

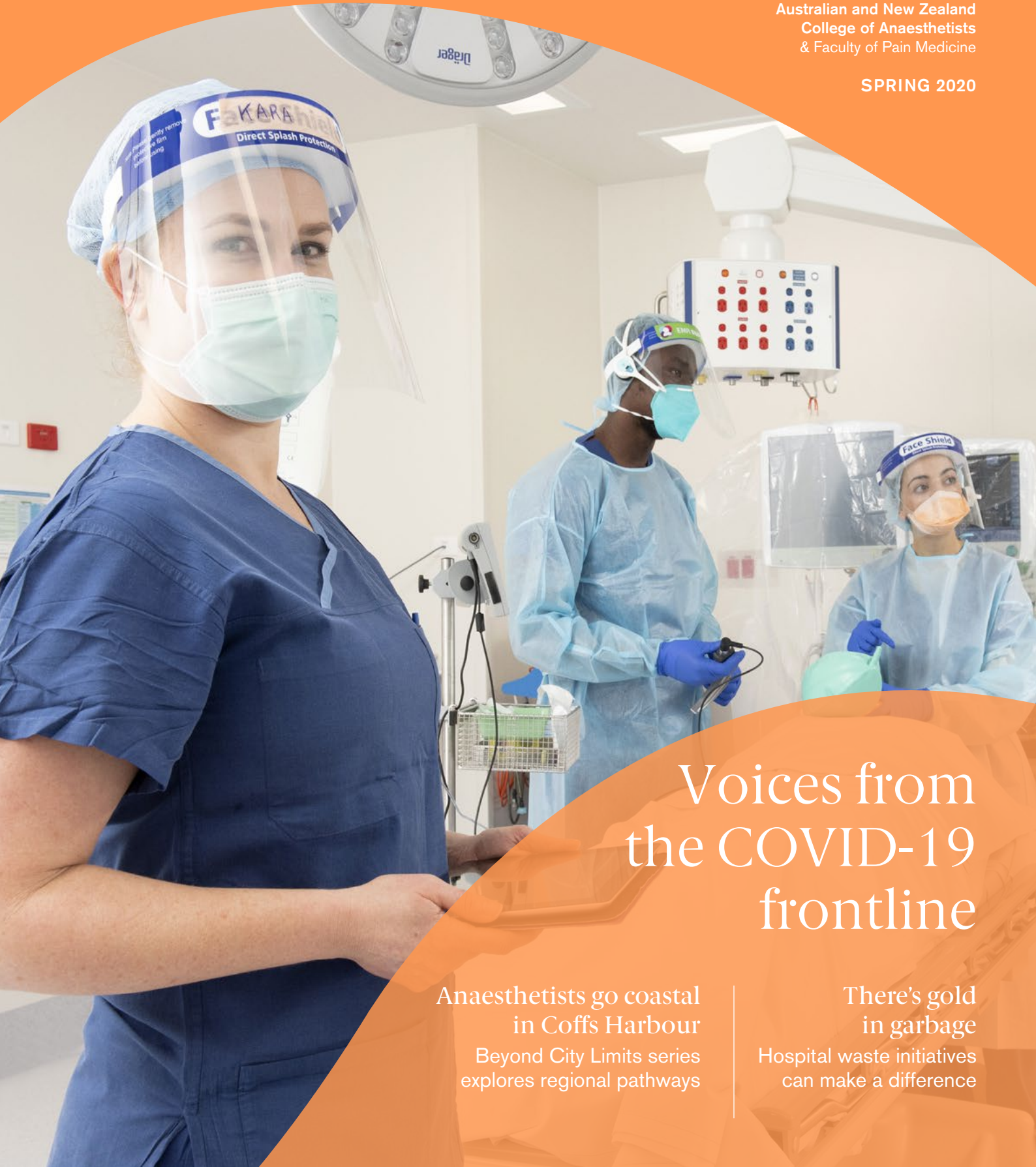


ANZCA
FPM

Bulletin

Australian and New Zealand
College of Anaesthetists
& Faculty of Pain Medicine

SPRING 2020



Voices from the COVID-19 frontline

Anaesthetists go coastal
in Coffs Harbour
Beyond City Limits series
explores regional pathways

There's gold
in garbage
Hospital waste initiatives
can make a difference

Contents

Beyond City Limits series
heads to Coffs Harbour
on page 36.

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ANZCA Bulletin

The Australian and New Zealand College of Anaesthetists (ANZCA) is the professional medical body in Australia and New Zealand that conducts education, training and continuing professional development of anaesthetists and specialist pain medicine physicians. ANZCA comprises about 7500 fellows and 1700 trainees mainly in Australia and New Zealand. It serves the community by upholding the highest standards of patient safety.

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*Editor's note: The *ANZCA Bulletin* did not intend for the Winter 2020 edition article "Online data tools can help anaesthetists" to be read as an endorsement of a particular digital application over another. We apologise if the article has been misconstrued in this way.

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Photograph: Elizabeth Oswald



Pandemic challenges now our new normal

TĒNĀ KOUTOU, E HOA MĀ.

I managed to start my term as president of ANZCA on 4 May 2020, just as the COVID-19 pandemic was biting New Zealand and Australia. People were in justified fear of their lives. They were adjusting to restrictions on a scale not experienced since World War II.

Very little was known about the virus. Uncertainty was everywhere. One of the few certainties was that anaesthetists would be on the frontline in the management of the most acute cases.

Against that backdrop, all the comforting traditions and rituals of the handover of the governance of ANZCA were impossible. Instead of gathering the new council in one place to start our new working relationships in person, we were constrained by the limitations of a camera, a microphone and a screen.

Zoom, almost unheard of a year ago, is now the glue that holds organisations together. While it is vastly better than phone conferences, it's hard to get the "heart to heart" without the "kanohi ki te kanohi" (the face to face). It is still possible to get from a set of meeting papers at the beginning to a set of minutes

at the end, but the missing elements include the more relaxed and free-flowing conversations over lunch and dinner, where good solutions to seemingly intractable problems sometimes emerge. Also missing is togetherness in time. Five hours of time zones separate the western and eastern boundaries of ANZCA. To take part in the same conversation, Western Australia has to be up early, or New Zealand has to stay up late.

On 4 May 2020, six of the ANZCA Council members were new. It is a credit to them, and to the returning councillors, that the new relationships are off to a good start.

The hardest project so far has been to find a way to conduct the trainees' exams. COVID-19 restrictions on gatherings and travel have upended the basic principles on which exams have been conducted until now. For consistency of standards, they were always held in the same places, at the same time, sitting the same papers under the same invigilation and questioned viva voce by the same panels of examiners. Suddenly, most of those requirements could not be satisfied. Alternatively, no more exams could be held in 2020. That would clog the pipeline of training for significantly longer than merely during the year of interruption.

The different viewpoints were hard to reconcile. The examiners focused on standards, with a concern that the graduates of 2020 should not be perceived as less thoroughly examined than their predecessors and their successors. They also had a justified anxiety that, while video conferencing has become workaday, a technological failure in a single region could damage the integrity of the whole exam process, to such an extent that recovery would be impossible.

The hardest project so far has been to find a way to conduct the trainees' exams."



The trainees had equally valid concerns. No one who has sat a high-stakes exam is ever too old to remember the emotional stresses that go with it, even in the best of times. Candidates pace their preparation in sprints and rests, the sprints requiring intense mental and emotional effort. To have the rhythm of their preparation interrupted unpredictably by the caprice of outbreaks of the virus is an exhausting and dispiriting experience for them. That effect is worsened by long periods of uncertainty, while plans to examine in two countries, then in different regions, and then in different hospitals within regions were put together, against a backdrop of fresh outbreaks.

Meanwhile in the background, work is going on at pace to develop a robust technology-assisted exam, in which everyone can have confidence. With so many variables, there is no perfect answer. Each new problem sparks a search for the best alternative, or the less bad one.

Advocacy for the past few months has been concentrated on getting the right level of protection by "fit testing" masks, and ensuring an adequate supply of personal protective equipment (PPE) for our people. As always, we do this in a collaborative and courteous manner, while not soft-peddalling that this is crucial to the safety of clinical staff and patients alike.

Meanwhile, for me and for the ANZCA councillors, committee members and staff, life is a seemingly endless procession of Zoom meetings. The impact on the running of college activities has been immense. Despite this, we are in a stable position, and are able to continue support for fellows and trainees.

Kia ora tātou katoa – literally, "Let us all be well!"

Dr Vanessa Beavis
ANZCA President

"With so many variables, there is no perfect answer."

College embraces change in time of COVID-19



In recent months, ANZCA has been very active in the media with advocacy and promotion of ANZCA's support for appropriate use of personal protection equipment (PPE) and the safety of healthcare workers.

We continue to have ongoing discussions with the office of the Australian chief medical officer about the impact of COVID-19 on college's activities. The New Zealand National Committee has also been engaging with government to promote the role of anaesthesia and the need for improved access to pain medicine in the lead up to the New Zealand election.

The impacts of travel restrictions and social distancing requirements has had a huge impact on college events. As we've navigated through the "new normal" of Zoom we have also been busy with increasing our capacity to hold online college events and webinars, something we would never have contemplated six months ago.

In the first six months of the year, ANZCA has had about 80 webinars and staff have collectively participated in more than 20,000 Zoom meetings, with more than 50,000 participants, totalling in excess of 1.8 million minutes.

We are now in the process of upgrading each of our offices across Australia and New Zealand to have at least one Zoom enabled meeting room, ensuring our investment in the technology will continue to be utilised in the future.

The added advantage of Zoom meetings is the flexibility it gives our fellows, trainees and staff as they undertake college business, not to mention the savings in time, effort and costs.

The team in the Faculty of Pain Medicine has been working tirelessly over the past few months delivering on the successful tender received from the Therapeutic Goods Administration (TGA) to provide Better Pain Management module access to 10,000 Australian medical and allied health staff.

In just three months they have already exceeded their target, having registered over 2400 healthcare professionals and improving the knowledge and understanding of opioids in the management of chronic non-cancer pain.

The faculty team is also completing a literature search to inform the Pain Management Health Practitioner Education Strategy, a key grant awarded to the faculty this year.

The strategic goal of developing training in procedural pain medicine has advanced significantly this year with the pilot program set to be delivered for the 2021 academic year.

Nigel Fidgeon
ANZCA Chief Executive Officer

AS WE EMERGE from winter it seems hard to imagine that our lives were upended by COVID-19 back in March.

Despite the pandemic rollercoaster ride, significant work has been happening behind the scenes across the college in Australia and New Zealand. The impact of the coronavirus and the restrictions introduced by state and territory governments in Australia and the New Zealand government over the last few months has led to a new way of doing things for all of us.

A significant issue for the college has been the impact on exams. The logistics of conducting primary and final exams during the pandemic has been challenging for trainees, examiners, specialist international medical graduates and our staff who have had to comply with different jurisdictional restrictions across multiple sites in Australia and New Zealand.

A lot of time has also been spent finalising our plans to hold technologically-assisted vivas and we've ensured that information about the exams is regularly updated on our website and distributed to candidates.

All but our Melbourne office staff have returned to work in their respective workplaces. Those of us in St Kilda Road are anxiously waiting to hear when ANZCA House can reopen.

I'm pleased to report that the college has been successful in securing an additional year of Australian government funding for specialist training positions (STP). We now receive funding for 42 STP positions across Australia and ANZCA's management of the STP program was complimented by KPMG during the audit process. The management of STP funding by the college and the positive relationship with the Commonwealth has led to STP support project funding for trainees and supervisor wellbeing.

Free ANZCA Doctors' Support Program



How to make an appointment:

To speak with a counsellor over the phone or make an appointment to see a consultant for a face-to-face session:

- Telephone 1300 687 327 in Australia or 0800 666 367 in New Zealand.
- Email eap@convergeintl.com.au.
- Identify yourself as an ANZCA fellow, trainee or SIMG (or a family member).
- Appointments are available from 8am to 6pm Monday-Friday (excluding public holiday).
- 24/7 emergency telephone counselling is available.



HELP IS ALSO AVAILABLE VIA THE

Doctors' Health Advisory Service:

NSW and ACT	02 9437 6552
NT and SA	08 8366 0250
Queensland	07 3833 4352
Tasmania and Victoria	03 9495 6011
WA	08 9321 3098
New Zealand	0800 471 2654
Lifeline	13 11 14
beyondblue	1300 224 636

FANZCA and FFPMANZCA logos

Fellowship of ANZCA and FPM are internationally recognised hallmarks of specialists of the highest professional standing. The logo is a symbol that the holder has not only met the requirements for admission to fellowship, but also remains a member in good standing with a professional organisation that has the highest aspirations for safe and high-quality patient care.

We've developed some simple guidelines for the use of these logos and the files are available in the fellows' toolkit under the "Fellowship" tab on our website – anzca.edu.au/fellowship/fellows-toolkit/fanzca-and-ffpmanzca-logos.

Fellow of the Australian and New Zealand College of Anaesthetists



Fellow of the Faculty of Pain Medicine



ANZCA and FPM in the news

COVID-19, PPE and fit-testing top issues for media

The COVID-19 pandemic and concerns about fit-testing and personal protective equipment (PPE) guidelines continue to dominate media requests for expert comment from ANZCA and anaesthetists, and reporting of the specialty in the context of the coronavirus.

ANZCA's lead role in engaging with state and federal health ministers on the issue of fit-testing and PPE attracted strong interest from *The Sunday Age* on 16 August. A letter from President Dr Vanessa Beavis to the ministers featured in a page 5 "lead" article in *The Sunday Age* and online articles that were syndicated to the *Sydney Morning Herald*, *WA Today* and the *Brisbane Times* with comments from ANZCA's Safety and Quality Committee Chair Professor David Story who was interviewed about the letter. The article reached nearly 800,000 readers.

Professor Story was also interviewed by Australian Associated Press for an 8 August article about the supply of PPE in Victorian hospitals as concerns continued to mount about the COVID-19 infection rates of health workers in Victoria. Professor Story's comments were included in the article which was syndicated to 32 online media outlets across Australia.

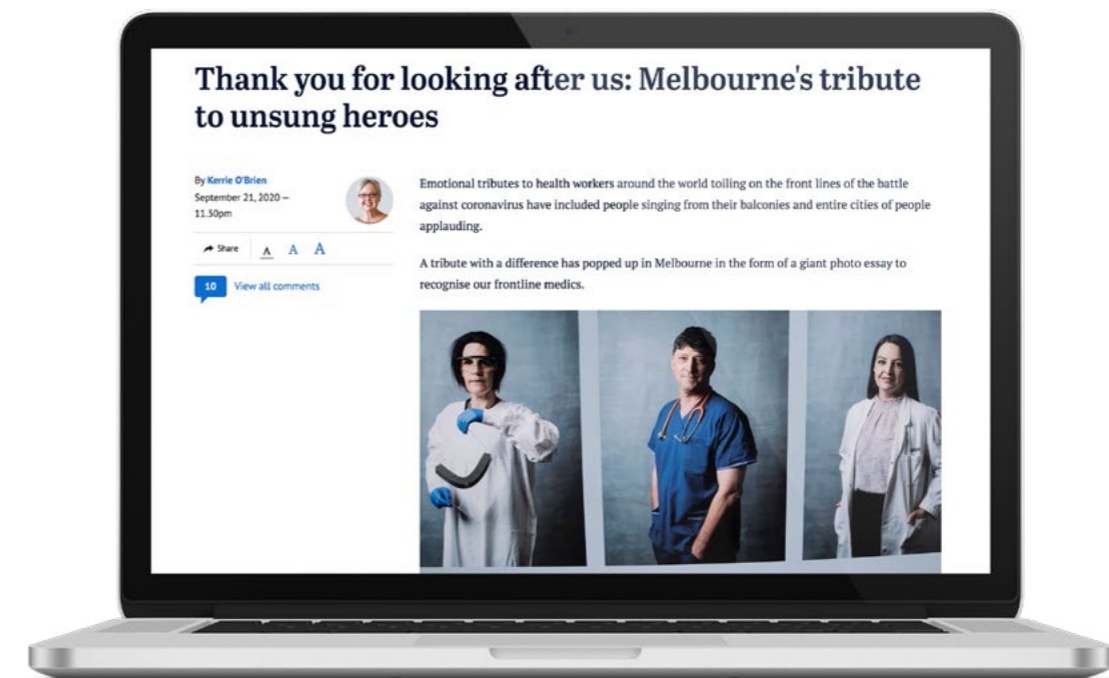
Professor Story was interviewed by *The Age* for a page one 17 September article about the staged resumption of elective surgery in Victoria in late September and the impact the restrictions may have had on patients

with chronic conditions. Professor Story expressed concern about elective surgery patients battling chronic health conditions such as diabetes, heart disease and hypertension, who might have delayed seeing GPs and specialists. The article also appeared in *Sydney Morning Herald*, *WA Today* and the *Brisbane Times* online news sites reaching an audience of over 500,000 people.

One of Australia's largest regional TV networks, WIN News, followed up the article with a Zoom interview with Professor Story for WIN TV News Bendigo as elective surgery resumed in regional Victoria on 17 September. The interview was used in their 6pm evening TV news bulletin.

Professor Story co-authored an opinion article "Careful, medicines can also be poisons" with Alastair Stewart, director of the Australian Research Council Centre for Personalised Therapeutics Technologies, in *The Australian* newspaper on 25 August. The article stressed the importance of science and high-quality clinical trial evidence in determining the safety of treatments for COVID-19.

A portrait of Professor Story for a Melbourne "pandemic heroes" photographic display became the focus of an article in *The Age* on 21 September about the project. Channel Seven News Melbourne interviewed Professor Story about the project which also featured portraits of



other clinicians and healthcare workers. Melbourne's 5km lockdown travel rule meant the TV crew could not film Professor Story at the photo essay site in inner Melbourne so they had to interview him at home instead.

Several fellows working in the frontline of Victoria's "second wave" of coronavirus infections were profiled in broadcast and print and online media reports. Dr Forbes McGain, deputy intensive care unit (ICU) head at Footscray Hospital, was interviewed in an ABC 7.30 report about the second wave of COVID-19 cases in Victoria. On the night 7.30 visited the hospital, intensive care nurses and physicians were treating three patients, and a fourth suspected COVID patient.

Dr McGain was also the subject of an article in *The Australian* on 29 July "Hospital breakthrough removes the fear factor" which explained how the COVID-19 ventilator hood he helped develop with Western Health and the University of Melbourne separates medical staff from the patient without losing line of sight, containing the droplets.

Melbourne fellow, Associate Professor Alicia Dennis, was interviewed for an ABC national radio AM segment on 26 August about the Victorian Government's PPE action plan and the COVID-19 infection rate among healthcare workers. Professor Dennis noted that "the magnitude of the problem is devastating and tragic". The segment attracted an audience of 400,000 people. Associate Professor Dennis also co-authored an article for *The Conversation* on 4 August, "PPE unmasked: why healthcare workers in Australia are inadequately prepared against coronavirus".

Another Melbourne fellow Associate Professor John Moloney, head of The Alfred hospital's emergency department, was profiled in an article in *The Age* on 30 July "Inside Victoria's aged care tragedy" which detailed the issues of transferring elderly residents from aged care facilities to hospital. The article reached a combined print and online readership of 500,000 people.

ANZCA councillor Dr Stuart Marshall wrote an article for *The Conversation* on 19 June about how the 80s TV show *MacGyver* is inspiring doctors and healthcare workers during the pandemic to think outside the square and "create workarounds to fill the perceived gap between what they have and what they need".

