AUSTRALIAN
Anaesthetist
THE MAGAZINE OF THE AUSTRALIAN SOCIETY OF ANAESTHETISTS • **JUNE 2025**

WHAT A DIFFERENCE A DECADE (OR TWO) MAKES IN THE HUMANITARIAN SPACE

HUMANITARIAN AID AND DISASTER – WHEN GOOD INTENTIONS AREN'T ENOUGH

FRONTLINES OF HEALING: HUMANITARIAN ANAESTHESIA IN WAR ZONES

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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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Would you like to contribute to the next issue?

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

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

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

DISCLAIMER

This edition of Australian Anaesthetist contains a series of articles written by colleagues who have worked in regions of military conflict, providing their expertise in humanitarian roles.

The ASA does not take sides nor express opinion on specific military conflicts affecting other nations. As a doctors' organisation the ASA does of course abhor the concept of warfare, and particularly its horrendous impact on innocent civilians.

We recognise that individual ASA members may hold and express strong opinions on these issues, which is their right. If ASA members wish to contact us with any responses to these articles, we encourage this.

This publication simply aims to highlight the incredible work performed by our colleagues working in conflict zones and humanitarian disasters, often involving considerable personal sacrifice and risk, and to give them the well-deserved opportunity to tell their stories.

DR MARK SINCLAIR
PRESIDENT

FROM THE ASA PRESIDENT

WELCOME TO THE JUNE 2025 EDITION OF AUSTRALIAN ANAESTHETIST.

This edition features a number of articles from colleagues who have served in war zones and regions experiencing humanitarian crises. Firstly of course, I thank them for their contribution to our magazine, which will no doubt be of great interest and educational benefit to our members. But I would also like to express on behalf of the ASA, our great admiration for the enormous sacrifices these colleagues make, and for the risks they take to their own personal safety, in providing their expertise to those in desperate need.

As noted on page 2, our aim in publishing these articles is purely to highlight the amazing humanitarian work our colleagues perform in these dangerous regions, not to support one side or the other regarding specific armed conflicts.

I also wish to acknowledge all of our colleagues who serve in the Australian Defence Force and thank them for their contribution to our nation, and again highlight the enormous personal sacrifices involved in their work. I also acknowledge and express my admiration to our numerous colleagues who serve in conflict zones, and areas affected by other natural and human-made disasters, in a civilian capacity, but who are not featured in this edition. Please do not feel that such articles are restricted to this edition. If you currently serve or have served in past humanitarian efforts, in military or civilian roles, by all means send us your stories.

Our magazine is being sent for publication literally within a couple of days of the May federal election. By the time members receive their copy, no doubt the full results in all seats in the House of Representatives and the Senate will be available. Regardless of the final numbers, particularly in the Senate, the current federal government has clearly had an emphatic victory. The ASA will continue to have its activities and opinions put to our leaders, regardless of their political persuasions, in the interest of our members and our patients. This is our only role in this space, and recognising our members' diversity of views, the ASA does not support any specific political group. We always work with both members of the government, and with members of their opposition, and with smaller political parties, regardless of which political party occupies which role.

On a more general note, the ASA continues to be actively involved in numerous issues relevant to our members. We highly recommend reading through the ASA's regular email newsletters, as these will naturally be more up to date with immediate events. As before, chief among these remain the registration of international specialist anaesthetists, the ongoing attempts to enhance the scope of practice of other healthcare professionals, the anaesthesia workforce situation, the difficulties being experienced by some of our salaried colleagues especially in NSW, and the issues facing healthcare in the private sector. We also plan to meet with Department of Health representatives regarding the Medical Cost Finder website. With the federal government having been re-elected we expect action on the policy of making information regarding doctors' fees across the board available on this website. Clearly, more information is needed and again, members should watch for our regular electronic updates.

The ASA exists to serve its membership, and we not only welcome input and ideas from members at any time, we actively encourage it.

Dr Mark Sinclair

MB BS, GAICD, FANZCA

FROM THE CEO

DR MATTHEW FISHER
CHIEF EXECUTIVE OFFICER

THE THEME OF THIS EDITION IS ANAESTHETISTS IN WAR ZONES AND HUMANITARIAN CRISES. HAVING NOT EXPERIENCED EITHER, I REFLECTED ON WHAT I EXPERIENCED WITH ONE OF AUSTRALIA'S MOST WELL-KNOWN AND DESTRUCTIVE BUSHFIRE EVENTS, ASH WEDNESDAY – 16 FEBRUARY 1983. MY MEMORIES ON THE VICTORIAN SURF COAST AT THAT TIME ARE OF THE HEAT IN THE LEAD UP, THE SMOKE AND THE SMELL, THE FIERY GLOW, THE AFTERMATH, THE DEVASTATION YET RANDOMNESS OF SOME DESTRUCTION AND THE EERIE LANDSCAPE AFTER THE FIRE HAD PASSED. THE WORK OF THE FIRST RESPONDERS AND COMMUNITIES IMPACTED WAS INSPIRATIONAL. I SOURCED AN ABRIDGED VERSION FROM THE HISTORY PAGES OF FOREST FIRE MANAGEMENT VICTORIA HTTPS://WWW.FFM.VIC.GOV.AU/HISTORY-AND-INCIDENTS/ASH-WEDNESDAY-1983.

Over its 12-hour rampage, more than 180 fires, fanned by winds of up to 110 km/h, caused widespread destruction across Victoria and South Australia on Ash Wednesday, 16 February 1983. In Victoria, 47 people died, while in South Australia there were a further 28 deaths. Many fatalities occurred because firestorm conditions were caused by a sudden and violent wind change in the evening which rapidly switched the direction and size of the fire front.

The speed and ferocity of the flames, aided by abundant dry fuels and a landscape immersed in smoke, made it almost impossible to suppress and contain the fires. In many cases, residents fended for themselves as the bushfires broke communication lines, cut off escape routes and severed electricity, telephones and water supplies. It was not possible to outrun them. Spot fires simply leapfrogged across the parched landscape and there often seemed to be no distinct fire front, but instead hundreds of rapidly developing spot fires that eventually joined. A strong south-west wind change began moving through Victoria by early evening. Most of the life and property losses occurred in the hour or so following the wind change. Cooler weather on the Thursday allowed consolidation, backburning, blacking out and patrols to continue. Heavy rain fell across Victoria during the week after Ash Wednesday which extinguished most of the remaining smouldering edge, but in some cases caused flash flooding and landslips.

More than 16,000 firefighters attended the Ash Wednesday fires. The Victorian State Emergency Service, Australian Red Cross, Salvation Army, St John Ambulance Brigade and many other volunteer organisations, and countless individuals, greatly assisted by supporting the welfare of firefighters, particularly after the 16 February Ash Wednesday emergency.

There was shock, heartache, anger, blame and bewilderment. This was followed by months of clean-up and relief works, with years of recovery and rebuilding of lives, homes and communities.

The legacy remains however, the community has moved forward strongly in the ensuing 42 years.

My focus will now shift to reflections on my first three years as CEO of the ASA and some of the achievements before focussing on the future. Leadership, teamwork, culture and strategy drive performance and outcomes. I believe that this is the description of the ASA.

There is a balance in getting the platform for action right for achievement and we commenced a review of our IT system in late 2022 which was implemented in 2024 and will serve the ASA well into the future. We have adopted an engagement culture and continue to build on this through having the right people doing the right things in the right way with a sense of "having a crack." We changed investment advisor to Morgan Stanley and auditor to Nexia Australia, both who bring further

confidence to our finances and actions. The commissioning of our Workforce supply & demand modelling to 2032 enabled us to build our positioning for advocacy that has been guided by Civic Partnership. Our engagement with government and other stakeholders has grown and it was fortuitous it coincided with our 90th Year celebrations provided which enabled us to affirm the role of anaesthetists and the ASA.

Looking forward, our Strategic Plan 2024 to 2027 provides the blueprint for further achievements. We continue to be an exemplary society of anaesthetists advocating for the specialty, patients, patient safety and an accessible, equitable health system. The mission of the ASA is to 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 do 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.
- Ensure good governance and management.

On this last point, we are undertaking a review of the Constitution and by-laws. The ASA is a charity registered with the Australian Charities & Not for Profits Commission (ACNC) and the ASA Board is undertaking a review of the ASA Constitution and bylaws to ensure contemporary compliance with the ACNC. As background, the ASA was grandparented as a Charity in 2012 and we are deemed a large charity.

Fast forward a decade and the ACNC is reviewing compliance of charities with legislation and activities to ensure Professional Associations and Societies fit their charitable purpose as described by legislation. What our initial review of the Constitution has revealed are some clauses that not only may be inconsistent with charitable status but add a complexity to operations that is not contemporary.

The ASA Board has taken legal advice from HWLE from a governance perspective on future considerations and are balancing the dual outcomes of contemporary compliance and improved effectiveness at an operational level to build on our first 90 years. This is a significant and fundamental piece of work we must do and will be ensuring that we communicate this well with you as a member.

Matthew Fisher

PhD DHlthSt (honoris causa)

Contact

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

Get involved in your ASA ...

Seeking new members

The Communications Committee is seeking new members who are passionate about effective communication. If you are interested in enhancing the communication strategies of the ASA please send an email to Marketing and Communications Specialist, Brittney Beynon at 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

WHAT A DIFFERENCE A DECADE (OR TWO) MAKES IN THE HUMANITARIAN SPACE

MY FIRST MISSION TO A CONFLICT ZONE WAS WITH THE RED CROSS IN 1990. IT SEEMS A LIFETIME AGO.

Khao-I-Dang was a bamboo and thatch refugee camp on the border of Thailand and Cambodia, purpose built to accommodate 300,000 refugees from the Vietnamese Cambodian war. The hospital of KID was the only surgical facility for over two million Khmer refugees living in Thailand along the Cambodian border. It served both civilian and military populations. The International Committee of the Red Cross (ICRC) was responsible for surgery whilst Medécins Sans Frontières for paediatrics and obstetrics.

The Khmer Rouge occupied the southern parts of the border whilst the Sihanoukists and supporters of Lon Nol were in the north. Delicate diplomacy was needed to reconcile the political agendas of the Thai government with the humanitarian needs of the Cambodian civilian population and the various military factions.

This diplomatic arrangement was a far cry from the haggling with militia commanders in Somalia in the late nineties and the vulnerability and kidnapping of humanitarians in Darfur, Sudan in the noughties.

The Red Cross and other international humanitarian organisations like the World Food Program (WFP), UNICEF, OXFAM, MSF, Care, the International Rescue

Committee (IRC) and a host of other alphabeted agencies had their respective mandates, and largely unfettered access to "do good". Their legitimacy and freedom to work arose from the ability of the agencies to meet the urgent humanitarian needs of food, shelter and health. Coordination of the various humanitarian actors and delivery of aid were the only concerns.

But within a decade safety had become an overriding constraint for humanitarian work in conflict zones and services were being outsourced to local partner agencies. It was becoming increasingly dangerous for expatriate actors to "do good".

In Khao-I-Dang surgery and anaesthesia in the four "tabled" OT was very simple. Ketamine sufficed for the mine injury amputations and debridement of limb wounds on three of the four "tables" whilst simultaneously the more serious gunshot, shelling and grenade body cavity injuries received GOH (nitrous oxide gas, oxygen and halothane) from a CIG Midget. There was only hand ventilation and the minimal monitoring of a FOP (finger on the pulse), BP and ECG.

The one in two roster was tiring with 36 hour shifts. The days were unpredictable with a routine start-of-day hand over ward round and the morning planned surgery of debridement and wound closures, interrupted at any time by "Clashes" and "Incoming." This would result in a rush to the Triage station to assess and prioritise the casualties. As well, emergency surgery from the KID camp itself and the obstetric caseload kept us very busy.

The severity of the war wounds was initially a brutal shock. Mine explosions usually destroy both legs and the forward swinging arm. The damage was horrific. It was not helpful to think about the future of these amputees whose lives were saved. At times the futility of the work was overwhelming.

Even now an eon later, a number of patients remain clearly etched in my memory: the family of five who had had a grenade thrown through their window to settle a village dispute, (grenades cost 20 Thai Baht, or one US dollar); the young man who had lost three limbs and both eyes from a mine blast who succumbed during resuscitation; and a young Khmer girl with breathing difficulties who presented from the camp in the middle of the night.

The girl was a very small four year old in respiratory distress with a foreign body intermittently obstructing her airway. Nothing was visible on laryngoscopy and without a bronchoscope there was nothing more to be done. ICRC policy dictated that our care was limited to basic life saving surgery. There was no possibility of referral to a better equipped hospital.

I could not watch this child perish, so overnight I gave her repeated inhalational anaesthetics as she re-obstructed, attempting to shift the foreign body. Holding her upside down by her feet and vigorously slapping her chest seemed ridiculous, but would clear the airway for a number of hours. At dawn I went to see the Head of Mission to ask that she be transferred to a Thai hospital for a bronchoscopy.

"Impossible". It was against ICRC Standard Operating Procedure.

I left the camp after the morning handover railing against the absurdity of the situation. Coming from a health care system in Australia where everything is possible, I was now working in a system where only the basics were available. Three antibiotics, no blood components, limited post operative analgesia and a handful of simple investigations and X-rays. But just up the road in the Thai hospital, everything was possible.

On arrival at the camp the next morning, the small girl, clutching the hand of her grandmother, came up to me with a yellow topped specimen container containing a large seed. At least with this patient we had made a difference.

My next ICRC mission in the mid-nineties was with a Flying Surgical Team (FST) in Somalia during the famine and civil war relief efforts of "Operation Restore Hope". I flew in a small plane from the Red Cross briefing in Nairobi to Mogadishu to join my team. This was an unsafe mission. Security was the number one consideration. On the perimeter of the airstrip below were a number of "Technicals", converted four wheel drive utility vehicles with a .50 caliber gun mounted in the tray and a flag fluttering their agency or allegiance.

