tropical warmth with several outdoor social functions including the gala dinner at PeeWees at the Point, the Welcome Reception at Wharf One, and a family friendly evening at the Mindil Markets. The warmth and vibrancy of the city were matched only by the rich discussions and exchanges that took place within these halls. We were privileged to hold this congress on the lands of the Larrakia people, whose deep connection to this land and their ancient knowledge systems inspired us throughout our time here. The Lee family provided a moving welcome to country as well as a traditional smoking ceremony at the Welcome Reception. We are grateful for their welcome and sharing their connection to this special place with us.

Our theme, "Engaging, Enhancing, Evolving," was brought to life through a series of sessions that explored the latest developments in anaesthesia. This was reflected in the altered format of the Kester Brown lecture this year, with eight keynote speakers providing their thoughts on the future direction of medicine and anaesthesia from their unique lens as part of the opening ceremony. Thank you and congratulations to the Kester Brown lecturers; Associate Professor Suzi Nou, Professor Ramani Moonesinghe, Professor Ki-Jinn Chin, Dr Fiona Lander, Professor Shalini Dhir, Professor Anne Tonkin AO, and Associate Professor Bisola Onajin-Obembe.

We were very fortunate to have Professor Daniel Sessler open the lecture component of the meeting with a thought-provoking, conversation-stimulating plenary entitled 'The

Gathering Storm: Future Directions and Threats to Anaesthesia'. We encourage everyone to read this Rovenstine Lecture, published this year in Anesthesiology.

This year's Pioneer Lecture was one of the highlights of the meeting. Dr Brain Spain was this year's honoured Pioneer and to emphasize his important work and connection with Darwin, Sacha King (the director of the Darwin based Two-Two-One mental health charity) provided us all with insight and strategy into the mental health epidemic. Suzi Nou then delivered a beautiful tribute to pioneers and the importance of being on the frontline and front foot. Finally, Brian Spain shared some of the amazing work he has been a part of including the Bali bombings, establishing an anaesthetic program in East Timor, and building the anaesthetic department in Darwin. He is the first 'pioneer' to speak as part of the session, which should become a regular occurrence as it added richness and context.

A wide range of outstanding Special Interest Group (SIG) sessions were well attended and well received; Airway, Regional, History, Acute Pain, and Neuroanaesthesia. These lectures sparked new ideas and some fantastic conversations in Darwin and afterwards! There are a large amount of people at work who are now beginning sentences with, "Well, I heard a great talk on this at the Darwin NSC and..." Our huge thanks to the SIG chairs for all of their work in curating these important sessions! Highlighting the Northern Territory and the strengths of our keynote speakers, we also had lecture sessions on Careflight, Sustainability, Perioperative Medicine, Social Media, and Leadership and Change Management. We are proud that the scientific content included so many core and important aspects to the diverse roles in our specialty.

The scientific research submitted and presented gets better every year! We congratulate everyone who presented their work as a poster, orally in a prize session, or in our inaugural 'Spark' lunch sessions for junior researchers. Further details about the prizes awarded this year can be found in Associate Professor Alwin Chuan's article also in this magazine.

We are proud of our record-breaking 80 concurrent masterclasses and workshops held on a single day, the first day of the meeting! The logistics and coordination to achieve this feat was only possible because of the hard work of the workshop and masterclass coordinators, as well as the commitment of all our speakers and facilitators. There truly was something for everyone with great discussions, simulation practice, and plenty of CPD points achieved!

And of course, we have to mention a huge highlight for the meeting and many attendees, our very special guest attendance of Dr Will Flanary (aka DR. GLAUCOMFLECKEN!). In addition to his social media lecture and being present for selfies with almost every attendee at the social events, his plenary was extremely funny but also so poignant and moving. We thank the chairs Dr Tej Mettho and Dr Alison Brereton for gracefully and sagely leading the Q&A session for some thoughtful and deeper responses.

The On Demand content is available for conference attendees until early January 2025 and is also available to purchase post-conference for those who missed out.

We extend our deepest gratitude to the organising committee, our keynote speakers, our workshop, sessional and masterclass speakers and instructors, our session chairs, our sponsors, and all of you who attended. Your dedication to our profession and to each other made this event not just possible, but fun, and truly special. The memories we created here in Darwin will stay with us, reminding us of our shared journey as anaesthetists and lifelong learners.

Thank you for being a part of this incredible experience. There are many who we owe a deep and heartfelt thanks to, and the sheer goodwill that we encountered from people willing to pitch in to make this an amazing event was overwhelming. We look forward to seeing you at ASA NSC Canberra 2025!

- **Dr Brigid Brown**
  Convenor
- **Dr Indy Lin**
  Scientific Convenor

Dr Brian Spain
Darwin Location Coordinator and Representative

Dr Ruth Barbour
Workshop Coordinator

Dr Charlotte Taylor
Workshop Coordinator

Dr Agnieszka Szremska
SGD / Masterclass Coordinator

Dr Reshma Pawar
SGD / Masterclass Coordinator

Dr Tim Donaldson
Social Coordinator

Dr Div Kumar
Social Coordinator

Dr Tejinder Mettho
Social Coordinator

Dr Tom Goddard
Treasurer / Industry Liaison

Dr Paul Maclure
Prizes/Research Coordinator

Dr Mila Sterbova
TMG Representative

Dr Edwina Stenner
TMG Representative

Dr Charlotte Wade
Social Media/Communication Liaison

Dr Leah Moffat
General Committee Member

Dr Mendel Au
General Committee Member

Dr Joseph Jang
General Committee Member

Dr Maxim Nagorny
General Committee Member

Dr Sam Paull
General Committee Member

Dr Philip Hanford
General Committee Member

Dr Clayton Lam
General Committee Member

Dr Emily Jaarsma
General Committee Member

Dr Alice Short
General Committee Member

Dr Vida Viliunas OAM
ASA Vice President

Dr David Elliott
NSC Federal /Sci. Program Officer

Ms Rhian Foster
ASA Education and Events Manager

EXHIBITION HALL

NSC24 Social Coordinator, Dr Tim Donaldson, Dr Sophia Bermingham and ASA Operations Manager, Suzanne Bowyer

A&IC Editor-in-Chief, A/Prof John Loadsman, ASA CEO, Dr Matthew Fisher and ASA President, Dr Mark Sinclair

ASA members and staff interacting at the ASA booth

Australian Anaesthesia podcast host, A/Prof Suzi Nou and Prof Ramani Moonesinghe

ASA Membership & Administration Support Officer, Katie Cunningham

NSC24 Convenor, Dr Brigid Brown and Scientific Convenor, Dr Indy Lin

NSC SESSIONS & WORKSHOPS

Chief Medical Officer of NT Health, Dr Jeremy Chin

ASA President, Dr Mark Sinclair with Kester Brown lecturers, Prof Ki-Jinn Chin, Prof Ramani Moonesinghe, Prof Anne Tonkin, Dr Fiona Lander, Prof Shalini Dhir, A/Prof Suzi Nou and A/Prof Bisola Onajin-Obembe

Managing Director of Two Two One Mental Health Charity, Ms Sacha King

Dr Will Flanary aka "Dr Glaucomflecken"

A/Prof Suzi Nou presenting the pioneering lecture on Dr Brian Spain

ASA EAC Chair, Michael Lumsden-Steel presenting at the Business and Billings session

NSC SESSIONS & WORKSHOPS

Launching NSC25 with ASA Vice President, Dr Vida Viliunas OAM, Scientific Convenor, Dr Adam Eslick and Convenor, Dr Girish Palnitkar

Dr Mingota da Costa Herculano, A/Prof Suzi Nou and Dr Filomena Monica at the WELI Breakfast Session

A/Prof John Loadsman's final A&IC Editor's session

NSC24 Scientific Convenor, Dr Indy Lin, Chair of the Science Prizes and Research Committee, A/Prof Alwin Chuan, ASA Best Poster Prize Winner, Dr Clayton Lam and ASA President, Dr Mark Sinclair

ASA President, Dr Mark Sinclair

NSC24 Scientific Convenor, Dr Indy Lin, Convenor, Dr Brigid Brown and ASA President, Dr Mark Sinclair

WELCOME RECEPTION

Welcome to Country and traditional smoking ceremony by Trent Lee

A&IC Editor-in-Chief and Ben Barry medal recipient, A/Prof John Loadsman and ASA President, Dr Mark Sinclair

QLD Chair, Dr Graham Mapp presented with Certificate of Appreciation by ASA President, Dr Mark Sinclair

NSC24 Convenor Dr Brigid Brown, ASA Events and Education Manager, Rhian Foster and Scientific Convenor, Dr Indy Lin

Delegates interacting at the Welcome Reception at Wharf One

Dr Katherine Jeffrey and Dr Murray Selig

HEALTHCARE INDUSTRY RECEPTION

Dr Brigid Brown, Dr Sophia Bermingham, Dr Charlotte Taylor, Dr Agnieszka Szremska and Dr Marni Calvert

Dr Glen Abbott and Dr Will Flanary

Dr Bernice Teh, Dr Will Flanary and Dr Grace Gunasegaram

Delegates networking and connecting at the Healthcare Industry Reception

Dr Will Flanary and Dr Christopher Ryan

Dr Fernie Boge, Dr Graham Mapp, Dr Phillip Melksham and Dr Will Flanary

GALA DINNER

Gala dinner at Pee Wees at the Point

Dr Grace Gunasegaram, Dr Janette Wright and Dr Kushlani Stevenson

Dr Merredith Cully and Dr Julia Rouse

Dr Charlotte Taylor, Dr Anna Freney, Dr Sophia Bermingham, Dr Brigid Brown, Mr James McArdle and Dr Chelsea Hicks

Mrs Cheryl Bowdwen and A/Prof Alwin Chuan

ASA President, Dr Mark Sinclair and Ms Bel Simmons

ASA NSC 24 DARWIN

6 – 9 SEPTEMBER

Engaging Enhancing Evolving

SPEAKER SPOTLIGHT

This year's congress featured a diverse lineup of key figures in the field of anaesthesia from across the globe. Discover the insights and wisdom shared by this year's speakers. Prior to the congress, we asked our keynotes to share what inspired their presentations and the key takeaways they hope to impart on delegates.

Dr Will Flanary

An ophthalmologist and comedian who moonlights in his free time as "Dr Glaucomflecken"

As a survivor of two bouts of testicular cancer in his 20s and a sudden cardiac arrest in his 30s, Dr. Will Flanary has a lot of experience as a physician and as a patient. He started "Dr. Glaucomflecken" as an ophthalmology resident, fresh off his second occurrence of testicular cancer. It allowed him to express frustration toward his genitals for having betrayed him and tell jokes about his life as patient, physician, and unwilling participant in the US healthcare system. As an internet comedian-ophthalmologist who has also been a patient too many times, Dr. Flanary will deliver a unique presentation that uses powerful and humorous storytelling to illustrate the patient experience and promote the human side of medicine.

Prof Ki-Jinn Chin

Professor in the Department of Anesthesiology and Pain Medicine at the University of Toronto, Ontario, Canada

The successful application of regional anesthesia is more than just putting a needle into patients. It's a multi-faceted process that starts with selecting a core set of versatile techniques to master, and then understanding when they are best employed. This includes recognising the specific side-effects and limitations of each technique, as well as the surgical considerations and perioperative goals that apply to the individual patient being treated. We'll discuss all this and more; including practical tips on how to optimize for safety and success when performing nerve blocks, as well as how to learn and continually improve on one's skills.

Ms Sacha King

Managing Director
Two Two One Mental Health Charity

Often we believe people in health care have good mental health and wellbeing, however, although health workers have knowledge they also have some of the highest rates of suicide and workplace stressors of any profession. Caring for people is a high pressure job and we need a moment to stop and reflect on our own wellness. My name is Sacha King, I am a qualified social worker and counsellor and I started Two Two One Mental Health Charity six years ago to share the message of mental health literacy across the community.

In September I am excited to present Mental Wellness in High Pressure Workplaces to the Australian Society of Anaesthetists National Scientific Congress 2024. This presentation will focus on practical biological, neurological, and psychological hacks to manage stress, embed mindfulness and help grow our brains in a way the enhances emotional regulation, resilience and wellness.

A/Prof Suzi Nou

Past President of the
Australian Society of Anaesthetists
and Clinical Associate Professor,
University of Melbourne

I've been asked to talk about the Northern Territory, pioneers and pioneering work. Every pioneer needs a frontier. I'll talk about the frontiers that I am passionate about: global health, gender equity and communication. I want to introduce the concept of being an everyday pioneer. Where are the frontiers in your practice and what do you do to overcome them?

Dr Fiona Lander

Australian Lawyer and Medical Doctor,
and an Associate Partner at
McKinsey & Company

At McKinsey & Company, we work with organisations to create sustainable, long-term change. The "atoms" of an organisation are its people - and resistance to change can sometimes seem insurmountable, especially in more traditional healthcare settings. However, our experience in thousands of public and private sector organisations has demonstrated consistent recipes for success when it comes to moving people to action. These include frameworks such as McKinsey's Influence model, which focuses on the importance of factors such as role modelling, and the stories we tell about change, rather than simply looking to improve the capability of individuals. I hope that attendees will come away from my presentation with practical tools that will assist them in implementing transformative change wherever they are working.

A/Prof Bisola Onajin-Obembe

Past President of the Nigerian
Society of Anaesthetists
Consultant Anaesthesiologist
and A/Professor of Anaesthesia
at the University of Port Harcourt,
Rivers State, Nigeria

I am aligning with the theme of Engage, Enhance and Evolve. For these to happen, we must consider elements of human resource management namely human capital theory, workforce analytics, and strategic workforce planning. The Covid-19 Pandemic made the world realise that work-based / workplace learning, and capacity development are exceptionally important. Transformational change will only happen in each country by inclusion of national stakeholders, participatory actions, and implementation. I plan to share my heartbeat for anaesthesia workforce, diversity, equity, and inclusion, as well as my personal experience with transformational change. Transformation is an unending journey, and we must know when and how to pivot so we can evolve.

Prof Anne Tonkin AO

Chair, Medical Board of Australia

One of my highest priorities as Chair of the MBA is practitioner welfare, and specifically the wellbeing of practitioners when they become involved in a regulatory process. In the workshop program, I'll be talking about what to expect if you receive a complaint, busting some myths about the likelihood of serious effects on your career, and provide some suggestions about how to look after your wellbeing while the regulatory process is ongoing. I'll also take you through some real life cases to illustrate the process.

In the plenary panel session on "Future Directions", I'll discuss some of the upcoming regulatory challenges facing the Medical Board and Ahpra over the next few years.

Prof Shalini Dhir

Director of Regional Anaesthesia at the Schulich School of Medicine, Western University, London, Ontario

Dr Elisa Bertoja

Staff Anaesthetist, University College London Hospitals NHS Foundation Trust

Prof Daniel Sessler

Vice-President for Clinical and Outcomes Research at the University of Texas Health Science Center, Houston

Prof Anil Patel

Consultant Anaesthetist
The Royal National ENT & Eastman Dental Hospitals (former Royal National Throat Nose and Ear Hospital), London

Dr Mark Koning

Anaesthetist and Intensivist Rijnstate Hospital, Arnhem, The Netherlands

A/Prof Lachlan Miles

Staff Specialist and Deputy Head of Research at the Department of Anaesthesia at Austin Health

Professor Ramani Moonesinghe

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

Dr Elmar Helmich

Anaesthetist

Whangarei Hospital, New Zealand

UP CLOSE WITH NSC24 KEYNOTES

At the NSC 2024, Australian Anaesthesia podcast host A/Prof Suzi Nou sat down to record podcasts with our keynote speakers. Please enjoy reading the highlights of her discussions here. Listen to the full interviews via the links provided.

EP #91: Catching up with ophthalmologist and comedian **Dr Will Flanary,** *aka "Dr Glauckomflecken"* at the Darwin NSC.