In Adelaide, Dr Tom Painter was interviewed for an 8 July *Adelaide Advertiser* article "RAH on guard for a second-wave surge" about the national COVID-19 screening project. Dr Painter confirmed that elective surgery patients at the Royal Adelaide Hospital will be swabbed for COVID-19 while under anaesthetic as part of the study.

Media and television coverage of fellows was not confined to COVID-19 issues. Dr Richard "Harry" Harris, joint Australian of the Year in 2019 for his leadership of the Thai cave rescue, appeared in an episode of *Anh Do's Brush with Fame* on the ABC on 11 August.

In Perth, WA anaesthetist and researcher Professor Britta Regli-von Ungern-Sternberg was interviewed for an ABC *Country Hour* report on 15 August on her latest research into whether honey could help ease post tonsillectomy surgery pain for children. The five minute

story was broadcast in Qld, WA, Victoria and was also posted on ABC online.

Another Perth anaesthetist, Dr Hamish Mace, was interviewed by the host of ABC Radio National's *Health Report* Dr Norman Swan on 31 August about perioperative medicine research at Fiona Stanley Hospital. The research highlighted the clinical and cost benefits of iron infusions for patients with anaemia in the weeks leading up to surgery.

Queensland anaesthetist Dr Richard Cooper was interviewed by the *Daily Mercury* in Mackay for an August 7 article "How chewy might become tool in Mackay doctors' kit." He explained how researchers at Mackay Base Hospital are participating in the international CHEWY trial to examine whether chewing gum may be more effective than drugs in relieving post-surgery nausea. Dr Cooper is a principal investigator for the trial.

Perth fellow Dr Bruce Powell, whose first person account about his life changing cycling accident featured in the Autumn 2020 edition of the *ANZCA Bulletin*, was interviewed by ABC Perth radio host Geoff Hutchinson on 3 August for a 20 minute segment.

Carolyn Jones
Media Manager, ANZCA

Since the Winter 2020 edition of the *ANZCA Bulletin*, ANZCA and FPM fellows have featured in:

- 13 print reports.
- 30 radio reports.
- 140 online reports.
- 3 TV reports.



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**NATIONAL
ANAESTHESIA
DAY 2020**

**Anaesthetists:
Always ready**

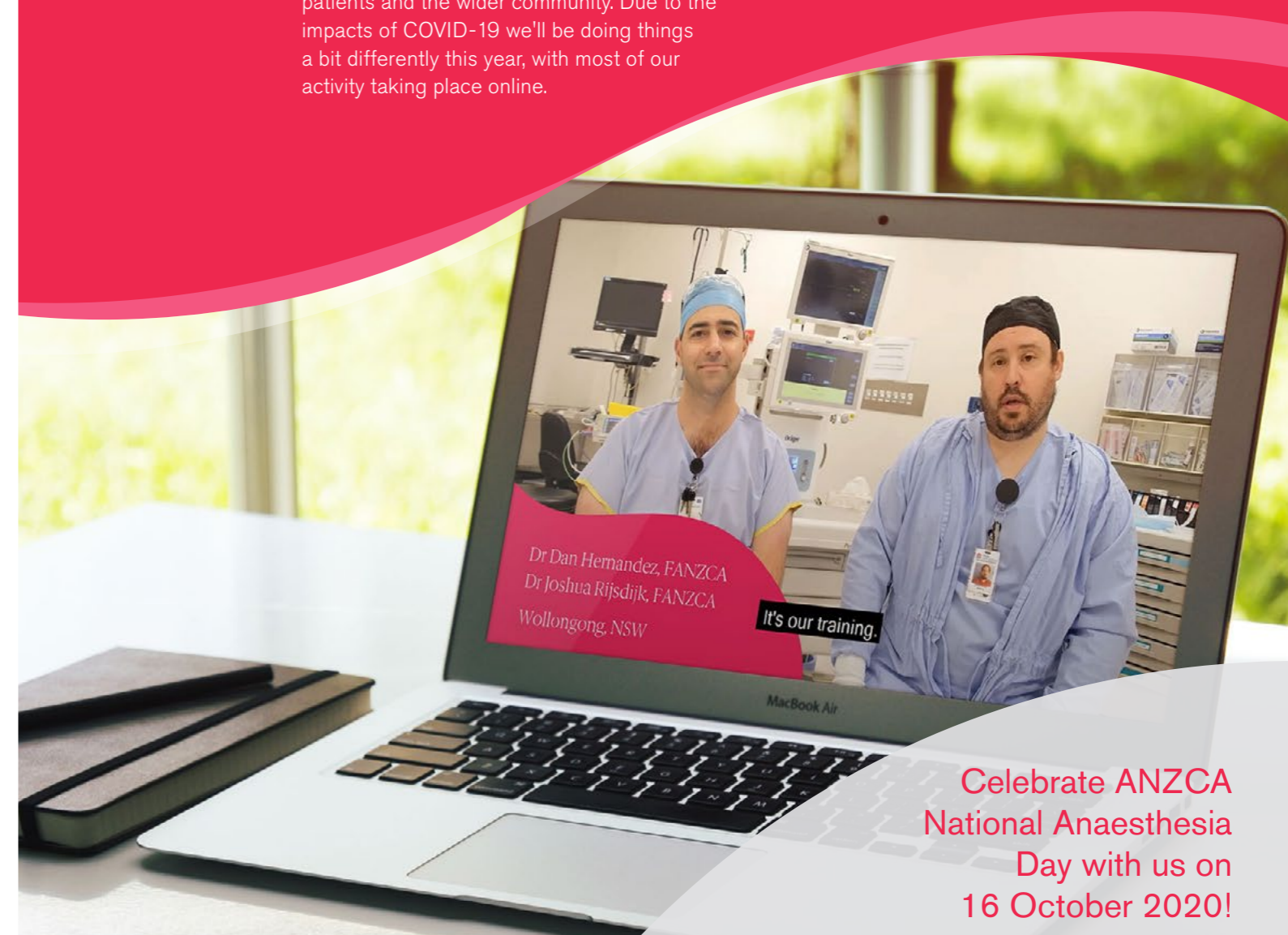
Each year, on 16 October, we celebrate the anniversary of the day in 1846 that ether anaesthetic was first demonstrated in Boston, Massachusetts by supporting public activities and displays in hospitals around Australia and New Zealand.

This year's theme for ANZCA National Anaesthesia Day is "Anaesthetists: Always Ready". This builds on the profile that our specialty has received as a result of the COVID-19 pandemic and the role our doctors have played. It's a chance for us to share the special attributes of anaesthetists with patients and the wider community. Due to the impacts of COVID-19 we'll be doing things a bit differently this year, with most of our activity taking place online.

We have invited our fellows, trainees, and specialist international medical graduates around Australia and New Zealand to share their experiences as an anaesthetist on the frontline, and how they are "always ready" for any emergency, via short videos.

The videos will be edited and shared via our YouTube, Twitter, and Facebook accounts, as well as being made available to play on a loop in your hospitals.

Keep watching our website for updates!



**Celebrate ANZCA
National Anaesthesia
Day with us on
16 October 2020!**

#NAD20 #AlwaysReady

Framework and module development progressing



AMIDST THE COVID-19 pandemic, our perioperative medicine project continues, with two education modules drafted and a third on its way, and our document detailing the phases in our perioperative medicine framework nearing conclusion.

We are undertaking an economic analysis of perioperative medicine based on last year's literature review, and this will be another important resource for explaining the benefits of perioperative medicine.

Perioperative medicine market research

Earlier this year, the results of our research into the perioperative medicine education market were released.

This research, undertaken by the Curio Group, found there is demand for a perioperative medicine qualification that includes a practical learning

experience and did not necessarily result in a tertiary qualification.

Incorporating non-clinical components, such as communication, leadership and collaboration skills, was seen as highly desirable.

The most likely candidates for doing a 12-month perioperative medicine qualification were those one to three years post-fellowship. The course should be multidisciplinary and inter-professional and have the potential for participants to upskill through completing individual units or modules.

Recognition of prior learning and experience is being considered and we are also considering how those now working in perioperative medicine may become supervisors of training.

Surveying geriatricians and others

The Royal Australasian College of Physicians (RACP) and ANZCA recently surveyed geriatrician consultants, trainees and specialist international medical graduates (SIMGs) on perioperative medicine. The survey was comparable to an earlier survey of ANZCA consultants, trainees and SIMGs. Findings indicated that:

- Perioperative medicine adds value to clinical practice through improved coordination with primary and community care, improving patient satisfaction through patient-centred goals of care and sharing best practice with all clinicians.
- The additional skills and knowledge that a perioperative medicine specialist brings is an understanding of intraoperative anaesthesia management, critical care and resuscitation, and general medicine.
- Sixty-six per cent of respondents agreed that it was reasonable to complete up to one year of additional training in perioperative medicine and 47 per cent would consider undertaking an additional year of training. This is similar to the responses from the ANZCA survey.

The College of Intensive Care Medicine's Perioperative Medicine Special Interest Group also recently surveyed its members. While a small sample, there is substantial participation in – and a desire to increase participation in – perioperative medicine led by intensivists as part of multidisciplinary teams.

Surveys of other disciplines are planned for later this year.

The Australian and New Zealand Society for Geriatric Medicine, with whom we are working on this project, is establishing its own perioperative medicine special interest group.

Perioperative care framework development

The Perioperative Care Working Group is continuing its work on expanding the perioperative care framework into a robust document that provides detail on the key stages identified in perioperative medicine.

The document also identifies two key groups within the process – the perioperative care team and the perioperative medical team.

The perioperative care team includes all individuals who may be involved in a patient's perioperative journey and may include doctors, nurses and other health professionals in hospitals or clinics, as well as family members or other carers.

The perioperative medical team is led by medically qualified specialists and works collaboratively with the surgical team and other health disciplines. The perioperative medicine team may include consultants and trainees in anaesthesia, internal medicine, geriatric medicine, other medical specialties, and intensive care.

Curriculum development

To date, two modules have been drafted by the Perioperative Curriculum Development Working Group, which is a subcommittee of the Perioperative Medicine Education Group.

Informed by the Perioperative Medicine Care Framework and the curriculum framework, the first module is titled "Perioperative Impact of Major Disease and Risk Stratification" which focuses on preoperative assessment and risk stratification to inform patient preparation optimisation and referral to other health professionals before surgery.

The second is "Planning for Surgery" focusing on the preoperative consideration of particular at-risk groups.

The Perioperative Curriculum Development Working Group expects to have a third module drafted by the end of the year.

Modules are being developed for each stage of the Perioperative Medicine Care Framework and will include content and assessment options.

Dr Sean McManus
Chair, Perioperative Medicine Steering Committee



College bursaries

Did you know each year ANZCA offers a number of bursaries to trainees who are experiencing financial hardship?

Eligible trainees can receive up to a 50 per cent reduction in their annual training fees. All applicants will also receive an extension to the annual training fee due date

Applications for 2021 will open in mid-November.

Please note: Applicants must be registered as a trainee with ANZCA.

Applications close 31 January 2021.

For further information, please contact the ANZCA Training and Assessments team via email at training@anzca.edu.au or call +61 3 9510 6299.

Leaps - AND - Bounds

ANZCA ASM MELBOURNE
30 APRIL - 4 MAY 2021



ANZCA
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Despite COVID-19 and in true Melbourne style, plans for the 2021 ASM are coming along in leaps and bounds.

Our regional organising committee looks forward to making it one to remember!

We'll be making some announcements in late October – stay tuned.





ANZCA and government

Upcoming elections in Australia and New Zealand

Australia

State and territory elections

A number of elections are coming up in Australia – those living in the Australian Capital Territory head to the polls on 17 October and Queenslanders on 31 October. An election in Western Australia is scheduled for 13 March 2021.

An election was recently held in the Northern Territory (22 August) and prior to this the college wrote to the Australian Labor Party (ALP), the Territory Alliance and the Country Liberal Party (CLP) to seek their position on a range of issues relating to pain services in the territory, including the impact of poorly managed chronic pain on Territorians (particularly Indigenous Territorians) and the lack of pain services and specialist pain medicine physicians in the Northern Territory.

Responses were received from the ALP and the CLP with both committing to meet and work with the college after the election to address the issues raised. ANZCA will use these responses to establish a platform for engagement with the ALP (who retained government) and the health minister Natasha Fyles, to continue to advocate for improved pain management services in the Northern Territory.

This follows advocacy work commenced in 2019 to support the launch of the National Strategic Action Plan for Pain. Then-college president Dr Rod Mitchell and FPM Dean Dr Meredith Craigie met with national and jurisdictional health ministers and their representatives in New South Wales, Victoria, Queensland, South Australia, Tasmania and the Northern Territory to encourage them to support the action plan and related issues.

The college will follow a similar advocacy strategy for pain services and any other relevant local issues in the upcoming Australian Capital Territory, Queensland and Western Australian elections.

Choosing Wisely update

Dean of the Faculty of Pain Medicine, Associate Professor Mick Vagg and college staff met with Scott Walsberger, Choosing Wisely Australia Lead and Bronwyn Walker, External Relations and Partnership Manager from NPS MedicineWise in August to discuss the faculty's plans to develop a new Choosing Wisely recommendation regarding medicinal cannabis.

Choosing Wisely Australia has a toolkit for clinical educators to assist member colleges and champion health services to develop case studies for education programs. The Royal Australasian College of Physicians has developed case studies on antibiotics and acute pulmonary thromboembolism, which are included on their website. ANZCA's Safety and Quality Committee, in consultation with the faculty, will consider the development of case studies for the anaesthesia and pain medicine Choosing Wisely recommendations.

Choosing Wisely Australia are also publishing featured stories on their website, which are case studies demonstrating how Choosing Wisely principles and recommendations are being implemented. The opportunity to develop a featured story about how the pain medicine Choosing Wisely recommendations have contributed to NPS MedicineWise educational programs on both opioids and neuropathic pain was also explored during the meeting.

Since May, a regular podcast from NPS MedicineWise has been published to help health professionals stay up to date with the latest evidence for medicines, tests and treatments, particularly during the COVID-19 pandemic. Hosted by a rotating group of interviewers including CEO and pharmacist Adjunct Associate Professor Steve Morris, and general practitioner and NPS MedicineWise medical adviser Dr Anna Samecki, they waded through the reams of information – and sometimes misinformation – to provide answers from trusted sources on quality use of medicines questions.

Episode 11 of the podcast series "Are you Choosing Wisely during the pandemic?" was published in August and features Dr Simon Judkins, an emergency physician working in Victoria at one of the Choosing Wisely Australia Champion Health Service hospitals. They discuss how the Choosing Wisely principles, particularly around resource stewardship and the importance of conversations about what care is necessary, have been relevant during the COVID-19 pandemic. They also look at how new pandemic guidance from Choosing Wisely Australia will help health professionals and consumers navigate the current environment. For more information and to explore these resources visit choosingwisely.org.au.



“We are committed to ensuring clinical input guides health care reforms to develop more sustainable models of care. We welcome further collaboration with the college to develop innovative models to expand access to pain management services to Territorians.”

Natasha Fyles, Minister for Health, Northern Territory



Clockwise from left: In discussion with Dr Olivia O'Donoghue (Medical Director Regional Training Hub – Top End Flinders Northern Territory), Ms Shilpa Walia (ANZCA Acting Operations Manager, Training and Assessment) and Dr Timothy Wonders (ANZCA trainee, Flinders Medical Centre).

Flinders Northern Territory Regional Training Hub

The college has been working with the Flinders Northern Territory Regional Training Hub on a number of initiatives to promote anaesthesia as a specialty and develop medical specialist training capacity in the territory. On 23 June the hub hosted an information webinar for medical students and prevocational doctors regarding college entry requirements, career pathways and local training options. Two informative presentations were provided to more than 20 attendees by college trainee Dr Timothy Wonders and ANZCA Acting Operations Manager Training and Assessment Shilpa Walia.

The webinar served as a great introduction for students and junior medical officers interested in living and training in the territory. The discussion gave viewers access to college education staff, Northern Territory-based consultants and trainees and local health services to assist with career planning, as well as outlining some of the unique and exciting possibilities for medical practitioners.

Northern Territory hospitals provide a range of services often not seen in similar-sized hospitals due to the wide range of medical conditions, cross-cultural blend of patients and combination of rural and remote locations. During the webinar Dr Wonders, who is in his final year of training, spoke about his journey living and working in the territory, covering topics such as rotational training options, career opportunities, skill development, patient care and work life balance. He noted that “the range of practices are quite broad with either the opportunity to stay general or to specialise in a particular sub-speciality area”.

In July nine colleges including ANZCA gave a short presentation outlining training opportunities in the Northern Territory to the Remote and Rural JMO Training Forum Steering Committee. This forum, of which Dr Brian Spain, Director of Anaesthesia and Co-Director of Surgery and Critical Care at the Royal Darwin Hospital is a steering committee member, works to support current and future prevocational junior medical officers and junior specialists living and working in rural and remote areas. Further information about the hub and a recording of the college webinar are available on the Flinders NT Regional Training Hub webpage at flinders.edu.au/flinders-nt/postgraduates/medical.

New Zealand

COVID-19 delays election

The New Zealand general election due to be held on 19 September has been postponed until 17 October. The near month-long postponement was decided on amid a second outbreak of COVID-19 cases, centred in South Auckland. After 102 days with no evidence of community transmission, the country's biggest city was put back under “level three” lockdown until 31 August.

New Zealand will also vote on two referendums on 17 October – the end-of-life choice and cannabis legalisation and control referendums.

ANZCA has surveyed the six main political parties with three questions relevant to fellows and trainees, however the answers to these have also been delayed by the postponement.

Advocacy has continued with ANZCA President Dr Vanessa Beavis, New Zealand National Committee Chair and Deputy Chair, Dr Sally Ure and Dr Graham Roper, meeting with the Director-General of Health, Dr Ashley Bloomfield on 6 August. Discussions included issues of importance to both anaesthesia and pain medicine and the impact of COVID-19 including personal protective equipment, pain medicine specialist position shortages, reporting and review of healthcare worker infection and the proposed use of rural generalist GPs.

The Council of Medical Colleges also held a marathon Zoom meeting on 27 August which included presentations from Health Workforce New Zealand, the Privacy Commissioner, the chair and CEO of the Medical Council of New Zealand, the chief medical officer of the Ministry of Health and the author and chair of the group who prepared the Health and Disability Systems Review.

Submissions – Australia

- Parliament of Australia Joint Standing Committee on Foreign Affairs, Defence and Trade: Inquiry into the implications of the COVID-19 pandemic for Australia's foreign affairs, defence and trade.
- Therapeutic Goods Administration: Consultation on the new Therapeutic Goods Order 106 – Data matrix codes and serialisation of medicines.
- Parliament of Victoria Legal and Social Issues Committee: Inquiry into the use of cannabis in Victoria.

Submissions – New Zealand

- Medical Council of New Zealand: Consultation on the practising certificate fee and disciplinary levy 2020-2021.
- Ministry of Health National Ethics Advisory Committee: Consultation on ethical framework for resource allocation in times of scarcity.
- Medical Council of New Zealand: Consultation on revised telehealth statement.
- Medical Council of New Zealand: Discussion paper on when artificial intelligence is involved in the care of patients.



COVID-19 continues to challenge

College works through pandemic issues

Exams dominate COVID-19 thinking

One of the most difficult issues the college has faced throughout the COVID-19 pandemic has revolved around the completion of exams for candidates sitting in 2020.

In August, the second sitting of the written exams was held for both primary and final candidates. Travel restrictions meant the written exams had to be delivered in regional centres and in the case of Victoria, in individual workplaces.