The Red Cross had a strict no weapons policy in the hospital and in our vehicles. But outside our various accommodations or in a Hilux close behind the ICRC vehicle, there always were a half dozen teenaged Somalis carrying AK-47s. In this failed state it was simply too dangerous to depend on goodwill. Legitimacy came with the Kalashnikovs. The militias were "leasing" vehicles, "letting" accommodation and running protection rackets. No one cared if we were there to "do good" or not. Our adolescent colleagues were just looking after their "assets".

The hospital in Mogadishu was located in an old prison. High walls and a single guarded gate provided security. We were in an area controlled by the militia warlord General Aidid (Black Hawk Down). At night we slept on the roof top of an electricity-less old luxury Italian hotel, protected outside by Aidid's militia guards. Overhead the noise of American helicopters and in the city the constant sound of gunfire and explosions.

There were 15 tables in the prison OT. The surgery was a never-ending list of gunshot wound debridements; looters and civilians caught in the crossfire between rival militias. There were occasional civilian emergencies, obstructed hernias and Caesarean Sections. It was all Ketamine and FOP. Oxygen concentrators were sometimes available.

After the overthrow of the dictator Siad Barré in 1990, Somalia had collapsed into famine and countrywide civil war between rival militias. The FST had been established as a highly visible Red Cross "action" and this mobile surgical facility was a small part of a much bigger operation, a massive ICRC feeding program of food kitchens. The Red Cross was spending USD $1 million a week on the intervention.

But despite the presence of a multilateral force led by the United States, (UNITAF), fighting and looting continued unabated. The FST was dispatched around the country to provide surgical care for wounded in a variety of locations: dispensaries in the middle of the desert, looted, empty ex hospitals (Las Anod) and functional facilities in the more "peaceful" parts of the country (Merca and Berbera).

The FST had to be completely self-sufficient. Our Nairobi warehouse was an Aladdin's cave of medical consumables, drugs and equipment. For each sortie, we would restock and repack our portable surgical service into a number of boxes which could be loaded onto a small plane and then Toyotas to reach our operating destination.

Anaesthesia was Ketamine, Ketamine and more Ketamine. The occasional spinal or regional block, or a muscle relaxant with Ambu-Bag IPPV were options. There were no blood tests possible although I could do simple group cross matching from relatives for life saving blood transfusions. Most of the wounds were peripheral gunshot wounds. More serious abdominal, chest and head injuries triaged themselves en route to our facility. There was often no "Recovery ward" for patients post op and I would leave patients on their sides in the shade outside the "OT," to be reassured the next day that all had survived.

The humanitarian space was shrinking and I had very mixed feelings about the value of these three months. Of course for the patients we treated it was worthwhile. But at what cost? Cynically I wondered whether it would have been simpler to fly crisscross patterns over the country pushing out pallets of US dollar bills[1]?

My last Red Cross mission was in the late noughties, with a Flying Surgical Team in Darfur, Sudan. There was a genocide in progress. The Arab nomad Janjaweed were encouraged by the Bashir Government in Khartoum to "ethnically cleanse" Darfur of its sedentary African pastoralists. The rape, pillage and murder attracted global attention.

We were based in Nyala, towards the border with Chad. The modus operandi was similar to the FST in Somalia, but for security reasons our activities were very restricted. We remained on standby for weeks at a time waiting for the "Green Light". Kidnapping and vehicle theft had made the work much more dangerous and Geneva was reluctant to risk the team just for publicity purposes. The ICRC had a strict "no ransom" policy in place. We were confined to our accommodation from dusk to dawn. Even weekend visits to the Nyala town market had become dangerous.

The humanitarian space to meet urgent humanitarian needs of food, shelter and health had now almost totally disappeared. What a difference a decade had made. In places of conflict and war, "doing good" was really no longer the issue at all.

Dr Haydn Perndt AM

References

1 From a paper published in 2025, reflecting contemporary views of humanitarian practitioners in Tigray, Somalia, South Sudan and Yemen: "The major conclusion derived from this study is that to a significant extent, the transition from in-kind assistance to cash transfers in conflict zones provides a flexible tool in the delivery of humanitarian assistance".

Journal of International Humanitarian Action. The effectiveness of humanitarian aid in conflict zones: practitioner views on the transition from in-kind assistance to multi-purpose cash transfers. Dani Alsina, Derek Eldridge. https://doi.org/10.1186/s41018-024-00165-6

HUMANITARIAN AID AND DISASTER – WHEN GOOD INTENTIONS AREN'T ENOUGH

NOVEMBER 2019, SAMOA. IT'S 4PM AND YOU ARE CALLED DOWN TO THE EMERGENCY DEPARTMENT OF THE TUPUA TAMASESE MEAOLE HOSPITAL, THE MAIN HOSPITAL IN THE CAPITAL, APIA. THIS IS THE FOURTH TIME YOU HAVE BEEN CALLED DOWN THAT DAY. SAMOA'S HEALTH SYSTEM HAS BEEN OVERWHELMED BY A MEASLES EPIDEMIC AND INFANTS ARE DYING. THE AUSTRALIAN GOVERNMENT HAS SENT A MEDICAL ASSISTANCE TEAM (AUSMAT) TO SUPPORT THE HOSPITAL AND VACCINATION PROGRAM

Some of the nursing staff for Koala Ward – the AUSMAT Paediatric HDU.

You are one of many on a team privileged to be working side by side with the Samoans. You are joined by other international teams like NZMAT and UKMAT. You will work for 14 long days without a day off, embedded in the local health care system. You will be relieved by another AUSMAT team. I was part of Team Charlie. These teams included nurses, paediatricians, intensivists, infectious diseases physicians, anaesthetists and epidemiologists. Team Alpha, the Needs Assessment Team, arrived first followed by Team Bravo. Team Echo were rehabilitation experts.

A one year old, 10kg, previously well infant has presented with severe measles. The child is not vaccinated. The rash is angry, thick and peeling. The child's eyes are glued shut with conjunctivitis. There is bleeding from the mouth from severe stomatitis. The inflammation and ulceration extend deep into the trachea. The child has been unable to breast feed for days. There is stridor, a tracheal tug and intercostal, sternal and subcostal recession. The baby is unconscious and floppy. The first set of observations include a heart rate of 200 bpm. Blood pressure and oxygen saturation are unrecordable. The clinical picture looks nothing like the textbook photo of a grizzly kid with a subtle blanching rash.

AUSMAT Paediatric HDU built on hospital grounds in Apia, Samoa.

The Samoan ED team, supported by AUSMAT ED nurses and physicians, are very slick. There is a protocol that works. We follow the protocol. They establish interosseous access and the child is given a 40ml/kg normal saline bolus. A VBG, blood cultures, and other tests are sent. An IV cannula is able to be sited and ceftriaxone is given.

The infant is now conscious but cerebrally irritated. Blood pressure is 70/40mmHg, heart rate is 170 bpm, sats are 88% on 8L/min oxygen via an oxygen concentrator. The VBG demonstrates a pH of 6.9, a $PaCO_2$ of 15 and a BE of -20.

Sometimes there are two of these resuscitations running concurrently.

The decision point now is whether to send this child to the full AUSMAT paediatric HDU or up to the bursting hospital ICU. That's why I'm there. I'm the AUSMAT HDU doctor. I've been working in Darwin for 20 years as an anaesthetist doing whatever came through the door. That also included 15 years of ICU on-call. AUSMAT has set up an 8 bed paediatric HDU ward in an air-conditioned purpose built tent on the grounds of the hospital. It is staffed by Samoan nurses and a cadre of AUSMAT paediatric nurses with ICU experience from large paediatric hospitals from around Australia.

If the oxygen saturation improves into the mid-90's on humidified high flow nasal prongs, then we go to HDU where there has been a 70% survival rate so far. If the

sats don't get to 90 on high flow, then I speak with my AUSMAT ICU and ED colleagues about the need to intubate. The mortality rate in ICU was running at 90%. Intubate too late and the baby will die. Intubate too early and you may make the chance of survival lower. We have pre-drawn syringes of fentanyl, ketamine and rocuronium in zip locked bags labelled either "5kg" or "10kg". We all carry pre-drawn syringes of adrenaline for a 10kg infant in our pockets.

From the lyrics by Paul Byrne off his song, Once In A Lifetime; "You may ask yourself, well, how did I get here?"

It started when I was a first year consultant in 2001, in Darwin. I was asked by the Director of Anaesthesia, Brian Spain, if I was interested in flying two hours to Dili, Timor Leste in a RAAF C-130 Hercules, to work with an Australian plastic surgery team for a week. Timor was transitioning to independence and the International Committee of the Red Cross (ICRC) was running the main hospital in Dili. I was hooked. Since then, I have done many short paediatric plastic surgery missions over the years.

In 2002, after the Bali Bombing, Royal Darwin Hospital became the initial receiving hospital for 61 burns victims. We had little formal training in disaster management and had never seen casualties from an improvised thermobaric bomb before. It was a wake-up call for us in Darwin to learn more.

During the election year of 2005 there was a second Bali bombing. The National Critical Care and Trauma Centre (NCCTRC) was established. Individual states had their own medical assistance teams and there was a push to centralise the Australian cache of support staff and equipment for rapid national and international deployment.

The Haiti Earthquake in 2010 was a waypoint towards a more professional approach to international humanitarian aid. Earthquakes have a high burden of orthoplastic injuries amongst survivors. A few international teams in Haiti had performed guillotine amputations because that's all they could do. Guillotine amputations are very difficult to remodel and rehabilitate. There was limited informed consent in a culture that stigmatises amputation. There was limited specialised orthoplastic teams available to deliver limb saving care.

Recipient countries had enough of teams with good intentions but limited training in disaster situations, flooding uninvited, into their hospitals. These teams arrived with no logistic support. They were a drain on already stretched systems as they demanded food, water, shelter, oxygen and medical supplies. In response, the WHO developed a framework to register and accredit international teams to help reduce the risk of foreign groups exacerbating the chaos of a sudden onset disaster. Countries in need could see what each team could do from that list. This would minimise duplication and omission of services.

In 2013, Australia sent a WHO credentialled AUSMAT Emergency Medical Team (EMT) Type 2 to Tacloban in the wake of Super-typhoon Haiyan. The Philippine government was able to coordinate the response. They could choose what international help they needed from the WHO registration list.

Again, I felt lucky to be part of Team Bravo. AUSMAT established a 35 bed field hospital with surgical capacity. We were invited by the recipient nation. We had a clear mission which was to provide surgical services until the damaged main regional hospital was repaired. We had uniforms so we were easily identifiable, we were vaccinated, medically fit and had specific cultural safety training. We were joined by Philippine nurses who could act as interpreters. We had security operating procedures. We were to remain on the grounds of our field hospital unless there was a medical reason to travel. There was no alcohol permitted for the duration of the deployment. We had ADF support to travel to and from the disaster area. There were 2 surgeons, 2 anaesthetists, 5 ED consultants, a large number of nurses, a radiographer and pharmacist in each team. Personnel were from all states and territories. Most importantly there was a team of logisticians to provide electrical power, 100L of water per patient per day, oxygen, sanitation and food. These logisticians were predominantly Australian fire officers. They are masters of improvisation when necessary.

Over 4 weeks, the Australian field hospital saw 2700 ED patients and 238 operations were performed. The theatre nurses worked late into the tropical hot and humid night resterilising the surgical instruments. The portable steriliser was big, cranky and heated the airless tent.

The majority of cases were straight forward. Ethical considerations and resource limitations were the most difficult issues to deal with. A group of senior clinicians, not directly involved in that patient's care, were often assembled to help make these complex decisions. We obtained local medical advice as to what their usual management was for these cases. It is important not to provide care beyond what is usually provided by the local health system.

There was a pre-deployment briefing and psychological assessment followed by a post-deployment debrief and psychological assistance offered if required.

Back to Samoa, 62 babies died during that 2019 measles epidemic. The Samoans and international teams saved many infant lives. A vaccination blitz occurred during a national lockdown. By the end of Team Delta's deployment there were no more deaths. AUSMAT's Paediatric HDU was empty. The tent was taken down and packed away. There was a great sense of a job completed.

For more information about how you can get involved with AUSMAT have a look at the NCCTRC website: https://nationaltraumacentre.gov.au/ausmat/join-ausmat/

Dr Philip Blum

HUMANITARIAN AID AND DISASTER RESPONSE

WHEN I WAS ASKED TO WRITE ABOUT MY EXPERIENCES AS AN ANAESTHETIST IN WAR ZONES AND IN PROVISION OF HUMANITARIAN AID AND DISASTER RESPONSE (HADR) I REFLECTED ON 35 YEARS OF SERVICE IN THE AIR FORCE AND THE OPPORTUNITIES IT HAD PROVIDED ME.

I have deployed six times with the Australian Defence Force (ADF) to war or warlike zones providing care for wounded and injured military personnel from Australia and coalition forces, and from opposing forces as well. I have also deployed on two HADR missions; one providing eyesight restoring surgery in southern China, and as part of the Combined Australian Surgical Team – Aceh (CASTA) immediately following the Boxing Day Tsunami 2004.

I have written and spoken in the past of my experiences and some of the impact they have had. This time I thought I would share with you some of my reflections on aspects of participating in HADR and military anaesthesia.

Preparation

Skills

We are all well trained at the completion of our ANZCA program. Our knowledge is at its peak, our skills are good, and developing with experience, our confidence to manage most situations is generally high. The real skills required for HADR are mostly of a non-technical nature. The ability to deal with high levels of uncertainty, the ability to improvise with available equipment and personnel, the ability to focus on your task while many other things are happening around you (black-outs, incoming fire, aftershocks etc) and the ability to do all this with a high degree of compassion and empathy.

