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

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WHEN A COLLEAGUE IS SUFFERING

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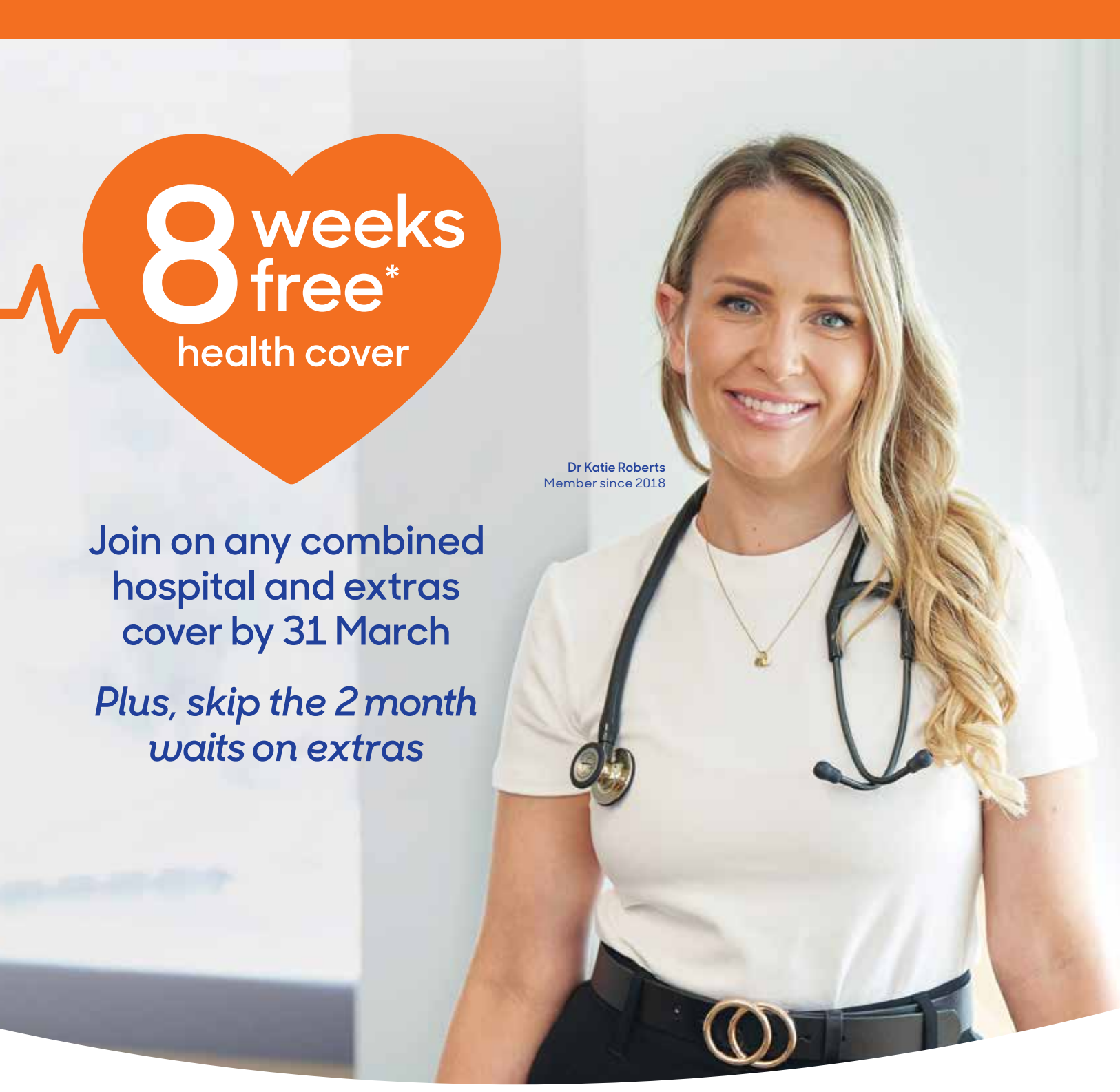

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AUSTRALIAN
Anaesthetist
THE MAGAZINE OF THE AUSTRALIAN SOCIETY OF ANAESTHETISTS

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

LETTERS TO AUSTRALIAN ANAESTHETIST:
Letters are welcomed and will be considered for publication on individual merit. The Medical Editor reserves the right to change the style or to shorten any letter and to delete any material that is, in his or her opinion, discourteous or potentially defamatory. Any major revisions required will be referred back to the author for approval. Letters should be no more than 300 words and must contain your full name and address. Please email editor@asa.org.au to submit your letter or to contribute.

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Contents

Would you like to contribute to the next issue?

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

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

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

DR MARK SINCLAIR
PRESIDENT

FROM THE ASA PRESIDENT

WELCOME TO THE FIRST EDITION OF *AUSTRALIAN ANAESTHETIST* FOR 2025. THE THEME OF THIS EDITION IS 'WELLBEING'.

Doctors have a well-earned reputation for being neglectful of this aspect of their lives, while of course striving to maintain and improve the lives of their patients, but things are no doubt changing. I hope you enjoy reading these articles, and we are, as always, most grateful to our contributors for sharing their expertise and interest in this area.

Of course, a number of other issues continue to need our input. To this end, I express my gratitude to the President of the Association of Anaesthetists (Great Britain and Ireland), Dr. Tim Meek, for his article on UK anaesthesia associates, published in this edition (page 13). As discussed in previous editions of *Australian Anaesthetist*, Australian initiatives aimed at expansion of the scope of practice of non-medical healthcare professionals are well underway. In some cases they are already established (eg. independent diagnosing and prescribing by pharmacists for certain conditions). The ASA, ANZCA and AMA will of course, along with other medical Colleges, Associations and Societies, continue to monitor these initiatives, and remain actively involved.

On 23rd December 2024, the Medical Board of Australia formally confirmed that appropriately qualified Specialist International Medical Graduates (SIMGs) from the UK and Ireland will be eligible for the Expedited Specialist pathway for anaesthesia (and also for general practice and psychiatry). These SIMGs will now be able to apply directly to the Australian Health Practitioner Regulation Agency (Ahpra) for registration as specialist anaesthetists, without the involvement of any other educational or accreditation body. Fellowship of the College of

These SIMGs will now be able to apply directly to the Australian Health Practitioner Regulation Agency (Ahpra) for registration as specialist anaesthetists, without the involvement of any other educational or accreditation body.

By the time of publication of this edition of Australian Anaesthetist, there will no doubt have been further developments. ANZCA has re-stated its commitment to supporting and providing a pathway for SIMGs which will lead to qualification as a FANZCA.

Anaesthesiologists of Ireland (FCAI) or of the Royal College of Anaesthetists (FRCA) will be required. Importantly, as 'Fellowship' of these Colleges does not necessarily mean the full training programme has been completed, a Certificate of Completion of Training issued by the UK General Medical Council or the Medical Council of Ireland will also be required. Additionally, all candidates will be required to complete an Effective Management of Anaesthetic Crises (EMAC) course and will require a period of supervision as they integrate into the Australian healthcare system.

By the time of publication of this edition of *Australian Anaesthetist*, there will no doubt have been further developments. ANZCA has re-stated its commitment to supporting and providing a pathway for SIMGs which will lead to qualification as a FANZCA. As highlighted previously, ANZCA has always done very well in this area, in terms of making the process as efficient as possible for SIMGs and their employers. But attainment of FANZCA is not compulsory for these SIMGs. So at present, a number of questions remain unanswered. Among these are: who will act as 'supervisors'? To whom will 'supervisors' report, and who will assess/approve such reports? Will they be financially compensated for their time by Ahpra if working separately to ANZCA, and will they require extra professional indemnity cover? To whom will non-FANZCAs turn if they require professional or psychological support (resources which are well and truly available to FANZCAs)?

I express my personal thanks to ANZCA President Prof David Story for keeping the ASA up to date on these matters. ANZCA representatives met with senior representatives of the federal Department of Health and Aged Care in mid-December, just prior to the Medical Board confirming the arrangements for SIMG anaesthetists. The lack of transparency in the process to date was highlighted by ANZCA, but also the fact that ANZCA remains keen to collaborate in the supervision and assessment of SIMGs. The concerns regarding legal liability of assessors and supervisors, if working independently of ANZCA (as ANZCA currently takes on this liability), were also made clear.

Members are encouraged to watch their email inboxes for our regular electronic updates, such as the monthly President's E-news, and also the College website anzca.edu.au for up-to-date information as it comes to hand.

Dr Mark Sinclair

MB BS, GAICD, FANZCA

FROM THE CEO

DR MATTHEW FISHER
CHIEF EXECUTIVE OFFICER

WELLBEING - A SIMPLE CONCEPT THAT IS SO IMPORTANT, AND OFTEN ORGANISATIONAL INITIATIVES HAVE BEEN DRIVEN AS AN AFTER-THE-EVENT BY PEOPLE WHO WANT TO MAKE A DIFFERENCE TO ENSURE PEOPLE DO NOT GO DOWN A DIFFICULT PATH. FOR EXAMPLE, LIFELINE WAS FOUNDED IN 1963 BY THE LATE REVEREND DR SIR ALAN WALKER WHO HAD RECEIVED A CALL FROM A DISTRESSED MAN WHO LATER TOOK HIS OWN LIFE. DETERMINED NOT TO LET ISOLATION AND LACK OF SUPPORT BE THE CAUSE OF MORE DEATHS, HE LAUNCHED A 24-HOUR CRISIS SUPPORT LINE. LIFELINE NOW ANSWERS OVER A MILLION CALLS A YEAR FROM AUSTRALIANS IN EMOTIONAL DISTRESS OR CRISIS, MADE POSSIBLE THROUGH THE EFFORTS OF 1,000 STAFF AND 10,000 VOLUNTEERS,

From its formation, the ASA continues to be committed to supporting your wellbeing and affirms this as part of our operations through our priority of supporting the welfare and wellbeing of members and in operating the Benevolent Fund for necessitous circumstances.