How did Dr. G come about?

It was in part a coping mechanism for me with my cancer diagnoses. I was diagnosed with cancer in medical school. I had done a little standup comedy and once I got too busy with medicine to do standup I started turning to social media. I used that as my creative outlet to not only process some of the things that I was going through in life but also, I just love telling jokes. Using social media was a great way to do it and there weren't a lot of people doing medical comedy. I thought, this seems like a large group of people that could use someone making fun of them. Sometimes we take ourselves very seriously for good reason, but sometimes a little bit too seriously.

And so I started Glaucomflecken. The word Glaucomflecken is actually an ophthalmology term. It's a term used for an exam finding in patients with angle closure glaucoma. But really the reason I chose it was just because I was trying to come up with the silliest word I could think of in ophthalmology. It was either that or Dr. Pseudophacodenesis, but that was a little bit too much. So I went with Glaucomflecken. I'm stuck with it now, but I think it works well.

Your audience seems to be composed mainly of doctors. Do your patients know about Dr. G?

Yes, it's a lot of doctors. Most of my patients in ophthalmology are older, so not exactly the TikTok generation. But, especially over the last couple of years, I've had more people come in and be like, "Oh my daughter found out "and sent me a video of yours." So, they hear about it a lot from their family members who maybe are on TikTok and social media a little bit more. At least once a day somebody brings it up and it's always fun. There's always this concern with healthcare professionals of saying things on social media and being nervous that it's going to make them look unprofessional. Certainly, there are things you can do that are unprofessional, but I think we're a little bit too scared about that because in the end I think patients really enjoy seeing that side of us.

Content production takes a bit of time. How do you balance your clinical work with being a content producer?

This was the most common question I got last night at the reception here – "Are you still practicing clinically?" People are always surprised to hear that I am in fact working four days a week, which is full time for ophthalmology.

So four days a week I'm either in clinic or I'm in surgery and then I have that one day a week where I'm either recording podcast episodes or making content. Then nights and weekends is when I fill in the rest of it.

Moving onto something a bit more serious. Managed care. You've had your own experience as a patient through this. Can you tell us what that was like?

I had my cardiac arrest back in 2020. I'm doing okay, now I've got my defibrillator, I'm good. When I went through that, that was the first time I really had a lot of difficulty with the health care system on the patient side of things. I've struggled on the physician side of things because of having to do prior authorisations, preapprovals, and dealing with denials from insurance. They're not wanting

to pay for things that I think patients should need and having to go through that process, that's painful. But then once I was on the patient side and all of a sudden, I had what are called surprise bills. Now there's legislation in the U.S to help protect against that. Basically, when I had my cardiac arrest, I was taken by ambulance to a hospital that was in my insurance network. But then some of the doctors in the hospital were out of network and that's where the complexity starts. I started getting all these bills and insurance was barely covering any part of it. It added up to thousands, tens of thousands of dollars. So, I was able to fight them. It was still nine months of angry emails, phone calls. It was a mess.

And you're on the inside, intelligent, capable. How do patients navigate this?

Exactly, how are our patients supposed to do it? They don't, they either just pay it and use up all their savings. So, it's horrible. It just gave me that insight into what our patients are dealing with on a day-to-day basis, but it also changed my comedy. I started making videos about the U.S. healthcare system. Then as I started doing that, people would email me and tell me about all these other terrible things that are happening in the U.S. healthcare system. Managed care-type things, hospital consolidation under these mega corporations that are taking power away from the people that actually do the work of healthcare and that is shaping the healthcare system in a way that's not so good in the U.S. So it's a shame to hear that some of that is starting to happen here.

It's starting to happen here and the insurers are saying "this is not managed care, we're not going to end up with the U.S.-style system, stop scaring people."

Yes, it is a bit of a slippery slope. You start giving up some power to them, they have so much money and so much influence that it can easily get away from you.

UnitedHealthcare, which is Optum, that's the largest insurer in the U.S., is now the single largest employer of physicians in the U.S. Now you also have private equity dumping billions of dollars into the U.S. healthcare system, buying up practices. It's a huge thing in anaesthesia. The purpose of them doing that is to make money. So it's this conflict between these private companies; their goal is to make money off of this endeavour to buy up hospitals and physicians to make money off of them versus obviously the physicians and healthcare professionals. That's not why you got into it.

No, exactly. Our goal is to get our patients through their episode of healthcare.

You're fighting these two motivations and the income-driven part is winning in the U.S.

If you could do something to prevent that, what would that look like?

It's really got to start with legislation and it's starting to happen. There's been more efforts to curb the corporate practice of medicine. That's kind of the catch all term for this type of thing. Passing legislation that puts more regulation on the corporate practice of medicine, either preventing big mergers or trying in some states to prevent corporations from owning healthcare practices, allowing more of that ownership to be taken up by physicians. We know that outcomes are better almost across the board when physicians own more of the healthcare system. I think it just comes down to those motivations - why are we doing this. Yes, it's great to make money. We all like making money, and physicians do very well, but when it comes down to how to run a healthcare system, we have a motivation to help patients that corporate entities do not have. They've not done that work. They don't know what it's like to take care of a patient, to watch a patient get sick, to watch a patient die, to watch a patient struggle getting the medications they need because their insurance company won't pay for them.

They don't have that insight and so that's why we need more ownership in healthcare by people that actually do the work of healthcare.

Is there anything that you would like to say to listeners, our Australian audience, anaesthetists in general?

Thank you for being so welcoming of Glaucomflecken. It was the coolest thing to find out that people from around the country like the videos. Originally, I just made them for myself and the people I work with but then to hear about all the love from this part of the world that I've never been to, it was so much fun. That's part of the reason I wanted to come back as soon as possible because the people are amazing and you guys are just fantastic.

Listen to the full interview on the Australian Anaesthesia podcast available on our website: https://asa.org.au/asa-public-podcasts and Apple Podcasts https://podcasts.apple.com/au/podcast/australian-anaesthesia/id1530484641

EP #92: Periop medicine and leadership with **Prof Moonesinghe**, Professor of Perioperative Medicine, University College London and Director of the Health Services Research Centre, Royal College of Anaesthetists.

Your main interest is periop medicine. What are some of the key messages you'd like to impart on us?

I think the first thing is for us to, as a profession, zoom out a little bit. Clearly on the day-to-day when we're giving anaesthetics or we're individually reviewing patients, we focus in on the detail and that's part of our job. We've got to be great at the detail and we've got to be meticulous and all of those things, of course we've got to do that. But more generally as a profession, we've got to zoom out a little bit and look at the bigger picture. We've got to look at the whole patient pathway. We've got to think about what we can do for the patients, not just during surgery, but before and after. I think one of the points I'm going to make in particular in my future directions chat later is this is not just about the patients, this is actually about our survival as a specialty as well. Technology's advancing, we've got rapid, rapid technological innovation across all of medicine, but it's really going to come to anaesthesia, it's already there. So, we've got to think about what's our role in patient care going to be in 20 years' time.

Yes, exactly. What do we add as people? Because what can robots not do? Do you think we will be replaced by robots one day?

Maybe not robots, but I think so much of what we do already has been replaced by machine intelligence. So let's think about the way that we administered anaesthetics back in the 1800s when we first developed anaesthesia. You had drops of ether going onto a cloth on the patient's face and all that. Now we've got machines that do all the monitoring for us. We've got machines that will basically do closed loop anaesthetic administration and monitoring and so on. We don't just tweak the volatile administration dose. We tweak what we want as the end-tidal concentration for the patient. All of that is advanced already just in the last 20, 30, 40 years. Ultimately what we do is very algorithmic and you remove some of the unwarranted variation by focusing in on the algorithm. I think what we will end up being as anaesthetists is much more about the holistic care of the care of the patient, much more about making sure we have the right patient having the right surgery for them at the right time and helping the patient to prepare and recover from the surgery, as well as looking after them during it.

Now we've got machines that do all the monitoring for us. We've got machines that will do basically closed loop anaesthetic administration and monitoring and so on.

I'm seeing a bigger focus coming through on patient-led decision making. Very nuanced discussions that we're entering into with patients, not just as anaesthetists but involving the whole perioperative team, intensivists, surgeons. This is a good step, right?

Totally, and I think alongside that, one of the things that we've got to really focus in on, is which are the outcomes that are important to patients? Because we focus on the stuff that's easy to measure, death within 30 days or while they're in hospital. Yes, of course it's an important outcome, but there's so much more to it than that. Again, as anaesthetists, focusing in on some of our own outcomes, like patient satisfaction, the patient experience, all that stuff, that's really important. But more broadly, what is it the patient wants to get out of the surgery? What is it they want to get out of the experience? And they don't just want to have the operation

> We've got to be great at the detail and we've got to be meticulous and all of those things, of course we've got to do that. But more generally as a profession, we've got to zoom out a little bit and look at the bigger picture. We've got to look at the whole patient pathway.

and recover from it. They want their life to either be extended or improved or both and so what's our role in that? How do we measure those outcomes? How do we as anaesthetists make sure that we respond to the data that we collect in order to improve those outcomes overtime?

You're the perfect person to talk to about this, because I know you've got a very big research portfolio. For people who are starting out in research, could you give us some some tips on how you might navigate that space?

I suppose the first thing I would say is, that research is such an interesting area to be in. It can feel really daunting. It can feel inaccessible to many trainees but actually, if you've got an inquiring mind which I think we all must have by virtue of the fact that we're here as health professionals, then you can do it. So that's the first thing. You need mentorship. Find someone that you can ally with that's going to give you some advice and help along the way and then start small and build from there. Collect some data, think about what you can do with it, start small and build. The final thing I guess is collaboration is the absolute key. So the more that you can work with people the better off you're likely to be.

You've held quite a number of leadership roles and you're a woman, you're a woman of colour, so am I. There's challenges with that, especially going into leadership roles in our slightly male-dominated specialty. What have you got to say for the women coming through in leadership?

Yes, it's a great question. So, again, allyship is really important. Your allies don't have to be other women or other people that look like you. They can be anybody. I've had some fantastic male mentors and allies that have really supported me. It's the right person no matter what they look like Then I think the other thing is just put yourself out there. Don't be afraid to fail. If you don't try you've got no idea whether or not you would succeed. So whether it's running for election, for a college or an association role, whether it's applying for that job that might feel like a bit of a reach for you, give it a go. I fail loads of times, and I continue to do so and that's okay because I think it perhaps proves that I'm trying to reach further and that's okay. It's okay to stumble. But then just pick yourself up.

I heard a great acronym for FAIL. First Attempt In Learning. We should all be failing because we should all be having first attempts. We should all be trying to learn and just extending ourselves. So that totally applies to what you just said.

Thank you very much for your time today.

Listen to the full interview on the Australian Anaesthesia podcast available on our website https://asa.org.au/asa-public-podcasts and Apple Podcasts https://podcasts.apple.com/au/podcast/australian-anaesthesia/id1530484641

EP #93: Regional Anaesthesia with **Prof Ki-Jinn Chin**, Professor in the Department of Anesthesiology and Pain Medicine at the University of Toronto, Ontario, Canada.

In terms of your practice now, how much do you think is regional versus non-regional?

It's very much a focus. I work in a tertiary hospital where we focus mainly on major orthopaedics and neurosurgery, so that's where I would spend most of my time. Between directing the regional anaesthesia fellowship and being the clinical director, probably about 50 to 60 per cent of my time is doing blocks.

Wow, that's a great number. You must be fantastic at blocks because it's great practice right. You get better with practice.

Yes, and I think the way Vincent set it up a long time ago with a block room, I think we've had a block room ever since I've been there.

We don't typically have block rooms typically in Australia. Can you tell me how they work.

With block rooms, you centralise the performance of all the blocks for the operating room complex in one location. So, anybody who's scheduled for a block will come to this block room, have their block and then they're passed off to the operating theatre.

There are pros and cons. You're centralising it, so the blocks tend to get done very well and very efficiently. I would say the biggest drawback is that it can de-skill people who aren't part of that block room roster and that's something I sometimes feel a bit guilty about. My other colleagues might not get the opportunity to even do spinal anaesthetics, except when they're on-call and then it can be very daunting. We try and do almost everything in the block room, but we still have a limited capacity. Our block room has four bays at the moment, so occasionally blocks have to be done in the operating room, but by large the vast majority are done in the block room.

You centralise the performance of all the blocks for the operating room complex in one location. So, anybody who's scheduled fo a block will come to this block room, have their block, and then they're passed off to the operating theatre.

So you've got a block room with four bays. How many theatres in your complex is this servicing?

There are twelve. We have a separate day surgery unit with four theatres, and that's got its own little block room. So, on a given day we might process anywhere from 15 to 20 patients coming through with having blocks.

Do you ever get fellows from Australia coming to your hospital wanting to do regional fellowships?

Yes, and I've been saying to people here, and this is not just because I'm in Australia, but I'm always very happy when I get an Australian applicant or a New Zealand applicant because in general, they perform extremely well.

I noticed that you also have a YouTube channel. You've made over a hundred videos to help guide people through the use of ultrasound and how to do blocks. When did that start?

I had been teaching it ever since I came on staff at the Western, which was in 2008. About 2010-2011, I took over as the Regional Anesthesia Fellowship Director. So as part of that, I was doing lots of introductory lectures to the incoming fellows on the fundamental techniques. It got to a point where I was thinking, there must be a better way, rather than me trying to schedule and find time to have these lectures and some of them can't make it.

I also realised that there was benefit in people being able to revisit the material because, as we all know, you don't really take everything in the first time round you hear it. I wondered, how can I give them something to keep going back to. I have to

I would say the most basic thing about regional anaesthesia, it is applied anatomy. That's also what makes it so interesting. So really understanding the anatomy of the block that you're about to do is key.

credit one of my former fellows, Herman Semby, a brilliant chap who came from the UK. He was already into video creation and it's thanks to him that he showed me that making these videos is quite easy and you can just put them up on YouTube. So, it was almost accidental, but driven by this desire to create a resource for my fellows and then it just kind of snowballed from there.

What are some of your top tips for people who want to improve their regional anaesthesia skills or maintain them. What are you commonly saying to people?

I would say the most basic thing about regional anaesthesia, it is applied anatomy. That's also what makes it so interesting. So really understanding the anatomy of the block that you're about to do is key. Also, it's very easy to get sucked into the technical needling bit, but you've also got to make sure that you're doing this for the right reasons – that its actually going to help the patient and that it fits into the overall perioperative plan. Increasingly I find myself making sure I really understand what the surgery involves, what the patient's pathology is and what their expectations are and then the blocks fit into that. Then when it comes to doing the block itself, understanding that it's a process. Give yourself enough time because you never want to rush. That's a certain way to set yourself up for either failure or causing harm. You want to create an environment so that you can find space both physical as well as temporal to be able to do the block. I would say to start small, find a willing surgical ally who will tolerate you and then once you start producing great results for them all the others will want to join in.

Where do you think we are heading with regional anaesthesia? What are some new things on the horizon?

There's been a lot of attempts to tie regional anaesthesia to its impact on longer term outcomes. I think we're realising that some of those haven't come to fruition. For example, does it reduce cancer recurrence? Does it change morbidity, mortality? I think the most notable example, which continues to be debated to this day, is with the hip fracture trials, and spinal versus general. I'm not going to go there, with the one caveat being just remember that all those eligible patients could have received either anaesthetic technique. There are going to be some situations where particularly a spinal is probably the better choice. But I think, regional anaesthesia isn't necessarily going to change things six months, one year down the road. But at the same time, I think there is merit in what it does for the immediate recovery and enhancing recovery and I think patients appreciate that. Giving them that smoother ride and better experience, even though, six weeks later at the surgeon's office, they don't remember it. I think in the moment we're making a difference. Also related to that, is the emphasis now on same-day discharges, and I think COVID really brought that home. Regional anaesthesia has a real role in making sure patients can get out of the hospital the same day in a good condition, in a good state. So, I think that is going to keep regional anaesthesia alive.