Attention has now turned to the vivas where the introduction of videoconferencing is now a large focus for both our anaesthesia and pain medicine candidates.

We have established a working group to ensure reliable, stable videoconferencing can be introduced in areas where there are not enough examiners to be able to oversee the exams face-to-face. This group has been carefully observing the outcomes of videoconference exams held by educational groups and colleges both locally and overseas.

In recognition of the disruptions caused by the pandemic, candidates who are successful at the 2020 viva exam sittings will have their exam backdated to the original scheduled date. This allows for continued progression into provisional fellowship, and for the time that has accumulated since the original exam date to be credited toward provisional fellowship if all requirements have been met.

The pandemic has also had an impact on the Effective Management of Anaesthetic Crises course, with many earlier this year cancelled. Our directors of professional development are working on solutions to this issue.

Thanks must go to our primary and final exam subcommittees who are working tirelessly with ANZCA staff, most who are still working remotely, on the best solutions for our trainees, who appear to be coping admirably in these incredibly stressful times.

PPE statement

Meanwhile, our personal protective equipment (PPE) statement has been updated. This fourth release strengthens recommendations as to when airborne precautions should be used.

ANZCA's Safety and Quality Committee (SQC) Chair, Professor David Story, collaborated with former SQC chairs Dr Nigel Robertson and Dr Phillipa Hore and with SQC deputy chair Dr Jo Sutherland on the new version.

The revised statement incorporates lessons learned from the impact of COVID-19 on healthcare workers in Victoria and the most recent advice from the Infection Control Expert Group which advises the Australian Health Protection Principal Committee (AHPPC).

Dr Vanessa Beavis
ANZCA President

FELLOWS AT THE FRONTLINE IN VICTORIA'S SECOND WAVE

When coronavirus infections started to surge again in July, anaesthetists at the Royal Melbourne Hospital played an essential role in treating nearly 40 per cent of cases from the state's COVID-19 "hot spot" areas. Here, three fellows and one trainee recount their experiences.



Dr Kara Allen
Specialist Anaesthetist,
Royal Melbourne Hospital

IN LATE FEBRUARY I received a message from a friend. It was a social media post about the activation of the Australian Health Sector Emergency Response Plan. I had heard about the novel coronavirus but had filed it away under things to think about once our new electronic medical record was implemented. Australia had escaped SARS, MERS and Ebola – surely this was just another outbreak that would pass us by.

In the first week of March this perspective shifted rapidly. While the state government proposed an elective surgery blitz to offset the effect of anticipated cancellations, there was a huge appetite for training in personal protection equipment (PPE) and management of COVID-19 patients across the hospital. We did a

rapid literature review, and started simulating the patient journey of the COVID-19 positive patient through the hospital to identify where our processes needed to change. At the same time, we instituted training in airborne PPE donning and doffing, although access to N95 masks was scarce. We were fielding many questions about the difference between fit checking and fit testing, when airborne protection versus droplet precautions were needed, and what the screening of perioperative patients would entail.

Across the precinct, groups of anaesthetists undertook simulated intubation of COVID-19 positive patients. At RMH we trained 170 staff in five business days in donning and doffing and developed cognitive aids



Dr Kara Allen, Mr Deng Deng, Associate Nurse Unit Manager, Dr Jina Hanna, ANZCA provisional fellow, Dr Alexandra Hill, anaesthesia trainee.

All photos: Elizabeth Oswald, Clinical Photographer, Royal Melbourne Hospital.

with the infection prevention service. We simulated the transfer of a positive patient from the emergency department (ED) to theatre, and from ED to ICU, as well as integration of anaesthetists into the ED team, utilising the Safe Airway Society guidelines¹. We found common challenges, similar to overseas colleagues^{2,3}, in planning patient flow particularly cleaning, communication and strategies to reduce contamination while conserving PPE.

At the same time, the Royal Women's Hospital was preparing for the arrival of pregnant patients who were COVID-19 positive by using simulation to embed resources. As with the RMH simulations, each iteration revealed new challenges, which then had to be rectified and the results communicated broadly.

Like the rest of Australia, we went into lockdown and waited for the cases to arrive. Optimism increased as restrictions eased, only for an increase in community transmission to cause the state government to institute a further lockdown.

During the brief reprieve, we continued to practice the pandemic plan for patients who needed urgent surgery who could not be cleared of coronavirus. As the "real deal" started arriving, we adapted quickly, familiar with the screening tools and the process to plan for a COVID-19 case.

“Protecting my wellbeing has been a critical part of maintaining momentum for me. Rest is an essential part of resilience and must be prioritised.”

We seemed to go overnight from one case a day to up to three at a time. It was not uncommon after hours to have an emergency COVID-19 theatre running, receive a trauma call and attend a code stroke, all of which required COVID-19 precautions.

Our cognitive load has increased substantially. PPE is draining to wear for hours at a time, and a simple case may require two to three hours in PPE, plus or minus lead.

Communication within the room and with the team outside is challenging. We have found the "huddle" at the start of every list, and before the start of each known COVID-19 case, invaluable for team cohesion.

I'm very conscious of the incredible challenge to doctors in training at every stage – from prevocational to trying to finalise requirements for fellowship. We've tried to maintain normality in terms of completing workplace-based assessments (WBAs), regular updates and continuing rotations where possible. Exams are a huge source of uncertainty and anxiety and our trainees have been amazing in adapting and responding to the increased workload. Many of them have participated in the process of resource development and have demonstrated great leadership.

Life outside the COVID-19 theatre has also changed. Instead of eating in the tea room with a group of colleagues we are encouraged to socially distance as it's the only time we aren't wearing masks and face shields.

When I'm not in PPE, I'm at home supervising the second stint of home learning for three kids who all have different curricula, a real challenge even with a Masters of Clinical Education!

Protecting my wellbeing has been a critical part of maintaining momentum for me. Rest is an essential part of resilience and must be prioritised. Constant change, coupled with the threat of personal harm, and removal of the usual coping strategies of socialisation and outdoor exercise has increased the challenge of staying well.

The lessons I will take away from this experience will likely inform my work for years to come. Use the time you have to prepare the basics. Good PPE, slick communication and robust staffing strategies are absolutely essential. Be prepared to respond rapidly. While PPE is the last line of defence, it is the only one that the healthcare worker has control over. Often perioperative staff look to us as leaders – the goal posts are constantly shifting but keep reinforcing the basics and be open about what you know. Our department leadership organised fit testing and access to PPE for all anaesthetists during the lull, which provides "psychological PPE" to those working in this "second wave".

A new normal seems a long way away at the moment. Hopefully we can eventually return to business as usual in Victoria, perhaps with slightly higher than previous levels of PPE.

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Dr Jai Darvall

Anaesthetist and Intensive Care Specialist, Royal Melbourne Hospital



UNDER NORMAL CONDITIONS at the Royal Melbourne Hospital (RMH) I divide my time equally between anaesthesia and intensive care. At the start of July, we quickly realised that the magnitude of the “second wave” of COVID-19 ICU work at RMH was going to be much greater. Our hospital catchment covers numerous public housing towers and nursing homes, where major outbreaks of COVID-19 were spreading, as well as a significant portion of North-Western Melbourne also seeing high case numbers.

The Department of Anaesthesia and Pain Management promptly released me to the ICU fulltime, where we very quickly became busy. At the time of writing, the RMH ICU has managed 50 per cent of Australia’s total “second wave” critically ill patients, although I note numbers are starting to significantly increase in other Melbourne ICUs, particularly in the west.

“I’ve found this time confronting, but purposeful.”

While many patients have been older, with significant comorbidities, it has been very confronting to care for a number of patients aged in their 30s, 40s and 50s. Many of these patients have been remarkable for their ordinariness; they could easily be any of us. We recently admitted a young mother of three, profoundly hypoxic, who rapidly required intubation and ventilation. Within a week, we also admitted her critically-unwell husband. Fortunately both recovered, however, this reinforced the potential devastating impact of this disease across all ages, not only for those infected.

One of the greatest tragedies of this pandemic has been the exclusion, with rare exception, of visitors from our ICU irrespective of the COVID-19 status of the patients. This has profoundly affected the way we do business. As a state trauma centre, we continue to see the usual road trauma victims through our doors, and patients still present after strokes, sepsis or cardiac arrests.

The emotional toll of critical illness on relatives is heavy at the best of times, but being unable to see or touch their family

member, and having to liaise with clinical staff in masks over video screens, has been harrowing for everyone.

Among perhaps the worst aspects of critical care in this pandemic has been the impact on families of end-of-life care for patients dying of COVID-19 disease. For these families, there is no sitting quietly by their loved-one’s bedside, no final hug prior to extubation.

I worry that the vicarious trauma on staff will be felt for a long time to come, particularly for our amazing nursing staff who shoulder much of this extra burden, and who are already working incredibly hard at considerable personal risk. We share these end-of-life issues with our aged-care colleagues at our sub-acute campus, who are doing an amazing job in very difficult circumstances.

On a personal note I’ve found this time confronting, but purposeful. While we have had to learn some intricacies about COVID-19 disease management, much of the routine care required is “core business” in the ICU. The workload can be challenging – unless presenting in-extremis, our model of care at RMH sees patients retrieved to the unit, where ICU staff can then intubate safely in one of our many negative pressure rooms. This has required some tweaks to our normal processes. Despite all this, I feel well prepared. The Department of Anaesthesia and Pain Management at RMH organised formal mask fit-testing, and knowing I am wearing appropriate PPE certainly helps during the daily proning and aerosol generating procedures in COVID-19 positive patients.

It’s strange, but I find there is less anxiety among the ICU staff working with large numbers of COVID-19 patients than there is among my colleagues in theatre, where positive cases have remained fortunately rare. I wonder whether this is due to dealing with known patient status, where uncertainty is replaced by a simple resolve to get on with patient care.

More recently, of course, this is being sorely tested as we witness many of our fellow nurses and doctors working directly with COVID-19 patients themselves becoming infected. This, I know, is at the back of all of our minds as we buddy-check each other prior to entering each room.

One nice side effect for me of this at-times heavy work environment: on days off I’m enjoying the learning-from-home with my three kids much more than others seem to be the second time around!

Dr Nick Jansen

Obstetric anaesthetist and member of the State Health Emergency Response Plan (SHERP) (formerly DISPLAN)



I’M ONE OF three or four ANZCA fellows who work at both the Royal Melbourne Hospital and the Royal Women’s Hospital. My normal working week is two days at the Women’s and two days at RMH.

Since 2006 I have been part of the FEMO Program (Field Emergency Medical Officer Program) which is part of the broader State Health Emergency Response Plan (SHERP). Many of my older (and younger) colleagues will remember this as Medical DISPLAN, with my current role formerly known as an “Area Medical Coordinator”. SHERP provides an overview of the arrangements for the management of complex health emergencies in Victoria particularly those that require a significant and coordinated effort. There are seven of us in metropolitan Melbourne comprising both anaesthetists and emergency physicians. We are on call for a minimum 48 hours a week in one of two capacities: either a field emergency medical commander (FEMC) or a field emergency medical officer (FEMO) role.

Over the years our collective experience has involved surface transport accidents (such as the 2007 Burnley Tunnel explosion), bushfires (major deployments in both the 2009 Black Saturday fires and the 2019/20 fires), hospital evacuations, complex medical emergencies (such as patient entrapments) and the 2017 Bourke Street tragedy.

While we have certainly considered pandemics in the context of the 2003 SARS-associated coronavirus (SARS-CoV) and the 2009 H1N1 novel influenza A virus (Swine Flu), I don’t think any of us expected to experience a global pandemic as seen with COVID-19.

At the end of July, it was becoming increasingly apparent that there was a major problem in Victoria’s aged care sector after multiple coronavirus outbreaks were being reported in nursing homes.

I was asked to attend St Basil’s aged care home in the Melbourne suburb of Fawkner, as a FEMO, to assist Ambulance Victoria to triage and evacuate residents to a number of private hospitals. I found it a confronting experience.

I attended on the second day of evacuations and fortunately didn’t observe some of the worst cases that were being reported in the media. Nonetheless as an acute care clinician I found the aged care environment very unfamiliar.

The entire St Basil’s workforce had been replaced by interim personnel – none of whom knew each other. It gave it a very surreal feeling of an international humanitarian mission. Many residents appeared incredibly frail and given the staffing situation it was hard to imagine they were receiving their usual nutrition, hydration and care.

Since my time at St Basil’s I have reflected on several things. I found it remarkable how versatile the skills of an anaesthetist are. I’m regularly the in-charge anaesthetist at Royal Melbourne where we have 16 theatres, three-day procedure rooms and multiple off the floor locations (cardiology and interventional radiology). At times, it too, is not unlike a war zone.

I've realised those organising skills we use in the operating theatre, every day, are actually quite transferrable to the evacuation role. In a strange way it also made me go on to feel much safer working in the operating theatre.

The following Friday I was part of a team that performed a caesarean section (for major placenta previa) at the Royal Women's – she was our first known COVID-19 positive patient there. I couldn't help but compare my experience earlier that week at the nursing home. The operating theatre environment was, by contrast, so incredibly controlled. It challenged my view of anaesthetists as true "frontline" workers.

I'm very proud of the way my colleagues have responded to this crisis. We recently had a 40-year-old woman at Royal Melbourne, 27 weeks pregnant with twins, who was being ventilated in our ICU after infection with COVID-19. Within days of her admission a WhatsApp group organically appeared and soon had over 20 participants: obstetricians, anaesthetists, intensivists, maternal foetal medicine specialists, neonatologists, infectious diseases specialists and obstetric medicine physicians.

Many of these clinicians are extremely senior people, some of the Parkville precinct's best medical minds, who were all taking part for no other reason than to help (at that time) a single patient and her unborn children.

We now hold regular RMH/RWH collaborative meetings about the growing number of COVID-positive pregnant women, most of whom are fortunately still able to be managed as outpatients.

At the Royal Melbourne we have also formed an in-house obstetric special interest group of ANZCA fellows who can provide care for critically ill parturients being cared for in a non-obstetric hospital. I'm very pleased that this first ventilated pregnant patient was subsequently extubated and discharged from intensive care and went home. She went on to have a caesarean section at 34+ weeks and delivered two healthy twins. It was a great outcome for her and her babies, and the medical team who helped her get there.

As we face this human crisis, it reminded me, that despite the fear, uncertainty, stress and relentless lockdown, life really does just go on.



Dr Alexandra Hill

Anaesthesia trainee,
Royal Melbourne Hospital



“Since my time at St Basil's I have reflected on several things. I found it remarkable how versatile the skills of an anaesthetist are.”

MOST ANZCA TRAINEES will agree 2020 has given us challenges we could never have expected at the start of the year. As an advanced trainee at the Royal Melbourne Hospital (RMH) during both the first and second wave of COVID-19 infections, it has been interesting to observe and reflect on the impacts of the COVID-19 pandemic both on our work and training but also on life outside of anaesthesia.

Getting used to the new “COVID-19 normal” has meant countless changes to our daily routines such as avoiding public transport, factoring in a long walk from the bike cage to the main entrance to be temperature checked, and working out how to drink a coffee while wearing a face shield. It seems there is no aspect of our lives that has been unaffected.

Stage 4 lockdown in Melbourne means that there are limited reasons to leave the house and socialising outside work is impossible, so although coming to work has brought its own stress, having the opportunity to come to work and catch up with colleagues has certainly been a silver lining and brought some normalcy, despite our physical distancing practises and PPE requirements.

Having worked at the RMH as a second year registrar, the contrast in everyday practice between 2018 and now is stark. Because of the high prevalence of COVID-19 positive patients in our catchment area, all patients, regardless of COVID-19 screening and swab status, undergoing aerosol generating procedures (AGP) are cared for with “respiratory plus PPE” meaning N95 masks, eye protection, full gown and gloves. Team members not essential for intubation and extubation are asked to leave theatre and only permitted to re-enter at eight minutes post AGP. The increase

in theatre time for each case has been noticeable. Thankfully the reduction in elective surgeries seems to have helped offset the increase in time taken for each case but overall the trainee experience certainly has been affected, particularly with regards to case mix and meeting volume of practice requirements.

After anaesthetising several COVID-19 suspect patients, I've noticed some particular challenges. In addition to caring for a sick patient, there are communication challenges with the N95 mask and faceshield often muffling conversation and making it difficult to pick up on non-verbal cues. The PPE equipment, while essential for personal safety, becomes uncomfortable and sweaty after prolonged use and a few hours in theatre with a COVID-19 suspect case can feel like an eternity without the opportunity to duck out for a quick break.

Adding the difficulty of off the floor cases to this situation only adds another layer of complexity to the case for the anaesthesia team. While we have developed solutions to some of these challenges, such as bluetooth headsets for communication, these cases are undoubtedly taxing for the teams involved.

As a trainee at the RMH, I have been reassured by the approach to the COVID-19 pandemic both within the department of anaesthesia and the broader hospital with staff safety the clear priority. We have been fortunate to have access to suitable PPE, fit testing for N95 masks and a framework to foster a safe work environment with specific protocols developed by the department as well as dedicated ongoing PPE training and simulation sessions. This has certainly helped to ease the underlying nerves of coming to work during the second wave in a hospital which has seen high numbers of COVID-19 patient admissions.

For the moment it seems that the end of this pandemic is a long way off. Although it has been a difficult time I think there are positives in the lessons we have learnt and believe that our anaesthetic practice will improve as a result of the pandemic.

I wish everyone good luck and good health in getting through these challenging times!

“There are communication challenges with the N95 mask and faceshield often muffling conversation and making it difficult to pick up on non-verbal cues.”

Anaesthetists drive leading COVID-19 research



Associate Professor Forbes McGain and engineer Professor Jason Monty from the University of Melbourne. Photograph: Penny Stephens/Western Health



Professor Guy Ludbrook.

ANZCA FELLOWS HAVE been at the forefront of COVID-19 research projects that include the hunt for a vaccine and groundbreaking developments in hospital treatment equipment and ventilator manufacturing.

In Melbourne, Associate Professor Forbes McGain has been working with Western Health and the University of Melbourne to develop a ventilation hood that is placed over COVID-19 patients and is designed to contain the droplet spread of the coronavirus.

Associate Professor McGain, who works for Western Health at Melbourne's Sunshine Hospital, told *The Australian* the study feedback from the first 20 patients had been "overwhelmingly positive".

The ventilation hood separates medical staff from the patient without losing line of sight and contains the droplets. The hood creates a bubble around the patient, not only ensuring that staff are protected but also allowing staff to provide less invasive therapies.

The ventilation sucks air away from the patient but restricts the flow of droplets, with the hood acting as a barrier. It also enables other intensive care machines to function without compromising the safety of the staff.

The project was made possible with the support of Melbourne University's School of Engineering, led by Professor Jason Monty.

In Adelaide, Professor Guy Ludbrook, Director of PARC Clinical Research, an early phase hospital and university clinical trials unit, is one of three investigators on the first Phase 1 human clinical trial of COVAX-19, an Australian COVID vaccine being developed by Vaxine Pty Ltd, SA.

PARC Clinical Research has donated \$A400,000 worth of work to conduct the trial, in lieu of funding being provided from other sources.

Forty volunteers under 65 years of age have received a vaccine dose and a booster three weeks after. Data on efficacy (immune responses) is expected soon.

Professor Ludbrook said another 30 volunteers (over 65 years of age, or COVID-19 antibody positive) would be dosed in coming weeks with planning for phase 2 and 3 trials now underway.

Both Associate Professor McGain's hood project and the sponsor of the COVAX-19 vaccine project, Vaxine Pty Ltd, recently received a funding boost from the Australian Government's Medical Research Future Fund (MRFF) in early September as part of a \$A4.1 million package for five COVID-19 research projects.