We have all been exposed personally and/or professionally to challenges to wellbeing, whether that be yours, mine, or someone else's. How we actively respond is important. At a personal level as the father of two boys, I have been acutely aware of the statistics related to young males and the potency of RUOK and sharing time, particularly on road trips. Another personal example from what seems a lifetime ago was as a Victorian surf coast lifeguard experiencing, through the communications system, the tragedy of a friend on a separate beach ten kilometres away and the efforts of the lifeguard 'family' to respond to the critical incident. The impacts were significant on us all and even though it occurred more than 30 years ago, the memory and trauma can make it feel more recent for all involved. The 'good' that came from this tragedy was an operational review and a change in systems and processes to minimise risk and the likelihood of a repeat. What was affirmed through this experience was the wrapping of arms around the lifeguard family by the family as we needed the trust and confidence in one another when it mattered. That spirit, culture and care still exists within that group today when our paths cross even though we bear little resemblance to what we once were.

As a CEO, the wellbeing of an organisation at an entity and people level is foremost. At an entity level of a membership organisation, the metrics of wellbeing can be straightforward. Are we achieving what we set out to do? Is the culture of the organisation appropriate and positive to underpin what we do and reflect the values of the ASA? Is our membership

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What was affirmed through this experience was the wrapping of arms around the lifeguard family by the family as we needed the trust and confidence in one another when it mattered.

growing, satisfied, and engaged with what we are doing? Are we growing the equity (financially, socially and reputationally) of the business to ensure we can achieve with the intent to evolve and exist for the next 90 years? I can only comment on my experiences to date that have been in building on the platform of achievement over the first 90 years. The objective answer would be yes and the layers in that answer can be unpacked over time by others.

Throughout the year we will provide updates on the progress of the ASA in what we are doing on your behalf.

At an operational people level, we come from a value base of support and respect where trust, honesty and teamwork are at our core to act in the best interests of the ASA now and into the future. Our formative experiences, in my case as a (not extensive and in no order) child, father, partner, younger brother, friend, dinosaur lifeguard, CEO and board director, have shaped me. As I age, the perspective changes and the focus on wellbeing amplifies. To paraphrase Beyonce in her beautiful song I Was Here (yes, my music tastes grounded in Australian pub rock are broad) - I want to leave my footprints on the sands of time. Know there was something that I left behind. The hearts I have touched, will be the proof that I leave. Left this world a little better just because I was here.

Attending to people and wellbeing can do that.

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**

WHEN A COLLEAGUE IS SUFFERING

Grief and guilt persist, tenacious in the gut, as a huge hollow, like a crater pit, ready to erupt at the whiff of a familiar scent, or the trill of a beloved tune, or the flickering of the moon.

Anger, too, percolates subliminally. Surely he must have known how much we valued his skills, his wry humor, and his gentle ways.

What consuming darkness persuaded him to end his days?

FROM THE POEM APRIL PAIN: AFTERMATH OF A COLLEAGUE'S SUICIDE

BY KATHRYN E. MCGOLDRICK, M.D.

I began my training in obstetrics and gynaecology 33 years ago and over that entire one third of a century I have been aware that depression and suicide are particular risks for my anaesthetic colleagues. Although I have not, personally, known of an anaesthetist who has taken their own life, many of the anaesthetists with whom I work have experienced such losses.

In a recent comprehensive review, Harvey and colleagues[1] state that:

"Being a physician has long been considered one of the most rewarding and sought-after occupations. However, this work also comes with stressors, some unique to the medical profession, others typical of high-pressure, highly skilled occupations. International attention on mental ill health and suicide among physicians has increased. In the medical community, this concern has escalated after a number of high-profile suicide clusters among physicians and, over time, by an increasing amount of data highlighting high rates of mental health symptoms, suicidal ideation, and completed suicide. These reports have forced the medical profession to reconsider its own vulnerability."

The authors reported that, rather than exposure to "human ill health and suffering," there were more prosaic factors at play. These included "typical psychosocial workplace risk factors, such as excessive or conflicting job demands, an imbalance of work and family life, long working hours, and interpersonal conflict… [with] additional risk factors appear for junior physicians during training, including excessive working hours, study, and examinations." In their comprehensive systematic review Dutheil and colleagues identified anaesthetics as a profession at high risk of suicide.[2]

During my term as the RANZCOG President I was confronted with specialty trainees who took their own lives. Indeed I was a witness in a Coronial inquest into one such death. These were shocking experiences and underscored the vulnerability of specialty trainees in particular. So profound was my distress that, toward the end of my term as president, I made a decision to make public my own experience with mental health problems and suicidal thoughts.

As an intern I tried to kill myself, an event that I wrote about in the *Medical Journal of Australia* in 2018. For many years I thought that my emotional turmoil at the time had gone unnoticed. How wrong I was. It was only after my story was published that I learned that some of my fellow interns were worried about my mental state. In response to that article my wonderful friend and colleague Dr Kate Tree wrote "If I asked "how are you", or "are you okay", and you looked awful but said you were fine, in 1988 I am afraid that I did not have any effective strategy to turn to next."

Anaesthetists are professionals who function at a high level, and it is a common experience that work performance can continue even if the person is quite unwell. It is often stated that for high functioning individuals work performance is the 'last thing to go.'

My colleagues had sensed my inner turmoil but, as so many of us understand, knowing what to do next is commonly a major gap in our knowledge and experience. We may have a strong sense that a colleague is suffering but feel wanting in knowing how to respond. We want to help but may not be sure what to do. Taking this perspective, I would like to propose some suggested ways forward for each of us to consider.

Only doctors really understand what it is like to be a doctor, to work in the environment we do, and experience the demands placed upon us. For this reason we are ideally placed – more so than any 'employee assistance program' – to develop an empathetic stance toward our colleagues.

Doctors in general – and anaesthetists in particular – commonly face a suite of stressors in their occupation. Most of us will have long term 'chronic' issues to deal with such as long working hours, challenging workplace conditions, demands from our patients, and a heavy workload. On top of these anaesthetists of have acute additional stressors such as adverse patient outcomes, having to deal with patient complaints, all dealt with in a relative professional isolation. These workplace issues are only part of our life stories – we have personal stressors in our relationships, health, finances, and our home lives.

Burnout, fatigue and disrupted sleep, feelings of loss of control over our professional lives all can manifest. It can be easy to rely on alcohol to cope, or sometimes prescribed medications. Whatever our work situation, like everybody else, doctors may experience depression, anxiety, and other common mental health problems. It is common for our profession to have deep concerns about seeking help from professional colleagues due to concerns about potential effects on our medical registration and repercussions from Ahpra and the Medical Boards.

Medicine is a caring profession and, naturally, we care deeply about our work colleagues and friends and their wellbeing. Yet each of us holds concerns about what to do to help a colleague in distress. We don't want to intrude unnecessarily, or offend one of our workmates if they're simply having a bad day or going through a rough patch that they're dealing with. Sometimes it can be difficult to discern whether there is a problem at all.

The first step in helping is recognising that a colleague is experiencing emotional or mental health problems. In many cases there are few certain signs unless the person opens up to you and seeks help. More often we find ourselves trying to 'read the tea leaves.'

Some important signs to look out for, and that might indicate a colleague is suffering include:

- Being difficult to get hold of, with calls not returned or returned after prompting.
- Not coming to meetings, audits, or other workplace activities.
- Arriving late and showing a noticeable change in punctuality.
- Changes in the standard of patient care, perhaps with errors or complaints.
- Increased conflict with nurses and other staff members.

Anaesthetists are professionals who function at a high level, and it is a common experience that work performance can continue even if the person is quite unwell. It is often stated that for high functioning individuals work performance is the 'last thing to go.'

Depression very commonly leads to sleep problems and sometimes this becomes obvious in the workplace with reduced energy and tardiness. Difficulty concentrating and making decisions can be another feature, and these may manifest as disengagement and seeming disinterest. There may be an increased tendency to cynicism and limited communication and engagement with colleagues. Unusual absences, from work or social activities, that are not typical, may occur.

In many cases we may see few outward signs of distress even if we are very close to a colleague who is on the brink. After the loss of senior Brisbane gastroenterologist Dr Andrew Bryant, in

an interview for *The Australian* newspaper published in 2018, his son John said that there were no indicators of terminal despair. "He was a bit flat, but as far as we could tell he was just tired from work, and that wasn't too unusual. He was never someone to complain but he didn't reach out for the help he obviously needed. Maybe the signs were there. But at the time it wasn't enough for us to really take notice, unfortunately."

We all want to help our colleagues and friends. Taking the step and directly approaching someone can be daunting, though, particularly so if the person is senior and working at a high level. If you have concerns then it is important to plan your conversation, to think through what you plan to say. Perhaps you are not even the best person to raise it – you may know of others who are closer, know them better, or are experienced in the issue. Choosing the right moment is a key consideration: somewhere quiet and private, not a communal area with nurses and staff walking by, and at a time when there will be no distractions. Have a plan too – a very good place is one of the state-based doctors' help lines. These are run by experienced doctors and usually are available 24 hours a day.

There is no right way to start such a difficult conversation and nobody is good at it. The most important think is to show that you care, that you want to be supportive. Be prepared to listen. Explain that you have observed, or heard, some things that have worried you. That you care and that you want to listen and help. Also, remember that there is no evidence at all that mentioning suicide makes a person more likely to take their own life. You will not be able to solve all of a colleague's problems - but you can let them know that you want to help. If the conversation, or subsequent ones, make you concerned about suicidality then you should seek skilled help urgently. I would recommend calling one of the doctors' help lines – the numbers are listed below – urgently to marshal professional assistance.

As an intern I was in the process of killing myself. The only reason I survived the attempt was that I was interrupted by another doctor-in-training who sensed trouble and wanted to protect me. For that I remain eternally grateful. Many of my colleagues have not had the luck that I had. For thirty years after the events I was too ashamed to talk about them.

The time for silence has passed.
Let us do everything we can to help.