It's been wonderful chatting with you. Is there anything else that you want to say before we wrap up, either about regional anaesthesia or medicine in general?

I want to say to especially the younger members of our profession out there, remember that it is a patient in front of you, that a lot of times when you're trying to get to grips with the enormity of all that knowledge that's being thrown your way, you just want to operate by rote recipes. But as you go along, this is a privilege of anaesthesia, you're only ever looking after one patient at one time and it's almost a tragedy if you don't take the time to tailor care to that patient and their specific needs. It's something I do a lot. So, I'd encourage everybody to treat the person right there in front of them in the moment as an individual and say "How can I make your care the best possible?"

That is a wonderful take home message. Thank you very much for that and thank you again very much for your time. Not just here at the podcast booth, but coming to Darwin all the way from Toronto.

Listen to the full interview on the Australian Anaesthesia podcast available on our website https://asa.org.au/asa-public-podcasts and Apple Podcasts https://podcasts.apple.com/au/podcast/australian-anaesthesia/id1530484641

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On behalf of the ASA NSC 2024 Organising Committee, we would like to thank all the sponsors and exhibitors who supported this year's NSC.

We look forward to welcoming you all to Canberra in 2025.

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By doctors for doctors

A special thanks to Avant for their support in making it possible for Dr Glaucomflecken to join us in Darwin!









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 2025.

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.

PRE-NATIONAL SCIENTIFIC CONGRESS (NSC) ADJUDICATED GRANTS

Annual Research Grant Award Winner

Dr Chuan-Whei Lee

Dr Chuan-Whei Lee is a Consultant Anaesthetist and Pain Medicine Specialist in the Department of Anaesthesia and Pain Management, Royal Melbourne Hospital, and Clinical Senior Lecturer and PhD candidate in the Department of Critical Care at The University of Melbourne. Her clinical and research interests include pain management in the older person, surgery at the end of life and the integration of palliative care principles in the perioperative period.

Preoperative illness phase assessment in high-risk patients considered for surgery (PIPAH study)

When delivered at the end of life, futile treatment costs the Australian healthcare system $150 million per year and has significant personal costs to patients and their families. This observational cohort study will explore the impact of end-of-life assessments in high-risk surgical patients and decisions to proceed to operative management. It will also investigate the association between illness phases, a cross-sectional assessment of the end-of-life status based on acute and chronic illness, and markers of perioperative futility such as survival, burden of treatment, quality of life, disability free survival and decision satisfaction. Improving the understanding of these patient-centred and -reported outcomes within the context of perioperative end-of-life assessments will provide anaesthetists with important information for shared decision-making discussions and potentially mitigate the risk of futile surgery.

Kevin McCaul Prize Winner

Dr. Divya Iyer

Dr. Divya Iyer is a third-year Anaesthetic Registrar with a strong background in pharmacology and toxicology, having previously worked as a Hospital Pharmacist and Poisons Specialist. Her expertise in drug safety and patient management, particularly during the perioperative period, drives her current focus on obstetric and paediatric anaesthesia in Melbourne.

Ergometrine and coronary artery vasospasm in pregnant and recently pregnant patients – A narrative review and case report

This review highlights the cardiovascular risks of ergometrine, particularly its potential to induce coronary artery vasospasm in obstetric patients. With the increasing prevalence of pre-existing cardiac conditions and cardiometabolic risk factors among pregnant women, ensuring safe use is crucial. The review examines recent case studies and proposes a management algorithm to help clinicians recognize and manage these rare but serious complications. A recent case report from the authors' institution is also included to underscore these concerns.

NSC DARWIN 2024 WINNERS

Gilbert Troup Prize Winner

Dr Ben Khoo

Dr Ben Khoo is a Resident Medical Officer working at the Central Adelaide Local Health Network, the project was conducted in collaboration between The Queen Elizabeth Hospital Anaesthetics and Respiratory Departments. He undertook this project with his co-investigator A/Prof Venkatesan Thiruvenkatarajan.

Diagnostic accuracy and validation of novel B-APNEIC score for predicting obstructive sleep apnoea in a South Australian population: a cross-sectional study.

This project was conducted to validate the novel B-APNEIC score, which is a new scoring system aimed at refining OSA screening in the perioperative setting. The B-APNEIC score performed with significantly higher sensitivity and similar specificity in predicting severe OSA when compared to the existing STOP-Bang score, and will be a useful new tool in perioperative OSA screening.

Gilbert Troup Prize Runner-up

Dr Hugh Slifirski

Dr Hugh Slifirski is a Resident Doctor at Austin Health in Melbourne with a strong interest in anaesthesia and critical care research.

Massive Fluid Transfusion (greater than 20 litres) in Adult Liver Transplant Recipients – a Single Centre Observational Study of the Victorian Liver Transplant Unit

Liver transplantation (LT) is prone to large volume bleeding and often requires large transfusions of fluid and blood products. Dr Slifirski's team defined a priori an ultramassive fluid transfusion (UMFT) as a total perioperative transfusion >20 litres of crystalloids, colloids, blood products, and coagulation factors that were administered intraoperatively and for the first 24-hours postoperatively. They found that at Austin Health, Melbourne, 1 in 10 adult LT recipients required an UMFT. UMFT was associated with increased mechanical ventilation hours, ICU and hospital length of stay, however, there was no association with increasing fluid volumes and number of packed red blood cells and mortality, demonstrating that UMFT can be done safely in LT.

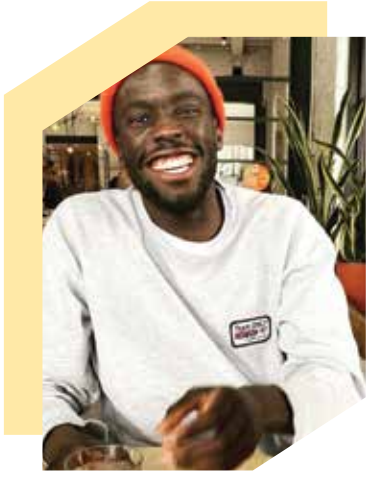
National Scientific Congress Best Poster Prize Winner

Dr Clayton Lam

Dr Clayton Lam is a Critical Care Resident Medical Officer working at Flinders Medical Centre with a keen interest in pursuing a career in anaesthesia. Having presented at numerous departmental, hospital and national level conferences, Dr Lam is committed to ongoing quality improvement and research projects alongside his clinical interests.

Ensuring eco-responsibility: An audit of clinical waste sharp bins in operating theatres at a major tertiary centre

Clinical waste is the facility's most expensive waste stream, and its disposal has the largest carbon footprint of any waste stream due to high temperature incineration in gas-fired furnaces. Hence, there are significant financial and environmental implications from inappropriate clinical waste disposal. This audit highlights the effectiveness of raising awareness about proper disposal of clinical waste sharps via educational initiatives, posters, and dedicated tempered glass bins, resulting in improved compliance with sharps disposal guidelines at a tertiary healthcare facility. Healthcare professionals must be eco-responsible, recognising the larger environmental impact of improper sharps disposal in line with local and national clinical waste disposal guidelines.



National Scientific Congress Best Poster Prize Runner-up

Dr Anei Ochan-Thou

Dr Anei Ochan-Thou is a Junior Medical Doctor in Melbourne. Dr Ochan-Thou and his team are deeply inspired by environmental sustainability and reducing wastage in healthcare settings.

Audit of Discarded Medications in an Australian Metropolitan Public Hospital (PubRUM Study): A cross-sectional analysis

This audit focussed on medication wastage at a public hospital through the Public Return of Medicines (PubRUM) initiative. It founds an extrapolated total wastage of greater than $100,000 in a calendar year for both in-date and expired medications.

Trainee Members Group Best Poster Prize Winner

Dr Glen Abbott

Dr Glen Abbott is an Advanced Trainee from Concord Hospital in Sydney. Dr Abbott has a keen interest in regional anaesthesia and is currently preparing for the part 2 exam.

Effect of IPACK (infiltration between the popliteal artery and the capsule of the knee) Block on Post-Operative Opioid Requirements in Total Knee Replacement: A Retrospective Cohort Study

This retrospective cohort study evaluated the impact of the IPACK block versus conventional periarticular local anaesthetic infiltration. The study showed a 25% mean reduction in oMEDD (oral morphine equivalent daily dose) in patients in the IPACK block group.

Trainee Members Group Audit/Survey Prize Joint Winner

Dr Hugh Slifirski

Dr Hugh Slifirski is a Resident Doctor at Austin Health in Melbourne with a strong interest in anaesthesia and critical care research.

Compliance to Novel Recovery Spinal Anaesthetic Discharge Protocol at Austin Health

At Austin Health in Melbourne, a new postoperative protocol was implemented for patients who received a spinal block as part of their anaesthesia. The protocol required ward nursing staff to perform hourly postoperative neuro-observational assessments (including sensation and Bromage scores) until the spinal block fully resolved, shifting this responsibility from the post-anaesthetic care unit (PACU) to the ward. Dr Slifirski's team conducted an audit to evaluate nursing staff compliance with these assessments before and after the protocol was introduced. The results showed improved adherence to neuro-observational assessments, a reduction in PACU admission times, and no increase in spinal-related complications.

Trainee Members Group Audit/Survey Prize Joint Winner

Dr Kaitlin Hastings

Dr Kaitlyn Hastings works at Werribee Mercy Hospital in Victoria as a Critical Care Resident, with the aim of pursuing anaesthesia training. With a previous career as a pharmacist and interest in pain medicine, Dr Hastings' identified and conducted this audit with the support and guidance of the Anaesthesia and Pain Medicine Department at the Royal Melbourne Hospital where she was working until early 2024.

An audit of the pectus excavatum (Nuss bar) procedure

This audit examined the demographics, standard of care and outcomes for Pectus Excavatum surgical patients at the Royal Melbourne Hospital between 2014 and 2023. This data was compared to other centres to identify areas for improvement and to support the introduction of a clinical care pathway. Despite the use of multimodal analgesia, this audit identified high rates of acute postoperative and persistent pain, consistent with findings from other centres. This requires an ongoing multimodal and multidisciplinary approach to reduce long term sequelae.

NERIDA DILWORTH PRIZE WINNER

Dr Ethan Fitzclarence

Dr Ethan Fitzclarence is an AT1 training in WA. Dr Fitzclarence is a member of the WA Trainee Committee.

Detection and quantification of nitrous oxide leakage

Nitrous oxide is commonly used for its anaesthetic and analgesic properties, however can cause personal and environmental harm. This audit presented a simple method of identifying and quantifying unnecessary nitrous oxide leak from hospital pipelines. Leak rates ranged from 18 to 55% of total nitrous oxide purchase in the hospitals tested in WA, allowing for further testing to isolate and correct the leaks, minimising the associated harm.

INTERVIEW WITH PROFESSOR VICTORIA ELEY

ASA PHD SUPPORT GRANT 2014

Can you tell us where you currently practice, and your clinical-academic mix?

I have worked as a Staff Specialist at the Royal Brisbane and Women's Hospital since 2007, providing obstetric and adult services. Since about 2009 I have undertaken research, but it was not until 2023 that I had a paid research position, with a Metro North Clinician Research Fellowship.

Until the end of 2024 I am divided between 0.3 FTE Staff Specialist at RBWH, 0.3 FTE Metro North Research Fellowship and 0.3 FTE University of Queensland Mayne Professor of Critical Care. This will be become more manageable from the start of 2025, after my research fellowship comes to an end.

What are your academic interests?

My personal research areas of interest include care of the obese patient (obstetric and non-obstetric) and the use of antibiotics in the perioperative period. In each of my roles (hospital, health service and university), I have a responsibility to build research capacity. By supervising and supporting others in their areas of research passion, I have the opportunity to contribute to a much broader range of research topics within critical care.

What made you decide on pursuing your academic career?

It started with a clinical question – we were always recommending that pregnant women with obesity should have an early epidural. I observed some patients did not receive this advice well and some anaesthetists didn't think this was good advice to give! So I wondered – what kind of evidence do we have to back up this recommendation? This led to my first research project and subsequently to my PhD. Like many practice recommendations, this one remains largely based on expert opinion.

I found that I really enjoy reflecting on clinical practice and 'questioning everything'. I love chatting with colleagues who share this questioning mindset and having debates over different aspects of modern clinical care. Many of these people are anaesthetists and I have also formed strong research relationships with nursing and allied health professionals which are very rewarding.

I found that I really enjoy reflecting on clinical practice and 'questioning everything'. I love chatting with colleagues who share this questioning mindset and having debates over different aspects of modern clinical care.

How did the ASA PhD Support Grant help?

The ASA PhD Support Grant was my first successful external funding application. Many people don't know that researchers spend hours and hours writing applications for grants to support their research. These funds may pay for equipment, research staff, statisticians or other research costs. In my case, I used money from the ASA to pay for the costs of recording and transcribing hours and hours of interviews that were undertaken as part of my PhD. This saved me additional time and money, as I was still undertaking my clinical work at the same time as finishing my PhD.

Having some successful funding on your CV is critical in applying for more grant funding, no matter how small the initial amount of money. After the successful ASA PhD Support Grant, I obtained some funding from my hospital and then from the University of Queensland. Then two years later my team were successful with an ANZCA Grant. These were for projects unrelated to my PhD and allowed me to pursue other research ideas. It isn't obvious to those outside of research, but most researchers will make many unsuccessful applications for grant money. A little bit of money can go a very long way.

Did completing a PhD help in building your academic career?

At the time, doing a PhD with The University of Queensland was the best way to access experienced researchers to help me on my journey. Most universities offer a structured approach to completing a number of projects over three to six years, which comprises a PhD. Throughout the course of my PhD, I had expert researchers guiding me and they continue to provide amazing mentorship to this day. They not only helped me complete my own PhD, but they connected me with other experienced researchers, and I started to build my own network.

What aspects of your academic career have been the most rewarding?

The most amazing experience has been working in multidisciplinary teams. The quality of research is often better when there are lots of different perspectives and types of expertise available. By engaging with multidisciplinary teams, I have had opportunities to attend different conferences, publish in different journals and explore more ideas within my particular area of interest. It broadens my outlook in both clinical and academic life.

Looking into the future: where is your research taking you?

For me, being involved in research is a good balance to providing anaesthesia care in a large public hospital. I aim to increase the research capacity at the Royal Brisbane and Women's Hospital and encourage more anaesthetists to start a PhD. I would like to make it easier for clinicians to choose a research pathway in parallel to their clinical workload.

What's your advice to ASA members thinking about starting out in research, or contemplating undertaking a PhD?

First wonder – why do I want to do this? Do a PhD because you really want to find the answer to a clinical problem. Don't do it for someone else and make sure you care about your research findings. Completing a PhD is a long road and you need to remain engaged and enthused.

Find the right supervisors to help you on your journey and accept their feedback and support.

A group of clinicians who are also PhD students can be a useful sounding board when things are tough. Even when we are researching different clinical problems, our departmental researchers benefit from a supportive group around them. "What form do I need for this?" - someone else will know, or know who to ask!

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Assoc Prof Alwin Chuan

Chair, Science Prizes and Research Committee

Australian Society of Anaesthetists®

2024 marks **90 years**

of the Australian Society of Anaesthetists.

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

Learn more about our first ninety:

www.ourfirst90.asa.org.au

Our first 90 **years** 1934-2024

90TH ANNIVERSARY DINNER

ADDRESS BY DR MARK SINCLAIR

27 June 2024

Dr Mark Sinclair, ASA President

The Australian Society of Anaesthetists has been Australia's professional body for anaesthetists since its founding in 1934. Today the ASA has over 4,000 members across the country. To celebrate its 90th anniversary, this year the ASA has embarked on a program of activities, events and advocacy to promote the role the ASA has played in supporting the healthcare of the almost four million Australians who receive treatment by the profession each year.