Professor David Story, the chair of ANZCA's Safety and Quality Committee, has played a leading role in the development and manufacturing of lightweight and portable ventilators. As deputy director of the University of Melbourne's Centre for Integrated Critical Care he has been working with biotechnology company Grey Innovation to build 2000 ventilators as part of Australia's COVID-19 response.

The company is among a group of manufacturers that secured \$A31 million in Federal Government funding to build ventilators in Victoria.

Professor Story, who is one of Grey Innovation's key medical and clinical advisory team members, said increasing local ventilator production was crucial because a shortage of ventilators would put lives at risk.

The notus Emergency Invasive Ventilator Program is a Grey Innovation led initiative supported by the Victorian Government and Advanced Manufacturing Growth Centre (AMGC). With time to market critical, and under advice from its medical advisory team, the program will use a certified mechanical ventilator design from a leading medical device company under licence for production in Victoria.

Carolyn Jones
Media manager, ANZCA

Coping in a pandemic: A trainee's perspective

Anaesthesia registrar Dr Richard Seglenieks gives his assessment on how COVID-19 has impacted Australian and New Zealand trainees for whom 2020 is no ordinary year.

WHILE THE PANDEMIC has impacted everyone, these effects are not evenly distributed. In general, younger people have and will suffer greater impacts in almost every way except for the direct health effects from infection. As an overall younger group, trainees are also likely to suffer greater negative effects.

Training

At work, we're doing fewer cases overall, with a different case mix, and more of us are working in intensive care units (ICU). Redeployment to ICU also impacts trainees continuing to work in anaesthesia, as they need to undertake a greater proportion of after-hours work to maintain required staffing levels. These changes affect our ability to meet volume of practice (VOP) requirements, complete workplace-based assessments (WBAs) and sign off our specialised study units (SSUs).

There are additional demands placed on us, such as personal protective equipment (PPE) training, simulations, learning guidelines and refreshing ICU knowledge, which further distract from our usual focus. Many of us are working at reduced efficiency, through a combination of stress, prolonged exam study, and the additional cognitive load of altered routines. The formats and content of our teaching and meetings have changed, while access to courses (emergency management of anaesthetic crises → EMAC), advanced life support – ALS), exam courses, and so on) and conferences is limited.

Most of our training requirements are unchanged. The main difference is increased flexibility in deferring some requirements to the next training period, thus increasing the burden of requirements in following years. It's important to highlight that disruptions this year will have flow-on effects over the next year or two for most trainees.

Exams

Delays, changes and uncertainty around exams are the greatest source of stress for many trainees. Given the dynamic and variable nature of restrictions on travel and large gatherings, plans have changed multiple times regarding exam dates and locations. The interval between the written and viva components has now



been extended to seven to eight months – a long time to maintain peak knowledge across a broad curriculum.

ANZCA has assured candidates of multiple contingency plans, however many trainees have been frustrated and distressed by the uncertainty and sometimes limited communication of these plans. Many trainees are relieved that the college's initial position ruling out electronic or videoconferenced exams this year (due to justifiable concerns regarding the reliability and quality of online platforms) has been revisited.

There are still some major concerns among trainees, including the potential need to re-sit the entire exam if unable to attend the viva on the designated date due to infection, symptoms, or being furloughed following a high-risk exposure.

Health

We are all at high risk by the nature of our work. In Victoria, more than 2500 healthcare workers have tested positive to COVID-19, with 70-80 per cent suspected to have been contracted at work^{1,2}. Trainees are not immune to this risk, with numerous stories of young, previously healthy people suffering severe illness and even dying from COVID-19, and evolving evidence of long-term impacts following infection.

Restrictions and concern for potentially contracting or spreading infection prevent some of us from engaging

in our usual hobbies and physical activities. With gyms and sporting venues closed, I would be surprised if many people aren't more sedentary than usual. I'm sure studying for a major exam for an additional six months can't be healthy either.

Australians have reported high rates of stress, anxiety and depression during the pandemic³. The figures were already concerning pre-pandemic but rates of severe psychological distress in young Australians have seen relative increases of 50-60 per cent over the last three years⁴. Isolation, loneliness, and strained relationships are serious risks. Young people are more lonely than other age groups⁵, though healthcare workers are partially protected as we are still going to work and interacting with our colleagues and patients on a regular basis.

As doctors, we face unique challenges that may impact our mental health. Caring for patients with COVID-19 can be an exhausting and confronting experience, particularly when our patients suffer serious morbidity or mortality. Doctors tend not to seek psychological help when we should, and evidence indicates a 10 per cent risk of longer-term mental health issues for front-line workers in a pandemic⁶.

Financial

Younger people will bear the brunt of the economic impacts, with lifelong effects⁷. Without the financial security that many Australians have built over years of economic growth, young people are particularly vulnerable to economic downturns. Levels of unemployment and under-employment among young people were already disproportionately high before the pandemic, and this trend has accelerated in recent months due to job losses in industries such as hospitality and retail⁸. While we are relatively protected from this as doctors, our partners, family and friends may not be.

Other

Trainees have also experienced a range of other impacts, including delayed and modified job application processes, altered fellowship plans for this year and next, and changes to planned rotations (particularly those moving to/from rural locations and ICU).

Silver linings

One possible positive outcome from the pandemic is an end to the pervasive culture of presenteeism (for example, working while sick) in medicine, though there have been mixed reports about how the pandemic has actually impacted this practice⁹.

The capacity for our usually reasonably static systems to make radical changes has been really impressive and refreshing. In my hospital, for example, our main ICU has become a COVID-19 unit, with the non-COVID-19 ICU patients now cared for in what was our recovery room, which has in turn shifted to our holding bay. Our departmental meetings have shifted to Zoom, and while this has some downsides, I think these are outweighed by the ability to dial in from the car, the anaesthetic room, or home.

We are now much better at consistently and appropriately using PPE in clinical settings, there's a renewed sense of camaraderie among staff in the face of new challenges, and a number of departments have also started up new welfare and wellbeing initiatives to help support staff.

This is a tough time for everyone. Please look after yourself, your colleagues and the trainees in your department.

Dr Richard Seglenieks

Anaesthesia registrar, St Vincent's Hospital, Melbourne

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“Caring for patients with COVID-19 can be an exhausting and confronting experience, particularly when our patients suffer serious morbidity or mortality.”

Who's who?

The impact of personalised theatre caps in Starship Hospital operating theatres

EFFECTIVE COMMUNICATION, AN element of which is utilising an individual's name, is a crucial component of the efficient and safe team¹⁻³. Unfortunately communication failures within the operating theatre (OT) occur in up to 30 per cent of exchanges and can result in patient morbidity and mortality⁴.

Multiple barriers to using names in the OT exist; this has been compounded by the widespread use of personal protective equipment (PPE) necessitated by the ongoing COVID-19 pandemic⁵⁻⁷.

The #theatrechallenge has received attention as a method of improving staff name visibility. Funding was secured from the Starship Hospital (SSH) Foundation to supply all staff members in theatre (including HCAs and radiographers) with cotton theatre caps embroidered with their name and role.

The hats were introduced in August 2019 and an audit cycle was completed pre- and post-introduction.

Key results:

- Name visibility increased from 15% (17/113) to 68% (74/108) (p < 0.01).
- Staff correctly identifying their colleagues by name increased from 74% (223/302) to 89% (218/224) p < 0.01).
- 100% (50/50) of staff felt that the caps had helped them use names.
- 97% (29/30) of staff thought the caps had improved communication.
- 97% (29/30) of staff felt that knowing a name made it easier to raise concerns.
- 100% of patients (20/20) thought the initiative was a good idea.
- 100% (20/20) of patients thought that staff names were visible enough after the introduction of the caps compared to 50% (10/20) before (p < 0.01).

The personalised theatre caps have greatly increased name visibility of staff and, while we cannot demonstrate a change in patient outcome, members of the operating room team identify their colleagues by name more accurately and there has been a qualitative improvement in both collegiality and communication.



Putting a name to a face – Dr Gareth Jones in his personalised theatre cap.



“Multiple barriers to using names in the operating theatre exist; this has been compounded by the widespread use of personal protective equipment (PPE).”

Mae Beloria Masinading (nurse), Janella Rojo, Mayessa Aler (nurse), Graeme van der Meer (ENT consultant), Milayla Warman (nurse), Linda Chapman (nurse), Graham Knottenbelt (consultant anaesthetist), Steven Bryant (anaesthesia technician).

There will always be detractors from new initiatives, but we can see no negatives. There is no evidence of an increase in surgical site infection rates with different theatre headgear⁸⁻¹⁰ and, while there is an initial financial outlay, that is partially mitigated by the decrease in usage of the disposable theatre caps. There is also a potential environmental benefit, and with the current ANZCA focus on providing environmentally sustainable anaesthesia, we believe that this is a valid and realistic option to help us meet that goal.

The operating theatre provides unique challenges to communication; this has never been as evident with coronavirus altering the way in which many of us work. The use of theatre caps with names and role identification is a simple initiative which we have demonstrated can bypass some of the barriers to communication and thus improve patient safety and team collegiality.

Dr Gareth Jones
Anaesthesia registrar, Auckland City Hospital

Dr Graham Knottenbelt
Consultant anaesthetist, Starship Childrens Hospital, Auckland

Dr Dug Yeo Han
Clinical Research Biostatistician, Starship Child Health, Auckland

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ANZCA Citation

Dr Peter Edgeworth Lillie AM

The ANZCA Citation is awarded at the discretion of ANZCA Council in recognition of significant contributions to college activities.

SOUTH AUSTRALIAN FELLOW, Dr Peter Edgeworth Lillie AM, has been selected by ANZCA Council as a recipient of an ANZCA Citation.

Dr Lillie has had a long and distinguished career in anaesthesia and is an outstanding clinician and leader.

He has made a major contribution to the status of anaesthesia, perioperative medicine and pain medicine in South Australia through his outstanding commitment to clinical medicine, teaching and leadership.

Dr Lillie worked at the Flinders Medical Centre from 1980 to 2020. During this time, he was one of the founding members of the liver transplant service and cardiothoracic service. In addition to contributing to patient care in these areas, he has also provided care to critically unwell and premature neonates. This necessitated significant on-call commitments, incredible anaesthetic knowledge and skill, which he continued to provide anaesthesia until his retirement.

Dr Lillie has embraced innovation and progress in anaesthesia and perioperative medicine, including the use of transoesophageal echocardiography in cardiothoracic cases and implementation of perioperative surgical pathways very early on.

Dr Lillie became head of the Department of Anaesthesia and Pain Management at Flinders Medical Centre (FMC) in 2001 and remained so until this year. During this time he oversaw the expansion of the department to more than four times its original size, including the amalgamation of the Repatriation General Hospital's anaesthesia department. More recently, he managed the implementation of South Australia's "Transforming Health" strategy, which included the transfer of medical and surgical services to Noarlunga Hospital in Adelaide's southern suburbs.

His commitment to improving the FMC anaesthesia department and outstanding leadership attracted a



Dr Peter Lillie

highly skilled and dedicated group of anaesthetists. His "can do" approach also supported progresses in pain medicine at FMC, including fostering the growth of a new acute pain service and the setting up a multidisciplinary paediatric pain medicine clinic that was ably led by Associate Professor Meredith Craigie, the Faculty of Pain Medicine's immediate past dean.

Dr Lillie has fostered an inclusive and fair workplace, including gender equity in hiring staff and supporting flexible workplace practices, long before this was the norm. This is exemplified through his employment of anaesthesia trainees prior to their maternity leave, ensuring that they were financially supported during this process. His colleagues describe him as "loyal, always supporting members of his department plus a brilliant clinician".

Dr Lillie has also made significant contributions to the Australian Society of Anaesthetists (ASA) and ANZCA. He served as an examiner for the Faculty of Anaesthetists and then the college for 12 years from 1988-2000, and prior to that coordinated and taught the Adelaide Primary Examination Course. He has been a visiting speaker on courses in Hong Kong and Auckland and involved in teaching nursing and medical students through Flinders University. He is also a dedicated member of the ASA, serving as the association's federal treasurer for 15 years between 1988 and 2003. He was awarded the President's Award in 1995 and life membership in recognition of his service.

Locally, Dr Lillie served as the chair of the South Australian Group of Directors of Anaesthesia for 20 years and has been a great advocate for anaesthetists, representing the needs and importance of anaesthesia in South Australia and ensuring its recognition as a vital part of the state's perioperative service. His remarkable service and dedication were acknowledged in 2019 when he was awarded an Order of Australia in the General Division.

Peer support: Practical approaches

Self matters

This is the first of a *Bulletin* series, reflecting ANZCA support for thoughtful, considered and impactful strategies on wellbeing. Now, more than ever, we need to look out for each other, so it is fitting that this inaugural column addresses peer support. Ideas for future topics and contributors are welcomed to lroberts@anzca.edu.au.

Dr Vanessa Beavis
ANZCA President

THE COVID-19 PANDEMIC has changed our lives, leading to many impacts on ANZCA and FPM fellows, trainees and specialist international medical graduates (SIMGs).

The various phases of the outbreak (impact, heroic, disillusionment and recovery/reconstruction) create different challenges; these are exacerbated by future uncertainty¹.

Our responses are influenced by our individual makeup, and our health and social networks. Some of our experiences are shared across the general population, whereas others are unique to our roles on the frontline and in our stages of training and SIMG assessment.

While hugely disruptive, the pandemic is also highlighting opportunities for us to better support colleagues. Peer support is one of those avenues, providing a practical way to look out for our peers. It strengthens our connections with and sustaining of each other, allowing us to share experiences, normalise reactions and better build communities².

What is peer support?

In peer support, as the name suggests, colleagues at a similar level support each other through shared or similar experiences. It can be formal (structured) or informal, one-on-one or in a group³. Examples include buddy systems, peer review groups, and systems organised by departments or practices⁴.

Peers can also be supportive of each other in groups convened for other purposes (for example, study groups and peer groups established for quality assurance and education⁵). Although support often occurs informally there are advantages when it is explicit in group goals and processes.

Peer support should involve agreement about the goals and logistics of how you will support each other including timing and frequency of meetings. Of course, at this time, this may need to involve distance means. Peer support is enhanced by training in how to be present and balancing listening and sharing², and by training in mental health first aid⁴.

The main role of a peer supporter is "bearing witness" to the other clinician's experiences which may include fear, grief, distress, blaming or anger. Peer support is not about fixing the situation, rather its value lies in non-judgemental listening, empathic sharing in others' experiences and being there with them through these³.

Important elements of compassion for our peers include listening ("being present"), understanding, empathic responses and intention to support⁶. The value in this "witness" role is that it is protective for future wellbeing and mental health. The table below lists some principles for supporting our peers.

Helpful	Watch out for (not so helpful)
Connect	Intellectualising
Collaborate	Going for a quick fix
Stay curious	Being judgemental
Validate with empathy	Equating your experiences with theirs



Dr Kym Jenkins and Dr Lindy Roberts

What peer support is not

Peer support has boundaries and limits³. Though peer support has a preventative role for stress and burnout, it is not a substitute for necessary professional clinical care, by your general practitioner or other specialist.

It is crucial that we recognise the limits of our role in peer support. Things to look out for (in a peer or yourself) that indicate a trained clinician is required include signs of burnout, anxiety or depression, significant distress, impairment or other physical or mental illnesses. Critical also is ensuring the safety of the other person. Urgent intervention may be required if a colleague is too unwell to work and/or is engaging in behaviours injurious to themselves or others.

The Wellbeing Special Interest Group resource documents include how to recognise when professional help is needed⁵. In this situation, senior and experienced advice should be sought.

Dr Lindy Roberts AM,
ANZCA Director of Professional Affairs (Education)

Dr Kym Jenkins
Immediate Past President, Royal Australian and New Zealand College of Psychiatrists

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The Royal Brisbane and Women's Hospital peer-support program has the following key elements⁴:

- Developed by anaesthetists for anaesthetists.
- Promotes culture of understanding & encouraging help-seeking.
- Confidential and voluntary.
- Evaluated.
- Coordinators and team of trained responders (psychological first aid).
- Automatic follow-up after critical incidents.
- Regular peer support meetings.
- Access to resources and expert assistance (defined triggers for referral).

Practical resources on peer support

- *Peer support: a brief guide*, by Jenkins and colleagues³. Includes practical ways to set up peer support, challenges that may occur and how to manage these, and when peer support is not enough.
- *The Pandemic Kindness Movement*, hosted by the NSW Agency for Clinical Innovation: Fellow health workers have curated resources for ready access during the pandemic including for strengthening peer connections (<https://aci.health.nsw.gov.au/covid-19/kindness/love>).
- Videos by Professor West, The Kings Fund, *Looking after colleagues during the COVID-19 crisis*⁶ and by Professor Shapiro, Harvard Medical School, *Peer support in the time of COVID19*¹.
- Training courses, for example, peer support facilitation training by Hand 'n Hand and the Black Dog Institute (more advanced skills for those with peer support experience), and local courses such as *The Bonstato course* at Royal Perth Hospital, WA (<https://rph.health.wa.gov.au/Our-services/Centre-for-Wellbeing/Education>).
- SuperFriend *Connect with a buddy* (<https://www.superfriend.com.au/covid-19-support/buddy-guide/>). Although aimed at the general public, it has a sensible buddy checklist, tips for having buddy conversations and innovative ways to keep connected in light of physical distancing.

ANZCA's doctors' health and wellbeing resources

ANZCA has confidential and free health and wellbeing resources for fellows, trainees, specialist international medical graduates and immediate family members including the 24-hour ANZCA Doctors' Support Program.

This is an independent counselling and coaching service available via the helpline, online live chat, the app and face-to-face meetings. It provides support for a variety of work-related and personal problems that may be affecting work or home life. The Aboriginal and Torres Strait Islander Peoples Helpline is also available on 1300 287 432.