Professor Steve Robson

If you or someone you know needs assistance, confidential advice and support is available:

1300 374 377 (1300 DR4DRS)

Doctors' Health in QLD (07) 3833 4352

Victorian Doctors' Health Program 1300 330 543

Doctors' Health NSW (02) 9437 6552

Doctors' Health Advisory Service WA (08) 9321 3098

Drs4Drs TAS 1300 374 377

Drs4Drs ACT 1300 374 377

Doctors' Health SA (08) 8366 0250

Doctors' Health NT (08) 8366 0250

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1. Harvey S, Epstein R, Glozier N, et al. Mental illness and suicide among physicians. Lancet 2021; 398: 920–30
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PRIORITISING MENTAL WELLBEING

We play a crucial role in patient care, yet the demands often take a huge toll. It is important we look after our own mental, emotional and physical health. We are exposed to unique stressors including high pressure environments and emotionally taxing situations. These stressors, with or without other compounded factors, such as relationship circumstances at home, can lead to presentations in mental health conditions including anxiety, depression and substance use disorder which are all prevalent within this industry. It is important to implement practical strategies to maintain our own wellbeing in this demanding field.

Unblocking Challenges

As anaesthetists, we face challenges within our workplace being exposed to demanding work schedules and high intensity work. Similar expectations of workload can be at home. This can lead to exhaustion and burnout syndrome at the workplace, substance use disorder and mental health presentations[5].

- Studies have shown that Substance Use Disorder (SUD) is treatable[2].
- SUD and mental health conditions are associated[2].
- 83.3% of people who died by suicide had risk factors identified, the most recorded being mood affective disorders (including depression)[3].
- Doctors specifically reported significantly higher rates of psychological distress and suicidal thoughts compared to the Australian population and other Australian professionals[1,3].
- In 2020, the requirements to make a mandatory notification changed aiming to support health practitioners to seek help about their health without fear of a mandatory notification[4].
- Treating practitioners in Western Australia providing a health service to a practitioner-patient or student are exempt from the requirement to make a mandatory notification. In all other states/ territories, the circumstances for treating practitioners to make mandatory notifications are more limited than they are for other groups[4].
- The Australian Health Practitioner Agency (Ahpra) has provided detailed guidelines for us to navigate what is 'reasonable belief' in mandatory notification if a health practitioner is practising and placing the public at substantial risk of harm[4].
- You do not need to make a mandatory notification if a practitioner or employer has made a mandatory notification, and safeguards to reduce the risk to the public are being put in place[4].
- The Mayo Clinic importance of transitioning to the Well-being 2.0 phase was validated and released in late 2019[7].
- The scapegoating and finger-pointing that divided physicians and administrators in the Well-being 1.0 phase are replaced with a mindset of physician-administrator partnership to create practical and sustainable solutions. In the Well-being 2.0 phase, the organisation transitions from viewing wellness as a necessary cost centre to viewing it as a core organisational strategy. This provision for Australian anaesthetists in particular rural hospitals can be challenging.
- Education and awareness for health practitioners, their workplace organisation(s) and the regulators are in place. However, culture can be an obstacle.

Tragic Impacts

- A health practitioner's wellbeing is linked to impaired professional performance, a loss of workforce numbers, and increased costs to the healthcare industry[5].
- There is measurably significant total risks and costs including monetary to the industry and community [5,6,7].
- Maintaining wellness and looking after ourselves among high-pressure environments is vital to reducing medical error, sustaining performance and patient care [5,6].
- Workplace culture impacts on perceived loneliness, isolation and high risk of suicide [5,6].
- As a result of these stressors, it can lead to mental health presentations and in some cases substance use [5,6]. This is a major problem affecting anaesthetists due to the relatively easy access.

Strategies and Support

- Prioritising self-care through physical, mental and emotional strategies can significantly improve the health of anaesthetists and the care provided to patients.
- An ASA vision is to provide the best wellbeing conditions for every anaesthetist in training or practice so they can achieve their full potential.
- We represent via the ASA Wellbeing Advocates Committee through education, support and advocacy mission.
- As representatives, we can liaise at your local department, hospital and government MPs.
- The tripartite ANZCA, NZSA and ASA Wellbeing SIG Executives are also volunteers ensuring wellbeing resources are there for you https://libguides.anzca.edu.au › wellbeing
- Searching for evidence-based pre-clinical interventions for mental health conditions, the ASA Wellbeing Advocates Committee invested in mindfulness awareness and practice, and peer support for members[1,5,6,7,8,9].
- The ASA is a partner of the HandnHand Peer Support organisation (handnhand.org.au) and provides peer support facilitator training workshops across the year, fostering open dialogue and support among colleagues.
- The ASAEd Wellbeing resources include 'Wellness on-the-fly' series to support your physical, emotional and mental health (https://asa.org.au/asaeducation/wellness-resources).
- The wellbeing activities for CPD hours can be both Practice Evaluation and Knowledge and Skills.
- We have recently released wellbeing knowledge and skills CPD recordings and when you apply the proposed activities, they will count towards your wellbeing practice evaluation CPD hours. (View 'how to do so in 3 simple steps for your Wellbeing Practice Evaluation CPD hour').

- Consider contacting your GP/professional support, or complete 10 short questions to self-assess your distress level. The K10 test is evidence-based[10], preclinical intervention that will only take around 5 minutes to complete. Click here to access the test and count it towards your practice evaluation CPD hours. Remember there is no need to show the questionnaire answers to your CPD home.
- The ASA promotes education and awareness on burnout syndrome, SUD and mental health conditions to empower a pause and seek help early.
- If you require emergency assistance, please contact 000 for emergency services.
- For crisis support please contact Lifeline on 13 11 14 or Beyond Blue on 1300 22 4636.

Dr Lan-Hoa Le
ASA Wellbeing Advocates
Committee Chair

References

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7 https://www.mayoclinicproceedings.org/article/S0025-6196(21)00480-8/fulltext Physician Well-being 2.0: Where Are We and Where Are We Going? Volume 96, Issue 10P2682-2693October 2021
8 HIMS Australia https://www.aushims.org.au Human Intervention Motivation Studies for pilots
9 https://pmc.ncbi.nlm.nih.gov › articles › PMC3679190Effects of Mindfulness on Psychological Health: A Review of Empirical Studies
10 Anxiety and Depression Test K10 Beyond Blue https://www.beyondblue.org.au › mental-health › k10

The ASA Wellbeing Committee has representatives in all States and Territories for your contact. The ASA Wellbeing Secretariat is Ms Sue Donovan sdonovan@asa.org.au

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

Australian Society of Anaesthetists®

members for members

Peer Support Programme

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

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

Benefits of peer support

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

Are you looking for peer support?

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

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

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

ASApeersupport@asa.org.au

ANAESTHESIA ASSOCIATES:

the UK experience and some lessons learned

FOR THE UNINITIATED, ANAESTHESIA ASSOCIATES (AAS) ARE NON-PHYSICIAN PROVIDERS OF ANAESTHESIA IN THE UK, FORMING PART OF THE GROUP KNOWN AS MEDICAL ASSOCIATE PROFESSIONS (MAPS)[1,2]. IT IS NO EXAGGERATION TO SAY THAT THIS TOPIC IS ONE OF THE MOST DIVISIVE ISSUES IN UK ANAESTHESIA.

There is not space here for a forensic analysis, but other accounts are available. Whitaker[3] provides a political view and in recent weeks, Greenhalgh[4] and McKee and colleagues[5] have published thorough and compelling systematic evaluations of how we got to where we are. These should be viewed as essential reading. What follows is an outline of the key milestones leading to where we are, with some thoughts about how antipodean colleagues might avoid some of the pitfalls (although I make no promises…)

The model of non-physicians providing anaesthesia is clearly not new and exists all around the world in various forms. However, in the UK, beginning with the inception of the Association of Anaesthetists in 1932, anaesthesia has progressed from being not even recognised as a specialty to being one which is provided by specialist doctors, based upon an established system of undergraduate study in medicine and post-graduate training and exams within a college framework. Anaesthesia has an undeniable and very much envied reputation for safety first. Consequently, anything seen to reverse the existing model always had potential to cause upset, and with hindsight, perhaps that potential was unrecognised.

In the early 2000s, some UK anaesthetists began to be interested in developing non-physician anaesthesia provider roles and established local schemes under entirely local governance. This was by definition the province of enthusiasts, often in areas where physician cover was hard to recruit. These practitioners progressed to undertake a wide variety of anaesthesia procedures (including general, spinal and regional anaesthesia) under a variety of supervisory models. It is clear that many had great autonomy and became very experienced at their particular niche, working in what we would now term an extended role. However, they did not belong to any recognised staff group and their practice was unregulated, unlike any other group that provided direct health care interventions.

In time, a small number of universities went on to develop courses for AAs. Entry requirements are a health science degree or work in an allied health professional role, so commonly learners are drawn from occupations such as

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physiotherapy or operating department practitioner (in itself controversial by dint of taking away from cohorts with their own workforce pressures). The two-year degree is undertaken whilst working in a trainee AA role in an employing hospital. Teaching is delivered locally and using online resources with workplace-based assessments, which some have criticised for the lack of independent verification of clinical competence. The majority of time is spent clinically, gaining practical experience. At the end of the course, there is a final examination undertaken at the base university.

Nonetheless, most UK anaesthetists remained unaware of AAs and for many, the first they heard was in 2016 when the Association of Anaesthetists (of Great Britain and Ireland) and the Royal College of Anaesthetists issued a joint scope of practice document for AAs (now archived). This described the scope only at qualification, leaving it clear that pending national guidance, any extended roles would have to be under local governance.

The then absence of a mandatory register meant that the exact number of AAs working was not known, but there were fewer than 200. All might have continued quietly but for a perfect storm of circumstances, the first of which has nothing to do with AAs, but has to be taken into account.

This first circumstance was an agitated physician workforce. Several years of austerity with below inflation (sometimes zero) pay awards to doctors had led to a real terms decrease in salary from 2008 to 2022 of 20-30% for all grades of doctors, worse than for every other group of UK workers. For resident doctors, this also came on top of typical student loan debts of £80-100k, which would sap typically 6% of their income for most of their career. There were also severe bottlenecks in training, meaning hundreds every year could not progress and had to follow other career pathways or consider emigrating. For many locally employed doctors, it simply reinforced their feeling of being overlooked and exploited for service. This heralded a period of anger and unprecedented industrial action amongst doctors.