One of these activities was a special 90th Anniversary Dinner held in late June at the National Museum of Australia, which sits beside the west basin of Lake Burley Griffin in Acton in the Australian Capital Territory. The dinner, for approximately 50 guests, brought together key stakeholders, including political, bureaucratic and healthcare industry leaders.

Following is an excerpt of an address given by ASA President, Dr Mark Sinclair, to guests attending the 90th Anniversary Dinner.

A special welcome to the Federal MPs and Senators we have in the room tonight as our guests. We know the Parliamentary sitting week is very busy, and we appreciate your attendance.

To our medical and other colleagues from the health industry a special welcome to you also.

I also welcome our members of the Board of the ASA, and our Past Presidents, with a special mention to Dr Bob Hare, our most senior ASA Past President; Bob was president from 1980 to 1982.

I would also like to make a special mention of Ms Tien Kelly who is representing Senator Gerard Rennick (QLD) tonight, who is unfortunately an apology. Ms Kelly is the great granddaughter of the late Dr (LTCOL) Arnold Robertson OBE who was president of the ASA from 1951 to 52. We are so glad you could join us tonight and thank you for letting us know of your family's connection to the specialty.

When we looked at our 90th anniversary, we knew we wanted to do something to mark this milestone and to take stock of where we have come from and what's ahead.

Part of that 'something' is tonight. When it came to a venue in Canberra, we naturally thought of the National Museum.

On March 11, 2001, when the museum was opened by the then Prime Minister John Howard he said:

"This is a unique museum; in some respects it is very un-museum like. What it does unusually, and I think very attractively, is seek to interpret the history of our nation. Not only in terms of events and objects but also in terms of the life experience of people from different backgrounds, Indigenous people, people who came to this country having been born elsewhere, and people who have been born in this nation."

So, we are truly glad and honoured to be able to share this venue with you all tonight.

As with our early anaesthetists, we face ongoing challenges.

Our success as an organisation shouldn't mask the challenges that many in the profession face in their various jurisdictions.

When the ASA was founded in 1934, it had only 100 members across a country of three million square miles.

With communications poor, and distances vast, the amount of work and determination to bring our organisation together was significant.

Nowadays – thousands of members who can all be instantly connected.

Indeed, just like this museum likes to tell the story of Australia, we also form part of that Australian story, starting in 1934.

Dr Mike Freelander MP, Chair Standing Committee on Health, Aged Care and Sport presenting at the ASA 90th Dinner.

Wendy Askew, Senator for Tasmania and Dr Michael Lumsden-Steel, Chair ASA Economics Advisory Committee.

Dr Matthew Fisher, ASA CEO and Kylie McQuellin, NZSA CEO.

Each person tonight will receive a copy of our 90th Anniversary book, it's the first edition and includes some photo reminders of the years past.

Coming into 2024 we were faced with numerous challenges as a profession and workforce – and challenges we needed to go away and do our homework on.

For the past 25 years investment in health by default has meant investing in new infrastructure – new hospitals, new wings, new buildings – bricks and mortar stuff.

But then the buildings were completed and are still there. What we need is the same focus, investment and support in supplying these facilities with sufficient numbers of medical professionals and indeed other health care professionals.

And we're falling short. Growing number of anaesthetists but demand is increasing more. Need to train more.

As a result of this challenge the ASA this year commissioned a detailed workforce analysis, performed by the HealthConsult group, and we also liaised with the Department of Health and Aged Care on this.

I won't bother boring everyone with detailed data tonight, but we will discuss this when the report is launched on August 14 at Parliament House.

Another solution which has been mooted (in the Kruk report): import overseas-trained anaesthetists. Two issues arise here.

The people we bring in must be able to demonstrate the same degree of expertise and experience as Australian anaesthetists. ANZCA must remain intimately involved here – it is the body whose core mission is exactly what is needed – ensuring top quality, world-class anaesthesia services continue to be provided to Australian patients, by appropriately trained and qualified doctors. No other body such as a medical board has this expertise. By all means seek to reduce unnecessary duplication, red tape and expense to applicants (ANZCA already does well here compared to other like bodies), but quality and safety remain paramount.

Secondly, other countries are also experiencing significant shortages, and this there raises the ethics of bringing them here at the expense to their own health care systems. Even first world countries with doctors with quite comparable skills and experience are in shortage compared to us – I have a graphic produced by the World Federation of Societies of Anaesthesiologists which shows the world's nations and how many anaesthetists they have per head of population – despite our workforce issues we are actually better off then NZ, USA, UK and substantially better off than Canada and South Africa.

There is a lot to unpack here, but I wanted to let you know – work needed to be done to both quantify the problem and also project out the future workforce demand.

Our report has done that.

If there is one thing that the ASA has endeavoured to do under all of our current and past leaders is to tell our story better, take our rightful place in the healthcare discussion and to elevate our point of view – we have the ability to make a difference to the future.

This museum was created to tell the story of Australia, tonight we have told you of our 90-year story, and our commitment to doing the best we can for Australians for as long as we can and do it just a little bit better every day.

Thank you.

Dr Mark Sinclair
ASA President

ASA HEALTH WORKFORCE PARLIAMENTARY ROUNDTABLE

IN MID-AUGUST, THE AUSTRALIAN SOCIETY OF ANAESTHETISTS HOSTED A PARLIAMENTARY ROUNDTABLE AND LUNCH AT PARLIAMENT HOUSE IN CANBERRA. THE EVENT WAS CO-HOSTED BY DR MIKE FREELANDER MP, CHAIR OF PARLIAMENT'S STANDING COMMITTEE ON HEALTH AND AGED CARE.

The event was also used to launch the ASA's timely, and important, Anaesthetist Workforce Modelling Final Report (Workforce Report) which details a sobering assessment of the sustainability of Australia's anaesthetist workforce.

The roundtable and lunch were attended by a number of MPs, Senators, and Ministerial Advisors, including the office of Australian Minister for Health, the Hon Mark Butler MP, Shadow Minister for Health Senator Anne Ruston, and former Regional Health Minister Dr Dave Gillespie MP. Also represented were members of other parliamentary bodies such as the Parliamentary Standing Committee on Industry, Science and Resources, the Parliamentary Friends of Preventative and Public Health, and the Parliamentary Friends of Nursing.

The roundtable was attended by fellow specialists, Colleges and peak bodies including:

- ANZCA
- Department of Health and Aged Care
- Consumers' Health Forum
- Australian Healthcare and Hospitals Association
- Rural Doctors Association
- Endocrine Society of Australia
- Australian College of Nursing
- ANZ Society for Vascular Surgery
- AMA (President Prof. Stephen Robson)

On the day, the ASA was joined by Associate Professor Dr Greg Jenkins, Chair of Trainee Selection at the Royal Australian College of Obstetricians and Gynaecologists and Dr Megan Belot, Immediate Past President of the Rural Doctors Association of Australia and a Rural Generalist (Anaesthetics). They spoke of the shared challenges of other specialties, particularly in regional, rural and remote communities.

Associate Professor Gregory Jenkins, Chair of Trainee Selection at The Royal Australian and New Zealand College of Obstetricians and Gynaecologists, Dr Matthew Fisher, ASA CEO, Dr Megan Belot, Immediate Past President Rural Doctors Association of Australia, Dr Vida Viliunas OAM, ASA Vice President and Dr Mark Sinclair, ASA President.

Anaesthetist Workforce Modelling Final Report

The key topic of the day however was the future of the anaesthesia workforce in Australia. In mid-2023 the ASA commissioned the Workforce Report by HealthConsult to explore the current state of the anaesthetist workforce in Australia and develop a planning model up to 2032. The report was commissioned to ascertain the extent of the issue, and identify possible solutions without compromising safety and quality, or overcorrecting in the short, medium, and longer term.

A key finding of the report is that there are predicted shortfalls in the supply of anaesthetists relative to future demand (up to 2032). Also, unless measures are taken now, Australia's anaesthetist workforce under-supply will worsen.

A copy of the Workforce Report was provided in hard copy to all attendees, as well as being released online. ASA Vice President, Dr Vida Viliunas OAM, and ASA President, Dr Mark Sinclair, both addressed the issues facing the anaesthesia workforce in Australia, as well as the HealthConsult report and its implications. They both reiterated the importance of maintaining the current medical model of anaesthetic care to ensure the safety and quality of outcomes.

According to Dr Sinclair, an addition of slightly more than 50 anaesthetists per year to the current ANZCA output is needed, to prevent more significant workforce challenges as we move towards the 2030s. With over 150 accredited ANZCA training locations across Australia, this would not place

A key finding of the report is that there are predicted shortfalls in the supply of anaesthetists relative to future demand (up to 2032). Also, unless measures are taken now, Australia's anaesthetist workforce under-supply will worsen.

Professor Steve Robson, AMA President, Dr Mike Freelander MP, Chair Standing Committee on Health, Aged Care and Sport, Dr Mark Sinclair, ASA President and Dr Matthew Fisher, ASA CEO.

Kylie Woolcock, CEO Australian Healthcare and Hospitals Association, Dr Megan Belot, Immediate Past President Rural Doctors Association of Australia, Dr Matthew Fisher, ASA CEO, Mr Sam Shipley, on behalf of Mark Butler, Minister for Health and Aged Care and Dr Vida Viliunas OAM, ASA Vice President.

Dr Peta Lorraway, ASA Board Member, Kylie Woolcock, CEO Australian Healthcare and Hospitals Association and Warren Entsch MP

too high a demand on individual public hospitals, and the funding required to invest in employing these trainees would not be excessive.

State government Departments of Health will of course have to share the responsibility here. Attendees at the roundtable were reminded that ANZCA has no control over the number of trainees working at accredited sites; this is the responsibility of the government departments which fund and run these hospitals (mostly state-based). ANZCA's role here is to accredit these sites as providing appropriate training and experience.

Dr Sinclair told attendees that other approaches currently under consideration present their own issues.

Importing overseas-trained doctors is of course an essential component of ensuring an adequate workforce across the board. But we must have the capacity to properly assess the experience and qualifications of these doctors. The medical colleges (including ANZCA of course) must remain central to this if our safe, world-class levels of patient care are to be maintained. Dr Sinclair also warned that this task should not be delegated to medical boards and government departments.

We must also be mindful of the current workforce challenges being faced by other nations, including most first-world nations, before encouraging doctors to leave their countries of origin for Australia.

Moves to increase the scope of practice of lesser-trained healthcare professionals may have some merit, but moving beyond their scope via task substitution is not the solution. This also risks our world-class levels of patient safety and quality care and should be resisted. Again, the workforce challenges currently being faced by other healthcare professions such as nursing, must also be kept in mind.

Both Dr Viliunas and Dr Sinclair cautioned against any reliance on short-term measures that may compromise standards, safety and quality.

The ASA again expresses its gratitude to the Parliamentary Friends of Medicine Group, led by Dr. Mike Freelander MP (Paediatrician, Member for Macarthur) and Dr. David Gillespie MP (Gastroenterologist and Diploma of Anaesthetics UK, Member for Lyne) for their assistance, as well as Mr. Leon Beswick and his team from the Civic Partnership for assistance with the logistics on the day and throughout this year.

A full copy of the Workforce Report, as well as a short Summary and ASA Recommendations, can be downloaded from the ASA website at https://asa.org.au/publications/anaesthetist-workforce-modelling.

Bernard Rupasinghe

Policy and Public Affairs Manager

2004 - 2013

REPRESENTING, SUPPORTING AND EDUCATING IN THE FACE OF INCREASING REGULATORY BURDENS

Navigating Regulatory Waters

The period 2004 - 2013 saw significant regulatory changes that impacted the healthcare sector. The ASA engaged with the Productivity Commission, AHPRA, and ACSQHC to address these changes. The ASA advocated for consistent standards and separate administration of these functions, anticipating potential conflicts with professional standards.

Building a Stronger Anaesthesia Workforce

Workforce studies were a major focus, with the ASA conducting member surveys to address concerns about employment and training capacity. The 2005 Productivity Commission review led to the concept of "task substitution" and the eventual establishment of the National Registration and Accreditation Scheme (NRAS) in 2010. The ASA highlighted the oversupply and maldistribution of anaesthetists, hosting a Workforce Summit in 2013 to advocate for better workforce distribution.

Economic Empowerment

The ASA achieved significant economic advancements for its members, including the inclusion of new anaesthesia items in the MBS, increased DVA payments aligned with Private Health Insurers' RVG schedules, significant increases in Workcover payments, and the standard practice of Informed Financial Consent following an ASA campaign.

Professional Advocacy

The ASA's Professional Issues Advisory Committee (PIAC) was established in 2005, advising the ASA Council on various issues, including the Good Medical Practice guidelines, the WHO Surgical Safety Checklist, and mandatory notification policies. PIAC played a crucial role in supporting vocational training and member support initiatives.

Setting Standards

ASA significantly contributed to professional conduct and education through the formulation of a Code of Conduct in 2005, introduction and review of Position Statements to aid members in navigating the evolving professional environment, creation of IAMONLINE Modules for online learning, and establishment of ANZTADC in 2006 to collect anaesthesia critical incidents online.

ASA's Evolution

Mark Carmichael was appointed CEO in 2012, and in 2013, ASA moved to North Sydney, NSW. During this period, "Anaesthesia and Intensive Care" journal celebrated four decades, and "Australian Anaesthetist" magazine replaced ASA News. The ASA PhD Support Grants were created in 2005, the Global Oximetry Project was initiated in 2010, and the 8th International Symposium on the History of Anaesthesia was held in 2013. The role of the anaesthetist as a perioperative physician was identified, communication workshops were conducted, and support was given to members in need. ASA members also supported the World Federation of Societies of Anaesthesiologists Congresses in Paris (2004), Cape Town (2008), and Buenos Aires (2012). This decade saw a significant increase in ASA membership.

ASA attendees at the WFSA Congress in Paris (2004) visiting the battlefields of the Somme

Looking to learn more?

Discover more about the evolution of the Australian Society of Anaesthetists across 2004 - 2013.

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

2014 - 2023

A DECADE OF CHALLENGES

CPD and Medical Registration

The decade began with significant changes to the Continuing Professional Development (CPD) program for medical practitioners. In 2013, ASA had been busy developing an online tool to assist members who chose to not use the ANZCA CPD program to record their CPD. This was shortly followed by the Australian Health Practitioner Regulation Agency (AHPRA) and Medical Board of Australia introducing new regulations for CPD, sparking debate about their utility and value. The ASA continued to provide certification services to its members with audit compliance, despite the increasing influence of CPD programs being advocated for, and today offers CPD support through our work with CPD Home.

A Contentious MBS Review

A comprehensive review of the Medicare Benefits Schedule (MBS) was initiated in 2014. The process was fraught with challenges, particularly for anaesthetists and anaesthestic practice. The review panel's recommendations threatened to drastically reduce patient rebates for numerous procedures – especially for endoscopic and ophthalmic surgeries. The ASA's policy and economic committees played a crucial role in mitigating the impact of these recommendations, successfully protecting patient access to affordable care.

Surgeon Mr Senthilkumar Sundaramurthy performs the first operation in a HALO PAPR unit

The COVID-19 Pandemic

The COVID-19 pandemic significantly disrupted the work of anaesthetists. The ASA actively advocated for the safety of our workforce in protection from infection, such as testing and promoting the use of HALO masks. Members were redeployed to various roles, including intensive care and contact tracing. The profession faced unprecedented challenges due to lockdowns and border closures.

Device check and donning of the HALO mask during the 2020 COVID pandemic.

The Decline of Medicare

Medicare, once a pillar of the nation's healthcare, began to show signs of strain. A decade of cuts and neglect by successive federal governments had placed a growing financial burden on Australian medical practitioners. As the cost of providing care and clinical practice continued to rise, the gap between MBS rebates and actual expenses widened, exposing growing cracks in the system. Significant investment and a commitment to long-term reform are needed to shore up Medicare's foundations and sustain equitable access to healthcare for all Australians.