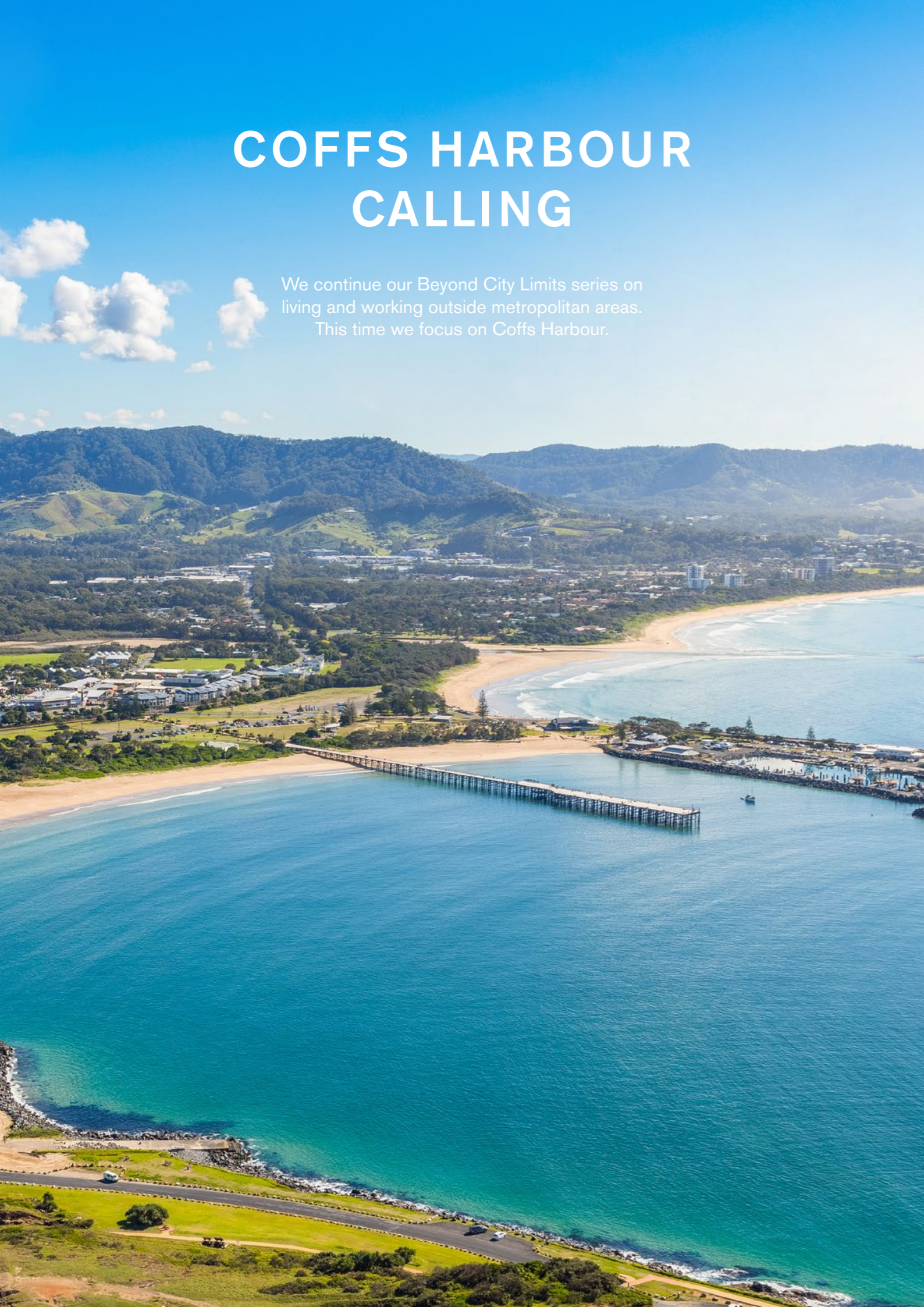
Go to www.anzca.edu.au/about-us/doctors-health-and-wellbeing.

Emergency contacts

- Your GP
- Doctors Health Advisory Service
- Lifeline 13 11 14
- ANZCA Doctors' Support Program (see above)
Australia: 1300 687 327
New Zealand: 0800 666 367.

COFFS HARBOUR CALLING

We continue our Beyond City Limits series on living and working outside metropolitan areas. This time we focus on Coffs Harbour.



DR ANGELA SUEN

DR ANGELA SUEN AND her partner, Dr Karen Wong, have been living in Coffs Harbour since 2014 when they moved from Sydney to take up anaesthesia positions at Coffs Harbour Health Campus. Dr Suen was appointed director of anaesthesia at the hospital in October 2018 and she heads a team of 11 FANZCAs. Dr Wong, a specialist anaesthetist, is an ANZCA supervisor of training in the department.

Half way between Brisbane and Sydney, Coffs Harbour is a booming coastal city. It is the hub of the Coffs Coast region and is surrounded by the beach and hinterland communities of Bellingen, Dorrigo, Sawtell, Nambucca, Coramba and Woolgoolga. With a growing population of about 73,000 people, the region is home to a broad mix of residents. Retirees flock to the area but there is also a steady influx of young families, students and backpackers.

With its sandy surf beaches, national parks, marine reserves, rocky headlands and mountain escarpments, the region is also an adventurer's dream especially for those into kayaking, fishing, bike riding, surfing and four-wheel driving. And if you're into kitsch Australian landmarks, the iconic Big Banana is a must-see! For foodies there is also a buzzing dining scene.

"I came to know about Coffs when I heard glowing reports about the place from Karen who came up here for her rural rotation from Prince of Wales Hospital," Dr Suen explained.

Dr Angela Suen heads the anaesthesia department at Coffs Harbour hospital.



Watching whales from her backyard in Coffs Harbour on the mid north coast of NSW is one of the joys of winter for anaesthetist, Dr Angela Suen.

"Having spent the majority of my training time in Sydney at Royal North Shore and Royal Prince Alfred hospitals, moving to Coffs Harbour was quite a change, but the great lifestyle Coffs Harbour offers makes it easy to adapt."

"Living and working in Coffs Harbour allows for a completely different lifestyle to metropolitan areas. Life outside of work is relaxed, but not isolated, with great cafes, and restaurants, and ample opportunities for outdoor activities. The clinical workload is interesting and varied, and the exposure to high acuity surgical cases ensures that we maintain our skills as generalist anaesthetists."

The Coffs Harbour Health Campus is a 292-bed regional hospital with construction now under way for a \$194 million five-storey (including helipad) clinical services building expansion with funding from the NSW Government. The first stage is expected to be completed by 2021.

Attracting and keeping medical specialists like Dr Suen and Dr Wong to work and live in Australian rural and regional areas is an ongoing challenge for state and federal health departments. The federal health department recognises this and funds specialist registrar positions through specialist medical colleges under its Specialist Training Program (STP). Additional training positions are now funded through a new STP Integrated Rural Training Pipeline (IRTP) initiative.

"Working in regional hospitals often requires us to be 'jacks-of-all-trades' if you will. This is a substantial advantage for registrars and residents wishing to gain exposure to a variety of specialties. At Coffs Harbour, trainees can expect to be exposed to surgical subspecialties such as vascular, ENT, paediatrics, obstetrics and orthopaedic surgery," Dr Suen said.

"While many registrars often feel apprehensive about rural placements at the beginning, by the end of their rotations they often report to us that they have enjoyed it very much and feel that they had opportunities to gain skills such as more complex shared decision-making and perioperative planning, which they may not have had in the city."



“We have such a strong sense of team in our department, with everyone going above and beyond to keeps things going.”



Dr Angela Suen, Dr Matt James and Dr Stephanie Naim

There are two STP-funded training positions among the six vocational registrar positions, and 11 visiting medical officers (VMOs) in the Coffs Harbour Health Campus anaesthesia department. The registrars include a 12-month independent ANZCA trainee (Dr Stephanie Naim, pictured), one rotational registrar from Royal North Shore Hospital (Dr Matt James, pictured), two rotational registrars from Westmead Hospital, one rotational registrar from Prince of Wales Hospital and one from Gosford Hospital. The department also takes on emergency and intensive care trainees.

Reflecting on 2020 so far and the months leading into it, Dr Suen said it had been a period unlike any other: “In November 2019, Coffs Harbour and its surrounds were threatened with bushfires. Many of our medical and nursing staff were affected, and unable to attend work, as they were either defending their homes or unable to get to work. This impacted our perioperative services significantly, however, the outstanding level of care we provide to our patients at Coffs Harbour Health Campus did not waiver. We have such a strong sense of team in our department, with everyone going above and beyond to keeps things going. Consequently, this allowed our registrars and residents to continue to advance their skill levels, and assist with procedures that they may not have been exposed to in larger metropolitan hospitals.”

“The 2020 pandemic of COVID-19 presented further challenges for healthcare services everywhere. It was particularly challenging for a small anaesthetic department like ours, with the amount of work that needed to be done to prepare ourselves for the potential inundation of COVID-19 patients into our facility.

“This involved all members of the anaesthetic department working collaboratively with other parts of the hospital to create a plan and provide education and training, to ensure preparedness of all staff.

“It provided an opportunity for us to continue to reflect on our practice, taking valuable lessons from our colleagues in the metropolitan areas of Sydney and Melbourne. Fortunately, the mid-north coast has not had any community transmission of COVID-19 to date. For that, we are very thankful to be living further away from more populated areas.”

Carolyn Jones
Media Manager, ANZCA



The popular Coffs Harbour jetty

DR STEPHANIE NAIM

DR STEPHANIE NAIM had only been able to spend about a month with her husband at their new home in Sydney earlier this year before she moved to Coffs Harbour to start her first year training in anaesthesia at Coffs Harbour Hospital. She had spent the last three years at Sydney’s Westmead Hospital, working there as a critical care senior resident in 2019.

This is the anaesthesia registrar’s second stint in Coffs, having first spent 10 weeks there during her residency in mid-2018 rotating in an anaesthesia term.

“I really think I struck gold by coming here,” she told the *Bulletin* from her Park Beach apartment on one of her days off.

Dr Naim is an independent trainee in the Department of Anaesthesia at Coffs, working alongside trainees from Royal North Shore, Westmead, Prince of Wales and Gosford Hospitals. While she is not on a rotational scheme training program, her training is still ANZCA-accredited. She will be working as an independent accredited ANZCA trainee at the Royal Hospital for Women in Randwick, Sydney next year.

“It is definitely a fantastic place to start my training and learn the bread and butter of anaesthesia.”

The forged links between Coffs and the aforementioned hospitals enables Dr Naim to enthusiastically participate via video link in the fortnightly Westmead and weekly Royal North Shore primary exam tutorials.



“I’m now preparing for the primary exam early next year, so being able to access these learning opportunities is immensely helpful in my preparation.

“Working at Westmead for the past three years provided me with a fantastic grounding in clinical medicine. You see there the whole spectrum of presentations in terms of acuity and complexity. By the time I started as an intern at Westmead, I had already been contemplating training in anaesthesia ever since I had done a critical care placement as a medical student at Sydney’s Liverpool Hospital. I particularly enjoyed the anaesthesia component of that term. I was inspired by one of the anaesthetists there, Dr Blair Munford, who took me under his wing and showed me the diverse and essential roles of anaesthetists on a daily basis.”

Dr Naim explained to the *Bulletin* how one of the advantages of working in a large regional hospital such as Coffs Harbour with its small department is that it gives specialist trainees the opportunity and confidence to participate in and contribute to departmental discussions around new ideas.

“As an anaesthesia registrar, you do have more responsibility, and not necessarily just in a clinical capacity. Working with (department head) (Dr) Angela (Suen) here has been really fulfilling and rewarding. She has given me opportunities to come up with and action new ideas such as facilitating consults to our department via the electronic medical record programs or working on improving the visibility of ‘difficult airway’ alerts in these programs. We can make technology work for us and being able to develop processes to take advantage of this is really exciting.”

“Coffs is truly a great place for a trainee, whether they’re rotating from another network or carving out a path towards joining a scheme training program. It is definitely a fantastic place to start my training and learn the bread and butter of anaesthesia. The department is very supportive. Trainees all get broad exposure across general surgery, obstetrics and gynaecology, trauma and elective orthopaedics, plastics, urology, ENT and dental surgery, as well as paediatrics. If you’re on call, you might get called in for anything from an emergency laparotomy or caesarean section to requests for epidural blocks on the birthing unit. Outside of work, if you did want to move away from the hustle and bustle of the city, this is the perfect place to unwind. It’s a beachside coastal community, but with lots of other nearby areas to explore such as huge parks and small towns.”

Dr Naim hasn’t ruled out returning to the region to work in the future: “I would definitely consider returning here down the track after fellowship.”





“As a trainee at Coffs Harbour I was exposed to most facets of anaesthesia including trauma, obstetrics and paediatrics.”

DR MATT JAMES



“I chose the rural preferential pathway which meant I could do a placement at Port Macquarie Base Hospital on the mid-north coast. I then had placements at Royal North Shore Hospital including in ICU as a critical care resident,” Dr James told the Bulletin.

“It was when I was going into my first year as an intensive care registrar that I decided to pursue anaesthesia as my specialty so I then completed a year in the anaesthesia department at Ryde Hospital in 2019. The main difference moving into anaesthesia was that I went from taking care of an entire room of patients with multiple medical conditions and health issues to having one patient a time for a period of time while they are under your care.”

“As a trainee at Coffs Harbour I was exposed to most facets of anaesthesia including trauma, obstetrics and paediatrics. On a day-to-day basis we shared the roster and there were six registrars, all at various levels of training. On evening shifts we worked from 3.30-11.30pm and then if you were rostered on the night shift you went home with the phone in case you need to be contacted.”

Although he has now returned to Sydney for the next stage of his training he hasn't ruled out returning to Coffs Harbour after fellowship.

“I grew up on the east coast of Australia and I love the beach lifestyle. In Coffs Harbour everything is so close to the water and property is cheaper. I could see the ocean from my balcony and it was great to be able to walk over the road and have a surf before work.

“It has been a strange few months because of COVID-19, especially with elective surgery being scaled back. Looking forward, though, the hospital is expanding and being modernised with new theatre facilities. There are beautiful coastal walks near the towns of Bellingen and Dorrigo with Sapphire and Emerald beaches also being a short distance away.”

HAVING SPENT SEVERAL years studying finance and accounting and then working in an advertising agency in Sydney Dr Matt James is a latecomer to medicine and anaesthesia.

The 34-year-old registrar recently finished a six-month placement at Coffs Harbour Hospital as part of his 12-month training rotation with Sydney's Royal North Shore Hospital. The keen surfer made the most of living across the road from Park Beach and regularly swam and surfed in between his work shifts at the hospital.

Born in Manly, Dr James completed a business degree at UTS in Sydney after leaving school and worked in advertising and marketing companies for several years. Conversations with friends who were studying and working in medicine sparked his interest and he started studying for the Graduate Medical School Admissions Test (GAMSAT). After passing the test he had a high enough score to enroll in the Bachelor of Medicine/ Bachelor of Surgery (MBBS) program at Notre Dame University in Western Australia.

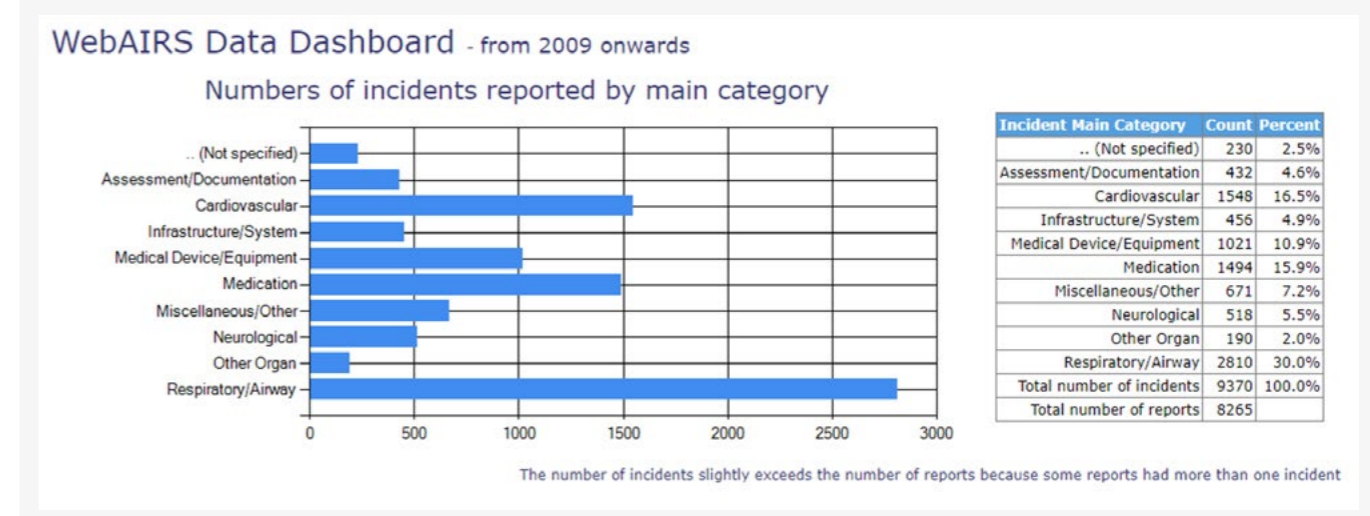
Clinical placements in the Kimberley and Margaret River regions in WA during his study introduced Dr James to rural and remote medicine and also gave him the opportunity to combine medicine with his love of the outdoors and surfing.

His next challenge was then to return to NSW and start seeking internships at hospitals there.

Watch Dr Matt James talk about his experiences in Coffs Harbour on the ANZCA website.

Safety and quality

WebAIRS advisory notices for anaesthetists (ANA) alerts



THE ABOVE DASHBOARD was taken from a screenshot on 21 August 2020 showing 8265 incident reports in WebAIRS. A breakdown of the main categories is shown in the bar graph. Respiratory, cardiovascular and medications are the most frequently reported incidents, followed by medical devices, equipment, infrastructure, system, assessment, documentation, neurological and other.

Examples of recent case reports added to the advisory notices for anaesthetists (ANA) alerts section, on the webAIRS website, fall within the following categories:

- Equipment malfunctioned when a lightweight aluminium crossbar slipped and fell on to the patient's face, as there was no safety mechanism in place to keep the crossbar from falling. There was no apparent harm to the patient following this incident, but staff are encouraged to check that equipment is completely tightened prior to the commencement of a procedure.
- Incorrect disposal of medications occurred in an emergency case, where drug packs had to be carried from the operating theatre to the emergency department. Drugs were later found lying unattended outside the emergency department with no staff in the vicinity. The drugs present a potential for spreading infection as well as presenting a danger for illicit use. All four of these drugs could cause respiratory depression, or respiratory arrest if administered incorrectly, or for the wrong purpose.
- A ropivacaine infusion was connected to the patient's intravenous cannula in error and was not noticed until the morning after surgery. This was an emergency case and the day procedure staff, deployed to work in recovery, were not familiar with the ward procedure. Upon discovery, the regional infusion was immediately stopped and disconnected, the anaesthetist in charge was notified, and the pain registrar and team reviewed the patient immediately.

- A known asthmatic patient was admitted to the emergency department with critically low oxygen saturation and was being treated for severe bronchospasm. Intubation was difficult, exacerbated by the need for the COVID-19 precautions. The personal protective equipment required for intubating a suspected COVID-19 patient increased this difficulty, with fogging of the goggles leading to unclear vision. A cardiac arrest ensued, the management of which was hampered by the need for COVID-19 precautions.

ANZTADC Publications Group

The Australian and New Zealand Tripartite Anaesthetic Data Committee is expanding the publications group and would like to invite all interested ANZCA fellows or trainees to apply. There are four editions of the *ANZCA Bulletin* per year, four editions of the ASA's *Australian Anaesthetist* and four editions of the NZSA *magazine*. Normally the same article is sent to the ASA and NZSA which in turn means eight unique articles are normally published per year.

Successful candidates would be formed into teams with a view for each team to create one article per year. After the publication of a case report in the *ANZCA Bulletin*, the *Australian Anaesthetist*, or the *NZSA Magazine*, a search of the database would be made for similar cases with a view to submitting for publication of a case series article in a journal.

Please apply to anztadc@anzca.edu.au stating your interest in analysing a special topic or category of incident.

Are you contributing to quality anaesthesia?

Visit the webairs website – www.anztadc.net – to register or email anztadc@anzca.edu.au.

Patients with a polio history — what anaesthetists need to know

Liz Telford OAM, a founding member of Post Polio Victoria, says anaesthetists need to be aware of the anaesthesia requirements of people with polio.

WHEN PRESENTING FOR surgery, people with a history of polio are often told that they are a rarity. It is estimated, however, that up to 40,000 people contracted paralytic polio in Australia between 1930 and 1988.

It is also reported that migrants and refugees are increasingly attending polio-related services, so although there are no official figures, we know that there are thousands of people with polio-related issues across Australia from as young as 30 years old.

Hospitals will be seeing polio survivors for at least the next six decades, with needs as broad ranging as childbirth to heart repairs.

