The patient and your colleagues in theatre have every right to expect that the Anaesthetist will perform to the reasonable standard of our profession at all times.

The law is clear on several levels that this right exists and that it will be enforced by disciplinary tribunals, employers, accrediting institutions and the courts. Even if no incident occurs or no harm comes to the patient, adverse disciplinary, career and reputational consequences can still result for the Anaesthetist if their supervision is found lacking.

Things can go wrong quickly, even during routine cases involving simple procedures on healthy patients. However, sometimes the Anaesthetist needs to move away from the patient's immediate vicinity for reasons of varying importance.

Protocols are in place for handover when the Anaesthetist needs to leave. The relevant standard is PS53 published by ANZCA.1

Obtaining alternative supervision is simple enough in a big theatre complex with many personnel present during business hours, but there are many variations on this scenario that are less clear cut.

Questions to ask when considering whether to leave the theatre or reduce supervision while still close by:

- What is the reason?
- How long could I be gone for?
- How quickly can I return and become fully engaged in care?
- What is the status of the procedure and the patient?
- Who is available and qualified to supervise in my absence?

If you decide to leave the theatre, it is important you:

- inform all in the operating theatre of the plan
- hand over to the person responsible in your absence who should be qualified, willing and able, and not involved in other tasks
- consider remaining in mobile phone contact with the theatre staff while you are absent.

Having decided to leave, has the plan above been implemented?

It is quite unlikely for a big problem to occur during your brief absence. However, if you leave the theatre many times over a long career, a preventable disaster becomes more likely. Having a defensible plan is the right way to go.

Reference

As a mature Anaesthetist, should you be considering retiring? Ah, retirement – golf, travel, grandkids, fine wine... You might also end up missing your colleagues’ banter, pondering your bantam-sized nest egg, and driving your spouse nuts. For some, unexpected illness may force the decision. For all of us however, the inconvenient facts of ageing need to be faced honestly. Neurocognitive skills decline, performance of stressful and complex tasks is reduced, along with speed and appropriateness of decision-making, and, importantly for Anaesthetists, manual dexterity and visual acuity are lessened.¹,²

And although older Anaesthetists tend to care for fewer patients having simpler procedures, they have substantially more cases involving litigation and severe patient injury.¹,²

So retirement should not be postponed until a mishap occurs or we receive the dreaded tap on the shoulder – “might be time to hang up the stethoscope”. As the old saying goes, better a year too early than a day too late!

Regrettably, the previously popular option of retiring but still undertaking limited prescribing or referring for relatives or friends is no longer allowed.

What about just having a break to think about your future? According to the Medical Board of Australia (MBA), up to a year’s absence from practice is okay, but if longer than that you will need to complete at least a year’s worth of relevant Continuing Professional Development (CPD) before returning to practice. Over three years of absence brings more onerous conditions.

The next thing to decide is whether you want to stay in any form of medical practice after pulling the pin on full-time clinical anaesthesia? The MBA website details alternatives, but here is the gist.

Could you move to part-time work or a change of field? MBA accepts part-time work with no clear minimum commitment specified. Changing your area of work will necessitate relevant training in consultation with the Australian and New Zealand College of Anaesthetists (ANZCA) and a professional development plan for consideration by MBA.

MBA has categories for those purely doing teaching, research or public speaking on health matters but it disallows prescribing and patient referrals. Naturally, if remaining in any form of clinical practice, CPD is mandatory.

ANZCA’s three options are for clinical, non-interventional, and non-clinical work; each having particular requirements for activities and credits.

After thinking about all that – and the looming possibility of revalidation – you might decide to “do an ABBA” and retire at the height of your success!

Retirement Options for Anaesthetists
By David Swift MBBS FFARACS FANZCA

Is retirement a transition from being a participant to merely an observer? Far from it!

Further reading:
Defence Update Autumn 2015 has a comprehensive feature on various aspects of retirement including some practical considerations to be aware of when planning your retirement.


References
The $ting of a Wisecrack…

A patient is undergoing surgery. Consider these possible scenarios while the patient is under anaesthetic. The Surgeon comments that the patient is one of the dumbest people he has ever met and he can’t believe they have a PhD. Or the anaesthetic nurse states that when she went to pre-op holding to check the patient in, the patient was in tears because she had to remove her nail polish – “how pathetic is that!” Or when prepping a morbidly obese patient, the scrub nurse jokes to the scout, “there’s not enough Betadine on earth to cover this belly”. Scenarios such as these occur every day in multiple operating theatres around the country. However, this doesn’t make it right or okay - even if the surgical team is making a harmless joke and no malice is intended.

The advent of entropy or BIS monitoring to measure depth of anaesthesia has considerably lessened the number of cases in which patients, post-operatively, report having awareness during the procedure (and can accurately describe conversations and other things they heard whilst undergoing surgery).