Curbing Threat of Managed Care

The decade also saw the emergence of managed care as a potential threat to the profession. A health insurance company sought an ACCC exemption from collective bargaining, but the combined efforts of the AMA, ASA, COPS and others, successfully opposed this move.

Looking to learn more?

Discover more about the evolution of the Australian Society of Anaesthetists across 2014 - 2023.

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webAIRS

webAIRS

Dr Martin Culwick, Dr Pieter Peach, and
The ANZTADC Case Report Writing Group

THE STORY OF ANZTADC AND WEBAIRS:

Pioneering Incident Reporting to Enhance Anaesthesia Safety – 12,000 reports and counting!

The journey of critical incident reporting in anaesthesia traces back to the innovative work of J. Flanagan in 1954, who first applied the technique to aviation incidents. In 1978, J. Cooper brought this approach to anaesthesia, publishing the groundbreaking article "Preventable anaesthesia mishaps: a study of human factors". Australia soon followed suit, with J. Williamson et al. publishing "Anaesthesia safety and the critical incident technique" in 1985. This paved the way for the Australian Incident Monitoring Study, which in 1993 published the insightful results of the first 2000 incident reports in Anaesthesia and Intensive Care (AIC).

Fast forward to 2006, and the Australian and New Zealand Tripartite Anaesthetic Data Committee (ANZTADC) was born, thanks to the visionary recommendations of two taskforces established by Professor Michael Cousins during his tenure as President of the Australian and New Zealand College of Anaesthetists (ANZCA). With strong tripartite support from ANZCA, the Australian Society of Anaesthetists (ASA), and the New Zealand Society of Anaesthetists (NZSA), ANZTADC set out on a mission: "To improve the safety and quality of anaesthesia for patients in Australia and New Zealand by providing an enduring capability to capture, analyse and disseminate information about incidents (de-identified) relative to the safety and quality of anaesthesia in each country".

The journey unfolded over three phases. Phase One saw meticulous planning to bring to life a web-based Anaesthetic Incident Reporting System (webAIRS). With a dedicated team at the helm, including a Co-ordinator appointed in 2006 and a Medical Director in 2007, ANZTADC conducted a comprehensive system design. The Inaugural Committee included three committee members from the ASA, three from ANZCA and one from the NZSA which was in proportion to the proportion of funding from each

.... ANZTADC set out on a mission: "To improve the safety and quality of anaesthesia for patients in Australia and New Zealand by providing an enduring capability to capture, analyse and disseminate information about incidents (de-identified) relative to the safety and quality of anaesthesia in each country".

organisation. In addition, the current Presidents and Chief Executive Officers (CEOs) of each parent organisation are also statutory members. They thoughtfully determined the dataset to collect, evaluated commercial incident reporting systems, and collaborated with international anaesthetic organisations to classify incidents. Crucially, they secured Qualified Privilege to protect incident reports in both Australia and New Zealand. In 2009, a pilot version of webAIRS was built, undergoing rigorous testing and refinement at early adopter hospitals. The launch of the full webAIRS program took place at the ASA National Scientific Congress in 2010, making it freely available to all ASA, ANZCA, and NZSA members.

Phase Two focused on expanding site recruitment and encouraging incident reporting. While initially hindered by ethics approval requirements at each site, a game-changing statement from the National Health and Medical Research Council (NHMRC) regarding Ethical Considerations streamlined the process for de-identified Quality Assurance (QA) data collections. This statement clarified that formal ethics approval was no longer required for de-identified data collections regarding QA but included a statement that the data collection process was required to meet the same ethical standards as those required for the collection of de-identified data. During the journey to collect the first 4000 reports, several illuminating analyses were published, spanning topics from emergency drugs to chewing gum in the pre-operative period. A milestone was reached in January 2017 with the publication of "Cross-sectional overview of the first 4,000 incidents reported to webAIRS" in AIC. These articles are available via links on the webAIRS website by clicking the green "Publications" button on the website or the direct link https://anztadc.net/Publications/News.aspx?T=Publications.

Phase Three saw the tireless efforts of ANZTADC come to further fruition. As site recruitment and incident reporting continued to grow, numerous insightful publications were released, all conveniently accessible via the webAIRS website. The database reached an impressive 12,000 incident reports in late October 2024, enabling a future comparison with the first 4000 reports and the second set of 4000 reports, which have both been published in AIC. This achievement is a testament to the dedication of past and present ANZTADC members, the skill of ANZTADC analysers, and the invaluable contributions of registered sites and individual anaesthetists who diligently report incidents.

Looking back, it's clear that with assistance from the tripartite, ANZTADC and webAIRS have made an indelible mark on anaesthesia safety in Australia and New Zealand. By providing an enduring capability to capture, analyse, and disseminate learnings from de-identified incidents, they continue to drive positive change through regular updates in e-News, Magazine and Bulletin articles, presentations at ASMs and NSCs, and peer-reviewed publications in the AIC.

To create an account to start submitting incidents, visit webAIRS https://anztadc.net/

To register a new site, follow the prompts in the registration process on the webAIRS landing page, 'Register' and 'Add new site', and anztadc@anzca.edu.au will receive an email to authorise the site and support you in your journey to increased patient safety.

webAIRS
www.anztadc.net

Australian Society of Anaesthetists®

New Zealand Society of Anaesthetists

ANZCA
Australian and New Zealand College of Anaesthetists and the Faculty of Pain Medicine

ASA MEMBERSHIP SERVICES

FIRSTLY, LET'S INTRODUCE THE MEMBER SERVICES TEAM, CONSISTING OF KATIE CUNNINGHAM, OUR MEMBERSHIP & ADMINISTRATION SUPPORT OFFICER AND NATALIE SINN (MYSELF) AS MEMBERSHIP ENGAGEMENT MANAGER. WE'RE COMMITTED TO ASSISTING YOU WITH ALL MEMBERSHIP ENQUIRIES AND ENSURING YOU MAKE THE MOST OF THE FULL RANGE OF BENEFITS AND SERVICES AVAILABLE.

It was a pleasure meeting so many of you at the recent National Scientific Congress in Darwin. The event was another outstanding success, perfectly blending a top-tier scientific program with exciting social activities. From meeting YouTube sensation Dr. Glaucomflecken (Dr. Will Flanary) to snapping selfies with baby crocodiles and snakes, this conference truly had it all!

We hope you're enjoying the enhanced ASA website and Member Portal. Designed with your convenience in mind, the portal offers quick and easy access to all your essential resources. We encourage you to explore the platform and familiarise yourself with its features by checking out our **Membership FAQ** section and watching some handy video tutorials https://asa.org.au/membership-portal-faq.

The Member Portal Dashboard: your central hub

The Member Portal dashboard gives you fast access to key ASA resources, including:

- ***Anaesthesia & Intensive Care* journal:** Stay up to date with the most current research and developments in your field.
- **ASAEd learning resource library:** Access podcasts, education resources, past presentations and much more.
- **Australian Anaesthetist:** Member magazine on topical issues for the specialty.
- **CPD Home Partner and Portal:** Track your Continuing Professional Development through CPD Home's user-friendly platform and app. * ASA members save up to 50% off subscription rates.
- **Events:** Register for career development courses, exam support sessions, peer support and networking events.
- **Patient information pamphlets:** Share important resources with your patients with ease.
- **President's E-News:** Get the latest updates and insights from the ASA leadership.
- **Relative Value Guide (RVG):** In addition to your RVG app, a PDF version is available online.

Supporting ASA members in research and development

The ASA is dedicated to supporting members, including trainees, in advancing research within anaesthesia, intensive care, and pain management to enhance patient outcomes. Key research areas include Environment, Innovation and Safety in Anaesthesia.

Additionally, the ASA offers a variety of scholarship opportunities outlined below:

- **Science Prizes, Awards, and Research:** The Science Prizes, Awards, and Research Committee (SPARC) manages grants and awards, including those linked to the National Scientific Congress (NSC) and state-administered prizes.
- **CRASH Scholarships:** Designed for members returning from leave and seeking to refresh their skills, the ASA provides 20 scholarships valued between $200 to $400 each financial year. *T&Cs apply.
- **Common Interest Group (CIG) Scholarships:** ASA trainees can apply for one of three CIG scholarships, each worth $5000, to attend international meetings in the USA, UK or Canada. *T&Cs apply.

Explore these opportunities and more on the Member Portal.

ASA Advantage Program: exclusive savings and discounts

You have access to exclusive savings and discounts through our ASA Advantage Program. Here's a summary of the great deals available to you:

- **Anaesthetic Crisis Manual:** ASA members receive up to 20% discount online.
- **Avis & Budget:** Enjoy 10% off leisure car rentals in Australia and New Zealand.
- **Corporate Car Programs:** with BMW, Audi, Lexus and Volkswagen.
- **Hilton:** Enjoy up to 10% off best available rates in Australia.
- **HWL Ebsworth Lawyers:** Receive 10% off their standard rates.
- **NobleOak Insurance:** Receive 10% off selected insurance products.
- **SimSTAT:** Save up to 50% off their online modules

These offers are just a few of the many ways we're providing added value to your ASA membership. Be sure to check

Stay tuned for renewal reminders

As the year draws to a close, please keep an eye out for your renewal e-reminders recently sent. To make your renewal process hassle-free, consider signing up for direct debit to ensure your membership is automatically renewed.

If you have any questions or need assistance, don't hesitate to reach out to the Membership Services Team at membership@asa.org.au

Wishing everyone a safe and enjoyable holiday season! We look forward to continuing to support you in the year ahead.

Natalie Sinn

Membership Engagement Manager

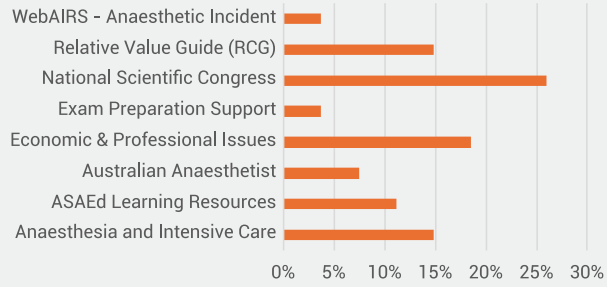
Thank you for your feedback

Thank you to everyone who participated in our ASA Member Survey conducted at the ASA Booth during the National Scientific Congress (NSC) in Darwin! Your feedback is incredibly valuable and will play a crucial role in shaping the future of ASA services and offerings.

Although the number of respondents was small, the overall feedback we received was overwhelmingly positive. Each participant was also entered into a draw for a complimentary registration to the 2025 NSC. We are thrilled to announce that the winner is Dr. John Woodall—congratulations!

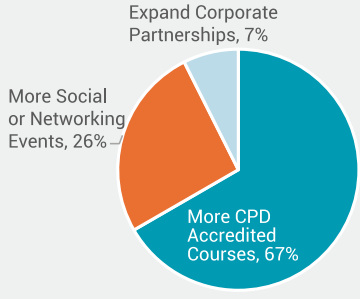
Here are some highlights from the survey:

Which ASA benefit do you find most valuable?



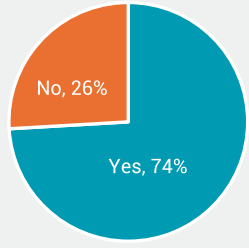
When respondents were asked to identify the most valued membership benefit, the National Scientific Congress was the most popular choice at 26%. This was followed by Economic and Professional Issues Support at 19%, with both the AIC Journal and RVG receiving equal support at 15%.

From these three initiatives, which would you like us to pursue?

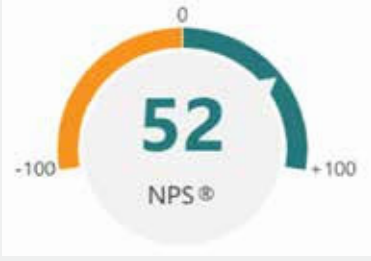


Among the three initiatives provided, the most popular choice was CPD-accredited courses, favoured by 67% of respondents. This was followed by social and networking events at 26%, while only 7% expressed interest in expanding corporate partnerships.

Do you support ASA adopting an opt in approach for publication hardcopies?



When asked about their support for ASA adopting an opt-in approach for hardcopy publications (including the AIC Journal, AA magazine, and RVG) 74% of respondents expressed approval, while 26% opposed the idea.



ASA achieved a net promoter score of 52, indicating a strong likelihood among respondents to recommend the organisation to friends or colleagues. In the context of professional organisations, a score above 50 is regarded as excellent, highlighting ASA's positive reputation and member satisfaction amongst respondents.

We'll be conducting our Annual ASA Membership Survey in June next year, and we look forward to hearing more from you.

IT'S CPD TIME!

Dr Vida Viliunas OAM

ASA Vice President and
Education Committee Chair

THE THEME OF THIS EDITION OF AUSTRALIAN ANAESTHETIST IS OUR FIRST 90 YEARS.

THE THEME OF THIS PIECE IS THE SUPPORT THE ASA HAS GIVEN TO ITS MEMBERS IN EDUCATION DURING THOSE YEARS…AND SPECIFICALLY DURING CPD SEASON.

In the 90 years since the inception of the ASA, anaesthesia has evolved. 1930s morbidity and mortality in operating theatres and intensive care, pain management techniques, the drugs and equipment we use are unrecognisable to the anaesthetist of today.

Drug development, monitoring techniques, regional anaesthesia, pain management capabilities and safety protocols all minimise risks and enable the care of today's complex patients. These advancements were made possible by research, the study of outcomes and the discipline imposed by evidence-based practice. The ASA has participated in and supported members in research, development and education in all of those areas.

ASAEd

The pandemic years changed the way we work. Whether learning and teaching safer ways of practising, developing protocols and looking after ourselves and our colleagues – it was a very busy time.

The COVID pandemic also changed the way we approach continuing education and skill maintenance – it revolutionised the way we access education. The disruption and expense of travelling no longer applied and access to international speakers became easy.

The ASA was able to launch ASAEd and a huge range of online resources as a result.

We developed podcasts, added to our YouTube channel and invested heavily in ASAEd for trainees and members. The ASAEd Learning Resource Library includes publications, learning guides, the Australian Anaesthesia magazine and Anaesthesia and Intensive Care journal as well as the latest updated Relative Value Guide, podcasts and videos.

CPD – yes you can!

The CPD landscape has had many changes recently. These seem to be increasingly burdensome for already busy clinicians who demand 'work-life balance'. The ASA supports activities that are practical and achievable for busy clinicians.

For what is now a yearly CPD program, developing the habit of entering activities contemporaneously helps to avoid a headache in December.

My personal practice is to get my formal CPD requirements completed well in advance of the end of the year. ASAEd resources are available to help you complete your CPD requirements.

CPD Plan and Reflection

Every medical practitioner needs to write a CPD plan and reflection. Do not delay, nor despair! Your nominated CPD home should have templates to help create these. It should be of comfort to know that the MBA stipulates that CPD plans "should not take long to complete and do not need to be a complicated document".

Equally, reflection need not be complex or onerous. It should answer questions about the achievement of the aims of your CPD plan, what you have learned and how you can improve professionally.

Both of these activities contribute to reviewing performance time.

Educational activities

Domain one (AMA's CPDHome program at www.cpdhome.org.au) or Knowledge and Skills (ANZCA CPD)

These should obviously be relevant to your scope of practice.

Visit Education and Events for learning resources at the ASA website to complete this domain. It should be readily achievable within a short timeframe.

Australian Anaesthesia Podcast with A/Prof Suzi Nou

Videos

Practice Evaluation Activities

Measuring Outcomes and Reviewing Performance

Many in private practice might struggle to satisfy the requirements of this domain. Again, these requirements are achievable.