We are generally not keen on having surgery due to the unique risks, however the misconception that we are a rarity indicates a lack of awareness by those who should be informed. Often with a background of negative childhood medical treatment, we have the responsibility of educating the medical staff looking after us in hospital, which creates a stress beyond the normal preoperative concerns.

Not only is the onus on us, the patients, to remember to inform the hospital of our polio history, we must also provide information on its surgery and postoperative implications, not knowing how this potentially lifesaving information will be received or if it will be heeded.

Polio does not “end” with the attack on the anterior horn cells of the spinal cord.

To manage anaesthesia risks anaesthetists must understand the post-polio sequelae (PPS), the neurological and muscular skeletal condition that develops 20 to 40 years later. The resulting cold intolerance, skeletal deformity, muscle weakness and denervation, osteoporosis and respiratory issues pose a number of risks. There is often increased sensitivity to sedating drugs, opiates, muscle relaxants and anaesthetic drugs^{4,5}. The usual question about drug allergies is not enough, as while the patient with PPS may not have any allergies they may not be aware of the sensitivity of their central nervous system.

Anaesthetists need to know that not all people with a history of polio will raise these issues. Some will not realise that their polio history is relevant to their impending surgery, or have the knowledge, confidence or the command of the English language to provide this information. The power imbalance between doctor and patient is often exacerbated when there is a history of childhood disability².

It is important for the anaesthetist to take the time to understand the patient's polio history.

We have many and varying hospital experiences. One anaesthetist initially refused to read the online resource regarding anaesthesia and polio provided by a patient about to have emergency surgery at a Melbourne hospital. With only a tense and brief preoperative discussion of her polio history, postoperatively the patient experienced hypotension, extreme cold and suffered a lower back injury from poor positioning.



Members of advocacy group, Post Polio Victoria

Positive examples occur such as when the anaesthetist took the polio history of a patient, read the information offered and discussed the PPS implications. The risk for the patient was reduced, and she had her surgery with the confidence that the anaesthetist understood her specific situation.

Polio already affects all aspects of our lives. It should not also be our responsibility to ensure that hospitals are safe for us. The COVID-19 pandemic, and those affected, will be considered and studied for years to come. Those of us living with the impacts of the global polio epidemic or lack of vaccination programs would like to have the confidence that when in hospital we are in the hands of people who have taken the time to educate themselves about our condition.

Liz Telford OAM
Post Polio Victoria Inc

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“The power imbalance between doctor and patient is often exacerbated when there is a history of childhood disability.”

Anaesthesia-related deaths

The New South Wales Special Committee Investigating Deaths Under Anaesthesia (SCIDUA) has been reviewing deaths associated with anaesthesia and sedation since 1960.

Example cases from the 2018 Special Report are being reproduced in the *ANZCA Bulletin* in an effort to enhance reporting back to the medical community.

The chair of SCIDUA represents New South Wales on the Mortality Sub-Committee of ANZCA's Safety and Quality Committee.



Gynaecological surgery

A 70-year-old female who presented for vaginal hysterectomy.

Background history:

Hypothyroidism and smoker.

Anaesthetic details:

Midazolam 2mg and then induced with propofol and remifentanyl target-controlled infusion. She was paralysed with vecuronium.

Bag mask ventilation was easy. Initial laryngoscopy revealed an unexpected grade 3 view. A bougie was used and patient intubated blindly. There was no end tidal CO₂ so the endotracheal tube was removed.

A second attempt with a bougie was made with tracheal rings felt to be identified and the endotracheal tube railroaded. Some end tidal CO₂ was present but ventilation was difficult. The patient was now bradycardic and hypotensive. This was treated with metaraminol initially and then adrenaline boluses. All drug infusions were stopped.

A widespread rash was then noted. The patient continued to deteriorate and six minutes post induction suffered a cardiac arrest. A transthoracic echo done during the arrest showed ventricular standstill and after 60 minutes resuscitation efforts were ceased.

This death was presumed to be due to anaphylaxis, however a tryptase level was not taken.

Source:

Clinical Excellence Commission, 2019. Activities of the Special Committee Investigating Deaths Under Anaesthesia, 2018 Special Report. Sydney, Australia.

SHPN: (CEC) 190448; ISBN: 2201-5116 (Print)

Introducing the ANZCA Global Development Committee

THE ANZCA GLOBAL Development Committee traces its origins to 2007 when an ANZCA Papua New Guinea (PNG) working party was formed. This group gave rise to the ANZCA Overseas Aid Committee in 2010. Under this name, the committee has provided support for education, training and development of safety and quality in anaesthesia in the Asia-Pacific region and around the world.

As language employed in the global health space has evolved, the committee felt it beneficial to look for a new contemporary name to better reflect the role and purpose of its work. With a number of options considered, the committee agreed that the ANZCA Global Development Committee best represented the work and strategic planning of the committee.

Continuing online support for our Asia Pacific colleagues

Due to the inability to deliver some committee initiatives this year as a result of COVID-19 travel restrictions, the Global Development Committee has had to consider alternative ways to support our colleagues in low- and middle-income countries. One such initiative is the committee's collaboration with Interplast Australia and New Zealand to bring a series of anaesthesia and pain medicine-related education webinars to clinicians across the Asia Pacific. In the coming months Interplast and ANZCA will host a number of webinars on various topics as identified by our colleagues throughout Asia Pacific.

The webinars consist of a 30-minute presentation from a clinician, followed by a 30-minute question and answer session. The live webinar is open to doctors in low resource settings through a registration process. At the completion of the webinar, the recordings are made available on the ANZCA website for all to access.

The inaugural webinar in the series, "ICU management of paediatric patients", introduced by the committee's Deputy Chair Dr Yasmin Endlich, and presented by paediatric intensivist Dr Andrew Clift, was held on 13 August. The webinar was aimed at any clinician involved in postoperative paediatric care and enjoyed a fantastic turnout with live participation of 88 clinicians across 18 countries, further indicating the appetite for such education sessions.

A recording of the webinar and information on upcoming sessions in the series can be found on the Asia Pacific resources section of the global health page on the ANZCA website.

In addition to the webinar collaboration with Interplast, the college, the Australian Society of Anaesthetists and the New Zealand Society of Anaesthetists have agreed to establish a Tripartite Online Education for Low and Middle Income Countries (TOELMIC) Working Group. The group aims to share information, create a collective resource of educational materials and collaborate in the development and delivery of online tools and educational materials for all member organisations to use in their work. This will ensure online anaesthesia and pain medicine resources developed in the global health space are not duplicated and that a collaborative approach is taken to ensure we can best support the educational needs of our colleagues in the Asia Pacific.

Dr Michael Cooper, FANZCA
Chair, ANZCA Global Development Committee



ANZCA's prof docs

What would you do?

Dr Peter Roessler explains ANZCA's professional documents using practical examples. In this edition, he addresses ampoule splitting.



WELCOME TO PETE'S APOTHECARY...

*Double, double toil and trouble; Fire burn,
and cauldron bubble.*

Eye of newt, toe of frog...

(Shakespeare's Macbeth, Act 4 scene 1).

*I've been asked to mix a brew, absolutely pure and true.
What needs to do?*

*Draw up fluid wicked and wild, then add the sleep but
not too mild.*

Now bid adieu!

(Pete Roessler, unpublished...thank goodness).

Covid-19 cast a large healthcare shadow that has necessitated a re-think of processes and procedures, with resetting of baselines and adapting to a new normal.

As anaesthetists we are in a unique position where we prescribe, dispense, (occasionally compound), and administer potent medications.

Historically, hospitals originally provided the basic essentials, and it was up to doctors to bring their own arcane supplies and consumables.

When I started out as a junior resident medical officer (last millennium) many surgeons still brought their own sutures, needles and so on to theatres. Anaesthetists would carry opiates, which constituted part of their "doctor's bag".

Concomitant with this was the use of multidose vials, which could be stored and later reused. Ampoules on the other hand, once opened, could not be sealed, and consequently, not stored. Furthermore, they were now open to potential colonisation by microorganisms (see *PS28 Guideline on infection control in anaesthesia* (section 4.4)).

As a result, practitioners had to ensure that each time contents were aspirated from vials or ampoules the needles or cannulae used were sterile to avoid the potential for cross-infection. Between 2008 and 2009 multiple patients were unfortunately infected with hepatitis C by one anaesthetist due to injudicious and improper technique.

It is for such reasons that ANZCA *PS51 Guideline for the safe management and use of medications in anaesthesia*, discouraged the practice of ampoule splitting in the absence of "appropriately conducted dispensing of ampoule or vial fractions by, for example, an accredited pharmacy". Over time there have been queries from fellows regarding ampoule splitting, and indeed objections to the college's position. In fact, it appears that the practice of splitting ampoules is far more common than has been appreciated. Interestingly, during this time there do not appear to be any reported cases of cross-infection (apart from the one above).

Given the unprecedented and unforeseen circumstances associated with COVID-19 it is not surprising that medical resources came under pressure with fears that demand may exceed supply. Drug shortages have arisen during this time, but shortages occur intermittently irrespective of pandemics, prompting the need to explore strategies aimed at conserving medications.

In addition, the college and its fellows are conscious of anaesthesia's environmental footprint and the need to minimise waste and pollution and adopt environmentally sustainable practices. This is outlined in *PS64 Statement on environmental sustainability in anaesthesia and pain medicine practice*.

So, faced with a decision whether to split ampoules in this context, what would you do?

ANZCA acknowledges the presence of the above concerns and while the risks previously identified are still applicable and not to be discounted, they are not insurmountable and require safeguards to be instituted.

Accordingly, *PS51* (5.5.6) has been amended.

A guiding principle is that any decision to split ampoules rests solely with anaesthetists, taking into account the specifics of each individual situation. The accompanying background paper provides further advice under item 3.8. It is important to appreciate that *PS51* is not advocating nor advising anaesthetists to split ampoules but rather acknowledges that there may be circumstances where it is warranted or justified.

In such cases it is imperative that strict processes are developed for dividing doses from ampoules so as to provide the same level of guarantee as from the manufacturer.



Contents of unopened ampoules are guaranteed by manufacturers, who have strict measures in place, must comply with regulatory demands, and be approved by the relevant jurisdictional authority (the Therapeutic Goods Administration in Australia and Pharmac in New Zealand).



However, once an ampoule is opened (assuming no manufacturing error) the responsibility shifts to the registered medical practitioner managing the patient and administering the medication. Herein lies the reason to ensure that strict procedures are followed.

Contents should not be left in open (unattended) ampoules, which provides an opportunity for tampering as well as contamination and/or introduction of microorganisms. To my mind, “best practice” involves drawing up the entire contents of ampoules in desired aliquots at the one time, into correctly labelled syringes, which are then capped, and stored in a safe place.

Distractions and interruptions during ampoule-splitting are fraught with danger and are to be avoided, especially if mixing medications into one syringe (compounding), as sometimes occurs with propofol and fentanyl, or fentanyl and midazolam.

Speaking of *witch*, going back to the potion being brewed before I was distracted, was the last ingredient added the *eye of newt* or *toe of frog*?

Professional documents – update

The ANZCA and FPM professional documents are available via the ANZCA website.

Recent updates

- Due to the disruptions caused by the COVID-19 pandemic, the review of *PS09 Guideline on sedation and/or analgesia for diagnostic and interventional medical, dental or surgical procedures* has been delayed, however we will endeavour to commence the review as soon as possible. The document development group (DDG) membership has been established and this is to become a co-badged document involving a true multidisciplinary collaboration between 25 colleges/societies.
- The DDG membership has been established for the development of for *PS49 Guideline on the Health of Specialists, Specialist International Medical Graduates and Trainees*. The DDG will include representatives bringing with them a diverse range of perspectives.
- Work has commenced on the development of *PS67 Professional document on end-of-life care for patients scheduled for surgery*.
- *PS55 Position statement on minimum facilities for safe administration of anaesthesia in operating suites and other anaesthetising locations* was released for consultation with stakeholders in August 2020.

- Post consultation review is being undertaken on *PS56 Guideline on equipment to manage a difficult airway during anaesthesia* with the draft document pending consideration for pilot phase.
- Post pilot review is being undertaken on *PS06 Guideline on the anaesthesia record*, *PS29 Guideline for the provision of anaesthesia care to children*, and *PS45 Guideline on fatigue risk management in anaesthesia practice*.

Currently in pilot

- *PS26 Guideline on consent for anaesthesia or sedation* (until October 2020).
- *PS51 Guideline for the Safe Management and Use of Medications in Anaesthesia* (until November 2020).
- *PS66 Guideline on the role of the anaesthetist in commissioning medical gas pipelines* (until October 2020).

Feedback is welcomed during the pilot phase for all professional documents. All comments and queries regarding professional documents can be sent to profdocs@anzca.edu.au.

Searching for the gold in garbage

Queensland anaesthetist Associate Professor Kerstin Wyssusek is recognised as an inspirational leader in hospital waste and recycling initiatives.

IN 2009 WHEN Associate Professor Kerstin Wyssusek started a new role as a consultant anaesthetist at a large Brisbane public hospital she was struck by the lack of waste segregation and recycling initiatives in the operating theatres.

While her fellow consultants and nursing staff supported the introduction of environmental sustainability programs to reduce the amount of waste collected on site, their experience at the hospital hadn't been positive.

"When I discovered there was no waste segregation in the hospital's operating theatres this sparked my interest and I started asking why?" Associate Professor Wyssusek explains.

"After talking to a couple of nurses I found out that they had actually started a waste management program

at the hospital but after a waste audit was conducted they were reprimanded by hospital managers for not separating the waste into the right areas so the initiative quickly came to a halt.

"It soon became clear that all that was needed was more information for staff on how to segregate the different types of waste using posters and promotional materials and once we started doing this everyone across the hospital embraced it. It was great to see how such a small change in practice and information can motivate staff."

A decade later Associate Professor Wyssusek was recognised by the Queensland Department of Health and Minister for Health Dr Stephen Miles for her commitment to the state's hospital waste and recycling initiatives. She received two Queensland Health Awards for Excellence at a presentation in Brisbane in late 2019 – the Individual Award for Outstanding Achievement and another as second runner-up in the Minister's Award for Excellence.

Associate Professor Wyssusek stresses that team support and advocacy is key to the success of sustainability and recycling initiatives.

"There's always a handful of people who are interested and committed and this then leads to more engagement and, ultimately, a change of practice."

She says in her experience over the past decade simple information for staff about how to separate general hospital waste such as paper and cardboard, sterile packaging and plastic is key to changing mindsets about sustainability and recycling initiatives.

Associate Professor Wyssusek was appointed Director of the Department of Anaesthesia and Perioperative Medicine at the Royal Brisbane and Women's Hospital, the largest anaesthesia department in Queensland, nearly five years ago. She leads a department of 150 anaesthetists and 80 anaesthesia healthcare practitioners.

She is an enthusiastic driver of quality improvement initiatives and since her appointment has initiated and supported the implementation of some 30 such measures in the department including establishing a Centre for Excellence in Innovation in Anaesthesia. The centre delivers education, training, simulation and research, with a research output of around 35 publications a year (a 700 per cent increase in department research over five years.)

Her department has also significantly reduced its use of desflurane, which produces the highest carbon emissions of any anaesthetic gas, by more than 70 per cent.

Associate Professor Wyssusek was the lead author in a 2016 paper *"The Gold in Garbage: Implementing a Waste Segregation and Recycling Initiative"* which described the program in her department¹.

Associate Professor Wyssusek and her team found that operating rooms produce about one-fifth to one-third of all waste in a hospital. Before the department's program was introduced all operating theatre (OR) waste was disposed of as clinical waste which is six to eight times more expensive than the disposal of general waste.

"Accurately segregating waste can have significant financial incentives," the report concluded.

"Our quality improvement project involved the implementation of processes that segregated general waste in the OR from clinical waste and translated to an almost 60 per cent reduction of waste disposal costs for OR waste. Further, we implemented a recycling program that reclaimed a portion of the general waste. In total, our efforts reduced the amount of clinical waste produced by the OR by 82 per cent, and the amount of total OR waste was reduced by more than 50 per cent."

Associate Professor Wyssusek says at the Royal Brisbane and Women's Hospital there is strong support for the environmental sustainability programs from trainees who then promote the initiatives to other hospitals when they transfer to other sites.

"It's great to see how simple ideas can snowball when you lead by example. The hardest part I found was overcoming hospital hierarchies but in the past 10 years I've noticed a significant shift in how hospitals now respond to sustainability and recycling initiatives. It's much better now than it used to be. It's now much easier to engage a waste manager in hospitals and there have also been legislative changes including the introduction of waste levies and fines for organisations and businesses that don't practice sustainability."

"The pioneer of course in sustainability in healthcare in Australia is Dr Forbes McGain (the Melbourne FANZCA and intensivist). He's led the way for anaesthetists in Australia, to think green," she says.

"Introducing a simple system to segregate waste is the first win and the second step is to start recycling from general waste by educating, informing and updating

hospital staff. Having that awareness among staff who are also environmentally conscious has really helped drive change in our department."

Associate Professor Wyssusek is now working on a new environmental sustainability project in collaboration with the University of Queensland and the Herston Biofabrication Institute in Brisbane to develop a "circular economy" approach to the medical plastics recycling process that could help hospitals become even more sustainable.

While she is passionate about environmental sustainability in healthcare she is also playing a lead role in ensuring the psychological wellbeing of doctors is recognised and supported by hospital administrators.

A unique wellbeing peer support program initiated in Associate Professor Wyssusek's department by Queensland anaesthetist Dr Gemma Slykerman has now been embraced by other departments in the hospital and other Australian anaesthetic departments.

The program provides a peer-driven, confidential, psychological safety net for all Royal Brisbane and Women's Hospital anaesthesia staff. It focuses on collegial support in times of stress, as well as promoting a workplace culture of understanding for staff suffering psychological strain. Associate Professor Wyssusek says while staff had the option to obtain support at any time from a responder of their choosing, they don't need to actively seek it out in the event of a critical incident because it is automatically provided to them.

Consultant anaesthetists trained in psychological first aid act as responders, offering support as well as resources and psychologist referral as required.

"Collegial support in times of stress is so important and we're excited that this innovative program has been acknowledged by the hospital as a program that is well worth supporting," Associate Professor Wyssusek explained.

Carolyn Jones
Media Manager, ANZCA

Reference

1. (AORN journal 103(3):316.e1-316.e8 · February 2016 DOI: 10.1016/j.aorn.2016.01.014)

A video interview with Associate Professor Wyssusek is on the ANZCA website.



Associate Professor Kerstin Wyssusek, Director of the Department of Anaesthesia and Perioperative Medicine at the Royal Brisbane and Women's Hospital

Medical waste increasing during pandemic

THE COVID-19 PANDEMIC has resulted in a massive expansion in healthcare associated waste.

While this has been necessary to ensure protection of healthcare workers (HCWs) and patients, it is projected to cause significant environmental impact.

There has been a significant increase in personal protective equipment (PPE) production, utilisation and disposal worldwide, due to the use of PPE in the care of COVID-19 affected patients, recommendations for widespread mask wearing in many settings, and a general increase in vigilance regarding PPE usage among HCWs.

The World Health Organization (WHO) has estimated that the global pandemic response will require 89 million disposable face masks each month¹, which will end up being incinerated, in landfill or contaminating the environment.

Additionally, it has been recommended that single use equipment is utilised in the care of these patients, resulting in increased use and disposal of anaesthesia equipment (for example, breathing circuits, HME filters and video laryngoscope blades). The increase in waste from the medical sector during the pandemic has been reported to be up to 65 per cent².