The second circumstance was the launch by the UK government in 2023 of its Long-Term Workforce Plan[6]. Amongst the document's many initiatives was an announcement to increase the number of AAs by 2000, albeit over a decade. There was no similar plan to increase training places for doctors. This was a red rag to a bull. For many it cemented the belief that the whole MAP program was simply designed to replace doctors with cheaper non-doctor alternatives. As resident doctors were quick to point out, AAs do not incur any student debt from their course and are employed throughout training and if employed on a typical pay scale, would be in a better financial balance than a resident doctor for many years, leading many residents to question the balance of their personal investment versus reward. Added to unresolved worries about scope of practice and supervision, the die was set for conflict, played out in a fierce and often unpleasant battle on social media.

The debate was extremely polarising, with one extreme calling for the abolition of AAs entirely and the other pointing to the very successful schemes in place and to the need to get spiralling waiting lists under control. Some saw the government trying to do medicine on the cheap, some saw a means to provide health care in a locally responsive way. Some saw protectionism for doctors' jobs, others argued that what was being protected was the profession of anaesthesia.

The ultimate destination was an emergency general meeting of the Royal College of Anaesthetists, called by members making use of its rule-book[7]. Two of its resolutions specifically related to AAs: a pause on recruitment and a resolution that local opt-outs of national supervision standards were not supported, pending the onset of regulation and the publication of a full national scope of practice. This led understandably to much doubt over the future of the AA project.

The 2016 document had highlighted the lack of and need for regulation and for a national scope for extended roles. This vacuum created concern on all sides. It was expected that when a regulator was appointed, they would issue such guidance. Ultimately, this turned out not to be the case and it fell substantially to the Royal College of Anaesthetists

to do this work, by which time much ground had been lost.

Regulation (of both MAPs and the curricula for their courses) eventually began in December 2024, enshrined in legislation which cements the MAP roles in law[8]. Legislation was passed using a statutory instrument, which drew some criticism as it was not honed by debate in parliament. The choice of the General Medical Council as regulator has been controversial, it having been a regulator only of doctors since its inception in 1858. This controversy is currently the subject of legal challenge[9].

Coinciding with regulation, the Royal College of Anaesthetists published its 2024 interim scope of practice for AAs [10]. The scope tries to navigate a tricky course, providing a safe scope for a non-medical workforce, one which is acceptable to supervising doctors but cognisant of the effects of a somewhat more limited scope than many originally envisaged. In keeping with the firmly-held views mentioned earlier, to some the scope is too restrictive, to others not restrictive enough. But to the majority it seems to have been accepted, if not welcomed, as a pragmatic starting point in an impossible situation, which will be subject to review and refinement in the light of future evidence.

This is far from the end of the AA story; quite the opposite. Although the 2024 scope document was always for an early review, this will happen even sooner because the UK government has now, two decades after creation of the role, announced a formal review of the safety and place of MAPs[11], set to report in the spring. Who knows what it will conclude? Everyone looks likely to have to reconsider their position when it reports.

So what lessons are there for a government or health care system wishing to explore the introduction of AAs or an equivalent role? Doctors and policymakers will each have their own agenda, which should be anticipated. Occupants of the new role, once created, will also have theirs. Each of the paragraphs above has a lesson. Some could have been predicted, others were a product of circumstance, but all of them would be best avoided if re-running the project. There are specific important areas that that should be addressed right at the outset to ensure they are understood and agreed by all parties: the purpose of the proposed role; the proposed scope of practice; the proposed model of supervision; and how medicolegal liability will be addressed.

The Association of Anaesthetists has been involved in all the key stages and has issued position statements along the way [12,13]. We had two representatives on the Clinical Reference Group and Core Writing Group for the 2024 scope and we endorsed the document[14]. The involvement of anaesthetists' professional membership organisations such as ours and the Australian Society is vital.

For me, the biggest overarching lesson comes from considering the order of events in the UK:

1. Enthusiasts develop the AA role;
2. Higher education courses are designed and implemented to support the role;
3. The first scope of practice is written;
4. A regulator is appointed;
5. Legislation is passed enshrining the role;
6. A government review into the safety and place of AAs and other MAPs is launched.

My takeaway is that we have done everything in the reverse order that should have happened and looking around me, to coin a punchline, "If I wanted to get there, I wouldn't start from here."

I wish you luck on your journey!

Dr Tim Meek

President, Association of Anaesthetists, UK

COI : TM was a member of the Clinical Reference Group that advised on the writing of the 2024 scope and of the Core Writing Group that produced it.

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AUSTRALIA NEW ZEALAND REGIONAL ANAESTHESIA GROUP (ANZ-RA)

REGIONAL ANAESTHESIA IS A RAPIDLY EVOLVING SUB-SPECIALTY WITHIN OUR PROFESSIONAL PRACTICE. USE OF ULTRASOUND TECHNOLOGY TO ENHANCE ACCURACY OF NEEDLE PLACEMENT AND UTILITY OF REGIONAL BLOCKS CONTINUES TO IMPROVE PATIENT CARE. THERE IS CONSISTENT STRONG INTEREST IN REGIONAL ANAESTHESIA AS AN IMPORTANT ANAESTHETIC SKILL SET.

Throughout 2024 the regional anaesthesia group have been in a process of evolution aiming to refine how we can best achieve effective education and collaboration both locally and internationally. This exciting process of growth has led the Regional Anaesthesia Special Interest group to embrace a new name more in keeping with our purpose and ongoing relationships. I would like to welcome all our existing and potential future members to the Australia New Zealand Regional Anaesthesia group (ANZ-RA).

The core aim of the regional anaesthesia group is "promotion of science and education through the exchange of ideas between anaesthetists and other individuals/groups that share an interest in regional anaesthesia". To this end, our group is increasingly working to engage with equivalent international RA focused groups and individuals to promote RA education and the pursuit of academic collaboration.

The SIGs welcome members from both New Zealand and Australia, and they come under the governance of the tripartite bodies (ANZCA, the ASA and the NZSA).

ANZ-RA will be the special interest group for anyone keen to further their knowledge of regional anaesthesia. ANZ-RA will continue to work within the framework of the tripartite bodies and therefore the structure of the group is largely unchanged. We do however plan to continue to strengthen relationships with our partner international organisations and improve our ability to promote regional anaesthesia education across Australia and New Zealand.

ANZ-RA is an active group with many educational and academic projects underway.

January 2025 saw the inaugural World Regional Anaesthesia Day education events in both Australia and New Zealand. There were free online learning opportunities covering RA for shoulders, RA in trauma and compartment syndrome risk, thoracic spinals, knee arthroplasty and hip arthroplasty. ANZ-RA has been working in collaboration with the European Society of Regional Anaesthesia (ESRA) on this and other educational events and we look forward to ongoing accessible World RA education events in coming years.

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ANZ-RA is now engaged with the Asia Oceania Society of Regional Anaesthesia (AOSRA) and looking to build relationships and opportunities to connect with our near neighbours in Asia and the Pacific. AOSRA hosts monthly webinars and Australian anaesthetists will be presenting at the November webinar this year.

ANZ-RA is also continuing to develop relationships with the many inspirational regional anaesthetists from the American Society of Regional Anaesthesia (ASRA). We were delighted by the visit of Prof Ki Jinn Chin to both Darwin and Hobart late last year. His lectures and workshops were exceptional and very much appreciated. Australia is also soon to welcome exceptional speakers from both RA-UK and ASRA to our shores in March 2025 for more exciting RA teaching opportunities.

By the time of publication of this edition the world-renowned regional anaesthesia conference, Australasian Symposium on Ultrasound and Regional Anaesthesia (ASURA) will have been held in Hobart from 13-15 March. The ASURA programme had a plethora of learning opportunities including world leading plenary speakers, cadaveric workshops and a range of small group sessions to refine ultrasound guided regional anaesthesia (USGRA) practice. ASURA was privileged to feature 3 exceptional international speakers (Prof Amit Pawa from the UK, A/Prof Nadia Hernandez and Dr Maggie Holtz both from USA). As always, the focus of ASURA was the hands-on small group teaching of USGRA skills, and its success in catering for all USGRA abilities. ASURA was a wonderful opportunity for both novice and expert regional anaesthetists to build confidence through focused learning and is always a pleasure to see the dedicated volunteer expert USGRA teachers from ANZ-RA team in action.

The latest biannual newsletter for ANZ-RA was released in February and emailed directly to all ANZ-RA members. The newsletter included discussion of topical regional anaesthesia techniques along with tips for education and training.

Increased opportunity for professional discussion of in-the-moment regional anaesthesia experiences has proven to be very helpful for ANZ-RA members. We have a WhatsApp group where tea-room style conversations regarding management of challenging RA cases, discussion of new RA equipment or bigger questions regarding department/ hospital organisation in relation to RA can be communicated. This method of discussion and education by passionate users of RA has been a very productive way to stay connected and learn from each other. Such online resources are particularly useful for those working in smaller departments with less opportunity for in person RA discussions. ANZ-RA members are welcome to join the WhatsApp discussion using the QR code below.

ANZ-RA is very keen to support and promote access to cadaveric RA teaching workshops. We are fortunate to have some excellent learning opportunities in Australia and New Zealand involving cadaveric specimens for application in ultrasound scanning and regional anaesthesia. ANZ-RA anticipates improved access for this style of teaching in both Australia and New Zealand in coming years. We have dedicated teachers involved in cadaveric lab RA workshops based in Perth, Brisbane and recently Newcastle has launched as an exciting location for future workshops.

Regional Anaesthesia continues as a strong interest for many anaesthetists in Australia and New Zealand. ANZ-RA is committed to improving teaching and education for any anaesthetists who want to improve their skills in regional anaesthesia and will be an accessible, productive and welcoming group. ANZ-RA warmly welcomes all members of the NZSA, ASA and ANZCA with an interest in regional anaesthesia to join ANZ-RA using the link below, so you can stay connected with regional anaesthesia education and conversations. The RA SIG and now ANZ-RA has always been a positive group defined by a generous community of passionate RA teachers. The strong sense of community and the generosity with which my colleagues have embraced RA teaching continues to amaze me. From the founding members of the RA SIG through to the many active engaged RA teachers across Australia and New Zealand I thank you for making this group so special. I know that proud tradition of exceptional RA teaching will continue throughout the life of ANZ-RA.