- The hours quickly add up for virtual or face to face morbidity and mortality meetings with colleagues for measuring outcomes hours if members do not have access to other meetings.
- Use a spare clinical session to complete a peer review with a colleague that contributes as a mandatory higher specialist requirement as well as being a reviewing performance activity.
- The multisource feedback activity forms can be handed out and collected at the end of a day for review with a colleague.

Higher specialist requirements for 2024 – Medical Board of Australia

If you have not already completed an emergency response activity and there are no regional meeting opportunities on your horizon, you can complete the Major Haemorrhage activity online with BloodSafe (and the time taken contributes to educational activity hours).

Anaesthesia	A specialist anaesthetist must:
	• complete at least one emergency response activity per year
	• complete at least one of the following activities per year to directly evaluate and reflect on their own clinical practice:
	  • structured patient survey
	  • multi-source feedback
	  • peer review
	  • clinical audit
		education activity
		
		reviewing performance and/or
		measuring outcomes activity

Best wishes for completing your CPD requirements this year on time. CPD should be relevant to your scope of practice. The ASA is here to help make it practical and achievable for you.

Dr Vida Viliunas OAM

ASA Vice President and Education Committee Chair

DR PETER WATERHOUSE
PIAC CHAIR

PROFESSIONAL ISSUES ADVISORY COMMITTEE

2024 In Review

AS THE YEAR DRAWS TO A CONCLUSION, THE EMERGING PROFESSIONAL ISSUES FROM 2024 WILL EVOLVE AS WE MOVE INTO 2025.

Workforce and the expedited International Medical Graduate pathway

The Commonwealth Government is pressing ahead with plans to fast-track equivalence assessment for specialists from the UK and Ireland. Despite a looming deadline, it is not clear how these doctors will be supervised upon arrival. The Australian Medical Council will need to enlist currently registered specialists for this purpose, which until now has been conducted under the auspices of the Colleges.

Anaesthesia, psychiatry, general practice and obstetrics are the first groups affected. Accordingly the colleges and professional associations representing these specialties have been actively engaging with state and federal governments.

At the time of writing the governments have been unmoved by input received from medical groups. There appears to be a perception that obstruction by medical colleges is to blame for the shortage or maldistribution of doctors in Australia. It will be interesting to see who is blamed if the proposed changes to our assessment process do not alleviate the problem. There has also been little acknowledgment that the current system protects patient safety by ensuring uniformly high standards for our specialist workforce.

It is interesting to note that a third of Australia's current specialist workforce are international medical graduates.

Workforce modelling commissioned by the ASA estimates that an additional 50 domestically trained anaesthetists per year would substantially address the predicted workforce shortage. To achieve this increase would require the commitment of state health departments and is subject to local factors. This kind of "organic" workforce growth would be free from the risks of expedited international specialist assessment.

Health checks for older doctors

The Medical Board of Australia is seeking feedback regarding a proposal to require older doctors to undergo regular health checks. The Board says a higher rate of notifications against late-career doctors may justify mandatory assessment of those continuing to practice into their seventies.

At the time of writing the governments have been unmoved by input received from medical groups. There appears to be a perception that obstruction by medical colleges is to blame for the shortage or maldistribution of doctors in Australia.

Under current rules the Board may require any doctor to undergo health assessment if it perceives the need.

Private hospital funding

Private hospitals are becoming less profitable. Obstetric units are the most vulnerable but the entire sector is under pressure.

Hospitals claim that insurers are providing inadequate indexation when funding contracts are renewed. This has led recently to a higher than usual number of contracts not renewed, or more commonly renewed at the eleventh hour after a public showdown between hospital and health fund.

Compounding this pressure is the rising out of pocket expense borne by patients directly. Here again the health funds have a case to answer, with an increasing number of policies containing exclusions. Indexation of rebates has also been well below inflation.

The government has so far been reluctant to get involved. The Commonwealth Minister for Health has indicated that he has no appetite to bail out failing hospitals.

The Australian Medical Association is encouraging the government to establish an independent umpire for the private hospital sector. Again, the government has not made any commitment as yet.

Happy Holidays!

I wish all readers an enjoyable and relaxing Christmas break. Thank you for your interest in the professional affairs of our vocation.

See you next year.

Dr Peter Waterhouse

PIAC Chair

DR MICHAEL
LUMSDEN-STEEL
EAC CHAIR

ECONOMIC ADVISORY COMMITTEE

Anaesthesia in Australia

Presentations given at the ASA National Scientific Congress in Darwin reinforced the looming disaster which is the provision of anaesthesia services by non-medical providers such as nurses and physician assistants. Add to this the state governments' failings to plan, fund and build the health services necessary for today, let alone the future. Ambulance ramping, elective surgery cancellations, elective surgery waitlist blowouts, and outsourcing public hospital surgery to private hospitals are outcomes of these failures to invest and build a health system to meet demand. Fortunately, whilst the recent ASA workforce survey has identified that we have a small, current workforce shortage of anaesthetists, medical anaesthesia solutions are rapidly and readily achievable.

The Department of Health and Aged Care, in the Nursing Supply and Demand Study 2023 to 2035, predicts an alarming 79,475 nurses are required to fill the nursing workforce shortage by 2035. Anaesthesia workforce and capacity is not the reason for surgery being delayed or cancelled. Quite frankly, I have had enough of this task (and what the government labels as 'role') substitution nonsense, driven by politicians demanding quick-fix solutions for problems years in the making. Maximising scope of practice, and role subsitiution argument hinges on the assumptions based on outcomes from medical anaesthetists, that someone else can do that 'task', leaving doctors to do the more complex work. However if there is an emergency, an anaesthetist will be immediately available to rescue the patient from the situation. Their model seems to be based on following the US and UK models of developing a cadre of physician assistants and nurse anaesthetists. Nurses are cheaper than doctors, right? Wrong. There is no evidence that anaesthesia delivered by non-medical providers saves money or improves outcomes. The NHS experience of having physician assistants deliver anaesthesia is having a negative impact on healthcare delivery - the teaching and training of anaesthetists, the morale of anaesthesia trainees, and now the morale of the public. In 2024, scope of practice is at risk of being determined by political need and individual ambition, self assessed capacity and not an outcome from a robust selection, rigourous training, assessments, examination and ongoing feedback overseen by medical colleges and the Medical Board of Australia.

In the US system, where anaesthesia is provided by a specialist anaesthetist, or a medically supervised nurse provided anaesthesia, is further diluting. Where previously one specialist anaesthetist supervised a number of nurse anaesthetists, this supervision is increasingly being diluted, with "nurse anaesthetists" pushing and gaining independent anaesthesia practice without onsite medical supervision in several states, to the concern of US specialist anaesthetists, and this is creating division. In New York, nurse practitioners have initiated proceedings towards 'same task same pay' as physicians (https://www.medscape.com/viewarticle/new-york-nurse-practitioners-sue-state-over-pay-equity-2024a1000ijd).

The introduction of physician- and anaesthesia-associates and role substitution into the NHS has been truly remarkable. At the outset, was this seen to be inevitable and therefore little resistance offered by the various medical leadership and bodies including the Medical Council, Colleges and Associations? The examples in some NHS hospitals where this was locally driven, with the careful selection and upskilling of a small number of senior anaesthetic nurses support by the anaesthesia department cannot be

extrapolated to a large opened-up free-for-all pathway solution for direct anaesthesia providers. Were the very bodies that demonstrated years of integrity, and ultimate oversight by the medical boards and health departments for ensuring patients receive medical care by medical practitioners distracted by COVID, NHS workload pressures and NHS funding challenges, enabling opportunistic exploitation? Were NHS patients truly informed of the role substitution by physician assistant anaesthesia providers and the limitations of their anaesthesia provider, to be able to give informed consent for their anaesthesia? In the UK, anaesthetists have formed together and mobilised under 'Anaesthetist United', and now the British Medical Association are launching legal action against the doctors' regulator, the General Medical Council, and published a press release in 24 June 2024:

"over the way in which it plans to regulate physician and anaesthesia associates, in what the BMA says is the dangerous blurring of lines for patients between highly-skilled and experienced doctors, and assistant roles."

BMA council chair Professor Philip Banfield announced the launch of the judicial review claim at the BMA's Annual Representative Meeting in Belfast this morning (Monday). Commenting, Professor Banfield said:

"PAs are not doctors, and we have seen the tragic consequences of what happens when this is not made clear to patients. Everyone has the right to know who the healthcare professional they are seeing is and what they are qualified to do – and crucially, not to do.

"Doctors are 'the medical profession'. To describe any other staff as medical professionals not only undermines doctors and the rigorous training journey they have been on, but also confuses patients, who rightly associate the two terms as one and the same.

"The central and solemn responsibility of the GMC is to protect the public from those who are not registered qualified doctors, pretending to be doctors. It has become increasingly clear that broadening the term 'medical professionals' to include those without medical degrees has had the effect of making this task far harder, when recent experience has now shown that this represents a dangerous blurring of this critical distinction.

"We have had enough of the Government and NHS leadership eroding our profession, and alongside Anaesthetists United, we are standing up for both doctors and patients to block this ill-thought-through project before it leads to more unintended patient harm. It's not too late to row back from this uncontrolled and ill-thought out experiment in dumbing down the medical skills and expertise available to patients."

How has this happened in the UK and the US, and what can we learn?

This is not just about workforce, it is actually about the healthcare system being cut to the bone and then being expected to function fully. It is impossible to argue that the safety of anaesthesia in Australia will not be compromised, and adverse events will not increase, when the level of competency, development, refinement, training, skill, and consolidation that comes from a rigorous five-year ANZCA-accredited training program, from a workforce that has already completed a minimum of four years of medical training and two years of work as doctor-in-training, is replaced by a nurse and/or physician anaesthesia provider.

Is the ACT and Queensland the ground zero in Australia for non-medical anaesthesia to take off? With mixed messages coming from health ministers, pro-nurse anaesthesia promoted in certain centres, and the 2026 World Congress of Nurse Anaesthetists being held in Brisbane, now is time for the Australian anaesthesia workforce to regroup, unite, provide leadership and support to drive the medical-lead anaesthesia solutions needed in Australia.

The provision of anaesthesia care is not a just a task, and any attempts to fragment anaesthesia care and outsource anaesthesia to multiple providers will dilute the quality and safety built into the system that the healthcare system have refined over decades, and the public has confidence in. A registered 'specialist anaesthetist' is a medical practitioner who has had multiple points of selection, assessment, clinical performance review, extremely robust and grilling examinations, and has demonstrated fitness for the privileges and responsibility to make independent clinical assessment, clinical decisions and formulate an anaesthesia plan, to direct and undertake medical treatment on patients with the patient's consent efficiently and independently. As doctors, we have the privilege, insight, and skills to ensure that patients have a highly trained and suitably qualified and medically lead team delivering their care, and are a part of an entire perioperative and surgical team.

The provision of anaesthesia care is not a just a task, and any attempts to fragment anaesthesia care and outsource anaesthesia to multiple providers will dilute the quality and safety built into the system that the healthcare system have refined over decades, and the public has confidence in.

In Australia, the public hospital system is the provider of care for our population, supported by the private hospital system. The public hospital system is the healthcare provider for our vulnerable population, those that may have low health literacy, are not privately insured, may have high complex comorbidities, might require complex social behavioural support and the majority of trauma victims.

The public hospital system is the engine room for training doctors and future specialists in anaesthesia. Anaesthesia in public hospitals is almost exclusively provided by a medical anaesthesia provider who is providing anaesthesia at the level of clinical privileges that they have been assessed and granted. This will be an anaesthetic trainee, anaesthesia career medical officer, a GP anaesthetist or a specialist anaesthetist. The anaesthesia trainee, having already completed a medical

degree, has then worked in accident and emergency departments, medical and surgical units, intensive care units, and other rotations before commencing anaesthetic training. This pathway is not only an essential component of mesh or network of medical care 24/7, it provides ongoing development and evolution of clinical knowledge, clinical assessment, clinical decision making, and increasing individual clinical competency. The initial assessment, treatment and management of sudden patient deterioration and in-hospital cardiac arrest after hours is often by junior doctors supported by anaesthesia trainees at many but not all public hospitals. The ability to undertake rapid assesments, formulate and rapidly execute appropriate medication and airway management interventions, and communicate this concisely are critical skills of anaesthetists. Emergency after hours care, not just limited to surgical patients but inclusive of women in labour and patients in severe pain is provided by specialists or trainees, with an on-call specialist anaesthetist support that provides 24/7 obstetric anaesthesia cover.

Where the clinical care is delivered by an anaesthesia trainee, the level of supervision of anaesthesia trainees is clearly defined by ANZCA. The safety and integrity of care delivered by anaesthesia trainees is the background of years of ANZCA overseeing specialist anaesthesia training and accrediting anaesthesia departments to provide that training.

Anaesthesia in private hospitals is largely provided by specialist anaesthetists, with some anaesthesia provided by general practice anaesthetists, and limited anaesthesia training is provided in private hospitals. Noting that 65% of elective procedures are undertaken in private hospitals, and many jurisdictions continue to rely on outsourcing public work to the private health care system, any changes in the anaesthesia provider pathway is at risk of creating a two-tiered system - public hospital anaesthesia being provided by non-medical anaesthesia providers who have inferior training, inferior experience, inferior skills and inferior assessment capability, and also threatens to undermine the service delivery role that doctors can provide.

Non-medical anaesthesia providers have not been required to meet the same standards for selection at any point for anaesthesia training. Specifically, this is the selection of an individual into medical school for training - the consolidation as a doctor in the first few years post-graduation, the selection for the incredibly robust specialist anaesthesia training program, and have not completed the intense academic learning, work-based assessments and volume of practice required in the ANZCA training program.

The Problem

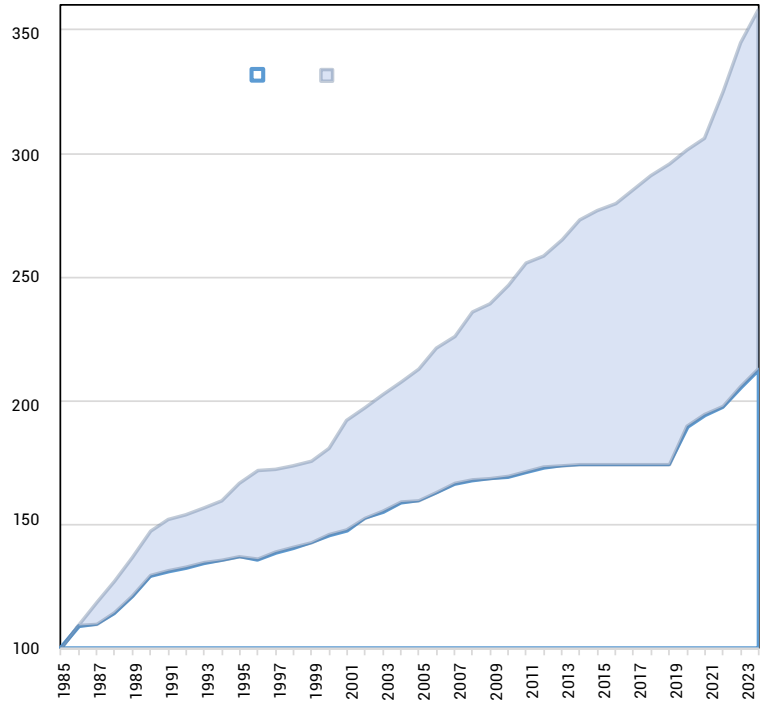
We do have a problem - and it is a budget problem - specifically the chronic underfunding of healthcare. States and territories have the National Health Reform Funding Agreement with the Federal Government to fund public hospital activity, but this is grossly inadequate and has never been funded to meet demand.