The US Centre for Disease Control and Prevention (CDC) has recommended that COVID-19 hospital waste be handled through routine procedures³, which require it to be disposed of as infectious/clinical waste, and is generally incinerated. Overall, there has been an increase in production and disposal of plastic products worldwide, with decreased recycling of these materials back into the supply chain. This is expected to have a substantial environmental impact for many years to come^{4,5}.

It must be stressed that the safety and protection of HCWs and patients is paramount in the pandemic, and it is essential that PPE and disposable equipment is fully utilised in line with national and/or local infection control guidelines.

“As our knowledge about COVID-19 is continually evolving, so too is the discussion about environmental sustainability during this period.”

Currently it is a challenging task for anaesthesia departments to prioritise greening activities. However, this article is a brief consideration of how environmental sustainability goals may be maintained during this difficult time. This year has highlighted the essential relationship between population and environmental health, and the importance of measures we can undertake to reduce the significant environmental impacts of the health sector. It has also highlighted our collective capacity as health professionals to enact change within our sector.

It should be acknowledged that efforts to reduce the spread of COVID-19 have resulted in several changes to the ways that we live and work which will benefit the environment. This includes a reduction in air and road travel and increased use of teleconferencing facilities for conferences, meetings and patient consultations.

In the UK, one NHS Trust has estimated that the use of teleconferencing for outpatient appointments has saved almost two million kilometres of patient travel, and 320 tonnes of CO₂ emissions, in two months⁶.

Additionally, we have seen manufacturers utilise waste products, and redirect manufacturing, to respond to shortages in the medical sector. For example, alcohol distilleries have utilised residue products to produce hand sanitiser and individuals have mobilised to produce cloth face masks from fabric remnants. These are examples of “closing a resource loop”, whereby materials are recycled into future manufacturing to reduce waste and minimise environmental impact.

It also demonstrates our capacity to mobilise locally available resources to respond to supply chain issues. The rapid adoption of these measures demonstrate that we can dramatically change the way that we work to minimise environmental impact.

There is little formal guidance at the moment as to how HCWs may optimise environmental sustainability while working with COVID-19 suspected patients. However, awareness of the issue is growing as challenges associated with the increase in waste generation become apparent. In the business community, there has been advice to take the time to reassess sustainability plans during the pandemic, and determine what actions are not currently feasible and where energies to improve sustainability are best directed.

In the health context, this would involve an acceptance of the need for increased waste associated with PPE and disposable items in the care of COVID patients, however taking some time to optimise other practices to improve environmental sustainability.



Anaesthetist Dr Jessica Hegedus (left) and anaesthetic registrar Dr Ryan Kwen at Wollongong Hospital wearing the reusable powered air-purifying respirators (PAPRs).

The ANZCA Environmental Sustainability Audit Tool contains an extensive list of activities that can be undertaken to improve sustainability in your individual or department's usual practice⁷. The listed general principles still apply during a pandemic.

It is important that we engage with hospital waste management services, and adhere to local waste management guidelines and procedures, to both protect staff health and the environment. While PPE and equipment used in the care of COVID-19 patients particularly requires disposal in infectious waste bins, generally we can be vigilant about the correct separation of infectious and non-infectious waste to minimise incineration waste and allow recycling of non-infectious, recyclable items.

Importantly, we can regularly review our practices and seek to minimise the production of infectious waste in the care of COVID-19 patients, for example, by avoiding unnecessary equipment being brought into a COVID operating theatre (OT) or reducing the number of staff in the OT. The use of reusable powered air-purifying respirators (PAPRs) and industrial elastomeric respirator masks are emerging as a potentially more sustainable alternative to disposable N95 masks, which also have potential benefits in terms of staff safety, long-term cost and reduced dependence on supply chains.

Finally, in the future it will be important to advocate for more sustainable options to be available for similar situations. For example, we can advocate for more environmentally friendly systems to dispose of infectious waste, or the production of suitable equipment and consumables with less environmental impact.

As our knowledge about COVID-19 is continually evolving, so too is the discussion about environmental sustainability during this period.

The ANZCA Environmental Sustainability Working Group would love to hear suggestions and feedback from ANZCA membership about how to consider environmental sustainability during the COVID-19 pandemic – email enviro-sustainability@anzca.edu.au.

Dr Jessica Hegedus
Anaesthetist, Wollongong Hospital, Member, Environmental Sustainability Working Group (ESWG)

Associate Professor Kerstin Wyssusek
Director Department of Anaesthesia and Perioperative Medicine at Royal Brisbane and Women's Hospital, Member, ESGW

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From London to Alice Springs

WHEN ANAESTHETIST Dr Heidi Robertshaw moved to the Northern Territory from the UK four years ago to take up a position at Alice Springs Hospital she relished the opportunity to be able to continue her speciality as a generalist.

A fellow of the Royal College of Anaesthetists she received her FANZCA through the specialist international medical graduate (SIMG) pathway earlier this year and was recently appointed as the new fellow representative on ANZCA's South Australian and Northern Territory regional committee. Her colleague, Dr Raveendran Harish, an anaesthetist and specialist pain medicine physician, has also joined the committee as a co-opted member.

Dr Robertshaw had first visited Alice Springs in 2007 when she and her Australian husband, Dr Greg McAnulty, an intensive care physician, spent 12 months working in the hospital before returning to London.

"The reason we came back was because we decided we needed a change. We had both worked in a trauma centre at a London teaching hospital with all the major sub-specialties on site. It meant my anaesthesia practice was getting more and more sub-specialised and we both wanted to broaden our practice again. We've been able to do that in Alice Springs. It's very much a generalist anaesthetic department here which is wonderful."

Dr Robertshaw works with six other FANZCAs and four GP anaesthetists in the department which is headed by Dr Jacob Koshy. About 80 per cent of the hospital's patients are Indigenous and the hospital manages general

surgical and orthopaedic trauma, including neurosurgical and vascular surgical emergencies. According to the Northern Territory's Department of Health about 8000 cases are completed each year in six operating theatres. The hospital has 186 beds which serves a catchment population of 60,000 across an area of 1.6 million square kilometres extending into South Australia and Western Australia.

The hospital also has the largest single-standing dialysis unit in the southern hemisphere with 360 patients on dialysis. Many of the hospital's obstetric anaesthesia patients have complicated conditions because of rheumatic valvular heart disease.

"One of the wonderful things about being a generalist anaesthetist again is that while some of the cases we deal with would anywhere else appear to be a simple anaesthetic procedure – such as a hernia repair – many of our patients here have many serious co-morbidities so this does make the anaesthetic challenge more demanding. Our patient population and the diseases many of them have make that a challenge every day for us," Dr Robertshaw explains.

Dr Robertshaw hopes her experience working as part of a regional workforce in a hospital with a large Indigenous population will be a valuable resource for the SA and NT Regional Committee.

"I hope I can offer a positive perspective. With the population we have Alice Springs is a challenging place to work. For people who want to continue to stretch and challenge themselves this is the place to do it but the pleasure and delight for me is being able to provide an anaesthetic service for Indigenous patients as well as the white population that's of a good standard."

"There's a big unmet health need in the Indigenous communities that we don't necessarily see as anaesthetists but which obviously feeds into our practice. Diabetes for example can be hard to manage for some of these patients who then come into the hospital with complications from that disease and badly managed blood sugars."

A typical week for Dr Robertshaw is varied and fulfilling with one night usually spent on call.

"We have permanent general surgeons, orthopaedic surgeons, gynaecologists and we also have visiting medical officers (VMOs) as well. In a typical week I might do a list of endoscopies for a VMO gastroenterologist visiting from Adelaide, a routine gynaecological list and a general surgical list."

"Some of our patients for instance might come from Tennant Creek which is a four-hour drive but that's what people do here to get to a hospital. For me coming from

"There's a big unmet health need in the Indigenous communities that we don't necessarily see as anaesthetists but which obviously feeds into our practice."



Dr Heidi Robertshaw and Dr Raveendran Harish

the UK the idea that you would drive for four hours to go to a hospital is still staggering but our patients will travel down on the bus even though they're in pain."

Dr Robertshaw says the hospital, which is managed by the NT Department of Health, is well resourced.

"We had a theatre refurbishment a few years ago so the theatres are of a high standard, the same standard I was used to in London. We have a very supportive director of medical services. One of the nice things about working in a small hospital is that people like the director of medical services are very approachable. The chain of command is shorter than you would find in larger hospitals."

One of the most noticeable changes she has observed since her first stint in Alice Springs in 2007 is the heightened visibility of Indigenous trainees and doctors.

"Just recently I did some lists with an Indigenous GP who is working in Tennant Creek and she had come down here to refresh her airway skills. In the past year we've had three resident medical officers (RMOs) in the department who are Indigenous and that has really been fantastic. They're obviously committed to country and the people here. For the Indigenous doctors here it is challenging for them because of family and community connections but it's a very positive thing to be seeing."

Carolyn Jones
Media Manager, ANZCA



Looking over Alice Springs at sunset

Russell Cole Memorial ANZCA Research Award 2015-20

Six years of progress in pain medicine

Since 2014 the Russell Cole Memorial ANZCA Research Award has supported six outstanding pain medicine research projects, making invaluable contributions to the advancement of pain medicine.

WHEN THE FOUNDATION established the Russell Cole Memorial ANZCA Research Foundation Award for the Cole family in 2014, they had two laudable objectives. The first was to honour the memory of Ann Cole's husband and prominent anaesthetist Dr Russell Cole, and his significant contributions to the development of anaesthesia and pain medicine. The second; a logical progression: to support continued advancement in pain medicine through dedicated innovation, a cause of which Dr Cole had been a pioneering proponent.

Each year since then, the Cole family has funded the award, providing a significant funding grant for an important research study in the field of pain medicine, with a preference for studies of relevance to the treatment of cancer pain. The award is bestowed annually by the ANZCA Research Committee after competitive peer review, to a project it has determined to be of high quality according to its strict assessment criteria.

The Cole family's generous and visionary philanthropic support through the award process has now supported six pain medicine research studies from 2015-20. Ranging from completed and published to currently in progress with promising initial results, each study has the potential to hold significant implications for improved scientific understandings, management and treatment of pain, for the benefit of future patients.

The ANZCA Research Foundation and ANZCA appreciate Mrs Cole's support of research studies advancing pain medicine, and the alleviation of cancer pain.

Robert Packer
General Manager, ANZCA Research Foundation

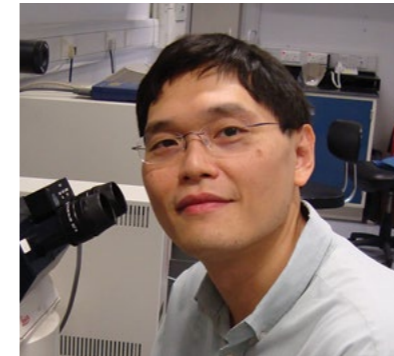


Dr Russell Cole

Dr Russell Cole obtained fellowships of the Faculty of Anaesthetists of the Royal College of Surgeons, the Faculty of Anaesthetists, Royal Australasian College of Surgeons, and of the Australian and New Zealand College of Anaesthetists. He pioneered the management of cancer pain in Melbourne, and published articles in peer-reviewed journals on the relief of intractable pain by nerve block. In 1962, he was appointed fulltime executive medical assistant at the Peter MacCallum Cancer Hospital, supervising the Consultant Pain Relief Clinic, in which he maintained a deep interest until his retirement. In 1965 he was appointed Director of Anaesthetics at the Royal Melbourne Hospital, succeeding Norman James and remaining in the post until 1980.

Supporting advancement through the foundation

Donations can be made to the foundation to help seed-fund vital research studies, or to support ANZCA overseas aid or Indigenous health programs. Donations can be made via the foundation pages on the ANZCA website, with subscription payments, or by directly contacting the foundation at foundation@anzca.edu.au. ANZCA, the Research Foundation Committee, and the foundation team sincerely thank all of our patrons and other donors who have already donated through their subscriptions, especially during this difficult time.



2020

Butyrate for the prevention and treatment of chemotherapy-induced neuropathic pain

Professor Matthew Chan, Chinese University of Hong Kong

Devastating oxaliplatin-based chemotherapy-induced neuropathic pain often lasts beyond the discontinuation of treatment. Previously, Professor Chan's team demonstrated that direct sodium butyrate supplementation may reduce oxaliplatin-induced pain.

Using animal spinal cord tissues, the team has shown that sodium butyrate reduced the level of histone deacetylase, indicating that a change in genome expression has an effect. They have completed genome analysis, and shown that a series of genes encoding potassium channels were dysregulated after oxaliplatin treatment, confirming the hypothesis that sodium butyrate may reduce chemotherapy pain.

In experiments in an animal model based on these results using a probiotic that produces butyrate (*Bacteroides uniformis*), preliminary data have suggested that pain was reduced after the administration of the probiotic.

This will require further testing, but the results are promising. The team hopes to move to the next stage so that the probiotics could be used to reduce pain in patients receiving oxaliplatin-based chemotherapy.



2019

Virtual reality as a treatment for pain in people with spinal cord injury

Professor Philip Siddall, University of Sydney

About 50 per cent of people with paraplegia and quadriplegia experience severe pain in the area where they have lost sensation. The best treatments provide only partial relief.

This project aimed to determine whether use of virtual reality (VR) could significantly reduce pain in people with neuropathic pain following a spinal cord injury (SCI), and whether the use of VR and changes in pain intensity are associated with changes in neuropathic pain-linked electroencephalographic (EEG) patterns.

Fifteen subjects from 30 to 76 years of age with pain duration from six to 39 years have completed the study.

The results of the study show reductions in pain intensity after both immersive (headset) and non-immersive (laptop screen) VR. Although the pain reductions after laptop screen VR are not clinically significant, further analysis shows intensity reduction using immersive VR with the headset is in the range considered to be clinically significant.

These results are extremely promising, and indicate that immersive VR using a headset may be a relatively easy and inexpensive way of reducing pain in this group of people.

The team plans to use the completed analysis of participants' EEG data to further explore whether VR reduces pain, its effect on the brain, and how that may explain the mechanisms behind the reduction in pain.



2018

The influence of genomic and neurophysiological factors on persistent pain after breast cancer surgery (PPBCS)

Dr Daniel Chiang, North Shore Hospital, Auckland

International studies suggest nearly half of all breast cancer surgery patients suffer pain more than six months postoperatively. This team's prior work found more than half of such patients in New Zealand are affected. Nearly a quarter reported moderate to severe pain.

This study intends to facilitate detection of patients at-risk of PPBCS, by identifying a range of risk factors including clinical, treatment, patient, patient genetic make-up, and preoperative pain processing factors.

The study is also examining the body's regulation of selected pain genes, to help better understand whether PPBCS results from these genes being turned off due to treatment.

About 220 patients were being recruited. In an interim analysis of 105 patients, 40 per cent reported PPBCS and 15 per cent reporting moderate to severe PPBCS. Patients with PPBCS reported greater daily living impairment, and greater psychological distress.

Association between genetic make-up and PPBCS has not yet been identified but the team believes this will emerge as they include more patients. They have, however, identified an association between patient genetic make-up and perioperative pain processing.

Preliminary examination of PPBCS risk factors has been completed, with preoperative pain, greater preoperative anxiety, current smoker, and moderate to severe pain at 14 days all associated.



2017

The long-term effects of spinal cord stimulation on neural function in chronic low back pain – a pilot study

Associate Professor Paul Wrigley, University of Sydney

Chronic low back pain is the number one disability cause in Australasia, yet sustained relief has been difficult with conventional treatments. Recently, new electrical spinal cord stimulation (SCS) patterns have delivered marked improvements.

The mechanisms of SCS are poorly understood, raising questions about long-term effects on nerve function. This study aimed to examine for such long-term effects.

The study is in its final year and has found no definitive evidence of neural damage from SCS devices. Continuation is vital to help to determine whether further large-scale studies are needed.



2016

Central sensitisation and auditory disturbances in complex regional pain syndrome

Adjunct Prof Philip Finch (pictured), Prof Peter Drummond, Murdoch University

This project aimed to debunk the myth that most complex regional pain syndrome (CRPS) patients exaggerate their symptoms; exacerbated when these appear to be linked with psychological distress. For example, pain can increase with loud noises, weather changes, or psychological triggers.

Instead, it investigates a more compelling hypothesis: that the failure of the brain to adequately suppress pain distorts normal sensory processing in CRPS, and that patients may learn to avoid stimuli (for example, stress, arousal and pain itself) that make symptoms worse. Outsiders may conclude that the patient is exaggerating or exacerbating their condition, when in reality there may be few other options for keeping pain tolerable.

The team found that in patients with CRPS noise-induced discomfort was greater on the symptomatic side of the body, and varied with pain intensity and other symptoms in the affected limb. Hence, noise-induced discomfort appears to form an important part of the overall picture in CRPS.

The team's findings partly support the original hypothesis that disturbances in CRPS spread beyond the affected limb to disrupt additional perceptual processes such as the perception of sound. They believe the results challenge prevailing dogma that CRPS is a psychological disorder, and will encourage the development of urgently-needed new approaches to managing CRPS pain.



2015

The role of toll-like receptors and androgen activity in dysmenorrhoea-related pelvic pain.

Dr Susan Evans, University of Adelaide

Women suffer a disproportionate amount of chronic pain compared to men, and for one in five young women their first pain symptom is dysmenorrhoea from menarche. This study investigated whether there was evidence of activation of Toll-Like Receptor 4 in young women with dysmenorrhoea-related pelvic pain, as a potential basis for the transition from dysmenorrhoea to chronic pelvic pain.

A first study found a lower EC50 (increased responsiveness) for IL-1 beta release from peripheral blood mononuclear cells following stimulation with LPS, as an estimate of TLR4 responsiveness. This was not significantly altered by the day of testing, or by the use or non-use of the oral contraceptive.

A second study found that young women reported an increasing number of days per month of pelvic pain as levels of androgens (testosterone) reduced, specifically; the free androgen index. Both these studies offer the potential for novel treatment options in the management of young women with pelvic pain.

Airway Leads update

Dr Yasmin Endlich



- Liaising with the intensive care unit and emergency department
- Ensuring consistency of airway assessment and planning.
- Investigating adverse outcomes and supporting colleagues involved in them.

Additional initiatives have been developed including:

- Sharing ideas and developments.
- Sharing knowledge and creating a network about the different courses around Australia and New Zealand.
- Sharing information about Fellowships that various hospitals are offering.
- Being involved in ANZCA ASM and ASA NCS meetings.
- Contributing to knowledge and ideas.

Participants of the meeting mentioned that in the current pandemic networking, support and collaboration are more important than ever.

Other topics discussed were:

- Establishment of a difficult airway alert.
- Universal video laryngoscopy.
- Difficult airway trolley.
- Collaborations across institutions and states.

The first Airway Leads network was launched in the UK in 2011 followed by the New Zealand Airway Leads network in 2018. The Australian network is developed by the executive members of the Airway Special Interest Group.

If you would like to get more information or be nominated, please contact the Airway Management SIG at [https://www.anzca.edu.au/fellowship/anaesthesia-continuing-education-\(1\)/airway-management-special-interest-group](https://www.anzca.edu.au/fellowship/anaesthesia-continuing-education-(1)/airway-management-special-interest-group).

Dr Yasmin Endlich
Chair, Airway Management Special Interest Group

THE FIRST AUSTRALIAN Airway Leads meeting was held on 24 June. It was an interesting online meeting with 45 members attending from nearly all Australian states.

Representatives from New Zealand (Dr Sheila Hart and Dr Chris Jephcott) shared their experience with the group. Each public hospital in New Zealand has a nominated Airway Lead. As a group, they have made progress in sharing:

- Education and training.
- Policies and guidelines.
- Equipment.
- Quality assurance.
- Regular meetings.