So many of our patients are suffering deep emotional pain as well as physical injury. They have lost their family, or even their neighbourhood. They have nobody to care for them, and nowhere to go once recovered, and often don't have the personal bandwidth to even comprehend what has happened.

Family

It is almost impossible to prepare your family for what you will experience. On many of my missions I had little idea what to expect. Some were benign, others extremely confronting, the one thing that is clear is that you can expect the unexpected. This makes it difficult for those at home to appreciate what you have experienced and often difficult for you to articulate. This may be a source of difficulty later, and help may be needed – there's nothing wrong with that. PTSD is common after missions like this, its curable and doesn't have to stop you from continuing to serve.

The CASTA Team on our last day In Banda Aceh January 2005

Professional Impact

Going on a HADR mission brings some incredible insights into how one may solve challenging clinical problems in unanticipated ways. This necessary improvisation is something you can bring back to your clinical practice at home and share with your colleagues. Many significant advances in the care of the trauma patient have come from innovations in care of wounded and injured combatants and civilians in war zones. Sharing these lessons is often easier than revealing the personal trauma you experienced and can be part of the healing process.

Courses

When you arrive at your destination it's going to be a steep learning curve. You may receive a handover from the outgoing anaesthetist, or there may not be one. You may be introduced to the people you are working with, you may have to build new relationships to make it work. You may bring your own state-of-the-art equipment and drugs, they may have been packed on a different plane and don't arrive for a week or at all. You will have to work with whatever you have. If you have never used draw over or imagined how to provide anaesthesia in austere environments and seek to do this kind of work you need to do some courses.

1. The Real World Anaesthesia course is a must do. Many of the principles of HADR will be discussed and you will learn from some truly experienced mentors.
2. Definitive Surgical Trauma Care (DSTC) is another must do if you are going to a war zone. It is a combined training course with surgeons, anaesthetists and nurses on the collaborative management of severe trauma – the sort that often needs surgery as part of resuscitation. It's a good course for anybody who has to manage trauma.

Mission

Your mission will be challenging. With the military it might be busy, it might be quiet, it might be Groundhog Day – every day is the same. Make sure you have something to do. Train with your team, look at policy and procedures and refine them, do structured education – these things will help pass the time and will make you better at managing cases.

Be aware you will see obstetrics – my commonest abdominal surgery in Bougainville was caesarean section – at any time in low resource countries 25% of the female population will be pregnant.

You will see paediatric patients – my youngest patient was three months old with pneumonia and hypoxia who needed IV therapy and ventilation (the grandson of a politically important person). Kids get hurt in conflict zones. They don't know about seeking cover and they pick up things which may explode. I have dealt with several paediatric gunshot wounds.

One of the most difficult challenges is that of moral injury. When working with the military there may be situations where treatment may be indicated but futile in the context you are in. Availability of some medications may be restricted to service personnel, or ongoing care may not be available. In Bougainville we were unable to dialyse a patient with renal failure secondary to malaria, a peacekeeping soldier would be transported back to Australia. In many low resource countries the services available to care for spinal and head injury do not exist, this means that applying the same management principles to these patients may not be appropriate. The inability to provide this care is enormously challenging.

With an Orthopaedic Colleague Kandahar Afghanistan 2013

Departure

At some point you will have to come home. There may be a team replacing you, there may not. The work will not be completed, but you will have to let go. It is unlikely you will ever see your patients again, loss to follow-up is the norm, but sometimes you do. It can be gut-wrenching to walk away from an unfinished job, but staying may not be an option – people in high places are the ones making the decisions.

Returning home will be a challenge. Your partner will have been running the household and depending how long you have been away they will have probably managed it well. You will have to reinsert yourself into the home in a sensitive way. Some may adopt the attitude that now you are back from 'holidays' you can do it all while they have a break – not appreciating what stress you have been under. This can be a challenging time and it may be difficult for you to express yourself and your emotional state. You may have a surreal feeling. I recall returning from Banda Aceh and feeing disquiet at the absence of debris and black bags with the deceased in them lining the streets. Black garbage bags are still a trigger.

Decompression

This is a term used by the military to encourage returning troops to take some time out before returning to the home routine. It means taking a vacation before returning to work – preferably with your partner and children – in a non-home environment. This gives you the chance to reacquaint with your family without the day-to-day responsibilities you all face. I strongly recommend you do this every time.

Aftermath

Adjustment

This may take some time, you may find yourself missing some strange things – like the constant sound of the generator, or the sound of gunfire. It may take some time to get used to your colleagues getting stressed over what you now see as minor issues. You may find yourself becoming irritated and even angry over small things. If you find this or your well-meaning colleagues point it out please accept that it is their way of suggesting you may need help. Do not be afraid to seek help; talk to friends and colleagues about your feelings and thoughts – it's never a sign of weakness or failure.

Consequences

Recently a dear friend of mine (who I deployed to Banda Aceh with) and I organised a reunion of the CASTA team in Sydney, to remember 20 years since our response to the Boxing Day Tsunami. That mission was for me and many of us both the best and the worst thing we had ever done. On return to Australia we had a perfunctory debrief and were then set free. Many of us never understood how we were chosen for the mission or, apart for the 108 lifesaving operations we did in 8 days, the impact of our mission.

I invited the senior government officer who sent us there to speak. He was able to shed light on the process and outcomes. This statement in particular made an important impact on the team – even after 20 years: *The impact of the work done by CAST-A changed the dynamic of Australia - Indonesia relations and has proved powerful in helping to build stronger ties between the two neighbours, which remain to this day.* CASTA became the model for AUSMAT and the impetus for its formation.

Things like that, which you don't appreciate at the time, helps you to realise that taking part in missions for HADR and War Zone care make a difference not just to the people we care for but for humanity at large. The personal cost is worth it.

A/Prof David Scott OAM

FRONTLINES OF HEALING: HUMANITARIAN ANAESTHESIA IN WAR ZONES

Introduction

Over the past two years, I have served as an anaesthetist in some of the world's most volatile regions—Afghanistan, Democratic Republic of Congo, Gaza, and Darfur—working with Médecins Sans Frontières (MSF) and the International Committee of the Red Cross (ICRC). These experiences have tested my professional skills and personal resilience. By sharing them, I hope to demystify the realities of war anaesthesia and provide a guide to those considering this path. The lessons, shaped by extreme conditions, reveal not only the challenges but also the profound rewards.

The Reality of War Anaesthesia

War zones are crucibles for medical professionals, where challenges span from physical hardship to the emotional weight of conflict. Resources are limited, supply chains are unreliable, and the environment is often saturated with noise, tension, and stress. Perhaps surprisingly, the technical aspects of war anaesthesia are often not as complex as one might imagine. Pre-hospital management of trauma is often non-existent in austere contexts. As a result, the "trial of life" has frequently been lost before patients arrive at the hospital, unless their injuries are fresh and occur close to medical care. Many with severe trauma—cranial, thoracic, or abdominal—die on scene or en route. Consequently, the majority of war surgery cases generally centre around orthopaedics and reconstructive plastic surgery rather than dramatic thoracotomies or laparotomies. And most patients require many visits to the operating theatre for repeated debridements, infection control surgery, and eventually, skin grafts.

Clinical Challenges in Low-Resource Settings

Resource limitations define the nature of war anaesthesia. Scarcity or absence of blood products is a common issue, complicating efforts to stabilise critical patients. The two primary modalities used in most low-resource anaesthesia are ketamine and spinal anaesthesia. In many austere contexts, if local providers of anaesthesia exist, they often rely exclusively on one or both of these two modalities for all cases, such as leaving the patient spontaneously breathing on Hudson mask oxygen under ketamine anaesthesia while having a laparotomy or craniotomy. Drawover anaesthesia is frequently utilised in humanitarian settings due to the lack of pressured gases and reliable power, and this demands an understanding of this technique and the ability to optimise it for challenging scenarios. In many contexts when using drawover, unparalysed patients will breathe spontaneously and paralysed patients will need to be manually ventilated with a self-inflating bag, since ventilators are often unavailable or non-functional. The unreliability of water, electricity, light, and temperature control compounds these difficulties.

Anaesthetic machines, ventilators, syringe drivers, and monitoring equipment (e.g. ECG, capnography, automated BP monitoring) are often unreliable or entirely absent. Anaesthetists must rely on their clinical judgment and experience rather than technology. Additionally, anaesthetists often find themselves juggling multiple roles in the operating theatre—assisting the OT team as a circulating nurse while managing anaesthesia (including manually ventilating the patient) independently.

In resource-limited settings, the role of the anaesthetist often extends well beyond the confines of the operating theatre. Anaesthetists are frequently called upon to conduct ward rounds, manage complex medical comorbidities,

Source: International Committee of the Red Cross https://www.icrc.org/en/document/democratic-republic-congo-war-surgery-saves-lives

oversee high-dependency units, and coordinate the ordering of medical supplies. A vital aspect of their contribution is the education and training of local healthcare staff—it is only through capacity-building activities that teams can achieve sustainable improvement in healthcare delivery that persists after they have departed. These expanded responsibilities highlight the importance of flexibility, adaptability, and a broad clinical skill set for anaesthetists working in such environments, since they would take most anaesthetists accustomed to high-resource medicine well out of their regular comfort zone.

Impact on Patients

Amidst the chaos, there are moments of deep fulfilment. Many patients are highly motivated, knowing that their families depend on them for survival, and as a result they work tirelessly through the rehabilitation process. Their recovery is often more rapid than we might expect, as they tend to be young and have minimal comorbidities.

The level of appreciation for medical care is often profoundly different from what clinicians experience in high-resource settings like Australia. Patients understand that without the presence of an anaesthetist, they might either not receive surgery at all, or they might undergo it without anaesthesia. Their gratitude is both humbling and deeply moving, and highlights the transformative power of medicine in even the most harrowing conditions.

Personal Transformation

These experiences have profoundly reshaped me, both professionally and personally. I have been reminded daily of the immense privilege afforded to me by my birthplace and the opportunities that followed. This awareness has instilled in me a deep sense of gratitude, which has become a guiding value in my life.

Working in conflict zones has reinforced the critical role of trust and collaboration within a team—especially in environments where resources are scarce, and mistakes have no margin for correction. Serving in small surgical teams with MSF and ICRC has also taught me an invaluable lesson: in the field, you don't get to choose your teammates. Spending two months working around the clock with the same surgeon is an intense experience, where both clinical skills and personality shape the mission's success. A skilled, adaptable, and cooperative team member can mean the difference between a manageable deployment and an overwhelming one.

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Skills and Qualities for Success

Adaptability is paramount. In settings with constrained resources, improvisation becomes a daily necessity. Anaesthetists must be comfortable working without assistance for anaesthetic tasks, which requires self-reliance, careful preparation, and clinical confidence. The ability to remain calm under pressure, function effectively within a multidisciplinary team, and demonstrate cultural sensitivity is equally important.

One of the greatest challenges can be the capacity building of local staff, who may have varying levels of foundational education and differing awareness of their knowledge gaps. Establishing rapport and finding a way to engage in constructive teaching—without causing embarrassment or loss of face—often requires considerable tact, empathy, and diplomacy.

It's crucial to be comfortable anaesthetising patients across all demographics, from infants to the elderly. Having said that, in many war zones, the prevalence of multiple comorbidities and advanced age is far lower than in settings like Australia, so generally the primary anaesthetic challenges come from the patient's acute situation, rather than any chronic disease processes.

Life in a Conflict Zone

The challenges of living in a war zone sometimes eclipse the work in terms of difficulty. Unless working with a military unit or a high-resource organisation offering aeromedical retrieval, close proximity to the active fire zone is often unavoidable—raising the risk of both accidental and intentional harm. Indirect effects like noise, stress, tension, and disrupted supply chains further complicate day-to-day living.

Furthermore, in most insecure contexts, one will be strictly confined to the living compound and the hospital, which can be a real challenge for some. Finding balance in these conditions is critical. Each person finds their own way to cope, but exercise, meditation, and social activities are often helpful. Likewise, having solo activities that provide an escape—such as reading books or watching movies with noise-cancelling headphones—can be invaluable. Availability of good internet connections is highly variable in different projects; good internet allows easy communication with loved ones back home, although this can also be a double-edged sword: a comforting escape but also a reminder of what one is "missing."

Although 6- to 8-week deployments as a humanitarian anaesthetist in conflict zones might seem short, the reality is that there are usually no days off, with ward rounds and surgery every day plus sometimes at night. In these contexts, longer deployments are generally not sustainable for anaesthetists doing 24/7 on call, and risk burn out from accumulated fatigue and stress.

Ethics in War Zones

Ethical dilemmas are inevitable in conflict zones, where the demands far exceed available resources. Balancing resource allocation, respecting cultural considerations, and making triage decisions requires a strong moral foundation. For example, during mass casualty incidents in overwhelmed facilities, clinicians may have to designate patients as "expectant" or "blue"—decisions that, in high-resource settings, are fortunately very rarely necessary. These moments force difficult choices, where saving one patient may mean withholding care from another. Taking time to reflect on these challenges beforehand, and considering your own ethical boundaries, can help prepare you for the stark realities of working in war zones.

Preparing for the Field

It is important to research different roles and organisations to find the right fit for your skills and interests. Many projects require generalist skills, while others focus on specific case types (e.g. burns, paediatrics). Being comfortable managing these cases is essential.

Courses such as the Real World Anaesthesia Course, held annually in Australia and New Zealand, can help prepare anaesthetists for working in low-resource settings.

For your first time working as an anaesthetist in an austere context, it is highly beneficial if you can organise to be paired with another anaesthetist who has experience in this setting. This could be through a short surgical mission or other projects; future deployments will be much less stressful if you have already gained some supported experience working in resource-limited environments.