Every state and territory has a health budget challenge - the true extent of the underfunding is impossible to articulate accurately. Each state reports waiting times differently; there is often an unreported, or hidden waiting list to see a specialist to confirm the need for surgery. Waiting lists can be massaged, so that patients are only added to them when a procedural date is known and they will have their surgery within the clinically relevant timeframe, as defined by the bean counters. The end result is that the public hospital capacity for elective and emergency surgery (infrastructure, workforce, equipment and consumables) simply hasn't been built.

And it's not just the public hospitals in financial stress. The increasing public awareness campaign by the Private Hospitals Association, combined with local hospital financial update briefings being provided to doctors, is alarming. Hospitals have reached the point of open campaigns against specific health funds.

The ASA workforce survey has been a great initiative and was driven by the ASA to get a better understanding of what is going on, and this has been presented to the Honorable Mark Butler, Minister for Health, when the ASA had its workforce meeting in Canberra on 14 August 2024.

MBS RVG unit value vs inflation ; 1985-2024



Medicare indexation since 1986 by the Commonwealth Government

Consumer price index; a measure of inflation reported by the Australian Bureau of Statistics

Proposed solutions for the Australian anaesthesia workforce

Firstly, the pipeline for doctors graduating from university in Australia is determined by the Federal Government number of funded medical student positions commonwealth supported places with the exception of self-funded medical school training.

Secondly, the states and territories working with the Federal Government determine public hospital funding, and through this the workforce needed to provide the services. Demand for services needs to drive funding, and not funding drive the service. It is imperative that there is strategic anaesthesia workforce planning to increase anaesthetic registrar training positions to meet projected service delivery requirements. Where trainees are unsuccessful in completing the ANZCA training program, the option of service career medical officer anaesthesia needs to be explored and supported in public hospitals.

Thirdly, attraction, retention and utilisation of specialist anaesthetists is driven by employment industrial conditions and arrangements (salary, allowances, flexibility, leave etc), the morale of the anaesthesia department, and the reputation of the medical facility. Areas experiencing anaesthesia workforce shortages, particulary staff specialists in NSW and the ACT, have arisen largely due to government failures to provide competitive employment conditions.

Fourthly, geographical location, remote and regional classification are workforce determinates, with more regional and rural locations having a higher reliance on locum and SIMG anaesthetists and less stable healthcare workforce (medical and nursing workforce) which can impact on patients in regional locations accessing care. The development of 'hub and spoke models', which ensures that each hospital is part of a clinical anaesthesia network and ideally aligned with the clinical referral pathways, would allow the development of incentivised internal locum pathways, and placement for clinical upskilling for those in regional centres, is encouraged. Regional centres could explore the development of incentivised regional hospital provisional fellowship year packages and development of incentivised regional hospital anaesthesia specialist attraction and recruitment packages, which might include commitment for upskilling and appointment to a major metropolitan hospital at regular intervals, to attract Provisional fellows and specialist anaesthetists.

Finally, maintaining efficient use of the workforce needs to remain a priority. The solution to a problem is not always another form, mandatory course, and checklist. Sometimes the solution to the problem is highly trained healthcare workers actually being able do their job, working well as a team, and being supported to do so, and being accountable for such.

In summary, anaesthesia in Australia has its safety record because of the undeniable quality and safety provided by medical specialist anaesthetists. Any actual workforce shortages need to be met with medical anaesthesia solutions in order to maintain the safety and efficiencies that specialist anaesthetists quietly deliver 24/7 , both now, and into the future.

Australia needs to have the discussion now that our pipeline for doctors needs to be modelled and based on Australia being self-sufficient in training its medical workforce (and healthcare workforce) and not on role substitution or expanding scope of practice.

Dr Michael Lumsden-Steel

EAC Chair

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Australian Society of Anaesthetists®

ASA Trainee Members

Apply for our 2025 International Scholarships

$5K*

A great opportunity for our Trainee members...

From 2024 CIG Scholarship Recipient Dr Harry Pearce:

"The society enthusiastically launched my foray into the international anaesthesia community via the Common Interest Group Scholarship. It's available to eligible trainee members and takes advantage of the strong ties between the society and their international counterparts - in my instance, the Association of Anaesthetists at their annual trainee conference in Glasgow. Representing our society at this forum means I see and learn from academic firsts and system advances at the coalface, and my trip is supported financially by the society. As I move into the next phase of my career, I look forward to finding my place amongst the common interest groups and continuing education arms inherent to the ASA's structure".

Each year the ASA awards a scholarship to three ASA Trainee Members to attend the annual meeting/conference at one of our participating overseas Societies. Each participating overseas Society provides one complimentary registration for the scholarship winner to their meeting.

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

For an application form, please email the Operations Manager, Suzanne Bowyer at committees@asa.org.au

CANADIAN ANESTHESIOLOGISTS' SOCIETY

Destination

NEWFOUNDLAND

Date

20-22 JUNE 2025

ASSOCIATION OF ANAESTHETISTS

Destination

LONDON

Date

26-27 JUNE 2025

AMERICAN SOCIETY OF ANESTHESIOLOGISTS

Destination

SAN ANTONIO, TEXAS

Date

10-14 OCTOBER 2025

ASSOCIATION OF ANAESTHETISTS TRAINEE CONFERENCE

CIG SCHOLARSHIP

Glasgow, Scotland | 27-28 June 2024

IT'S A GREAT THING TO BE AN ANAESTHETIC TRAINEE IN AUSTRALIA. WE PRACTICE IN ONE OF THE WORLD'S SAFEST HEALTH SYSTEMS, WITH HIGH STANDARDS OF CARE EXPECTED BY COLLEAGUES AND PATIENTS ALIKE. MOREOVER, LOCAL TRAINEES AND ANAESTHETISTS PUNCH ABOVE THEIR WEIGHT WHEN CONTRIBUTING TO THE COLLECTIVE GLOBAL KNOWLEDGE OF OUR CRAFT, CONSTANTLY PUSHING OUR SPECIALTY ONWARD AND UPWARDS.

Amid preparations for the final exam, I've lost count of the number of times I've been reassured that with Australian anaesthesia at such a high standard, I need only "talk about a normal day at work".

It's occasionally easy to forget that there is a global community of anaesthesia that we can cooperate with and grow from. I recently had the privilege of representing the Australian Society of Anaesthetists in just such a forum. In my time with our UK colleagues, while I hope I was able to contribute more than just the fine art of how to get a surf in before work, I benefited most from what they could teach me.

The setting was the Association of Anaesthetists Annual Trainee Meeting, this year held in the fine Scottish city of Glasgow. A city formerly famed for its industrial might and shipbuilding, a fierce cross-town football rivalry, and the ability to deep fry anything, it's no secret that the Glasgow Royal Infirmary is a world leader in management of both trauma and ischaemic heart disease.

But Glasgow, rejuvenated as the modern European City of Culture, is as fine a city as one could imagine to play host to a delegation of anaesthetic trainees. World leading specialists walk the hallways of modern Glasgow's major hospitals (which includes one of Europe's largest hospitals, Queen Elizabeth University Hospital), and it's now these same experts who sit amongst us at the conference, imparting their knowledge through thick Glaswegian accents. The program, entirely organised by a panel of trainees, covered an incredible range of themes core to modern anaesthesia.

The academic program was relevant and insightful, providing informative and genuinely utilisable content for major areas of anaesthetic practice. Having attended several local and international scientific meetings throughout my training, I'm yet to encounter a more targeted or useful collection of teaching on contemporary practice (a personal bonus in the lead up to the Final Exam).

But this is no ordinary meeting, and in addition to the insights from craft group experts, the academic portion of the conference was reinforced by dissecting down extensive AAGBI guidelines; in many circumstances by the author themselves. While we do have a number of local guidelines in Australia, we heavily utilise AAGBI's guidelines from afar, and it was gratifying to see them as much more than just a several-page recipe of best practice.

Further utilising the prowess of resources from AAGBI was a presentation by Dr Matt Wiles, Editor-in-Chief of Anaesthesia, who gave us his selection of the ten most relevant studies of the last twelve months. Hands-on skills sessions from experts in regional anaesthesia and airway management complemented the discussions, while hearing first-hand patient experiences ensured we didn't forget the true reason we were there.

Turning our attention from the present to the future; the conference attracted over 130 abstract submissions from local and international trainees. The content was diverse; ranging from a non-invasive haemoglobin monitor, to case reports of interventional radiology in the parturient, to determining the most aesthetic layout for the department office (anything with a coffee machine, it turns out). Ultimately, we heard from several of the most intriguing submissions, each delivered with passion. Although we have similar aptitude for abstract submissions within our scientific circles locally, these were all standout trainee-driven projects and judged by their relevance to their peers.

A fine selection of academia then, but what else is important to trainees? Well, training conditions and a fine malt whiskey, if this Scottish-based conference is anything to go by.

UK training conditions continue to be a hot topic for discussion, and this meeting was no exception. We heard from many registrars at various stages of training, with insights as to how their experience could be improved. Although they are provided with good protection from the extended working hours that plagues other specialty training within the NHS, the demands of the nonclinical requirements of training make for an exhausting experience, and regularly distract from their clinical work.

As I discovered quickly, UK training differs vastly to our own experience in Australia. Longer by several years, with less initial exposure to core practice, and a less hands-on approach to supervision, their training program produces knowledgeable practitioners ready to deliver safe anaesthesia. Talking to trainees throughout the conference, I hear serious desires for the merits of our own system; concentrated exposure to core and specialised anaesthesia, with an emphasis on a mentoring model, and an introduction to independence at the right stage.

We're fortunate to have the conditions we do, and we can take much from the experiences of our overseas colleagues in helping shape what this will look like in the future. Ultimately, it will be our representation and feedback that moulds the future of Australian anaesthesia. For me, this highlights the importance of trainee representation at meetings such as this, and the work of our Australian Society in speaking to our needs.

By this stage it's easy to become lost in the depths of scientific learning and trainee experiences, so it's a timely visit from Lord Provost (the Lord Mayor of Glasgow for those not Clydeside). After a stirring speech toasting the Scottish giants of medicine who walked before us, we're treated to the city's gift to the delegation – a selection of local whiskeys. And if I thought the Glaswegian accent was difficult to understand before they enjoyed a scotch, I had another thing coming.

All told, the Association of Anaesthetists' Trainee Conference is an exceptional experience for any trainee, but particularly for an Australian at the stage of training where contemporary knowledge and a real-world view underpin good practice. I'm grateful to the ASA for allowing me to represent our society as an ambassador, and it's my hope that many future trainees will choose to benefit from the knowledge and insights that our overseas counterparts can offer us.

Dr Harry Pearce

AMERICAN SOCIETY OF ANESTHESIOLOGISTS ANNUAL MEETING

CIG SCHOLARSHIP

IN OCTOBER I HAD THE OPPORTUNITY TO TRAVEL TO PHILADELPHIA TO ATTEND THE AMERICAN SOCIETY OF ANESTHESIOLOGISTS 2024 ANNUAL MEETING, COURTESY OF A SPONSORSHIP FROM OUR VERY OWN ASA. AT THAT STAGE I WAS AN AT1, WORKING AT OUR TERTIARY DEDICATED OBSTETRIC HOSPITAL IN WA, BALANCING WORK COMMITMENTS WITH STUDY FOR THE FELLOWSHIP EXAM.

Before the trip, I was quite concerned about taking time off so close to the exam. I travelled to Philadelphia with my parents who came along as guests to the conference (they are both doctors). My wife who was stuck in a compulsory intern rotation at home was less than impressed by me leaving her behind. We had a few days beforehand to explore the city and gain an understanding of its history (who knew that Philadelphia was the first capital city in the USA?). It was the meeting point where the Declaration of Independence was created, and the original American constitution was developed, and it is very clear that these themes of freedom and individuality continue to run strong in the culture of the Philadelphia population. We also had a couple of days after this exploring the nearby Pocono mountains where some bushwalking and waterfall finding provided some much-needed rest.

My fears around not studying for a period of time turned out to be unfounded considering the wealth of learning opportunities provided during the conference. As a meeting hub of over 12,000 delegates with 20 or more educational/scientific sessions to choose from every hour, and a small city of exhibitors, there were endless opportunities to immerse myself into everything anaesthesia as a profession has to offer. I attended a broad range of sessions ranging from the presentation of new Brain ERAS guidelines, to the perioperative management of liver disease, to the management of serious anaesthetic complications. I was

The conference provided the opportunity for engaging with colleagues from across the world, including obviously a majority from the United States. Hearing about different perspectives and practices in anaesthesia encouraged me to reconsider how I manage some of my patients. It was a good reminder that we sometimes practice in certain ways simply because this is the way it was always done in our hospital, or our region.

impressed by the professionalism of the entire event, with every session starting exactly on time, and presenters being provided sufficient opportunity to present their topic, rather than being rushed through sessions just to cram more in.

My favourite session was a presentation on the sedation of high-risk patients for minor procedures. I have long felt more comfortable with a patient awake or asleep. The 'grey zone' of conscious sedation in patients with significant comorbidities or anaesthetic risk factors fills me with dread. The session was broad, providing an overview of identification of high-risk patients, the potential physiological and pharmacological impact of anaesthesia, and provided succinct tips on minimising complications. None of this was new information, but to have it packaged in such a good way was quite valuable, and provides me with a framework for approaching these patients in the future.

The conference provided the opportunity for engaging with colleagues from across the world, including obviously a majority from the United States. Hearing about different perspectives and practices in anaesthesia encouraged me to reconsider how I manage some of my patients. It was a good reminder that we sometimes practice in certain ways simply because this is the way it was always done in our hospital, or our region. That's not to say that 'standard practice' is wrong, however remembering that there are alternatives is something I hope to integrate into my ongoing practice in order to better tailor my anaesthesia delivery to my patients. The melting pot of cultures and ideas extended beyond the clinical spectrum. With the conference being only a few weeks before the American federal election and in a battleground state, it was very clear that this was at the forefront of most minds, and unfortunately carried a lot of fear for individuals on both sides of the political divide. I can only hope that those on all aspects of the spectrum can put their energy into creating a better future, irrespective of whether they are happy with the political outcome.

As the dust settles on the trip, my key takeaways are twofold. Firstly, I will aim to not let fear get in the way of progress. Secondly, I will aim to continue searching for new knowledge in this field we get to practice in, to improve the experience and outcomes for the patients I have the privilege of caring for.

I would like to thank the ASA for the opportunity they provided for me. The ongoing investment in trainees is greatly appreciated.

Dr Ethan Fitzclarence

AROUND AUSTRALIA

Western Australia

Dr Archana Shrivathsa

Chair of the Western Australian Committee of Management

ASA 90th Anniversary Cocktail Party

On Saturday October 5th, WA anaesthetists past and present gathered to celebrate the 90th Anniversary of the ASA with a wonderful cocktail party at P&M Wine Bar. With a live jazz quartet and an exquisite range of local and international wines, we mingled and met old friends and new.

We welcomed ASA President Dr Mark Sinclair and Immediate Past President Dr Andrew Miller as special guests for the evening. A particular highlight was the presentation of the ASA Certificate of Appreciation to longtime ASA stalwart and past EAC Chair, Dr Rob Storer.

Many thanks to our TMG representative Dr Merredith Cully for organising this delightful evening!

ASA WA 90th Anniversary

CPD in Western Australia

We've had several well-attended ACE events recently including:

- Hocus POCUS Gastric & Lumbar Ultrasound workshop, instructed by Dr Kiran Venkateslu, Dr Scott Aaronson, Dr Lisana Rodrigues and Dr Chris Mitchell on Wednesday 21st August
- Morbidity and Mortality Workshop on Wednesday 16th October, facilitated by Dr Bridget Hogan

We're looking forward to the sold-out 2024 WA ACE Country Conference at the Pullman Bunker Bay Resort from November 15 to 17.

The WA Part 3 Course will be held Friday November 29th, convened by TMG representatives Dr Merredith Cully and Dr Kennia Lotter.

Nerida Dilworth Prize

The Nerida Dilworth Prize presentation evening was held on Tuesday 17th September, with four exemplary research and audit presentations from WA trainees.