Dr Katrina Webster

ANZ-RA Chair

ASSOCIATE 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 April 30

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

$3000 for each successful grant

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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

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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

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4. Jackson Rees Research Grant – deadline June 30

The grant is available to ASA members or trainee members for research projects in anaesthesia or related disciplines such as resuscitation, intensive care, or pain medicine. This grant provides significant support for a research project either in isolation or in conjunction with other research funding for the project.

$27,500 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.

MS SUZANNE BOWYER,
ASA OPERATIONS MANAGER

ASA 2025 MEMBERSHIP SURVEY

We value your membership and are always looking for ways to improve your experience. To better understand your needs and preferences, we will be asking members to participate in a membership survey in the coming months. The survey will have questions covering all aspects of the ASA business. Your input will help us shape future initiatives and ensure we continue to serve you effectively. The survey will be distributed to members early May 2025.

Why is a membership survey important?

A membership survey is important because it helps us better understand the needs, preferences, and opinions of our members. Here are some key reasons why:

1. Improving Member Experience

Surveys provide direct insight into what members value most and areas where they feel improvements are needed. This feedback will allow us to tailor services, events, and communications to better meet member expectations.

2. Strengthening Engagement

By giving our members a platform to voice their opinions, we are demonstrating that we care about your input. Engaged members are more likely to remain loyal and actively participate in the community.

3. Guiding Strategic Decisions

Surveys provide data-driven insights that can inform decisions on resource allocation, new initiatives, or policy changes. Understanding trends and common concerns ensures that strategies align with member priorities.

5. Building Trust and Transparency

Asking for feedback fosters trust, as it shows our members that their opinions matter. Sharing survey results and how they influence decisions further reinforces transparency. We look forward to sharing the results of this survey towards the second half of this year.

Ms Suzanne Bowyer
ASA Operations Manager

webAIRS

webAIRS

Dr Anna Steer, Dr Martin Culwick
and the ANZTADC Case
Report Writing Group

BRADYCARDIA AND ASYSTOLE IN A HEALTHY PATIENT DURING LAPAROSCOPY:

A WEBAIRS CASE REPORT

A healthy patient in their mid 40s with a normal BMI was undergoing general anaesthesia for an elective laparoscopic procedure. Shortly after insufflation of the peritoneum the patient developed severe bradycardia. Surgeons were immediately notified and desufflated the peritoneum. Atropine 1200 micrograms was administered intravenously followed by a fluid bolus. Despite these measures, the bradycardia progressed to asystole prompting a Code Blue call and commencement of external cardiac compressions (CPR). The patient had return of spontaneous circulation within approximately 30 seconds of CPR. Following the procedure, the intraoperative events were openly disclosed and discussed with the patient. No adverse outcomes were reported and the patient made an uneventful recovery.

webAIRS reports

The described case report is one of 35 similar incidents reported to webAIRS since its inception in 2009. The majority of these reports involve healthy, female patients, less than 50 years of age, undergoing elective procedures. A significant percentage of these patients required CPR. While most incidents report no lasting harm to the patient, they remain significant events due to the potential risks involved. It is likely that such incidents are underreported, suggesting that more anaesthetists may have encountered this complication than the data currently reflects. A detailed analysis of events during laparoscopic surgery with an additional focus on the potential equipment faults is planned for 2025.

The Australia and New Zealand Tripartite Anaesthetic Data Committee (ANZTADC) is encouraging anaesthetists to report all cases to webAIRS where an event in this clinical setting has occurred.

Recent safety issue

There has been a recent increase in reports of significant cardiovascular events following insufflation of the peritoneum. Safer Care Victoria has released an alert to hospital and operating theatre staff regarding a potential equipment fault in high flow insufflation units for laparoscopic surgery[1]. Intra-abdominal pressures and CO2 flow rates can be variable when insufflating the peritoneum resulting in both under-insufflation and over-insufflation. Over-insufflation resulting in elevated intra-abdominal pressures can lead to severe bradycardia and/or asystole. A/Prof Suzi Nou has encouraged ASA members to report these incidents to webAIRS via a recent video recording distributed via the ASA and various social media outlets.

Perioperative cardiac arrest during laparoscopy

Perioperative cardiac arrest, defined by five or more chest compressions and/or defibrillation in a patient having a procedure under the care of an anaesthetist, is an uncommon but significant complication of anaesthesia[2, 3]. The recent National Audit Project 7 report highlighted bradycardia as the second most common cause of perioperative cardiac arrest[2]. Insufflation of the peritoneum during laparoscopic surgery is a well-recognised precipitant of bradycardia, occurring in approximately 15% of laparoscopic surgical cases[4]. Yong et al analysed data from the Australian Incident Monitoring Study (AIMS) and identified 14 cases of cardiac arrest during laparoscopic surgery, with bradycardia preceding cardiac arrest in 75% of these cases[5]. Furthermore, Myles reported that bradyarrhythmias, including asystole, are common during laparoscopic procedures, particularly during CO2 insufflation or manipulation of pelvic structures[6]. Hoda et al. also reported on asystolic cardiac arrest during balloon insufflation for endoscopic extraperitoneal radical prostatectomy, suggesting a severe vagal reaction as the cause[7]. Hypercapnia, decreased venous return, and vagal response to peritoneal distention are likely precipitants[8]. These studies emphasise the need for awareness among anaesthetists and surgeons of this phenomenon and the potential life-threatening cardiovascular effects[6-8]. Management recommendations include immediate deflation of the pneumoperitoneum, atropine administration and cardiovascular support[5, 8]. Whilst there is insufficient evidence to support prophylactic anticholinergic pre-treatment, prompt recognition and management of these perioperative cardiac events results in low morbidity and mortality outcomes[2, 9].

We need your data!

Please report any incident in your anaesthetic practice, including near-misses and no-harm events to anztadc.net. Your data is de-identified, protected by qualified privileges and will help to further increase patient safety in anaesthetic practice across Australia, New Zealand and maybe world-wide!

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DR MICHAEL
LUMSDEN-STEEL
EAC CHAIR

ECONOMIC ADVISORY COMMITTEE

Welfare of the anaesthesia profession

TIME AND GOOD HEALTH ARE OUR MOST VALUABLE ASSETS. BALANCING OUR PERSONAL, PROFESSIONAL, AND FINANCIAL COMMITMENTS WHILE ADVANCING THE FIELD OF ANAESTHESIA OFTEN CREATES A STATE OF FLUX AND TENSION, PARTICULARLY IN MAINTAINING OUR MENTAL HEALTH AND ENTHUSIASM.

Accessing meaningful periods of leave in busy anaesthetic departments and groups seems to require ever more meticulous planning and coordination. Unfortunately, this leave is not always supported by employers or colleagues due to issues with staffing, list allocation, rostering needs, and individual flexibility.

The failure of governments to adequately resource health departments, the inability of health departments to properly fund hospitals, and issues with private insurers paying private hospitals, have led to predictable workforce, infrastructure, and equipment inadequacies we are all now seeing.

These pressure points inevitably impact our working environment, an environment our trainees increasingly accept as 'normal,' and the environment our patients must navigate through — when they can access the system. This ecosystem has limited capacity to expand rapidly, especially when operational healthcare delivery components are under-resourced to meet actual demand.

Consequently, anaesthetists must proactively create work arrangements and environments that provide clinical satisfaction and enable anaesthesia (and perioperative medicine) to be delivered in a positive and collaborative manner, all whilst ensuring high-quality specialist-led healthcare that the community increasingly takes for granted.

Perhaps it is because of this situation, that I increasingly find that the default position of those who are asked to take on additional clinical or professional roles, including professional representation, is to just say no. Are we teaching our future colleagues to say no?

This results in an ever-shrinking number of anaesthetists bearing a greater load of clinical and professional representation work, which is unsustainable for the welfare of those colleagues and contributes to their burnout. Furthermore, when too much reliance is placed on too few individuals, this becomes unsustainable for the whole specialty in the long term. In many professional associations today, unfortunately, 'succession planning' is more literally 'succession scrambling' as they struggle to fill committees and other leadership roles.

Perhaps we all need to reassess what is being asked of us, offload meaningless roles, and push back against increasing compliance, mandatory training, and governance requirements that often lack

evidence and divert time and resources from clinical activities and support tasks that truly matter.

It is a fine line however, because if we do not engage as anaesthetic leaders, others may step forward and make decisions on our behalf which may not be in the best interests of our patients, our specialty, or the health care system in general.

Currently in NSW, we are seeing the outcome from years of government neglect, lack of meaningful investment in the medical workforce, lack of health system funding, and the decay of NSW medical practitioner industrial negotiated outcomes in comparison to other states.

NSW has been haemorrhaging staff specialist to VMO positions, to private, to locum roles, and interstate. Public hospital specialists are saying enough is enough and are standing up for a health system in crisis.

The recent resignation of over 200 public-sector psychiatrists in NSW, about two thirds of the workforce, primarily due to low salaries and staff shortages, was the last resort after more than 18 months of government failure to address psychiatrists' concerns as the system imploded.

The outcomes of this are not yet clear and a protracted process in the NSW Industrial Relations Commission seems likely as the magnitude of the problem, and additional funding needed to fix mental health services in the public health system becomes more apparent. The system has quite rightly been described as threadbare and broken.

The NSW government continues to argue that it cannot afford to meet the demands of public sector psychiatrists which it says, if allowed, would result in higher taxes for the people of NSW. It has also threatened to "reform the mental health system" by reducing its reliance on psychiatrists and increasingly using counsellors, psychologists, mental health nurses and clinical nurses for the assessment of and, in some cases, the treatment of patients in the public hospital system.