Conclusion: Growth at the Edge

Working as a humanitarian anaesthetist in conflict zones is undeniably challenging, yet it offers profound rewards for those committed to supporting some of the world's most underserved populations. The clinical, physical, and psychological demands are considerable. Yet for those who choose this path, it's a chance to make a real impact—on patients, colleagues, and oneself. These experiences reshape not only lives but perspectives—offering a rare clarity about what truly matters. The challenges are immense, but so too are the moments of profound human connection and the hard-earned triumphs. Every act of care is more than just medical—it is a stand against suffering, proving that humanity and compassion can endure even in war zones.

Anonymous

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ANAESTHESIA UNDER FIRE:

Maintaining and Strengthening Services in Ukraine and Beyond

WHEN WARS ERUPT OR PANDEMIC HITS, LIFEBOX, THE GLOBAL NONPROFIT WORKING TO MAKE SURGERY AND ANAESTHESIA SAFER, STANDS WITH OUR PARTNERS AND HEALTHCARE PROVIDERS. THIS IS BECAUSE, IN THOSE MOMENTS, WHEN THE POWER CUTS OUT, WARDS OVERFLOW, AND RESOURCES VANISH, THE ONLY THING STANDING BETWEEN A PATIENT AND LIFESAVING CARE IS A HEALTHCARE WORKER DETERMINED TO DO THEIR JOB AND THE TOOLS THEY HAVE IN THEIR HANDS.

From the bombed-out hospitals in Ukraine to the remote operating rooms in the Democratic Republic of Congo and the overwhelmed COVID-19 wards in different low-resource settings, Lifebox has equipped frontline providers with the lifesaving tools and training they need to monitor oxygen levels, illuminate surgeries, prevent infection, and keep patients safe even when everything else is falling apart.

When the missiles struck Ukraine in February 2022, hospitals were damaged or destroyed; surgical teams were forced to work in bunkers and makeshift operating rooms, managing wounded patients amidst severe shortages of supplies and staff. Lifebox reached out to the Ukrainian Society of Anaesthesiology, whom we had worked with previously on access to pulse oximeters in Ukraine, to see if they needed support and they immediately responded with requests.

Lviv Emergency Hospital is one of the hospitals that experienced casualties flooding the hospital following the missile strikes that hit Lviv in March 2022.

"It was a mass casualty event. We had to recall the doctors back from their homes in the wee hours of the morning. We opened 20 operating rooms at once," recalls Professor Nataliya Matolinets, Medical Director of Anesthesiology and Intensive Care at Lviv Emergency Hospital. "Many casualties lost limbs. It was heartbreaking to break that news to them."

Throughout it all, anesthesiologists across Ukraine continued their work, sometimes from underground bunkers. For 40 days straight, many of them lived inside the hospital, working 24 hours a day to ensure continuous, lifesaving care as missiles continued to fall.

Working with the support of Blue Check Ukraine, a non-profit founded by actor Liev Schreiber and colleagues to assist local NGOs in Ukraine, Lifebox set out to support Lviv and other hospitals with essential anaesthesia equipment, as well as pulse oximeters, and surgical headlights.

"Lifebox gave us the equipment we needed to monitor and keep patients safe," says Professor Matolinets. "These essential tools made a critical difference when we needed them the most."

When the missiles struck Ukraine in February 2022, hospitals were damaged or destroyed; surgical teams were forced to work in bunkers and makeshift operating rooms, managing wounded patients amidst severe shortages of supplies and staff.

More than three years since the war began, Lviv Emergency Hospital has conducted thousands of surgeries, transforming itself into a hub of complex trauma, reconstructive, and rehabilitation care. The hospital now boasts the largest prosthetics factory in the country and performs advanced osseointegration surgeries. Its intensive care capacity has grown from 50 to more than 300 beds.

Lifebox's impact in Ukraine is part of how we work with partners experiencing humanitarian crises.

In the Democratic Republic of Congo, Lifebox has worked with Second Chance and the International Committee of the Red Cross (ICRC) to provide training and equipment to improve surgical safety.

When COVID-19 pandemic struck, essential tools like pulse oximeters and personal protective equipment (PPE) were limited. For surgical and anaesthesia providers, the crisis was twofold: managing a deadly respiratory virus while continuing to deliver lifesaving care in under-resourced operating rooms.

In collaboration with partners like Smile Train, ELMA Philanthropies, and the UBS Optimus Foundation, and the World Federation of Societies of Anaesthesiologists (WFSA), Lifebox provided critical equipment and training to protect patients and providers. Lifebox ANZ hugely supported Lifebox's COVID-19 response across the Pacific. As a result, 8,800 pulse oximeters were distributed across 53 countries to help detect and manage "silent hypoxia"- a dangerous drop in oxygen levels common in COVID-19 patients- and enable timely intervention.

Lifebox's lifesaving tools and training

During such crises, Lifebox pulse oximeters become lifelines, allowing providers to maintain a standard of care that would have otherwise been impossible under missile strikes, displacement, pandemics, and resource collapse. As patients stream in with injuries and severe blood loss, these devices are crucial for rapidly triaging and continuously monitoring oxygen levels, helping surgical teams prioritize the most critical patients and respond swiftly.

Frequent power cuts left operating rooms in darkness. Lifebox's surgical headlights provide a reliable, hands-free light source, allowing surgeons and anesthesiologists to continue lifesaving procedures without relying on overhead lighting.

Tools alone are insufficient to ensure surgical teams globally provide lifesaving care. Lifebox complements equipment with robust, evidence-based training that empowers providers to deliver safer care even under pressure. This includes on-the-job specialised training in teamwork strengthening and infection prevention and specialised clinical workshops in pulse oximetry, capnography, and safe operating room practices. These training modules form the foundation of Lifebox's framework for strengthening surgical systems.

"At Lifebox, we are committed to delivering not just tools and training to improve anaesthesia and surgical safety in low resource settings but also standing with surgical teams working on the frontlines of humanitarian crises," said A/Prof Suzi Nou, Lifebox ANZ Chair.

"But we can't do it alone. Sustaining and scaling these lifesaving initiatives requires all of us. We invite organisations and individuals to join us as we make surgery safer amid crisis, in recovery, and beyond."

The ASA is a proud supporter of Lifebox. To make a tax deductible donation and support the work of Lifebox in the region, please visit: https://www.anzca.edu.au/safety-and-advocacy/global-health/lifebox-australia-and-new-zealand

Lourdes Walusala
Media Relations Manager, Lifebox

THE REALITIES OF A MISSION TO GAZA

ON 31 DECEMBER 2024, A NEW REPORT BY THE UN HUMAN RIGHTS OFFICE ASSERTED THAT ISRAELI MILITARY ATTACKS ON AND AROUND HOSPITALS HAVE PUSHED GAZA'S HEALTHCARE SYSTEM TO "THE BRINK OF TOTAL COLLAPSE". APPROXIMATELY 80% OF GAZA'S HEALTHCARE SYSTEM HAS BEEN DESTROYED SINCE OCTOBER 2023.[1]

I spent a month working in Gaza in October 2024 as part of an Emergency Medical Team with the UK NGO Medical Aid for Palestinians (MAP). MAP has been working with Palestinian communities since the early 80s, delivering locally led health and medical care and immediate medical aid at times of crisis, while also developing local capacity and skills to ensure the long-term development of the Palestinian healthcare system.

Our team consisted of a vascular surgeon, a colorectal/general surgeon and myself – a consultant anaesthetist. None of us had ever met before, but we bonded during the arduous trip to enter Gaza – already kitted out in scrubs as our luggage allowance was heavily restricted. Entry to Gaza for healthcare workers is subject to need, selected according to COGAT - Coordinator of Government Activities in the Territories and the Gaza Ministry of Health and facilitated by the WHO with team members details scrutinised months before. The trip was by road and subject to multiple security stops and checks, crossing into Israel via the King Hussein Bridge from Jordan and then non-stop south down to the Kerem Abu Salem Crossing at the Israel-Gaza border. Once through the crossing, we transferred from the luxury air-conditioned coach into austere, armoured, UN-branded Landcruisers - 3 people per vehicle and travelled in a 7 car convoy through the dystopian, desaturated wasteland of Rafah to Khan Younis.

Entry to Gaza for healthcare workers is subject to need, selected according to COGAT - Coordinator of Government Activities in the Territories and the Gaza Ministry of Health and facilitated by the WHO with team members details scrutinised months before.

Dr Nabil and I with the portable capnographs

One of my favourite techs, Abdulrahman Ahmad

We were based at Nasser Hospital, one of the largest hospitals in Gaza which was slowly recovering after a major siege by the Israeli Military beginning in January 2024. Reports detailed that patients died due to lack of electricity, oxygen and medical equipment and a mass grave containing nearly 300 bodies was discovered after the withdrawal of Israeli forces in early April[2].

The standard hospital day started at around 8am with staff being brought in from the various displacement camps on three coaches and finished at 2:30/3pm with staff who weren't remaining on site for the rest of the 24 hour period being returned to their tents. We experienced a relatively calm first week allowing for semi-urgent and elective theatre cases to be performed. The types of cases included colorectal, breast and gynaecological cancers – often advanced tumours with metastatic disease. Chemotherapy is unavailable due to aid restrictions and radiotherapy has never been available in Gaza. A permit from the Israeli authorities is required to travel to the West Bank to access these services[3] – this is currently impossible. Other cases included limb and wound debridements, amputations and lung decortications – cases from previous Mass Casualty Incidents (MCI's) requiring ongoing surgical intervention. We also performed a large number of cholecystectomies – the high incidence of gallstone cholecystitis and pancreatitis has been attributed to the poor-quality tinned food which forms the major part of the diet in Gaza. Towards the end of our deployment, even this type of food was proving scarce in the markets.

Other procedures included a disproportionate amount of D's and C's, caesarean sections and hysterectomies, typically for menorrhagia from massive fibroids. Most women of childbearing age were anaemic according to WHO definitions.[4]

There were three theatre complexes – Main Theatres was administered by the Gaza Ministry of Health while Obs and Gynae and Burns, Plastics and Orthopaedics was administered by MSF although all theatres were staffed with local and NGO staff.

Each theatre had a different anaesthetic machine – none of which had been serviced or calibrated since the end of 2023. Isoflurane and Sevoflurane were available. Working software was variable and capnography and airway gas monitoring was non-existent, so I arranged for clearance to bring two digital portable capnographs. Occasionally a saturation probe was available and sometimes the adaptors fitted so the BP cuff would work. Laryngoscopes were LED type and batteries were scarce, – blades were wiped down with alcohol after use as were Guedel airways. HMEF filters were extremely rare and if used were used at the machine end only. There were enough anaesthesia drugs to give a basic and appropriate anaesthetic, but these often were inconsistent between the main theatre and the maternity department so one had to be adaptable to what was available on the day.

The anaesthesia team led by the Head of Department, Dr Nabil Al-Astal, gathered each morning to discuss distribution of the day's work, prioritise urgent cases and make perioperative plans. It felt like a safe and familiar space to me, and everyone would go out of their way to speak in English despite my protestations

We also performed a large number of cholecystectomies – the high incidence of gallstone cholecystitis and pancreatitis has been attributed to the poor-quality tinned food which forms the major part of the diet in Gaza. Towards the end of our deployment, even this type of food was proving scarce in the markets.

that I wanted to practice the Arabic I had been learning during the last eight months.

The anaesthesia registrars – the most junior often being first or second year interns seconded by the MOH to fill a service gap were allocated to a theatre along with an anaesthesia technician with a more senior trainee or consultant running the overall floor.

The anaesthesia techs have either a Bachelor's Degree in Anaesthesia or a two-year diploma in Anaesthesia from a recognised institution. They act at the level of a second-year basic trainee, assessing the patient, drawing up drugs and organising equipment. They also managed airways including intubation and are responsible for the patient in the immediate post-operative period including transfer to ICU.

They were truly indispensable during MCI's, which increased in frequency and intensity during the last three weeks with the majority of casualties being women and children. The theatre complex would rapidly become overwhelmed with patients being wheeled into and left in the holding bay with no other history other than what was before your eyes; paper was a very scarce commodity as were pens. The techs would run between 6 theatres – one maybe staffed with a thoracic surgeon doing a laparotomy, one staffed with a paediatric surgeon performing an amputation on an adult and some without a surgeon at all – assisting anaesthetists with whatever was necessary at the time – hanging blood, cannulating, drawing up adrenaline.....

During one horrendous MCI I found myself anaesthetising, intubating and resuscitating a patient singlehandedly, then scrubbing in to assist in a thoracotomy and laparotomy until another member of staff became available.

Fentanyl and ketorolac were used for intraoperative analgesia. Ketamine was mainly reserved for induction for the haemodynamically unstable and it was common practice to not administer volatile agents after IV induction. Nerve blocks were performed, but rarely and only by senior anaesthetists. ICU beds were rare leaving no option but to extubate patients from MCI's – it not being uncommon for a patient to have had a laparotomy, thoracotomy and limb amputation/fixation – and discharge them to a general surgical ward.

Towards the end of our mission, we would head straight for the ED department on hearing an explosion and assist in the management of the critically wounded – doing ABC's, inserting chest tubes and transferring patients to CT, theatre or ICU. Many dead and injured would flood the 4 bed resus bay along with distressed relatives, security guards and other healthcare workers. It was a scene of pure chaos sporadically washed down with a large bucket of water to clear the blood from the floor.

Through all this, the dedication of the medical students is to be commended. The two medical schools in Gaza, the Islamic University of Gaza and the Al-Azhar University were both bombed and destroyed on 10 October 2023. Medical students continue to turn up for lectures at the hospital to complete their end of year exams and finals. Many would volunteer on the wards, theatre or ED and some would act as translators for international medical staff. When time permitted I was able to give some formal lectures to final year students as well as theatre teaching to fourth year medical students.