Dr Ethan Fitzclarence awarded the Nerida Dilworth Prize by Dr Archana Shrivathsa

We would like to thank Drs Erin Chevis, Aloysius Ng, Ethan Fitzclarence and Nathan Blakely for presenting their projects.

The Prize was awarded to Dr Ethan Fitzclarence, for his presentation on nitrous oxide mitigation projects at Armadale and Albany hospitals in WA. Congratulations Ethan!

Queensland

Dr Brett Segal

Chair of the QLD Committee of Management

This is my first report as the new Chair of the QCOM. As outgoing chair, Dr Graham Mapp reported in the last edition that we recently celebrated the ASA's 90th Anniversary at The Queensland Club in Brisbane coupled with our 2024 AGM. As an addendum, it was well attended by former and current contributors to the ASA over many decades. We had some great stories from Queensland's Federal ASA Presidents, Dr Jim Bradley and Dr John Haines. John was particularly enthusiastically accounting the development and alas subsequent modernisation of the ASA logo! We were especially honoured to have our current President, Dr Mark Sinclair in attendance for the evening. Thank you must also go to Avant for sponsoring the event. I would like to thank Graham for his service as Chair over the last two years and for his ongoing service to the ASA and anaesthesia in general. I look forward to working with our committee and producing some good outcomes in our state.

ASA President, Dr Mark Sinclair presenting Dr Michael Tuch with 50 Years Membership award at the ASA QLD 90th Anniversary

ASA Past President, Dr John Hains and QLD Chair, Dr Graham Mapp at the ASA QLD 90th Anniversary

ASA SA 90th Anniversary

Workforce and SIMGs

We are still battling, like the rest of the country, with ongoing workforce issues which do not seem to be improving. We will continue to lobby our state government after the upcoming state election to try and encourage specialist anaesthetists into the regions by making it more attractive as well as making it easier for existing Queensland Health anaesthetists to undertake locum appointments within the state, if they wish. We look forward to engaging with the new health minister at the earliest opportunity to make a long-term sustainable solution.

Like every region in the country, we are following with interest the proposed changes to specialist recognition of substantially comparable specialist international medical graduates (SIMGs) by Ahpra bypassing the medical colleges. I, along with Dr Sarah Bowman, Chair of the ANZCA Queensland Regional Committee plan to discuss this with the new health minister and Director General of Queensland Health as a matter of urgency. We want to ensure that Queensland patients continue to receive the highest quality anaesthesia care that they have come to expect. SIMGs play an important role in our health services as well as participating in the training and assessment of our own trainees as well as new SIMGs who come to Australia. State and Federal governments need to address the supply shortfall longer term, rather than reactive measures, such as training more doctors and funding more specialist training posts through both State and expanded Commonwealth funding in both public and private facilities.

Public in Private arrangements

The Queensland Government continues to fund public in private arrangements, however, there continues to be no uniform schedule of fees, and variation can be significant between different hospitals. I plan to continue to fight for equity in this space.

I look forward to representing my Queensland colleagues over the next couple of years. I ask our current members to continue to recruit those colleagues who are not members. There has never been a more important time in our specialty to have strong representation to government, hospitals, health funds and our regulatory authorities.

South Australia / Northern Territory

Dr Nicole Diakomichalis

Chair of the South Australia / Northern Territory Committee of Management

Support

The ASA continues to work closely with the Australian Medical Association (South Australia) with regard to payroll tax. We continue to be a part of the conversations that are vital in conveying how private practice is structured in South Australia. Thank you to Dr Louis Papillion, Dr Tim Donaldson and Dr Sophia Bermingham for all of their work towards this. There are ongoing talks about public in private work and return to work rates, and the tireless efforts of Dr Tristan Adams has shed some light on this matter.

Represent

I am delighted to become the new SA/NT ASA Chair and I extend my thanks to Dr Tim Donaldson and Dr Sophia Bermingham for their great leadership and for supporting me as I take on this new role. I look forward to representing our South Australian ASA members and building on the brilliant work of my predecessors. We also welcome Dr Cheryl Chooi as our Deputy Chair.

Education

This year we celebrated the ASA's 90th Anniversary. The anaesthetic community of South Australia attended a cocktail evening at Victoria Park Social Club. It was a great opportunity to get together to catch up in a social setting and also to recognise the significant contribution the ASA has made and continues to make to our profession. There were several people in attendance including past Chairs and many long term and new members. A fantastic night was had by all. Thank you to our organising team Dr Rebecca Maddigan and Dr Cheryl Chooi.

We have our Part 3 course on the 30th of November, which is shaping up to be a fantastic educational event, highlighting the important aspects of transitioning to consultancy. Thank you to Dr Evelyn Timpani, Dr Mila Sterbova and Dr Krushna Patel for all of their efforts in organising this event, particularly whilst doing this during Final Exam preparation. We wish them and all of those sitting all the best in the upcoming exam.

We also want to once again acknowledge and congratulate the South Australian convenors, Dr Brigid Brown and Dr Indy Lin and the organising committee of the National Scientific Congress held in Darwin in September. It was fantastic to see so many of our colleagues travel to Darwin to attend the conference. It was a wonderfully organised and academically stimulating event with local and international speakers who kept the audience captivated.

New South Wales

Dr Simon Martel

Chair of the NSW Committee of Management

Representation

The last few months has been busy with meetings. The ASA policy advisor and myself met with lawyers from the Special Commission of Inquiry into Healthcare Funding. This was an opportunity to discuss the many issues raised in our submission, with the Commission particularly interested in issues affecting rural anaesthesia services. The ASA submission can be found on the ASA website under Policy and Advocacy – ASA submissions.

The ASA has continued to support staff specialist award reform in NSW, providing resources and advice for members who are involved in agitating for a modern award that reflects current anaesthetic practice. This included a meeting of anaesthetists and other specialists held at ASA headquarters.

AMA NSW members recently overwhelmingly rejected a remuneration offer from NSW Health of three per cent per annum over three years. AMA NSW are planning to proceed to arbitration to seek changes to the VMO determination. I and several other ASA members have met with AMA NSW to gather evidence for a work value case as part of that process.

Part 3 Course

The NSW committee held the ASA NSW Part 3 Course on November 16. We looked forward to a face-to-face meeting at the ASA headquarters, as we welcomed and educated the new fellows and final year trainees.

NSW ASA 90th Celebration

NSW celebrated 90 years of the ASA on Saturday 30th November, with a function at the ASA headquarters in Naremburn. We were pleased to welcome previous and current committee members, as well as others who have contributed significantly to the society, to celebrate the history of our wonderful organisation.

ACT

Dr Girish Palnitkar

Chair of the ACT Committee of Management

This year has been a busy year in the ACT.

Welcome Drinks

The year began with the Trainee Welcome and Drinks at the Ostani Bar. The evening was a great success with many new trainees attending and getting a chance to meet their consultants in a relaxed social gathering.

Education

One of the highlights of the year has been the trainee education nights run by Drs Vida Viliunas OAM, Kaylee Jordan and Margaret Buckham. Trainees have universally praised the efforts taken to assist them in their exam preparation.

Meeting with Department of Health and DVA

On 28 March, ASA CEO Dr Matthew Fisher along with Drs Michael Lumsden-Steel and Girish Palnitkar attended a series of meetings with officials from Department of Health and Department of Veterans Affairs. The meetings were extremely worthwhile as it consolidated the engagement between the ASA and the governmental departments. Discussions were made on a broad range of topics including, but not limited to, new item numbers, Medical Cost Finder, compliance issues, and issues regarding lack of indexation. The meetings were particularly important in creating channels of communication which will be required when tackling some of these complex issues.

ASA's 90th birthday celebrations

In late June, the ASA 90th anniversary celebrations came to Canberra. The evening was held at the National Museum of Australia and was a resounding success with a range of parliamentarians, ASA Past Presidents and ANZCA office bearers in attendance. Notably earlier in the day, ASA President Dr Mark Sinclair, ASA Vice President Dr Vida Viliunas OAM, and ASA CEO Dr Matthew Fisher had the opportunity to meet the Health Minister Hon Mark Butler.

Launch of workforce study to Members of Parliament

On 14 August, the ASA held a parliamentary round table to launch the much-anticipated ASA workforce study. Various parliamentarians, Department of Health officials and interested groups were in attendance. At the meeting the methodology and key findings of the study were presented for the first time. In addition, there were presentations from other key stakeholders from gynaecology to rural medicine. The meeting was particularly insightful as it described a data-driven measured approach to tackling some of the impending workforce issues.

Meeting of Parliamentarians

As a follow-up to the round table meeting, Drs Matthew Fisher, Vida Viliunas OAM and Girish Palnitkar met a wide selection of Senators and Members of the House of Representatives in October to discuss the workforce study in further detail. The purpose of the meetings was to reinforce the message that solutions to Australia's anaesthesia workforce issues can be rectified with relatively simple solutions within Australia and that there is very little data to support large scale importation of unvetted overseas anaesthetists. The discussions were frank but fruitful and were well received by all.

Preparation for NSC 2025

Currently all efforts are being put into preparation for the ASA NSC 2025 which is to be held at the National Convention Centre Canberra from 2 to 5 October 2025. As the ACT ASA Chair and Convenor for the event, I warmly welcome you all. The theme is 'Come Together' which is in reference to the meaning of the name 'Canberra' - a meeting place - in the local Ngunnawal language. The NSC promises to be a high quality 'power packed' meeting with three outstanding keynote invited overseas speakers in Profs Edward Mariano, Cynthia Wong and Tim Cook. Our invited Australasian keynote requires very little introduction, in Prof Alicia Dennis. October in Canberra is a fantastic time of year with the NSC coinciding with the famous Floriade Festival, Australia's largest open-air flower festival.

As you can see, we have packed a lot into 2024. A big thanks goes to the entire ACT ASA CoM team and to Ms Kym Buckley who manages to keep us all in check! Wishing you all a safe and happy Christmas and New Year break and hope to see many of you at the NSC in October.

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Wednesday January 22nd 2025

5pm (Perth), 7pm (Brisbane), 7.30pm (Adelaide), 8pm (Sydney/Melbourne), 10pm (Auckland) 90 minute session (presentations and QA)


Testing the boundaries of RA - segmental thoracic spinal anaesthesia
Professor André Van Zundert, *University of Queensland*

New considerations in upper limb blocks
Dr Michelle Chong, *St Vincent's Hospital Melbourne*


Chest blocks for trauma
Dr Lora Pencheva & Gus the Pain Dog! *Auckland City Hospital, New Zealand*

Moderator: A/Professor Alwin Chuan, *Liverpool Hospital, Sydney*

ZOOM LINK

Password: 22012025 (22 Jan 2025)

Thursday January 23rd 2025

5pm (Perth), 7pm (Brisbane), 7.30pm (Adelaide), 8pm (Sydney/Melbourne), 10pm (Auckland)
90 minute session (presentations and QA)

Blocks for total knee replacement
Dr Leigh White, *Sunshine Coast University Hospital*

Compartment syndrome and lower limb blocks
Dr Megan Grigg, *Royal Brisbane and Women's Hospital*


PENG blocks for hip replacements and fractures
Dr Brigid Brown, *Royal Adelaide Hospital*

Moderator: Dr Fraser Morton, *Royal Brisbane and Women's Hospital*

ZOOM LINK

Password: 23012025 (23 Jan 2025)

50 years Membership

Dr Ian Lintern Airey, OAM
Dr Ronald Winston Bailey
Dr David John Benson
Prof John Cade
Dr Joseph Zbigniew Ceglarski
Dr Raymond William Cook
Dr Terence Graham Coupland
Dr Peter Henry Cox
Dr David Edwards Davies
Dr Alan William Duncan, AM
Dr Ian Fleming Edmiston
Dr Lawrence Gadd
Dr Graham Cameron Grant, AO
Dr John Edward Harrison
Dr Patrick Kwing Shing Hung
Dr Patrick Bede Kelly
Dr Louis Klein
Assoc Prof Gregory Ernest Knoblanche
Dr David Victor Laurence
Dr Graham John Letham
Dr Gail Elizabeth Littlejohn
Dr James Beaumont Love
Dr Christopher John Lowry
Dr Margaret Ellen Lythgo
Dr Steven John Mamczuk
Dr Vladimir Martyn
Dr Stephen Peter McCready
Dr Donald Bruce McKenzie
Dr John Robert Murray
Dr Anton Lindley Neilson
Dr Mansukhlal Pabari
Dr William Henry Parkinson
Dr Beverley Joan Peers
Dr John Leslie Poole
Dr Frederick Geoffrey Prior
Dr John William Robinson
Dr Andrew William Ross
Dr Anthony William Stroud
Dr Geoffrey Talbot
Dr Richard S. Thomson
Dr David Peter Tomkins
Dr Michael Melvyn Tuch, RFD
Dr Douglas William Wilson
Dr Daniel K. Wong

DR MATTHEW LEACH

Dr Matt Leach, a highly respected specialist anaesthetist, member of the ASA, and recent Chairman of the Northern Rivers Anaesthesia Group passed away on May 23 aged 48. Matthew was a well-loved teacher and leader known for his kindness, generosity and support towards trainees and theatre staff.

Matt was born in Wollongong to Sheila and Gerard Leach. He was loved by his younger brother Ben. He finished his schooling in Wollongong and studied medicine at the University of NSW in Sydney. During those study years he lived with his best friends and made the most of being a student. In 1998, Matt and his future wife Celia spent a year away from study, travelling through Asia and India together.

After graduating from medicine, Matt worked at the Prince of Wales Hospital Randwick, Lismore Base Hospital, Broken Hill, St George, and Westmead Hospitals, amongst others. Matt completed his anaesthetic training at Westmead Hospital in Sydney where he was universally respected as a member of a busy anaesthetic department.

Celia and Matt married in 2005 in the Hunter Valley and soon started their beautiful family. After their son Manny was born in the UK they returned to live surrounded by friends in Leichhardt. Their family soon grew with daughters Frankie and Pia.

Matt and Celia embarked on their next chapter on the NSW North Coast, where they chased waves, sunshine and the coastal vibe, raising their loving family in Byron Bay. Matt loved nothing more than spending time with his family. He gave endlessly to his children, always saying YES. He loved his pets - two cats and a Border Collie. He was an excellent runner and would knock out half marathons every other day. He embraced singing and music, dancing, doing new things and learning new skills, including fishing, which he learnt with his beloved brother-in-law. He would give anything a go.

A passion for travel and family holidays often saw Matt at far corners of the globe. He was an enthusiast for fast cars, motorbikes, and was a strong supporter of the Parramatta Eels. Most importantly he was a devoted husband, father and son. He was deeply loved and cherished by his wife, son and daughters.

As an integral member of the Lismore Base anaesthetic faculty, Matt excelled as a clinician. He was a true generalist anaesthetist, being able to manage the most difficult of cases, complications or situations. He had a special interest in trauma, general surgery, emergency and regional anaesthesia. His smile, energy, and technical ability made any difficult work situations manageable.

Matt was a high achiever, yet extremely humble. His generosity was immense. He would offer to help others without hesitation, and often did this spontaneously. He contributed significantly to help those in need after the Lismore floods. Matt was willing to risk his health to help others. During the initial outbreak of COVID-19 he was one of the first anaesthetists in Lismore to provide emergency intubation services to COVID patients. His kindness and support to patients, staff, family and friends was remarkable.

Matt's passing leaves a deep void in the hearts of his family, friends, colleagues, and all who had the privilege of knowing him. His dedication to his profession and community will be remembered always.

- **Dr Kirryn Lowe**
- **Dr Dougal Miller**

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Call for Abstracts Launch

Tuesday 3 December 2024

Deadline for Submission of Abstracts

Monday 16 June 2025

Authors Advised of Submission Result

Friday 1 August 2025

#NSC25

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