Irrespective of whether a patient is appropriately sedated or anaesthetised, other “ears” may be listening.

The case

The recent US case of DB v Ingham (2015) is one in which the mocking of a sedated patient has come at a very high price for one medical professional.

Briefly, Mr DB was scheduled to undergo a colonoscopy under sedation. Before the procedure started, he set up the recording function on his smartphone so it would be ready for him to record his post-procedural discussion with his Gastroenterologist (Dr Solomon Shah), including recording any instructions that may be given to him.

After Mr DB had been sedated (and even before the procedure commenced), the surgical team started to insult and mock him. Many comments were made, including the following:

• The Anaesthetist (Dr Tiffany Ingham) told the sedated Mr DB that within five minutes of speaking with him pre-operatively she had wanted to punch him in the face and “man [him] up a little bit”. • When an assistant commented that Mr DB felt queasy when he saw a needle go in his arm, Dr Ingham said, “well, why are you looking then, retard”? • At some stage during the procedure when a medical assistant noticed that Mr DB had a rash, Dr Ingham warned her not to touch it and said she might get “some syphilis on your arm or something”, before adding, “it’s probably tuberculosis in the penis, so you’ll be all right.”

• Dr Shah and Dr Ingham discussed how they could avoid speaking with Mr DB following the procedure. Dr Ingham went so far as to say, “you’re going to have to have a timer go off or have like a fake page... I’ve done the fake page before”.

Although Dr Shah’s comments were not of the number and scale of Dr Ingham’s, he did not ask her to stop speaking disparagingly of Mr DB.

At the end of the recording, Dr Ingham was heard to say, “I feel bad. I shouldn’t be so mean.”

When Mr DB was on his way home following the procedure, he pressed “play” on his phone to listen to what Dr Shah had told him. Mr DB was shocked to discover he had inadvertently recorded the entire procedure and that he had been mocked from the moment he went to sleep.

Mr DB sued Dr Ingham and Dr Shah and their respective practices for medical malpractice and defamation. The case proceeded to trial. The case against Dr Shah was dismissed on the first day of the trial, although the case against Dr Ingham was heard over three days. A jury awarded Mr DB US$500,000 (of which US$200,000 was for punitive damages).

The case has received considerable publicity, both in USA and around the world. In the wake of the claim, Dr Ingham moved to Florida, and some media outlets report that she is not currently working.

Discussion

This case is a timely reminder to all healthcare personnel, not just medical practitioners, to be mindful of what they say intraoperatively. Leaving aside the possibility that a procedure may be inadvertently or intentionally recorded, it is unprofessional to speak about a patient (or anyone for that matter) in the way the doctors, particularly Dr Ingham, did in this case.

The THINK acronym would have well-served Dr Ingham – her comments were not True, Helpful, Important, Necessary or Kind.
Education Resources for Anaesthetists

MDA National delivers high quality education as part of our longstanding commitment to supporting, protecting and promoting Members. Much of our education is accredited, and all of it is complimentary for our Members:

- Face to face education events delivered around Australia, such as:
  - Practical Solutions to Patient Boundaries
  - Enhancing Patient Understanding - Health Literacy and Communication
- Booklets and information sheets on medical records, retirement from medical practice and other topics.
- Distance education options allowing you to accrue Continuing Professional Development (CPD) points anytime, anywhere. These include:
  - online and hardcopy education activities associated with our Defence Update publication
  - Practice Self-Assessment Handbook (Anaesthetic Practice) - designed to help you identify and mitigate potential risks that could threaten patient safety and/or satisfaction (to order your copy email peaceofmind@mdanational.com.au).

Upcoming events
For more information on face to face events, visit our online events calendar at mdanational.com.au or call our Member Services team on 1800 011 255. If you're interested in distance education options or other educational resources, log on to our Member Online Services.

Host a face to face education session
MDA National aims to provide face to face education sessions at Members’ request. All you need is a suitable room and a guaranteed group of participants. If we can fill your request, we will provide the session facilitator and all education collateral to support the activity.
For more information, call 1800 011 255 or Sandra Reed, MDA National Business Development Manager on 0419 269 733, email sreed@mdanational.com.au.

Medicare Audits
We have become aware of numerous Medicare audit activities affecting Anaesthetists and other specialists. For more information, see our Defence Update Winter 2015 at mdanational.com.au/en/Publications/Defence-Update.

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The information in Anaesthesia Update is intended as a guide only. We recommend you always contact your indemnity provider when you require specific advice in relation to your insurance policy. The case histories used have been prepared by the Claims and Advisory Services team. They are based on actual medical negligence claims or medico-legal referrals; however certain facts have been omitted or changed by the author to ensure the anonymity of the parties involved.