In August last year the ASA launched the timely, and important, Anaesthetist Workforce Modelling Final Report at Parliament House in Canberra. This report makes clear that there is a shortage of anaesthetists in Australia that will worsen over time if nothing is done. We are, potentially, looking at an undersupply of more than 500 anaesthetists in 2032.

Accessing meaningful periods of leave in busy anaesthetic departments and groups seems to require ever more meticulous planning and coordination. Unfortunately, this leave is not always supported by employers or colleagues due to issues with staffing, list allocation, rostering needs, and individual flexibility.

In response to these findings, the ASA has recommended that at least 50 additional anaesthesia trainees should be employed each year across the 150 ANZCA accredited hospital sites in Australia (with one-third of these being in rural locations). This would provide a relatively straightforward solution and at a reasonable cost. This is readily achievable, and we have both the time, capacity, and the willingness of medical students who rate anaesthesia highly as a career choice.

In addition to this, we need to do better when addressing and removing barriers for those with capacity to work a bit more, and to increase the work being done in outer metro and regional Australia by medically trained anaesthetists.

The financial cost of training and obtaining a FANZCA has been discussed on many occasions previously. A growing number of trainees have noted that their biggest variable cost is the cost to relocate for training. What has been highlighted recently by the ASA Trainee Members Group and state ASA chairs, is that trainees on regional training programs often receive far less financial support when they rotate into tertiary hospitals for key specialised study units, than city-based trainees who rotate out to regional centers. This is a big disincentive to committing to regional anaesthesia training and needs to be addressed. The other financial variable is of course, interrupted training when taking parental leave.

Under various industrial agreements that have been negotiated by the various registered industrial organisations representing doctors in training (AMA or State ASMOF), trainees will have access to paid sick leave, CPD leave, annual leave, and parental leave. These industrial entitlements provide a safety net for trainees to be able to access paid leave during their training.

It is important to note that these entitlements are generally not transferrable interstate should a trainee move, and certain jurisdictions do not allow, or have put up barriers for annual leave to be carried over into staff specialist appointments (i.e. NSW). It is

really important to be aware of what your state does support, and what will carry over when trainees become specialists, or change employers. Generally, only long service leave that has been accrued can be transferred from one public employer to another – provided there is continuity of service – and it can be a battle sometimes even getting this recognised by cash-strapped health departments.

Encouragingly, some employers will support periods of interrupted service (such as approved leave without pay for example when completing an overseas fellowship) so that the employee retains accrued benefits (e.g. sick leave, annual leave, long service leave etc.) when they return to that employer. It is important that trainees explore and are aware of what their employer will and will not support.

Depending on the pathway to fellowship, the age of obtaining fellowship is highly variable. Furthermore, obtaining fellowship may not translate into immediate financial freedom and wealth, as new fellows seek to consolidate employment as a specialist, often at the same time as juggling major life events. Anecdotal evidence and discussions suggest that it can take two to three years or more working as a specialist to consolidate financially.

Trainees that transition into staff specialist or visiting medical officer anaesthesia employment may retain sick leave and annual leave and be able to access paid and unpaid parental leave when employed as a specialist without any accrual or waiting period. Those who leave the public system however, and move into private practice, will have their annual leave paid out, long service leave is subject to accrual and payout rules. They also lose all other accrued benefits including paid sick leave. Anaesthetists who commence working exclusively in private practice post training generally have no leave entitlements. For them, every day of leave is self-funded.

So, what's the point of all this? If you are working in public practice, you should proactively plan and take leave while also pursuing hobbies that help you maintain your mojo. Those in private practice should do the same, building into their year an appropriate leave plan. The cost of annual leave, CPD leave, sick leave, long service leave and superannuation must be incorporated into your individual RVG unit value as this is completely self-funded.

Anaesthetists who commence working exclusively in private practice post training generally have no leave entitlements. For them, every day of leave is self-funded.

I'd also encourage all anaesthetists, if they have the capacity, to consider volunteering in a relevant profession body. This is often driven by altruism and a desire to give back to your profession and community. However, it can also provide excellent opportunities for professional development, networking and career advancement while also being personally fulfilling.

An important issue for all Australian anaesthetists at this point in time is the need to reinforce to legislators, bureaucrats, our patients and the broader community that anaesthesia must continue to be delivered by medically trained anaesthetists. In future, when my grandchildren undergo a medical procedure, their anaesthesia must be provided by a medically trained anaesthetist and not a nurse anaesthetist or 'physician assistant anaesthesia' provider.

So, in summation, planning and budgeting for leave, CPD activities, personal growth and having a buffer for unexpected life events is imperative, as is having an insurance plan (policy or self-funded) for when the unexpected happens. Doctors shouldn't have to rely on a GoFundMe campaign when adverse and unexpected events arise, but in 2025 that's what we are seeing.

Finally, this year as always, the ASA will continue to advocate strongly with all levels of government on behalf of anaesthetists and our future medical anesthesia workforce on issues as diverse as workforce, scope of practice, MBS indexation and health fund rebates. Our firepower is proportionate to our resources and the calibre of the ASA Board and Council, ASA committee members and our policy staff. Our effectiveness will increase however by having a stronger membership. So, my final challenges to ASA members in 2025 is do you have capacity to contribute to an ASA committee, or can you sign up a colleague who is not already an ASA member?

Dr Michael Lumsden-Steel

EAC Chair

DR PETER WATERHOUSE
PIAC CHAIR

PROFESSIONAL ISSUES ADVISORY COMMITTEE

HEALTH SYSTEM WELLBEING - A BROADER PERSPECTIVE

THE WELLBEING OF DOCTORS AND THEIR PATIENTS IS STRONGLY INFLUENCED BY THE HEALTH OF THE SYSTEM OF WHICH THEY ARE A PART.

American health insurance executive Brian Thompson was shot outside a Manhattan hotel in December 2024.

It is not clear why Mr Thompson or his employer, UnitedHealth Group, were targeted, although the alleged killer's notebook did contain negative remarks about health insurance.

The shocking assassination has prompted renewed public reflection on the American health insurance industry.

While expressing revulsion at Mr Thompson's murder, American doctors are open about the daily frustrations they face because of the ever-increasing power of health insurance companies.

To give an example from our own specialty, American insurer Anthem recently announced that anaesthesia claims would not be paid for operations that exceeded an arbitrary time limit. Fortunately the decision was reversed prior to implementation[5].

Press reports from the last few weeks provide a sobering insight into UnitedHealth and the wider American health insurance industry[1-4].

Very big business

UnitedHealth is a large firm. It is comparable to Apple in terms of revenue. It provides health cover for 50 million Americans, employing 440,000 staff. Listed on the New York Stock Exchange, it has a market capitalisation of US$465 billion.

Commensurate with its size, UnitedHealth has accumulated considerable market power. In addition to its health insurance business, it owns home-care companies and payment-processing software providers, amongst other enterprises.

The company has also bought up medical practices, now employing thousands of doctors.

This vertical integration allows for 'self-dealing', as each of the group's businesses creates work for the others.

UnitedHealth has obtained government work on a large scale. The Medicare Advantage program utilises healthcare companies to look after government-insured patients[6].

Rebates under Medicare Advantage are linked to a score assessing patient co-morbidities. UnitedHealth's software obliges doctors to consider each of these before progressing to the end of the consultation, irrespective of the patient's presenting complaint. Patients are then visited at home by a nurse, who adds extra diagnoses missed by the doctor.

Unsurprisingly, income from Medicare Advantage is growing strongly.

Overwhelmingly, doctors and patients are most frustrated by the process of prior authorisation for medical care.

Insurers don't publish statistics regarding denial of medically recommended care. Reported estimates suggest that about ten per cent of treatment is knocked back by insurers after being prescribed by a doctor. While UnitedHealth declines treatment at a higher rate than the industry average, some other companies deny a greater proportion of claims.

Whether or not proposed treatment is approved, an onerous and expensive administrative burden is imposed upon doctors by the authorisation process.

Overall, UnitedHealth is representative of the wider American health insurance industry. It provides a vital public service, but there is evolving dysfunction, as expensive administration and a culture of cost-shifting erodes the value to consumers. Similarly, the government is dealing with escalating costs as its payment schedule is manipulated to maximise rebates. Shareholders on the other hand are doing well, with the share price up 90% since 2021.

Whether or not proposed treatment is approved, an onerous and expensive administrative burden is imposed upon doctors by the authorisation process.

Despite the recent public reflection, it is far from clear that meaningful reform can be easily achieved. Disillusionment prevails across the healthcare industry, but positive steps remain elusive.

Could this happen to us?

Although the American health insurance industry seems very different from ours, several of the seeds of America's current dysfunction have already been sewn in Australia.

Today we have giant listed companies providing the majority of health insurance policies. They actively engage in self-dealing vertical integration and contracts with independent doctors and hospitals.

On the other hand, care of public patients has not yet been outsourced to private health insurers.

Most importantly, prior authorisation remains taboo in Australia. This is largely because the Medicare Benefits Schedule and prosthesis list explicitly determine which medical services will attract a rebate.

More immediate challenges

The prospect of a dystopian healthcare system in a decade or two is ominous, but there are more pressing problems to be dealt with at home in Australia[7].

According to the Australian Private Hospitals Association, the average operating profit margin for private hospitals has fallen below two per cent. In the period between 2019 and 2023, 71 private hospitals closed their doors.

Private maternity units are the 'canary in the coal mine'. Regional services in particular have been subject to consolidation or outright closure in many parts of Australia. However, major hospital groups are also suffering.

Of the two biggest national hospital groups, only Ramsay is currently profitable.

Healthscope, the other big national provider, was purchased in 2019 by Canadian asset management fund Brookfield for $4.4 billion. Since then, a further injection of $250 million has been made. This has not been enough to ensure stability and extra funding is being sought[8].

The failure of a major private hospital provider would be keenly felt, especially in regional Australia. In Darwin, Healthscope operates the only private hospital.

The financial challenge confronting Healthscope has highlighted a practice exhibited by many hospital operators under financial pressure: cherry-picking of more profitable procedures including arthroplasty and spinal surgery, at the expense of vital but poorly funded care including maxillofacial procedures.