Was I relieved to leave? Yes – I was exhausted, had suffered a nasty, mystery illness which left me delirious and on IV fluids for 4 days and I missed my family. Was I sad to leave – also yes. I had made many new friends from Gaza as well all over the world, learned many things about medicine, solidarity and life in general. Would I go back? Most definitely yes and I hope the Gaza that I return to will have had the punishing ongoing aid blockade of food, water, fuel and medicine lifted and a permanent ceasefire implemented, and those that those responsible will have been held to account for violations of international law.

Dr Saira Hussain

Specialist Anaesthetist
MBBS FRCA MA FANZCA

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MY EXPERIENCE IN JERUSALEM

THE MOUNT SCOPUS CAMPUS OF HADASSAH MEDICAL ORGANIZATION MIGHT HAVE THE MOST SPECTACULAR SETTING OF ANY HOSPITAL IN THE WORLD. PERCHED AT THE PEAK OF A MOUNTAIN NAMED FOR ITS ROLE AS A VANTAGE POINT FOR RULERS FROM THE ROMAN 12TH LEGION ONWARDS, A GLANCE TO THE WEST REVEALS THE OLD CITY OF JERUSALEM, GLOWING WITH THE GOLDEN LIMESTONE USED FOR MILLENIA THAT IS STILL LEGALLY MANDATORY CLADDING FOR ALL CONSTRUCTION. TO THE EAST LIE THE HILLS OF THE WEST BANK, THE DEAD SEA AND THE MOUNTAINS OF JORDAN.

I have personal connections to the city, my family having lived there as refugees after World War 2, as well as a close connection to the hospital which has inspired me with its role in bringing together the different communities in Jerusalem, as well as nearby Palestinian cities in which many staff and patients also live.

Jerusalem is beautiful, fascinating - and complicated. Healthcare is provided by a range of authorities - Israeli government hospitals, Arab hospitals, and Hadassah, an independent charity. The East Jerusalem Hospitals Network largely serving the inhabitants of the West Bank continues to assert its independence supported by a range of Christian and Islamic charities, as well as via funding from the US Government which waxes and wanes with politics. Australian donors have been instrumental in building the Gandel Rehabilitation Centre on the Hadassah site; the largest rehabilitation hospital in the Middle East with a fully-contained underground hospital held in reserve for wartime underneath it.

The operating theatre complex, like the lobby and cafeteria has people from every conceivable religion and sect in close proximity. Charedi Jews, families in traditional Muslim clothing, priests, and both Jews and Palestinians from the West Bank; the placid eye, perhaps, of the regional storm. The demographic geography of Jerusalem is hard to grasp for an outsider, but the hospital complex lies right up against what was the Israeli-Jordanian border until 1967. The Arab neighborhoods of Sheikh Jarrah and Wadi Joz lie directly in front, while Jewish suburbs start from the other side of the main road, and the Arab town of Issawiyeh with the highest minaret of the region lies up against the hospital's back fence. Most of the holiest sites of Judaism, Islam and Christianity are part of a hospital catchment area like no other, located between the high walls of the Old City below. The wartime absence of tourists in January 2025 presented a disorienting picture to anyone familiar with the city and the densely packed crowds of locals and tourists usually present. The Christian quarter was almost deserted and the spectacular Church of the Holy Sepulchre, the traditional site of

Emergency hospital deep below ground.

Australian donors have been instrumental in building the Gandel Rehabilitation Centre on the Hadassah site; the largest rehabilitation hospital in the Middle East with a fully-contained underground hospital held in reserve for wartime underneath it.

the crucifixion and burial of Jesus, was similarly empty.

Politics and identity go completely unremarked within the hospital walls; it is hard to imagine anyone being able to discuss current affairs in this setting and still get anything done.

Meanwhile, outside, there was a lot going on. These were the final days before the long-awaited January ceasefire and hostage/prisoner exchange; missiles from Yemen were whistling over the mountain and triggering air raid sirens across the country. Hadassah Mount Scopus, unusually, does not have its operating theatres underground for security, and the floor-to-ceiling sandbags for blast protection had only just been removed from the external corridors. Navigation was disrupted by GPS jamming that would place you in random cities across the Middle East. Reading the news it was easy to see why the words "Jerusalem" and "flashpoint" are so often linked.

But within the hospital conversations take place variously in Hebrew, Arabic and occasionally English if that's easier for everyone. One of my first tasks was to learn the name of seemingly every fruit in Arabic, as children were given a free choice as to which flavor of sevoflurane they wanted for induction and might choose moz, batikh or tut or anything else.

The caseload is as eclectic as the location, with a wide mixture of routine elective surgery as well as neonatal surgery. Another Hadassah campus, the Ein Kerem Hospital on the other side of Jeruselam is the region's designated trauma centre, but a fair amount of major trauma presents at the front door and is dealt with expertly in the trauma/shock room. The national, compulsory medical insurance system means that the patient population is extremely diverse in socioeconomic terms as well.

Obstetrics is particularly interesting, with a fertility rate in the city of around 4 and grand multiparity pretty routine. In fact there are nearby towns running at around 7, which matches the world's highest rates. Days are long. Routine work runs until about 3pm, followed by *kitzur torim*, the waiting list reduction work until late evening.

I was given temporary registration as a specialist without much fuss and worked as a consultant as well as providing some teaching on my niche fields. Anaesthesia is as one would imagine pretty similar overall but every now and then you would see unexpected things. Etomidate is favoured for fragile inductions, and "Dypirone" is used for just about everything. This non-steroidal anti-inflammatory - metamizole - is banned across the English-speaking world due to its association with agranulocytosis but all the staff were baffled that I had never heard of it, just I was baffled that they wouldn't just use parecoxib. Seeing desflurane on site but put away in the cupboard brought back memories of home - in fact, isoflurane is still routinely used alongside sevoflurane.

The most striking difference was not in the pharmacology, but lay in the attitude to patients' families. Multiple relatives would freely accompany the patient to the holding bay and indeed accompanied us to the theatre door for a critically ill relative. Laryngeal masks need to be removed in theatre, and as soon as the patient's observations are taken their relatives come straight in to PACU. In general the impression was one of shared care between the relatives and the staff. Similarly there seemed to be more fluid boundaries between staff roles. A cannula might be placed by us, or a nurse, or a surgical resident or surgical consultant, really whoever was closest. Surgical registrars would be as likely to do the PACU handover as the anaesthetists.

In a region so defined by division it was inspiring to see these diverse teams working together amidst both the stress of the overall security situation and the everyday relentless caseload of a high-density inner city neighbourhood. Just as others in the region persevere under challenging conditions, it was heartening to see medical staff at this site building and healing together.

Dr Mark Suss

REAL WORLD ANAESTHESIA COURSE

CHRISTCHURCH SEPTEMBER 2024

IT FELT LIKE WINNING THE GOLDEN TICKET. I HAD SET MULTIPLE ALARMS ON MY PHONE TO MAKE SURE I WAS ONLINE AND READY WHEN APPLICATIONS OPENED FOR THE 2024 REAL WORLD ANAESTHESIA COURSE (RWAC) IN ŌTAUTAHI CHRISTCHURCH. THE COVID-19 PANDEMIC HAD FORCED A THREE-YEAR HIATUS ON THE COURSE DELIVERY, LEADING TO A HUGE DEMAND AND INTEREST IN THIS COURSE. AND WITH VERY GOOD REASON. THIS TURNED OUT TO BE, HANDS DOWN, THE BEST FIVE DAYS OF POST-FELLOWSHIP EDUCATION I HAVE ENCOUNTERED.

The RWAC has its origins in Tasmania in the late 90s. Drs. Haydn Perndt and George Merridew had originally called it the Remote Situations, Difficult Circumstances, Developing Country Anaesthesia (RSDCDCA) course. Understandably, in due course, a name change was required. 'Real World' refers to the reality that 75% of the world's population live in low- and middle- income countries. Our anaesthesia training in rich countries such as Australia and New Zealand, is undertaken with automated end-tidal control software, state-of-the-art ventilation workstations, modern videolaryngoscopes and now, even AI-enabled ultrasound imaging systems. This does not prepare us for work in the Real World. Without pressurised gases and electricity, the 'modern anaesthetist' is up a creek without a paddle. Lack of fancy toys aside, there is still a great deal more to working in the Real World that is uncovered in this course – communication, culture and ethics to name just a few topics.

This was the fourth time that RWAC has been held in Christchurch. The first being not long after the devastating earthquake of 2011. Just being in the city was inspiring. There is still evidence of damage to buildings and infrastructure, but the resilience of the people and

This does not prepare us for work in the Real World. Without pressurised gases and electricity, the 'modern anaesthetist' is up a creek without a paddle. Lack of fancy toys aside, there is still a great deal more to working in the Real World that is uncovered in this course – communication, culture and ethics to name just a few topics.

the revitalised buildings everywhere made it a very exciting place to be. The tenacity, perseverance and grit of the city was evident everywhere. Visiting Christchurch in spring was also a delight. The gardens, the blossoms, the crisp air and the perfectly sunny spring days were refreshing. The city was buzzing with energy whilst also being surrounded by the tranquillity of nature. If you haven't been to Christchurch before, it should be on your to-do list. There is so much to see, do - and taste. The RWAC local faculty were very generous and show-cased their city with extracurricular activities throughout the five-day course, so it didn't feel like we were stuck inside missing anything.

What made this course especially amazing was the faculty. There were nearly the same number of instructors as there were participants, which not only provided incredible opportunities to learn but developed a real sense of camaraderie within the group. The course co-convenors Drs. Wayne Morriss, Ron Pereira and James Dalby-Ball were the absolute powerhouses of the course. They were so approachable - nothing was too much trouble for them. They are genuine and humble people, as were the rest of the faculty. Not only were there instructors from New Zealand, there were anaesthetists from around the world – Sierra Leone, Nepal, Fiji, the UK, Darwin and Melbourne. Instructors of all ages, bringing with them a huge amount of experience, expertise and enthusiasm to the RWAC. All there just for us. Amazing. Programmed throughout the course were presentations by the various instructors reflecting on their own journey and experiences providing healthcare in the Real World. So many stories and insights were shared; they were all truly inspiring. If any of them happen to be reading this – a huge thank you from all the participants. Your efforts were truly appreciated.

The operating theatre sessions for the RWAC were conducted within both the old and new parts of Christchurch Hospital. The remainder of the course was held at a facility called Manawa, right next to the hospital and the Avon River. Meaning heart, patience or breath in Te Reo Māori, Manawa is a brand new, purpose-designed, state-of-the-art health research and education facility. Furthermore, it has a great little coffee shop at the entrance - essential for the jetlagged

What made this course especially amazing was the faculty. There were nearly the same number of instructors as there were participants, which not only provided incredible opportunities to learn but developed a real sense of camaraderie within the group.

Aussies within the group! Manawa, the city of Christchurch and the amazing instructors provided the best foundations for a great course. The course content, refined over the last 30 years, is however, the fundamental reason why this course is so good.

One thing I was particularly looking forward to in the course was the in-theatre teaching about draw-over anaesthesia. As a trainee at Royal Hobart Hospital, I had previously had the opportunity to play with the components of draw-over circuitry, but never to a point where I would have felt comfortable actually using it. Getting to do so on consenting adults in a safe, monitored environment was a highlight of the course – well worth the protracted process of getting temporary New Zealand medical registration for it. For the instructors, it was a mammoth logistical task, which was carried out incredibly smoothly. The local anaesthetists tasked with actually looking after these patients were also amazing – they were incredibly obliging as we swanned in, did the fun stuff, then left.

Not only did we each get the opportunity to perform draw-over anaesthesia – we had some epic simulations. I won't provide any spoilers, but they were next level, very creative and a lot of fun. Think anaesthesia crisis with overlaid issues of language, culture and limited resources. Each scenario really put the pressure on, highlighted important non-technical points and provided a lot of opportunity for reflection (and laughs). The Manawa Simulation Centre and staff – especially anaesthetists Drs. Kelly Tarrant and Dan Hartwell, should be very proud of what they have developed – it is truly a world class, high-fidelity sim centre. The real star of the sim sessions, however, was the Oscar-deserving performance by Dr Elenoa Fesaitu, who put her heart, blood, sweat, tears and screams into her simulation. Totally next level!

The course content covered many other aspects of working in challenging environments – equipment maintenance, electrical safety, psychological adaptation, difficult clinical problems, preparing to go, ethics of aid, teaching, and much more. And nothing was sugar-coated. We were put under no illusions that global anaesthesia, whatever format, location or situation – none of it would be a walk in the park. The challenges facing global anaesthesia and surgical care are huge.

Thankfully, in addition to the lectures, workshops, simulations and reflections throughout the five-day course – we were provided with a course manual. This reference book has been carefully curated over the years, and is packed with a lot of useful information, making it an essential travel companion for any expedition.

During the week we were given opportunities to chat, debrief and depressurise with some extracurricular activities. If Dr Bryce Curran ever needs a career change – he would make a brilliant tour guide. He provided us with a running commentary as we bussed through the city and up into the beautiful Port Hills. On a sunny spring afternoon, we enjoyed walking (or running) in the hills, followed by the challenges of a "Clip 'N' Climb" indoor rock-climbing centre and tasting of some delicious local wines. We were totally spoilt. These opportunities really added the right amount of balance to this course.

To finish, I would like to quote three clever people.

Firstly - "I never went to a course where I enjoyed EVERY aspect of it". Dr Michael Kalkoff, RWAC 2024 course participant.

And next - "We need to advocate, educate and collaborate to provide the best possible care for patients worldwide. There are many opportunities for us to help our colleagues working in the Real World and this course will provide some of the knowledge and skills to make a difference". Dr Wayne Morriss, RWAC 2024 Convenor.

And last of all - "Be the change you wish to see in the world". Mahatma Gandhi (paraphrased).

As anaesthetists, we have been afforded so much privilege. We've already won the lottery; how about paying some of that forward? Do the world a favour and attend a future RWAC, then get out into the Real World.

Dr Shona Bright

Consultant Anaesthetist

ANZRA
AUSTRALIA NEW ZEALAND REGIONAL ANAESTHESIA

ACE
ANAESTHESIA
CONTINUING
EDUCATION

ASURA 2025

13-15 MARCH HOBART

AUSTRALASIAN SYMPOSIUM ON ULTRASOUND AND REGIONAL ANAESTHESIA

THE AUSTRALASIAN SYMPOSIUM ON ULTRASOUND AND REGIONAL ANAESTHESIA (ASURA) 2025 HELD IN HOBART DURING MARCH WAS A HUGE SUCCESS.

ASURA brought together almost 500 delegates from Australia, New Zealand and around the world to take a deep dive into ultrasound and regional anaesthesia.

There were over 70 different workshops and a full day cadaveric teaching session at the Menzies Medical Research Centre, Hobart. An astounding number of ultrasound machines came to Hobart to allow so many simultaneous teaching sessions, and we appreciate the support of Fuji-Sonosite, Mindray, GE Healthcare and Clarius.

Our international invited speakers were absolutely exceptional;

Dr Maggie Holtz from Atlanta, USA. Dr Holtz has a background in academia (Yale and Emory) and transitioned to become Medical Director of Regional Anaesthesia for a large group of private hospitals. Maggie shared her extensive expertise in relation to day case major joint replacement surgery, trauma anaesthesia, teaching strategies, and system management/efficiencies.

A/Prof Nadia Hernandez from Texas, USA drew on her experience at the largest trauma hospital in the USA and dazzled delegates with her renowned skills in POCUS and RA. Nadia's expert ability in ultrasound (used anywhere, in almost any situation) along with her dynamic style of teaching kept delegates entertained and engaged.

Prof Amit Pawa from London, UK, known worldwide as a champion of regional anaesthesia teaching, with an extraordinary ability to teach with clarity

ASURA has always been a workshop driven conference, with small group teaching and learning creating a productive experience and a strong atmosphere of collegiality within our subspecialty. Regional enthusiasts are so generous with their time and extremely friendly. I deeply appreciate and admire the huge number of over 50 ASURA volunteer teachers and speakers who give their time and enthusiasm to create a unique and positive learning experience for everyone.

and humour. Amit is widely published and much admired as a world class educator and innovator in the regional anaesthesia community. Amit's teaching at ASURA had a focus in RA for the trunk, but covered diverse areas including AI/ultrasound technology, RA for major joint surgery and awake breast surgery. I am certain the clarity of his teaching will inspire a new generation of delegates to listen in to his podcast "Block It Like It's Hot". Listen to Episode 28 for his wrap up on his experience at ASURA.

I have a deep respect and admiration for these three visiting international speakers. Delegates were enormously appreciative these exceptional teachers were willing to travel so far to inspire us all. We all enjoyed observing the collaboration and supportive relationships between the speakers and how they connected both with delegates and other plenary speakers. If anyone wants to share positive messages to thank our ASURA international speakers, they can be found on Instagram, X, Bluesky or LinkedIn (ASURA speakers would love to hear from their Kiwi and Aussie friends).

Hobart was a popular meeting venue and delegates enjoyed the local foodie scene, the crazy art at MONA, the charm of local architecture and the fun of the Salamanca markets. 2025 was also the first time ASURA offered fully sponsored scholarship positions for delegates from low income countries. As the accompanying article will describe, our scholarship winners from Fiji, Timor Leste and Malaysia were a much-welcomed addition to ASURA 2025 and we plan to make such scholarships a feature of future ASURA meetings.

As conference convenor I am appreciative of the excellent team that contributed to running such a logistically challenging technology and workshop driven meeting. The conference organising committee included; Dr Jana Vitesnikova, Dr Ranjita Sharma, Dr Alice Mulcahy, and Dr Pravin Dahal.

Thanks also to the ASA staff who expertly bring meetings to life and allow them to run smoothly, we are grateful to you all (including Rhian Foster, Rachel Cannon and the ASA crew who provided logistics support at the venue).

ASURA has always been a workshop driven conference, with small group teaching and learning creating a productive experience and a strong atmosphere of collegiality within our subspecialty. Regional enthusiasts are so generous with their time and extremely friendly. I deeply appreciate and admire the huge number of over 50 ASURA volunteer teachers and speakers who give their time and enthusiasm to create a unique and positive learning experience for everyone. ASURA is always a happy conference and I know that the ASURA 2025 delegates enjoyed this welcoming and inclusive atmosphere enormously. Thanks to all the speakers, workshop teachers, cadaveric session demonstrators and of course the delegates themselves who all together created a memorable, productive and fun ASURA 2025.

Dr Katrina Webster

ANZ-RA Chair

HELPING ANAESTHETISTS IN THE ASIA-PACIFIC:

The 2025 ASA-ASURA Scholarships

AT THE 2025 AUSTRALASIAN SYMPOSIUM ON ULTRASOUND AND REGIONAL ANAESTHESIA (ASURA), WE LAUNCHED A NEW SCHOLARSHIP INITIATIVE AIMED TO SUPPORT EDUCATION AND TRAINING OF ANAESTHETISTS FROM LOWER-MIDDLE INCOME COUNTRIES (LMICS) IN THE ASIA-PACIFIC REGION.

For many anaesthetists from LMICs, access to continuing education and international conferences can be prohibitive due to conference costs, accommodation and travel due to their weaker currencies and comparatively lower salaries. The organising committee of the 2025 Hobart ASURA conference felt very strongly that we establish a program to overcome this financial barrier for our colleagues in our geographical backyard.

To fund this, the committee allocated $10,000 from the conference budget. This initiative was met with immediate enthusiasm by the Australian Society of Anaesthetists, which contributed an additional $5,000. Together, this enabled us to award three fully funded ASA-ASURA scholarships each valued at $5,000.

Three highly deserving young anaesthetists Dr Karishma Naidu (Fiji), Dr Jonatas Madeira (Timor-Leste), and Dr Angelina Chong (Malaysia) were flown in and given complimentary accommodation and registration to ASURA. These three anaesthetists were identified as future leaders and trainers of regional anaesthesia in their countries by their host societies (Pacific Society of Anaesthesia, Asia-Oceania Society of Regional Anaesthesia). All three attended workshops to improve their own skillsets and a train-the-trainer session, so they can return as local champions in training the next generation of regional anaesthetists in their home countries.

I wish to thank critical individuals who shared and enabled this vision of international collaboration and equitable healthcare education to come to fruition: Ms Rhian Foster (ASA Education and Events Manager); Dr Katrina Webster (chair, ANZ-RA), Dr Justin Burke (chair, ASA Overseas Development and Education Committee); Dr Mark Sinclair (ASA President); and Dr Matt Fisher (ASA CEO). As we turn towards organising the next ASURA in Sydney 2028, the ASA-ASURA scholarship will return and continue this initiative.

Photo L to R: Prof Alwin Chuan, Dr Karishma Naidu, Dr Jonatas Madeira, Dr Angelina Chong, Dr Katrina Webster, Ms Rhian Foster.

I finish with some feedback from the 2025 scholars below.

"The main highlight was definitely being able to listen, learn and experience insightful discussions from Prof. Amit Pawa, A/Prof Nadia Hernandez, and Dr Maggie Holtz (all who are amazing educators in regional anaesthesia and POCUS whom I could only "see" on their social media platforms). I dare say every session I attended in ASURA were very helpful, applicable to my practice and were even good reminders on the details in various regional anaesthesia technique. The hands-on workshops, where we were able to practice and refine ultrasound-guided techniques under the guidance of excellent trainers. The interactive case discussions and POCUS live scanning sessions were also very beneficial in guiding me to apply them in my perioperative management currently. I am also grateful that with this ASA-ASURA scholarship, I was able to connect with various anaesthesiologists working in Australia, which I will always remember, alongside the amazing weather in the beautiful city of Hobart making it even more memorable.

Attending ASURA 2025 has inspired me to apply what was shared into my own practice and motivated me more in my passion for regional anaesthesia as part of my anaesthesia practice. I would like to thank ASA, ANZ-RA and the committee of ASURA 2025 for giving me this once in a lifetime opportunity to attend ASURA 2025!" **– Dr Angelina Chong**

"My key learnings included: discovering new applications of regional anaesthesia: learning about the feasibility and benefits of awake breast surgeries, which presents a promising option for patients in Fiji who are unfit for general anaesthesia. I was able to stay up-to-date with current best practices, acquired knowledge of the latest advancements in regional anaesthesia research and practices. It reinforced the importance of anatomical precision and its critical role of detailed anatomical understanding and mindful technique in minimizing nerve injury during regional blocks. Another valuable and cost-effective training technique for Fiji I learned was using a chicken breast for realistic needling practice, which I intend to impart on new trainees.

The exceptional live ultrasound sessions provided invaluable practical insights and enhanced visual learning. They facilitated hands-on learning with ultrasound and needling technique, enhancing practical skills. The expert keynote presenters delivered high-quality, evidence-based information, demonstrating strong leadership and expertise. Finally I had networking opportunities with over 400 anaesthetists.

Overall, ASURA 2025 was an exceptionally valuable, informative, insightful symposium. The key learnings and networking opportunities combined with the insights gained from the world class keynote speakers will undoubtedly improve my clinical practice, and enhance my understanding of regional anaesthesia. I am deeply grateful to the ASA for awarding me this scholarship, which provided an invaluable opportunity to experience this symposium firsthand and access cutting-edge information from leading experts in the field."
– Dr Karishma Naidu

Professor Alwin Chuan

Executive Committee, Australia and New Zealand-Regional Anaesthesia Board of Directors, Asia-Oceania Society of Regional Anaesthesia

PROFESSOR ALWIN CHUAN
CHAIR, SCIENCE PRIZES AND
RESEARCH COMMITTEE

FROM THE SPARC CHAIR

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

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

ENVIRONMENT & ANAESTHESIA
INNOVATION & ANAESTHESIA
SAFETY IN ANAESTHESIA

I invite members to apply for the multiple ASA research grants and prizes that are available in 2025.

Research Grants and Prizes for 2025

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

1. ASA Small Grants – deadline October 31

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

$3000 for each successful grant

2. ASA Annual Research Grant and scholarship – deadline June 30

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

Up to $75,000 over two years

3. Kevin McCaul Prize – deadline June 30

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

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

$11,000 for the successful applicant

4. National Scientific Congress (NSC) Canberra 2025 Presentation Prizes – deadline June 16

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

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

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

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

Canberra 2025 NSC abstracts submission portal https://asansc.com.au/call-for-abstracts/ or contact sdonovan@asa.org.au.

webAIRS

Dr Tim Basevi and the
ANZTADC Case Report
Writing Group

TRAINEE ENGAGEMENT WITH WEBAIRS:

ENHANCING PATIENT SAFETY THROUGH INCIDENT REPORTING

The role of anaesthetists in ensuring patient safety is paramount, and learning from past experiences is crucial to advancing our practice. The web-based Anaesthetic Incident Reporting System (webAIRS), established by the Australian and New Zealand Tripartite Anaesthetic Data Committee (ANZTADC), is a tool for capturing, analysing, and learning from anaesthesia-related incidents. While many consultant anaesthetists contribute to webAIRS, trainee involvement remains relatively low. Increasing trainee engagement with webAIRS presents a unique opportunity to enhance both education and patient safety.

Why Should Trainees Engage with webAIRS?

1. Educational Benefit – By contributing to webAIRS, we gain valuable insight into real-world anaesthetic incidents, develop a deeper understanding of patient safety principles and human factors in anaesthesia.

2. Fostering a Safety Culture – Reporting and reviewing incidents encourages open discussion about safety, reduces the stigma around adverse events, and promotes a proactive approach to risk reduction. webAIRS reporting can be utilised to correlate cases for morbidity and mortality meetings, facilitating structured discussions around adverse events and improving patient outcomes.

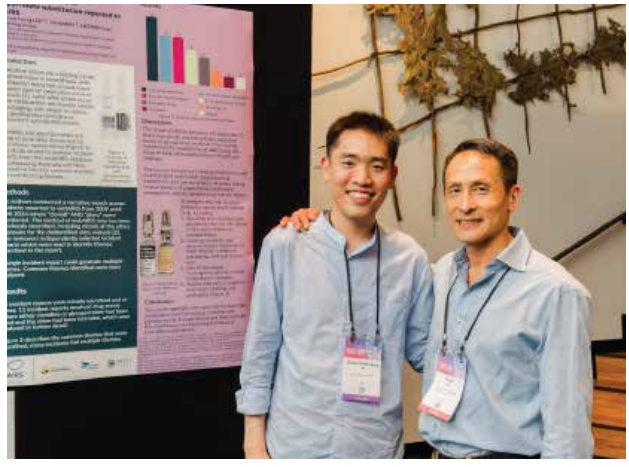
3. Professional Development – Involvement in incident reporting strengthens critical thinking and reflective practice, skills that are essential for anaesthetists at all levels. I have been a trainee representative on the ANZTAD Committee, giving me insight into the running of webAIRS, and the workings of committees in general. Some trainees have used webAIRS analyses for their audit or critical appraisal Scholar Role Activity, bridging the gap between theoretical learning and real-world application.

4. Influence on Future Practice – Data from webAIRS informs system-wide changes and guideline development, meaning trainee contributions can have a tangible impact on improving anaesthesia safety.