Political poison

The problem of private healthcare funding is too big to ignore, even though the government would like to.

With 70% of surgery being performed in private hospitals, widespread business failures in the industry would affect the whole community. Timely and affordable care might simply become unavailable to many Australian patients.

The government remains reluctant to intervene, even after the release of its review into the system[9].

The minister has said that he has no appetite for bailing out hospitals, and that discussions between insurers and hospital operators can ultimately bring about a satisfactory outcome.

This somewhat optimistic assessment depends to a considerable extent on upcoming health insurance premium increase. The official magnitude of the annual premium increase is subject to ministerial approval. Any negotiations between insurers and hospitals will be conducted against the backdrop of funding available from premiums.

With hospital costs increasing at well above the headline rate of inflation, there is no chance that the authorised premium increase will satisfy the industry. But to allow realistic indexation would risk a public backlash against the government at a time when cost of living is a sensitive issue.

Furthermore, the approved premium increase has been shown to exert little influence on the actual prices paid by consumers for health insurance. The minister has acknowledged the widespread insurer practice of closing older, cheaper policies and creating more expensive new ones to sidestep the prescribed premium increase.

So for now at least, the emerging trends of rising out-of-pocket costs and restriction of services are set to continue. It looks increasingly likely that the Australian healthcare system is heading for some kind of reckoning.

At the crossroads

It's difficult to predict how the current challenge will be dealt with. Despite its reluctance, the government will play a central role. Nobody wants to be the health minister who let the Australian healthcare system fall over.

What remains to be seen is how any extra funds are raised and distributed. Previous governments have bolstered health insurance participation with a tax rebate. This system has merit, but there's a risk that insurers might not spend all the extra money on patients. There is already a trend towards greater 'administrative' expense on the books of our largest insurers. Unfortunately, alternative strategies are no less problematic.

However the problem is solved, it would be reassuring to have an umpire to oversee the industry, especially to counter growing insurer influence over the delivery of medical care. If there is anything to be learned from the American experience, it's that medical care should be left to doctors and hospitals. Providing rebates is the only legitimate role for insurers.

Let us hope that we can avoid the American example, despite the early steps we have made down their path.

Dr Peter Waterhouse

PIAC Chair

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DR JULIA ROUSE
TMG CHAIR

TRAINEE MEMBERS GROUP COMMITTEE

WELLBEING

With recent trainee suicides and attempts in New Zealand and Victoria, the topic of trainee wellbeing should be a major agenda item for our profession. To think our trainees have been pushed to such a dark place, where suicide is the only option, is frankly devastating. As fellows and consultants, acting in a supervisory and role model capacity for our juniors, I believe we can play a crucial role in supporting budding anaesthetists navigate the challenges of training. As ASA Trainee Members Group (TMG) Chair, I often receive concerns from trainees. In attempt to share my insights and aid those wishing to help identify critical moments in training where we can support trainees, I will outline the top four concerns raised.

1. Getting onto training/ unaccredited years

I went to medical school with an intelligent, capable, warm, popular and handsome young man who had aspirations to get into anaesthetics. We had transitioned to different hospitals during our junior years however I knew he had untaken a service/ unaccredited year, in an attempt to build on his anaesthetic skills and develop solid references to get into anaesthetics. Early in my anaesthetic training, as ASA TMG junior state representative, I heard the news that he had not been successful in getting on to training after one or two attempts and had taken his own life. He reportedly received minimal support when unsuccessful in getting onto training. I was shocked and heartbroken for him, his family and our profession for losing such a valuable member of society.

I have received countless concerns to the TMG about how competitive anaesthetic training is getting. There is little we can do about the competitiveness however there is much we can do about supporting trainees through this considerably stressful and unsettling time. A time where juniors question their identity, abilities and grapple with uncertainty.

Things to do to support trainees:

- Share your journey into anaesthetics with those that may not have a direct path e.g. via ICU, GP, initial overseas training, service years
- Reassure them that they are good enough
- Offer to review their CV and provide constructive feedback
- Offer to undertake interview practice
- Offer to provide a glowing reference (if deserved)
- Make phone calls to help find a position to help them in their anaesthetic journey
- Make time to have a coffee/ meeting to make sure they are okay
- Recommend ASA PMET Super Saturday attendance, where ASA TMG Committee members share their experiences and advice regarding getting into training

2. Exams

Exams are important to ensure the safety of our community, with regards to anaesthetic practice. Exams nevertheless require considerable sacrifice and cause immense stress and anxiety for trainees. So much so that trainees have suffered well documented short- and long-term mental health conditions and have even been pushed to suicide in the lead up to exams or after receiving results. Our profession needs to do better for trainees on this front. Trainees require intense support with regards to exam preparation, both academically and emotionally. This is at an individual consultant, departmental, trainee scheme, college and professional society level. We should not believe that it is a rite of passage to suffer to such an extent that relationships fail, trainees are traumatised, and lives are lost. Exams are necessary however, as a profession, let's support trainees and colleagues during this time. Obtaining qualified anaesthetists from other countries is not the answer to bypassing trainees struggling with exams. Setting our standard and developing a culture focusing on support, wellbeing and longevity is.

Things to do to support trainees:

- Offer to provide teaching in a *psychologically safe environment* – if you are regularly making trainees cry or distressed (astonishingly reports we have received), please take a moment to reflect on your teaching technique. This approach to teaching is not evidence based or acceptable[1]
- Offer to provide regular, timely and meaningful feedback/ constructive criticism on SAQs and VIVA performances; the ASA online exam resources for trainees are invaluable
- Share resources and study tips widely
- Be flexible and compassionate with rostering, especially with regards to exam course attendance, study time and down time pre and post exams
- Provide immediate support and reassurance to those that have not been successful
- Share your stories of failure and what helped you to succeed in the end

3. Pregnancy and parental leave

We regularly receive questions and concerns about pregnancy and parental leave during training. Trainee treatment is vastly different between states, hospitals and even within departments. With trainees entering training later and later in life due to competitiveness as well as postgraduate medicine, advocating for trainee wellbeing in this space is a growing concern.

Things to do to support trainees:

- Pregnancy and family planning should be afforded the privacy it deserves. Pregnancy and family-related resources should be freely available e.g. rights to leave, return to work expectations etc
- Pregnant trainees should not be exposed to workplace hazards that may compromise their pregnancy e.g. radiation, contagious viruses i.e. COVID and CMV
- Pregnant trainees should be removed from after-hours and nights rosters as soon as possible and earlier if requested or if experiencing a high-risk pregnancy

- Trainees should be well supported during their return to work following prolonged parental leave, in a graduated fashion
- Parents should be provided with the leave required to care for their families, pre and postnatally
- Consider childcare commitments and significant expense when developing rosters
- Pregnancy and parental leave should not impact opportunities for list allocation or career progression
- Refer to professional and evidence-based guidelines regarding pregnancy and parental leave when developing departmental policies and procedures for trainees.

4. Bullying and abusive behaviour

Bullying is unreasonable behaviour that creates a risk to health and safety. It is behaviour that is repeated over time or occurs as part of a pattern of behaviour. Unreasonable behaviour is behaviour that a reasonable person, having regard to all the circumstances, would expect to victimise, humiliate, undermine or threaten the person to whom the behaviour is directed.

Despite more awareness of bullying, sadly recent trainee reports highlight ongoing bullying and abuse behaviour; up to 30%[2] . Bullying and abuse undoubtedly impacts trainee wellbeing. Trainees are already exposed to such high levels of stress with exams, training requirements, clinical emergencies and growing family responsibilities. Destructive and aggressive bullying behaviour should not be an added stress for trainees.

Things to do to support trainees:

- Lead by example: bullying and abuse should be deemed unacceptable. We can change this for future generations of trainees by making a commitment to stopping the cycle today and being role models for professional behaviour.
- Call out bullies rather than letting them continue their rampage on future trainees; escalate and report to SOT, HOD and OHS, if necessary, in a confidential way
- Provide support for trainees experiencing bullying and abuse
- Create easily accessible, safe and confidential means of escalation for victims
- Have a well-established and meaningful mentorship program for trainees to discuss, strategise and escalate concerns early

Trainee welling is paramount for the wellbeing of our profession. The concept of resilience puts the responsibility of wellbeing onto the trainees themselves; I would argue trainees are very resilient however pushed to the brink. We have a responsibility, as a profession, to identify system level stressors we can alleviate for the wellbeing and future of our trainees. I hope these insights shed light on current trainee concerns and how you can help.

Dr Julia Rouse
TMG Chair
Anaesthetic Fellow
MD, LLB(Hons)/B.Com(Hons), MMed (Critical Care), GradCert (Clinical Education)

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AROUND AUSTRALIA

New South Wales

Dr Simon Martel

Chair of the New South Wales Committee of Management

ASA 90th Anniversary NSW Function

A function was held on Saturday 30th November, at the ASA headquarters in Naremburn, to celebrate the first 90 years of the ASA. This was an opportunity to thank the many people who have been a part of the NSW Committee over the years, or who have contributed significantly to the ASA. Thank you to the ASA President and Vice-President, as well as previous ASA Presidents, who attended. An enjoyable night was had by all, and it was an excellent opportunity to learn some ASA history, and view the fantastic ASA Harry Daly museum.

Part III Course

A successful ASA NSW Part III course was held on Saturday 16th November at ASA headquarters. It was great to again be meeting face to face with trainees and new fellows to discuss the intricacies of practice as a consultant. The content and quality of the program was fantastic, and I would like to thank the many speakers, as well as Dr Katherine Jeffery and the ASA staff who helped organise the day.

VMO Determination

Members of the ASA continue to work with AMA NSW to build evidence for a work value case. That process was delayed whilst legislation was changed to allow a judge of the Industrial Court to arbitrate the case. Now that has occurred, we expect the AMA to progress to arbitration shortly.

Desflurane

The NSW Committee continues to monitor the effect of NSW Health's decision to unilaterally withdraw desflurane from the NSW Medicines formulary last year. According to feedback many have been able to continue to access desflurane in NSW public hospitals. We are very happy to receive feedback around access at nswchair@asa.org.au. This helps us to monitor the situation and advise other members who have questions.