5. Opportunities for Research and Publication – Trainees can engage in projects with ANZTADC. Personally, I have worked on analyses of topics for Safety Advisory Notices, collaborated on newsletter articles, and provided feedback and editing of additional committee publications. Some trainees have progressed from webAIRS analyses to presenting their findings at conferences or publishing in scientific journals. For example:

- Dr Tom Curtis presented at the recent 2025 Annual Scientific Meeting (ASM) in Cairns on wrong-sided block
- Dr Shawn Lee recently presented his work on ampoule swaps at the 2024 ASM in New Zealand.
- Dr Clayton Lam has had his webAIRS analysis on GLP-1 receptor agonists accepted for publication in the *Anaesthesia and Intensive Care* journal. His work also formed the basis of his Scholar Role (critical appraisal of a topic), and he has since contributed to a podcast with the New Zealand Society of Anaesthetists and a video education session with the Australian Society of Anaesthetists.

6. Leadership and Advocacy – Being part of the webAIRS team provides an excellent platform for leadership and advocacy in anaesthesia safety. As the trainee representative on ANZTADC, I have had the invaluable opportunity to contribute to discussions shaping the future of anaesthesia incident reporting. The experience has deepened my understanding of quality improvement and patient safety at a systems level.



Anaesthetic Trainee Dr Shawn Lee presenting his poster at the ASM where he met Canadian Professor of Anesthesia and regional guru Dr Ki-Jinn Chin.

Conclusion

Trainees play a crucial role in fostering a culture of safety in anaesthesia. By actively participating in webAIRS, they not only contribute to a growing body of knowledge aimed at improving patient outcomes but also enhance their own learning and professional development. As the future of anaesthesia, trainees should embrace webAIRS as a tool for continuous improvement and patient safety.

For more information on how to report incidents or to get involved, visit the webAIRS website www.anztadc.net

DR MICHAEL LUMSDEN-STEEL
EAC CHAIR

ECONOMIC ADVISORY COMMITTEE

Summary of 2025 RVG Changes

THE ECONOMICS ADVISORY COMMITTEE WAS PLEASED TO PUBLISH THE 26TH EDITION OF THE AUSTRALIAN SOCIETY OF ANAESTHETISTS (ASA) RELATIVE VALUE GUIDE (RVG) IN LATE MARCH.

The 26th edition contains several important changes and clarifications that reflect ongoing developments in anaesthetic practice and Medicare policy. All members should thoroughly review these changes to ensure compliance with current requirements. To help with this, the ASA has produced a plain-language summary which clarifies the key changes to the RVG in 2025. ASA members can view and download a copy of this document in the **members area** of the ASA website[1].

This article also outlines the key changes to the 2025 RVG.

These changes are the result of extensive consultation with members, collaboration with the Australian Medical Association (AMA), and engagement with the Medicare Benefits Schedule (MBS) Review. These updates aim to better align our item numbers with contemporary anaesthetic practice, improve clarity for billing purposes, and ensure consistency between the ASA RVG and the AMA Fees List.

We encourage all ASA members to familiarise themselves with these changes, particularly the new time-based item structure and the amendments to existing items. The ASA continues to advocate for appropriate recognition of the complexity and value of anaesthetic services, and the updates in the 2025 RVG represent another step in this ongoing process.

New Items

CV056 for Transoesophageal Echocardiography

ASA item CV056 has been introduced to be equivalent to the recently added MBS item 22054 and AMA Fees List item CV056.

ASA Item No.	Units	Description	MBS Item No.	MBS Fee or Units (if different)
CV056 +PM +T	18	Intraoperative two-dimensional or three-dimensional real time TRANSOESOPHAGEAL ECHOCARDIOGRAPHY by an anaesthetist, where the service: (a) includes Doppler techniques with colour flow mapping and recordings on digital media; and (b) is performed during cardiac valve surgery replacement or repair); and (c) incorporates sequential assessment of cardiac function and valve competence before and after the surgical procedure; and (d) is not associated with a service to which item CS936, CV730 or CV740 applies; and is provided on the same occasion as the administration of anaesthesia by the same anaesthetist.	22054	

ASA Time Items (T0015-T2400)

A new set of comprehensive items for recording anaesthesia/perfusion time under ASA guidelines has been introduced. The appropriate time item can be identified using the duration of anaesthesia in hours and minutes preceded by the prefix T-.

- From 00:01 hours to 02:00 hours units are allocated at one per 15 minutes.
- After two hours, time units are allocated at one per 10 minutes.
- After four hours, time units are allocated at one per 5 minutes (note that beyond four hours the MBS calculates time units differently).

Handy hint: *the RVG app was recently updated so ASA members can now use the Time Unit calculator in the app to calculate the applicable ASA Item / MBS Item numbers and their respective unit values.*

New MBS Item (22032) for Regional Catheter Insertion for Post-Surgery Pain Relief

A new 4-unit item for inserting regional nerve block catheters for post-surgery pain relief, in association with anaesthesia will be available in the MBS from March 2025. The ASA equivalent is **CV083** - 5 units. There is no MBS item for the use of Ultrasound (US) for the vascular access or nerve blocks in association with anaesthesia, the respective ASA items for US guide vascular access and nerve blocks are **CV800** and **CV805**.

ASA Item No.	Units	Description	MBS Item No.	MBS Fee or Units (if different)
CV083	5	Perioperative introduction of a plexus or nerve block to a peripheral nerve, using an in situ catheter in association with anaesthesia and surgery, for post operative pain management (4 basic units).	22032	

Amended Items

Item Code Realignments

To tidy clerical variations between the ASA RVG and its replication within the AMA Fees List, the ASA has agreed to amend several item codes to match their AMA equivalents. This was required due to limitations within AMA Fees List policy on revising or reusing existing item codes. These changes are primarily administrative in nature, designed to harmonise the ASA RVG with the AMA Fees List. This alignment simplifies coding and billing practices, reducing administrative burden and potential confusion when cross referencing between the different fee schedules.

Item Code Realignments (CD570/CD575)

ASA Item No.	Units	Description	MBS Item No.	MBS Fee or Units (if different)
CD570 +PM +T	8	- percutaneous procedures on the pericardium		
CD575 +PM +T	20	- percutaneous replacement of a heart valve		

Perineal procedure codes have been reorganised (CH903/CH905/CH907)

ASA Item No.	Units	Description	MBS Item No.	MBS Fee or Units (if different)
CH905 +PM +T	5	- for percutaneous perineal procedures on an intra-pelvic organ		
CH907 +PM +T	12	ANAESTHESIA for microvascular free tissue flap surgery involving the perineum	20905	10

Blood transfusion item CV000 is now CV040

In November 2024, the AMA Fees List agreed to replicate all the changes to the 2024 RVG, including the new ASA item CV000. Their system wouldn't allow item code CV000, so they instead used CV040. In the 2025 ASA RVG, the item code for CV000 has been changed to CV040 to align with the AMA.

ASA Item No.	Units	Description	MBS Item No.	MBS Fee or Units (if different)
CV040 +PM +T	6	TRANSFUSION OF BLOOD by an anaesthetist, including collection from donor, when used for intra-operative normovolaemic haemodilution, where the service is provided on the same occasion as the administration of anaesthesia by the same anaesthetist	22052	

CV001 Description Amended to Clarify it can be used for Cell Salvage

With the introduction of **CV000/CV040** the AMA Fees List identified **CV000/CV040** was a higher unit value and appeared to overlap with **CV001**, consequently the AMA Fees List removed **CV001**.

The ASA notes that **CV001** is not directly equivalent and covers broader services than **CV000/CV04**. Notably collection of blood by an anaesthetist where they are not transfusing the blood themselves.

This amendment to **CV001** clarifies the coverage of intraoperative cell salvage techniques and returns the unit value to its previous level. This change reflects evolving practices in blood conservation strategies and ensures appropriate valuation of these important techniques.

ASA Item No.	Units	Description	MBS Item No.	MBS Fee or Units (if different)
CV001 +PM +T	3	COLLECTION OF BLOOD FOR AUTOLOGOUS TRANSFUSION (including collection by intra-operative cell saver in non-cardiac surgery) when performed in association with the administration of anaesthesia. CV001 cannot be used in conjunction with CV040		

CV002 Description Alignment with MBS

On 1 November 2024, MBS item **22002** was amended, with the Department explicitly clarifying this change allows **22002** to be claimed for intraoperative cell salvage. The description of **CV002** has been amended, expanding the item's scope to align with the amended description of item **22002** in the MBS, ensuring consistency between the schedules and reducing potential confusion or claim rejection.

ASA Item No.	Units	Description	MBS Item No.	MBS Fee or Units (if different)
CV002 +PM +T	4	ADMINISTRATION OF BLOOD or bone marrow, when performed in association with the administration of anaesthesia	22002	

Implementation Guidance

These changes took effect from 1 April 2025. By now all ASA members should have:

1. Downloaded a copy of our plain-language **Summary of 2025 RVG Changes** in the members area of the ASA website at https://asa.org.au/publications/relative-value-guide
2. Updated your practice management software to reflect these changes
3. Informed administrative staff on the new and amended item numbers
4. Reviewed your billing practices to ensure alignment with the updated RVG.

The ASA Policy Team is available to assist members with any queries regarding these changes and can be contacted via email at policy@asa.org.au.

References

[1] https://asa.org.au/publications/relative-value-guide

MBS pre-anaesthesia consultation requirements

The conduct of pre-anaesthesia consultations continues to be an area of compliance discussion within the Department, particularly for high volume turnover lists such as endoscopy, urology and lens surgery day procedures.

Members must be aware that MBS pre-anaesthesia consultations (17610-17625) have both **time AND complexity requirements**, both of which need to be fulfilled to meet MBS requirements.

You should also ensure that you have read and are familiar with the relevant explanatory notes that are associated with MBS items. Pre-anaesthesia consultations that are undertaken on critically unwell patients, including intubated and ventilated ICU patients, are eligible MBS service.

For pre-anaesthesia, the relevant note is contained within the MBS book at TN.6.1.

> *Pre-anaesthesia consultations are covered by items in the range 17610 – 17625*
>
> *Pre-anaesthesia consultations comprise 4 time-based items utilising 15 minute increments up to and exceeding 45 minutes, in conjunction with content-based descriptors. A pre-anaesthesia consultation will attract benefits under the appropriate items based on **BOTH** the duration of the consultation **AND** the complexity of the consultation in accordance with the requirements outlined in the content-based item descriptions.*
>
> *Whether or not the proposed procedure proceeds, the pre-anaesthetic attendance will attract benefits under the appropriate consultation item in the range 17610 - 17625, as determined by the duration and content of the consultation….*

Note TN 6.1 also provides further guidance on the utilisations of the appropriate Items in common clinical situation.

The anaesthetist must perform the pre-anaesthesia consultation, or be directly supervising a registrar doing so, for the purpose of claiming an MBS item for the consultation. This cannot be delegated to another healthcare provider.

Further detail an anaesthetist must be aware of is at **TN.10.7 General Information:**

> The Health Insurance Act 1973 provides that where anaesthesia is administered to a patient, the premedication of the patient in preparation for anaesthesia is deemed to form part of the administration of anaesthesia. The administration of anaesthesia also includes the pre anaesthesia consultation with the patient in preparation for that administration, except where such consultation **entails a separate attendance carried out at a place other than an operating theatre or an anaesthesia induction room.**
>
> The pre-anaesthesia consultation for a patient should be performed in association with a clinically relevant service…

Further notes you should be aware of are:

> ***Note GN.6.16 Referral Of Patients To Specialists Or Consultant Physicians** provides the exception that anaesthetist do NOT a require written referral to undertake a pre-anaesthesia consultation performed by a specialist anaesthetist.*
>
> ***TN.10.3 RVG Unit Values***
>
> ***As per clause 5.9.5 of Schedule 1 of the GMST, all RVG items 23010 to 24136 apply to a service provided to a patient under anaesthesia, but only if the anaesthesia start and end times are recorded in writing.***

ASA podcasts

Dr Suzi Nou discusses requirements for pre-anaesthesia consultations in the ASA Talking Money podcast Episode 8 (September 2022); and in Episode 11 (March 2023) where she interviews Past President, Dr Andrew Mulcahy.

The Australia Anaesthesia podcast series and ASA Talking Money podcast series were created exclusively for ASA members and can be found at https://asa.org.au/asa-public-podcasts.

ANAESTHESIA IN WAR

Examples from the Harry Daly Museum

ONE OF THE FEW 'BENEFITS' OF WAR THROUGHOUT TIME HAS BEEN THE RAPID DEVELOPMENT OF MEDICAL EXPERTISE IN RESUSCITATING AND TREATING MASS CASUALTIES. AT THE TIME OF WAR, THIS WAS CHALLENGED BY DIFFICULT AND DANGEROUS ENVIRONMENTS, VERY LIMITED SUPPLIES OF DRUGS AND EQUIPMENT AND INADEQUATE NUMBERS OF TRAINED PERSONNEL.

The first war anaesthesia was used in was the American – Mexican war (1846-1848), and anaesthesia has been used in every conflict ever since. During the American Civil War (1861-1865), the Union army directed that an assistant surgeon be in charge of anaesthesia. As the Union army slowly encircled the Confederate army and strangled their supply lines, circumstances became so dire that the decision had to be made whether to have either chloroform or coffee only available for the soldiers. Fortunately for the wounded undergoing surgery, chloroform was chosen.

The Harry Daly Museum has items pertaining to the different theatres of war.

The Corfe-McMurdie Inhaler (WW1)

This inhaler was made at the 2nd Australian Casualty Clearing Station (2nd ACCS) in Blendecques, France, 1918, by Private Eric McMurdie (1890-1980). He was an optician from Geelong who constructed the inhaler from discarded shell casings and American Horlick's malted milk bottles. It was designed and used by Captain AJ Corfe (1876-1942) for the administration of ether and chloroform. The rubber connecting tubing has perished years ago. The glass vaporising bottles were hand engraved with measures and 'E' and 'C' for ether and chloroform.

Corfe practised in Glen Innes, NSW, for most of his life and enlisted in WW1 at age 40. He died in 1942 and his only child, Dudley Corfe, was killed a year later while serving with the RAAF.

The 2nd ACCS was mobilised from Albert Park, South Melbourne, in 1915. At the Battle of Messines in June 1917, they received 2,017 wounded in the first 20 hours and evacuated 2,000. In the first month, they performed 1,625 operations using only four operating tables. The 2nd ACCS were also pioneers in using early X-ray apparatus taking images in two planes and localizing shrapnel and other foreign bodies within a centimetre.

The date on the inhaler is 25 May 1918. The diary of the 2nd ACCS the day before states:

No 10 stationary hospital, St Omer, bombed 2 nights ago 2 medical officers killed + …orderlies and patients …

Medical and nursing staff are always at risk in war. The Corfe-McMurdie Inhaler is on permanent loan to the museum from Dr David Whish.

The Trilite Inhaler (WW2)

This portable light inhaler used trichlorethylene (Trilene) and has the obvious comparison to handheld analgesic inhalers using methoxyflurane as used by ambulance services in Australia today. It was designed to be robust, and used by non-medical personnel with minimal instruction.

The Trilite was developed by Dr John T. Hayward-Butt in England, with the advice and encouragement of Dr C Langton Hewer, for use in the field during World War II. Hayward-Butt was called up in 1940 while an anaesthetic registrar and designed the Trilite Inhaler while serving with the Royal Navy. However, the inhaler was neither patented nor reported upon until 1947.

It held a 6ml trilene glass ampoule - this was broken by the plunger and the wick soaked with trilene which was wrapped around a small vaporising chamber. The carrier gas was room air. It required about 20 breaths to achieve analgesia, and one glass ampoule lasted about 60-90 minutes. Other small trilene vaporisers were later developed and used for obstetric analgesia. Quantitative bench testing 45 years later in 1990 supported Hayward-Butt's initial assessment with a consistent vaporiser output at different temperatures.

These two pieces of equipment in the Harry Daly Museum exemplify the innovation and rapidity of design, manufacture and implementation of anaesthesia equipment to overcome the challenges of anaesthesia and analgesia in wartime conditions.

Dr Michael G Cooper AM

Honorary Curator
Harry Daly Museum

AROUND AUSTRALIA

Queensland

Dr Brett Segal

Chair of the Queensland Committee of Management

Surgery Connect/out-sourced public in private work

There is a still a large volume of work being outsourced from Queensland Health, making up a variable component to private hospitals' workload. The source of funding can be variable from central funding from QHealth in Charlotte Street and directly outsourced work from individual Hospital and Health Services. There are different levels of funding from these sources and anaesthetists should attempt to negotiate with their facilities. A reminder that collective bargaining can be done but do complete an ACCC Collective Bargaining exemption form prior to entering negotiations.

Task Substitution

Queensland is on high alert for task substitution from other non-medical groups providing anaesthesia or sedation services in some of our more remote and challenging environments. Recently published data from the British Medical Association shows the dangers and harm that is coming to their members' patients in the UK, with some astonishing claims. I would encourage all members to read this and to discuss with your local executives to not entertain this flawed plan. https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/workforce/physician-associates-and-anaesthesia-associates

ASA Queensland participated and supported ANZCA's Queensland Trainee Committee's Introductory Course in February for the new trainees on the Queensland training scheme. It was a well-attended, both face-to-face and online event. Following the course, the ASA hosted a small social gathering at a local watering hole where new and existing trainees came together with some members of the committee. It was a good opportunity to recruit some new trainee members.

We continue to sponsor the ANZCA Primary and Final Examination Mock Viva nights in Brisbane.

Western Australia

Dr Archana Shrivathsa

Chair of the Western Australian Committee of Management

ASA (WA) State Committee

Our state committee has been hard at work tackling private obstetric anaesthesia and accreditation and credentialling issues affecting WA members. With the re-election of the Cook Labor government at the March election, we anticipate significant changes in both public and private health landscapes in WA, hopefully to the benefit of our patients.

WA ACE Lecture Series

Building on the momentum of 2024 when the WA ACE Lecture Series pivoted to a more dynamic, accessible experience, the WA office continues to push the envelope. This shift not only brings focus to emerging issues but also offers a wider range of topics and emergency response activities, keeping up with the rapidly changing CPD landscape.

Band-aids Don't Fix Bullet Holes: An Update in Pain – 4th March

The WA ACE Lecture Series for 2025 kicked off with the first session for the year, *Band-aids Don't Fix Bullet Holes: An Update in Pain* delivered by Dr. Brien Hennessy, Consultant Anaesthetist at Sir Charles Gairdner Hospital.

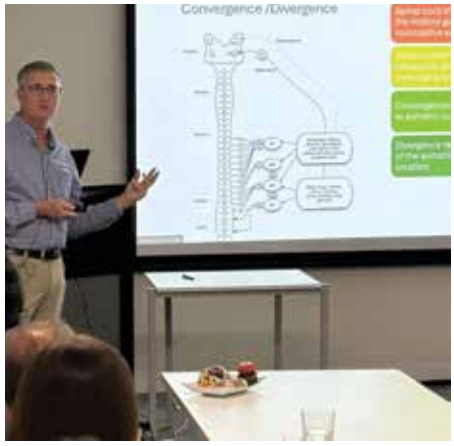
With 17 attendees in person and another 45 joining from the comfort of their homes, it was clear that this wasn't your average lecture. Dr. Hennessy's expertise hit the mark like a swift strike, leaving everyone in awe of the nuanced approaches to pain management that are shaping the future.

HOCUS POCUS Gastric and Lung Ultrasound Workshop – 27th March

For the "Spellbound Scans: Hocus Pocus Gastric and Lung Ultrasound Workshop" held on 27 March, the ANZCA WA team transformed the office into an ultrasound clinic, creating an immersive and hands-on learning environment.

The workshop was designed to address the evolving landscape of gastric scanning in light of the changes to GLP-1 guidelines, and the opportunity to learn basic lung ultrasound for anaesthetists. The delegates engaged in hands-on scanning sessions with live models with empty (fasted) and full stomachs, guided by expert facilitators and with ultrasound equipment kindly provided by Phillips, SonoSite and GE.

Thank you to Dr Adrian Goudie, Emergency Physician, FSH, Dr Joyce Leong, Paediatric Emergency Physician, FSH, Dr Matt Haggett Anaesthetist, RPH, Mr Simon Ferrero Sonographer, FSH, Dr Kiran Venkateslu Anaesthetist, RPH for facilitating this event.



ACE WA Country Conference 2025 – Kimberley Dreams & Trauma Teams, Broome 13-15 June 2025

Registrations are now open for the 2025 ACE WA Country Conference in beautiful Broome at the Cable Beach Club Resort.

Convenors Dr Pallavi Kumar (Fiona Stanley & Fremantle Hospitals) and Dr Kiara van Mourik (Royal Perth Hospital) have put together a dazzling academic and workshop program covering the management of injured patients across this vast state. Malignant hyperthermia, Acute Severe Behavioural Disturbance (ASBD) and regional workshops will be offered, as well as a Trauma Skills and Aeromedical Thrills tour of the Broome RFDS base.

We look forward to seeing you in June in sunny Broome!

Registration and the program are available at https://www.anzca.edu.au/events-and-courses/2025-wa-ace-country-conference

South Australia / Northern Territory

Dr Nicole Diakomichalis

Chair of the South Australia / Northern Territory Committee of Management

The SA/NT Committee met in person this March to discuss various issues effecting the anaesthesia workforce. The most notable issue was the work being done with Return To Work SA (RTWSA). Anaesthetic services have had a fixed rebate for the last 14 years in SA. The AMA have been negotiating with RTWSA for an increase in this rebate. RTWSA provided a proposal for review and feedback. We provided this to our members and sent out a survey asking for feedback on this proposal. Overwhelmingly the response was that whilst this proposal did reflect a much needed increase in remuneration, it still fell below the national standard for anaesthesia services. We await further response from RTWSA. Thank you to Dr Louis Papillion and the AMA for all of their hard work advocating for the anaesthetists in SA.

We are in the process of organising the Part 3 course for this year as well as other networking events such as Bright Young Things, an event open to new consultants.

DIANA CORALINE STRANGE KHURSANDI

30th April 1941 – 23rd December 2024

IT IS WITH GREAT SADNESS THAT I ACKNOWLEDGE THE RECENT PASSING AWAY OF MY COLLEAGUE, MENTOR AND FRIEND, DR. DIANA STRANGE KHURSANDI.

Diana was well known, not just within our College and Society but also more widely by the medical fraternity including colleagues specialising in doctors' health and welfare, and hundreds of junior doctors, IMGs and GPs.

Di was born and raised in England and completed her medical training in Oxford, Cambridge, and London, obtaining her British Fellowship in anaesthesia in 1972. In 1977, she migrated to Australia with her then husband, orthopaedic surgeon Dr Jim Khursandi, and their three little girls, Isobel and twins Catherine & Alice. They both took up specialist posts in Maryborough, Queensland.

Di was the sole specialist anaesthetist in town for ten years, providing the service along with GPs. She tackled this challenging role with passion and determination as she set about expanding and modernising the department. Within a few years she had established an ICU, a pre-anaesthetic clinic and many other changes. Over time, other specialist anaesthetists joined her and then the Hervey Bay hospital was opened as well.

Life was full, extremely busy and demanding. Her priority was her three girls for whom she sought to provide rich and meaningful childhood experiences. In addition to her work and family commitments, she also participated in madrigal singing, violin playing and crafts including quilting and crochet. She also maintained a magnificent garden.

She was elected to Royal Australasian College of Surgeons Faculty of Anaesthetists Fellowship in 1983 and elected to ANZCA Council in 1998 where she served for eight years. Di used her time on Council to advocate passionately and persistently for anaesthetists' health and welfare and was successful in founding the Welfare of Anaesthetists SIG (now the Wellbeing SIG). This was a ground-breaking effort unmatched at that time by any other medical College in our region. The SIG has gone from strength to

strength and raised awareness of health and welfare issues, helped foster a culture of care and support in our anaesthetic community, as well as continuing to provide educational resources on a range of topics.

Her efforts in welfare were fuelled by her own (and her mother's) experience of severe depression, described in a poignant article published in the BMJ in 19981 as well as personal knowledge of many anaesthetists and intensivists over the years troubled by battles with physical and mental health issues, substance misuse and tragic suicides and deaths.

Other trailblazing efforts include her publications of a study on gender issues in 19982 and a survey of anaesthesia retirees in 20213, both published in Anaesthesia & Intensive Care.

In 1997, Diana left Maryborough and relocated closer to Brisbane, to Caboolture Hospital. In 2004, she retired from clinical anaesthesia and took on roles as deputy Director of Clinical Training, which broadened her sphere of responsibility and nurturing, meeting the educational and psychological needs of junior doctors and IMGs working in Queensland Health hospitals.

However, besides founding and being the inaugural chair of the Welfare of Anaesthetists SIG, Di's interests extended way beyond welfare. She held several key roles within the ANZCA structure, in Education & Training, Quality & Safety, Rural SIG Chair, as well as gender equity and workforce issues, particularly for regional and rural services. She also served on the ASA Queensland state committee (1998-2007).

She was a medical adviser for QCAT for several years. She was also a member of the Postgraduate Medical Council of Queensland's Accreditation committee and Assessment subcommittee. She participated in PESCIs (pre-employment structured clinical interviews) for several years. She was a member of DHAS Queensland's committee for many years, as well as a member of the Southern Cross Orchestra's board. She was often asked to present or facilitate on a range of topics, most frequently doctors' health or retirement, at ANZCA, ASA, Rural SIG and other meetings.

She was elected to Royal Australasian College of Surgeons Faculty of Anaesthetists Fellowship in 1983 and elected to ANZCA Council in 1998 where she served for eight years. Di used her time on Council to advocate passionately and persistently for anaesthetists' health and welfare and was successful in founding the Welfare of Anaesthetists SIG (now the Wellbeing SIG). This was a ground-breaking effort unmatched at that time by any other medical College in our region.

Over the years, Di had been a powerful, passionate and persistent advocate for not only many generations of anaesthetists and trainees, but also junior and rural doctors, as well as international medical graduates.

In 2010, Di was honoured with the ANZCA Medal acknowledging her many years of outstanding contribution.

In addition, she was memorable for her warmth and compassion, her considerable empathy and her ability to make any conversation with her personal and caring. She was humorous and cheeky with a characteristic wicked laugh. She was musical, continuing with her violin lessons up to the last few months of her life. She was a voracious reader and loved telling her many grandchildren stories and sharing their dreams. She enjoyed watching quiz shows. She adored ballet, symphony music and opera. She enjoyed quilting, making every member of her family quilts they will treasure, and crocheted rugs and squares for charity. She loved hosting 'crafternoons' for cups of tea, crafting and chatting.

Diana was regularly sought after by generations of anaesthetists for advice, or just a comforting ear, someone with whom to share stories and troubles. Her advice was always sensible and wise.

Di's last years were troubled by chronic renal failure requiring thrice weekly dialysis, as well as many other serious health issues. Still, she bore her hospitalisations and illnesses with great courage and determination, managing trips to the UK to visit her twins and other family members and friends as well as her other commitments, plus concerts, plays and meetings. She passed away peacefully, in hospital, after a short illness on December 23rd, surrounded by her loving family.

Di was a unique, wonderful friend and mentor to me and many others. She is greatly missed.

She is survived by her three daughters, Isobel, Catherine and Alice, their partners, a host of wonderful grandchildren, and her two ex-husbands, Dr Jim Khursandi and Prof John Gibbs.

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2. Unpacking the burden: gender issues in anaesthesia Anaesthesia & Intensive Care 1998 Feb
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Dr Genevieve Goulding

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