General Anaesthesia in Dental Practices

We have received queries relating to the practice of providing general anaesthesia for dentistry in non-hospital settings. There were changes made to the NSW Private Health Facilities Regulation in August 2024, which has now come into effect, which may affect those members who provide general anaesthesia in non-accredited facilities. Members are advised to contact the ASA if they have any concerns.

Harry Daly Museum and Richard Bailey Library

The decision to make redundant the position of Archivist, Librarian and Curator, disproportionately affects NSW where the museum is located. The NSW committee has, and will continue, to support members who have been impacted by this decision.

Committee Membership

Given the size of NSW, representation is greatly enhanced by having members from many geographical regions and hospitals. We are always keen to welcome new committee members. Please contact nswchair@asa.org.au if you are interested.

Victoria

Dr Grace Gunasegaram

Chair of the Victorian Committee of Management

Represent

We continue to hold discussions with Return to Work and AMA Victoria to bring RVG rates for WorkCover cases in line with the rest of the country. In addition, workforce shortages in regional Victoria are deeply concerning. Changes to funding models, flexible public and private anaesthetic services for each community

including locums and VMO's, and regional training all need to be considered.

Educate

The 2024 Winter Anaesthetic Meeting (ASA/ANZCA) was a great success, with 268 attendees in total. Congratulations to convenors Dr Michelle Horne and Dr Geena Veerbeek. In addition to a fabulous speaker line-up and Emergency Response workshops, Measuring Outcomes workshops were included to help members acquire CPD hours for the Practice Evaluation subcategory. We look forward to welcoming delegates from all over Australia for our next winter meeting in August 2025 in Melbourne!

The ASA Victoria members celebrate its 90th Anniversary on the 18th of August. Dr David Pescod was acknowledged for his 20 years of affiliation with Mongolia; past president Dr Bob Hare spoke about his long association with ASA and future directions for anaesthetists; past president Dr Rod Westhorpe spoke about significant moments in ASA's history and evolution, including Dr Geoffrey Kaye's contributions and the history of the RVG. It was fantastic seeing so many of our members at the event.

We introduced a new initiative, the Career Connections Afternoon in late November, in recognition of the changing landscape of consultant position availability in Victoria. It was held in an informal networking setting, allowing an opportunity for one-on-one discussions between 30 attendees from different mixes of rurality and public, private or locum work. Thank you to Dr Kaylee Jordon and Dr Kristen Long for organising the event!

Update on Committee Changes

We have few changes to our committee. I was elected as Committee Chair and Dr Janette Wright was elected as the Deputy Chair. Secretary Dr Mark Suss and all other committee members will remain in their current positions.

Western Australia

Dr Archana Shrivathsa

Chair of the Western Australian Committee of Management

WA ACE Country Conference Pullman Resort, Bunker Bay

The sold-out ACE WA Country Conference held from the 15 to 17 November successfully brought together 127 delegates, ten sponsors, and featured a series of engaging keynote speakers and informative workshops. The theme was "Contemplation – Learning from Experience in Obstetrics" with eminent invited speaker Professor Victoria Eley, Research Lead at the Royal Brisbane and Women's Hospital.

Keynote presentations included Professor Victoria Eley's presentation on pain-free neuraxial anaesthesia and Dr. Matt Rucklidge's exploration of common challenges in anaesthesia. Interactive M&M sessions incorporated audience involvement in discussions of neurological conditions in obstetric patients presented by WA anaesthetists.

In the afternoon, the focus shifted to obstetric haemorrhage and critical care management.

Dr. Mathias Epee addressed placenta accreta spectrum, and Clinical Professor Nolan McDonnell provided strategies for managing postpartum haemorrhage. Professor Victoria Eley also highlighted the role of point-of-care testing in haemorrhage management.

These sessions were followed by an engaging discussion on the latest approaches to these high-risk obstetric scenarios. The afternoon concluded with an exploration of morbidity and mortality, featuring challenging cases such as severe obstetric sepsis and the perils of preeclampsia.

On the second day of the conference, CPD Emergency Response workshops were offered including CICO, Obstetric ALS and Major Haemorrhage with excellent attendance.

WA ACE lunch

Congratulations to convenors Dr Shilpa Desai and Dr Matt Browning on a fantastic conference, and thanks to all the speakers, workshop facilitators and sessions chairs for their time and effort.

ASA Part 3 Course

The WA Part 3 course was held on Friday 29th November at the UWA Club, convened by WA TMG representatives Dr Merredith Cully and Dr Kennia Lotter. The course was very well-attended, and featured the popular Heads of Department Q&A panel. WA public and private anaesthetists presented billing insights, credentialling, navigating PHI and tips on entering consultant practice. Speakers from MDA National and Avant discussed topical medicolegal issues and understanding a medical indemnity contract, and NOR Financial presented an overview of financial planning as a new specialist. To round out the day, a sunset mixer on the iconic UWA Club balcony offered a valuable and relaxing networking opportunity to Perth's incoming specialist anaesthetists.

WA Part 3 course

South Australia / Northern Territory

Dr Nicole Diakomichalis

Chair of the South Australia / Northern Territory Committee of Management

Support

We are continuing to connect with key stakeholders in both South Australia and the Northern Territory and have received invitations to provide feedback and submissions to important initiatives such as Return to Work SA. Thank you to Dr Louis Papillion and Dr Tristan Adams for their efforts in this area.

We celebrated the ASA's 90th anniversary at Victoria Park Social Club and are looking forward to organising more social events this coming year, providing opportunities for members to connect more often.

Represent

We have welcomed a new Chair, Dr Nicole Diakomichalis and new Treasurer, Dr Rebecca Madigan. We have Dr Cheryl Chooi as our Vice Chair. Thank you to Dr Sophia Bermingham, Dr Tim Donaldson and Dr Brigid Brown as the outgoing chairs.

Dr Matthew Fisher and Dr Tim Donaldson met with Dr Michael Cusack, SA Chief Health Medical Officer, at the beginning of last year. Various topics were discussed including workforce shortages and Public in Private work. We look forward to further collaboration with SA Health in the future.

We have had strong advocacy in the Payroll Tax space. The ASA and AMA met with representatives from Revenue SA, which allowed us to present questions put forward by our membership. Thank you to Dr Louis Papilion as our AMA representative.

Educate

A special mention to Dr Brigid Brown and Dr Indy Lin and their organising committee for a hugely successful NSC held in Darwin last year.

The ASA supported a Trainee Research Day held at the end of November, which was very well attended.

Thank you to our trainee representatives, Dr Mila Sterbova, Dr Evelyn Timpani and Dr Krushna Patel for their efforts this past year and in particular for all of their hard work organising the Part 3 course.

We are excited for the year ahead and look forward to representing our profession with strength and dedication.

Tasmania

Dr Alice Mulcahy from Hobart is the new Chair of the Tasmanian Committee of Management. Congratulations and thank you to Alice for taking on this important role.

HALMA UPDATE

THE HERITAGE OF THE ASA AND AUSTRALIAN ANAESTHESIA

THE ASA IS PRIVILEGED IN HAVING AN OUTSTANDING HERITAGE COLLECTION THAT REFLECTS THE DEVELOPMENT OF ANAESTHESIA IN AUSTRALIA AND GLOBALLY. THERE ARE ONLY A HANDFUL OF COUNTRIES LIKE AUSTRALIA WHO CAN BOAST OF THESE FACILITIES, AND IT REFLECTS THE DEPTH AND PROFESSIONALISM OF ANAESTHESIA IN AUSTRALIA.

There was a long period of transition for the Harry Daly Museum, the Richard Bailey Library and the Gwen Wilson Archives from the previous ASA headquarters during COVID and this is nearly finished with a re-ordering of the library collection awaiting to be done early in 2025 by the HALMA (History of Anaesthesia Library, Museum & Archives) committee.

This means that these resources are now available for members to visit, use and conduct research. A visit can be easily arranged by contacting the secretariat who can liaise with a member of HALMA to show you the facilities. All ASA members are encouraged to visit, even if only in Sydney for a few days. The heritage collection of the ASA is owned by the members of the Society and is there to be used. One project for HALMA is updating the online collection of the library and museum on eHive - the online museum platform. This will facilitate easier searching of the collections, which consist of over 2,000 museum objects and more than 3,000 books.


FISIOLOGIA

DEL DOLORE

PAOLO MANTEGAZZA

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FELICE PAGGI, EDITORE

1880

One project for HALMA is updating the online collection of the library and museum on eHive - the online museum platform. This will facilitate easier searching of the collections, which consist of over 2,000 museum objects and more than 3,000 books.

The Harry Daly Museum, thanks to the foresight of the ASA Executive during the move of the headquarters, is now housed in a high-standard professional area – this is the best preservation the museum has had in its very long history – this is through the five different homes of the ASA and other sites. The Museum has a selective acquisition policy with a greater interest in uniquely Australian pieces relating to anaesthesia that are not found elsewhere, and all acquisitions are vetted by HALMA.

The Richard Bailey Library is one of the best global collections of books and journals relating to the history of anaesthesia, resuscitation, pain medicine and related fields. Unfortunately, after 30 years, we no longer have a part-time professional curator due to recent budgetary constraints, but HALMA will be happy to help researchers find what they are looking for in any area of the development of anaesthesia. This could be for a presentation, for future meetings, or a publication – either by an individual, a department and of course the Society. Research done within the collection has been published in the History Supplement of Anaesthesia and Intensive Care, other journals and has also been presented nationally and internationally.

The Gwen Wilson Archives are a professional storage area of early documents on the development of the ASA and anaesthesia in Australia for the serious researcher. This archive will need professional organisation to aid in searching and hopefully in the future the ability to scan all the documents and have them available digitally.

HALMA ran a well-attended one-day meeting in September 2024, 'Beyond the Mask', and a further one to two are planned for 2025.

The heritage collection of the ASA is entering a new phase and is there for the membership – HALMA is planning to support this new phase of development.

Dr Michael G Cooper AM

Honorary Curator
Harry Daly Museum

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