Projects that the New Zealand group is working on are the development of a difficult airway registry and advocating for universal capnography.

In Australia, there are currently 41 nominated Airway Leads (Victoria/Tasmania 20, Queensland 10, Western Australia 5, New South Wales 5 and South Australia and Northern Territory 1).

The original aims of the airway network initiative are:

- Overseeing and assisting local airway training.
- Ensuring appropriate difficult airway equipment is readily available.
- Actively engaging in airway device procurement.
- Ensuring local policies for predictable airway emergencies exist and are available.
- Providing airway management education to healthcare workers.

Planning and flexibility is key to a successful return to anaesthesia after pregnancy

As part of the college's commitment to doctors' wellbeing, we are inviting trainees to share their experiences with flexibility in training. Provisional fellow Dr Bronwyn Posselt describes how her return to work at the Royal Hobart Hospital after having her first child has been a positive experience.

THROUGHOUT MY MEDICAL school and junior doctor years I formed the impression that having babies during training was a bad idea.

I was wrong.

Over the years I heard time and again that it was "best to wait" until consultant years. However, my husband and I found ourselves overwhelmingly ready to start a family when I was only midway through the ANZCA training program. When I fell pregnant the first time, I was worried about the career impacts and hid it from my colleagues. Dealing with full time work, exam study, horrendous early pregnancy symptoms and a subsequent miscarriage was challenging to say the least. The whole experience left me burnt out and wondering whether motherhood and completing my training were actually compatible.

I found out I was pregnant again the night before my Part 2 viva exam. I was terrified. My previous pregnancy had been the most challenging nine weeks of my life, how was I going to manage nine months? I decided to take a different approach this time. Many of my colleagues knew I was pregnant well before most of my family, and the support I received was overwhelming.

I met with my director early in the pregnancy to plan the pregnancy, my leave and my return to work. We agreed on no night shifts after 32 weeks and maternity leave from 36 weeks, with an option to change things as we went. Communicating with ANZCA was a breeze.

- ANZCA wants to hear from you about your experiences of returning to work. Please share your stories by contacting membership@anzca.edu.au.
- For information around interrupted training, including the application form, please contact the college's interrupted training officer at training@anzca.edu.au.
- For information and resources on doctors' health and wellbeing, visit the college website – anzca.edu.au/about-us/doctors-health-and-wellbeing.

A couple of emails and a form was all it took to get interrupted training and a reduction in my training fees approved for my maternity leave.

Despite my best planning efforts, I was still completely unprepared for the physical effects of pregnancy. While I was very happy to be having a baby, I hated every moment of the pregnancy. Eight months of continuous unrelenting nausea, on top of syncopal episodes, crushing fatigue, vomiting, insomnia and pelvic pain – it is hard to put into words the extent of the physical symptoms and the psychological impact of these. However, with rostering flexibility, breaks, utilisation of sick leave, and reduced shift lengths I was able to cope – just – and continued my training and full-time work until 36 weeks. I have no doubt that without the support of my colleagues I would not have been able to continue to work throughout the pregnancy.

Short-term contracts and lack of job security add an extra level of stress for doctors wanting to start a family during training. My baby was due two days before the expiration date of my current contract. For me, no contract renewal would mean no paid maternity leave. Furthermore, my husband's contract was going to end only a few weeks later. He has been a paramedic for 10 years, but it seems that short-term health contracts are not unique to medicine. We were both pretty sure we would both get through the reapplication processes but we did have fleeting moments of fear that we might have to move with a newborn to find work. I needn't have worried though. My department even gave me a two-year contract for my provisional fellowship, instead of the usual one year, so I could fit in my maternity leave and complete my training without worrying about job security.

Returning to work after a period of leave is daunting in itself, but even more so as a first time mum trying to figure out the parenting juggle. Even though Tasmania had no current cases, the COVID-19 pandemic and uncertainty over the future made formal childcare an unattractive option and border closures meant we couldn't rely on grandparents visiting to help out. Fortunately, our employers were really supportive and my husband and I were both able to drop to 0.5 fulltime



Bronwyn Posselt and baby Emerson

equivalent (FTE) and share the child care duties. What is more, my department kindly agreed to roster around my husband's shift work so one of us could be home.

Child care aside, I was still nervous about my return to work. Would I still remember how to give an anaesthetic? Was seven months away long enough to forget everything? A fairly structured return to work helped. Initially I worked fulltime hours for two weeks to get back in the swing of things. I had level one supervision with no afterhours work during this time. Coming back into a supervised position is a big advantage of returning to work as a trainee and I haven't felt out of my depth at all.

Having a baby during training was definitely the right choice for me. Early discussion of my plans, concerns and needs with my workplace and ANZCA really helped the whole process. Despite a horrendous pregnancy, I got through it because of the help and encouragement I received from my department.

I hope that my positive experience can not only show other trainees that starting a family during training is possible and a wonderful experience but anaesthetic departments around the country benefit by supporting their trainees to be successful in work while living all of the joys of family life.

Dr Bronwyn Posselt is a provisional fellow at the Royal Hobart Hospital.

2020 CPD verification update

IN LINE WITH the Medical Board of Australia (MBA) and Medical Council of New Zealand (MCNZ) the college will not undertake a 2020 verification of continuing professional development (CPD) activities (audit). This decision acknowledges the challenges in accessing evidence to support completion of CPD activities in new areas due to restrictions brought on by the COVID-19 pandemic.

It is a requirement of the MBA and MCNZ accreditation of our CPD program that there is a random audit process for CPD participants. To meet this requirement, each year the college selects a minimum of seven per cent of fellows and participants to have their activity records (CPD portfolio) verified.

In line with the current MBA and MCNZ position, the college has decided to:

- Not conduct a 2020 verification of CPD activities process, whereby participants will not be selected, notified or have their CPD portfolio evidence verified by the college this year.

- Evidence for 2020 CPD activities will not be requested from selected participants during subsequent college audits in 2021 and 2022.
- There are no changes to annual or triennial CPD requirements.
- CPD participants will still be required to meet their 2020 annual and triennial requirements to obtain either a certificate of participation or compliance.
- Those found CPD non-compliant for previous verifications or end of trienniums will be supported by the college and selected in future college verifications.

Full details are available on website news item at www.anzca.edu.au/news/cpd-news/no-2020-cpd-verification-update.

Reminder: 2018-20 end of triennium

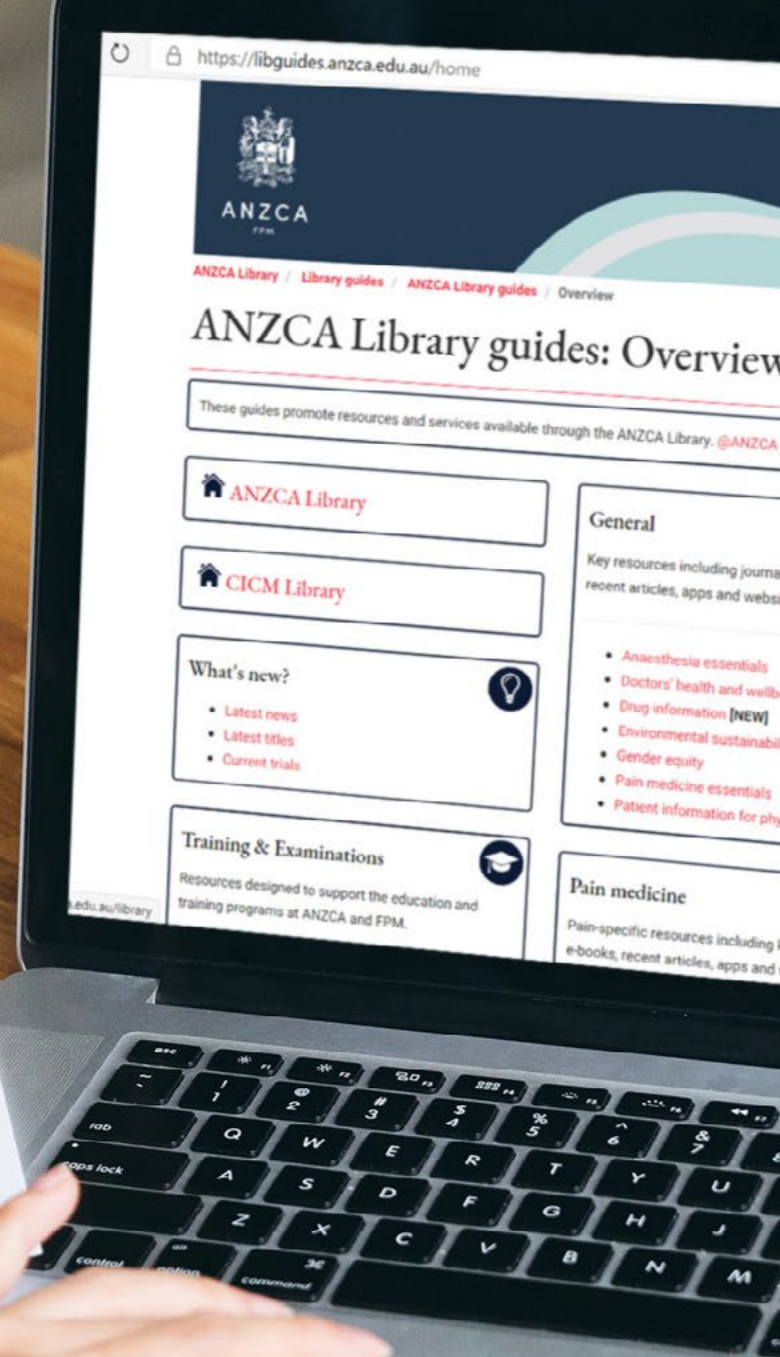
The 2018-20 CPD triennium with 1800 participants is fast approaching its final submission date of 31 December 2020. We recognise the restrictions, cancelled events/conference and unique work-demands due to the COVID-19 pandemic; however, after much consideration by the CPD committee there are no changes to annual or triennial CPD requirements.

The CPD team will be providing targeted support emails with information on the specific CPD activities not yet completed in your CPD portfolio. A completion email is provided once all CPD requirements have been met. We also recommend you visit our COVID-19 and CPD webpage at www.anzca.edu.au/education-training/anzca-and-fpm-cpd-program/covid-19-cpd-info. Here you will find our list of CPD activities specifically targeted at being completed online, remotely or in consideration of the pandemic's restrictions.

The CPD committee and team encourage participants within this triennium to promptly update their CPD portfolio and take steps to proactively ensure they will meet their CPD requirements or connect with the CPD team for support.



The ANZCA Library



Research Support Toolkit Launched

ON 30 JULY at the ANZCA Emerging Investigators Virtual Workshop, the ANZCA Library – in collaboration with the Emerging Investigators Sub-Committee, the ANZCA Research Foundation, the ANZCA Clinical Trials Network, the ANZCA Research Committee and the FPM Research and Innovation Committee – was pleased to announce the creation of a new research support toolkit (RSTK), which aims to bring together information resources related to the area of research.

The toolkit was developed over a period of almost two years and acts as a primer for emerging investigators and research co-ordinators who would like to learn more about working on research projects, and provides support materials for both new and established researchers.

The toolkit contains extensive links to existing college and library resources, as well as to the broader Australasian and overseas research community.

Sections include:

- Getting started.
- Setting up.
- Conducting research.
- Publishing and impact.
- Research support.

The toolkit can be accessed via the library or research sections of the college website or directly at: <https://libguides.anzca.edu.au/researchtoolkit>.

Further research support

The toolkit forms part of a broader Research Support Hub, which brings together the many library resources available to support general research.

Highlighted resources include:

- ANZCA Institutional Research Repository (AIRR).
- Databases and collections, including Medline, PubMed and ClinicalKey.
- Literature searching.
- Referencing.
- Research Support Toolkit (RSTK).

The hub can be accessed at libguides.anzca.edu.au/research.

AIRR | ANZCA Institutional Research Repository

Discover ANZCA's research and archive content

It is now possible to search and access any item added to the ANZCA Institutional Research Repository (AIRR) via the library discovery service, including the *ANZCA Bulletin*.

What is AIRR?

AIRR was developed to collect, preserve and promote the significant amount of important research published by our fellows and trainees. Content in AIRR is discoverable in Google and Trove and has a persistent unique identifier, allowing for long-term accessibility and identification. Recently, we have commenced adding some of our unique archive content – which includes the *ANZCA Bulletin* – to make these resources more accessible.

airr.anzca.edu.au/

What is the library discovery service?

The library discovery service allows our users to access the entire ANZCA Library collection through a single Google-like search interface. This includes access to full-text medical journals, articles, e-books, and print items. The discovery service was recently enhanced to include access to content found in AIRR.

anzca.on.worldcat.org/discovery

What content are we adding from AIRR?

- Fellow and trainee research publications.
- College publications, including key archive materials previously found on the college website.

Who can add content to AIRR?

It is possible for any college fellow or trainee to register as an AIRR user, and once authorised, self-submit their research publications and outcomes. Alternatively, users can ask the library and/or archives to submit content on their behalf.

Please see the AIRR library guide for more information about submitting content to AIRR: libguides.anzca.edu.au/research/airr



Contact the library: +61 3 9093 4967 library@anzca.edu.au anzca.edu.au/resources/library

What's new in AIRR?

Archived content now includes full-text access to past editions of the *ANZCA Bulletin*, *Australasian Anaesthesia* (the "Blue Book"), and *Acute Pain Management: Scientific Evidence*.

Coverage:

- *ANZCA Bulletin*
 - o Volume 18, Issue 1, March 2009 - Volume 29 Issue 2, June 2020
 - o Now fully indexed and searchable via the ANZCA discovery service (see below)
- *Australasian Anaesthesia* ("Blue Book")
 - o 2003 – 2019.
- *Acute Pain Management: Scientific Evidence*
 - o 2005 (2nd edition) – 2015 (4th edition).

Past editions of the *ANZCA Bulletin* that were previously only available in print format (1992-2005), have now been digitised and are in the process of being uploaded to AIRR.

How to access AIRR content via the library discovery service

The Archival Material item format filter can be used during discovery searches to isolate AIRR-related items. In addition, it is possible to use the Access Online button to open the AIRR record in question (and access the full-text where available).

Have we missed anything?

If you have any suggestions for publications to be added to AIRR, please email library@anzca.edu.au.

Searching for ANZCA Bulletin articles

The *ANZCA Bulletin* is now searchable via the library discovery service.

You can now search against article titles, authors, subjects and summaries for all content previously indexed on Informit (1995 onwards).

A dedicated search box has been added to the library journals page, which allows you to search exclusively against this content, and then connect to the full-text issues held in AIRR (where available).



We need your help! If you have Volume 13, Issue 3 of the *ANZCA Bulletin*, published in 2005, please email archivist@anzca.edu.au so we can complete our collection.

Meet your college Business Records Officer

Cassandra Gorton has been with the college since July 2019 and manages the college's archives, records, and information.

Cassandra can assist you with accessing college records, such as:

- Past fellow information for obituaries.
- Committee, board, and council minutes.
- Past curriculum information.
- Annual reports.
- College publications.

Email archivist@anzca.edu.au for more information.

Keeping up-to-date with COVID

The library is responsible for maintaining the college Coronavirus/COVID-19 resource guide.

The guide includes links to many key Australian and New Zealand COVID-19-related resources, including:

- Clinical resources.
- Wellbeing.
- Leadership/ethics.
- Equipment and tech.

The guide is updated weekly with recently published anaesthesia and pain-medicine focused articles (see Other Resources tab) that aims to keep you up-to-date with the latest research.

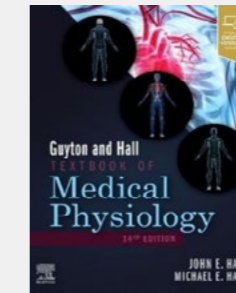
The COVID guide is available at: <https://libguides.anzca.edu.au/covid-19>.

If you're interested in setting up a personalised alert service to track recent-articles of interest (including COVID-19), then we recommend trying the Read by Q&MD app, available at: libguides.anzca.edu.au/apps/read.

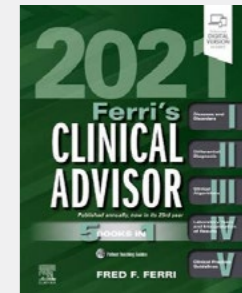
New titles in the library



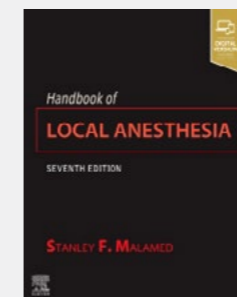
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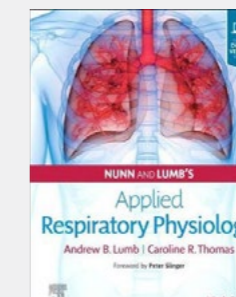
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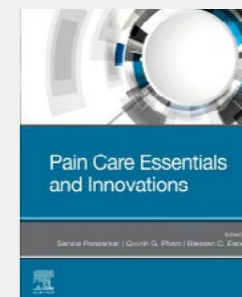
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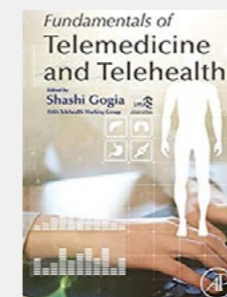
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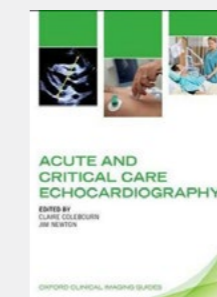
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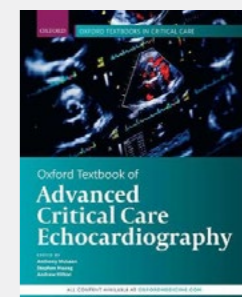
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Faculty of Pain Medicine



DEAN'S MESSAGE

Finding humour in pain



“What patients need from us is empathy, flexibility in how care is provided, and a willingness to explore a therapeutic partnership that respects their lived experiences.”

I HAVE WONDERED for some time about whether persistent pain has a funny side.

Pain is a universal human experience, and we have adopted a sociopsychobiomedical paradigm, so it would seem that there should be some form of humour which could be applicable and relatable. So often, the comedy of marginalised groups can give perspectives that are just not available to the people in positions of privilege or power. In Shakespeare, it is often only the fools who can tell the truth to rulers without fear of retribution.

So it was with real interest that I found out one of my patients runs an Instagram account with more than 54,000 followers that is devoted to memes about chronic pain and mental illness – @meme_the_sick_away.

While they can be savagely funny, I have to concede that health professionals don't always come off well in these memes.

Our patients don't expect us to be right all the time, and they are often painfully self-conscious about the level of engagement they need in order to explain their complicated lives. The line between wry humour and mean-spirited mockery can be tough to judge, but the popularity of these memes would suggest they strike a chord more often than not with their followers.

Reading through the experiences of commenters on the posts is also a sometimes sobering experience that reinforces just how inequitable the access to comprehensive, evidence-based pain management is in most jurisdictions.

What patients need from us is empathy, flexibility in how care is provided, and a willingness to explore a therapeutic partnership that respects their lived experiences.

Good medical care is knowing what drug to prescribe based on the diagnosis and clinical evidence, but excellent medical care is knowing how big the tablets are and whether your patient might find the side effects acceptable if you prescribe it for them. Scrolling through the memes of my patient's account, I am struck by the difference we could make by listening carefully and treating our patients as fellow travellers on a journey with an unknowable end point.

We will get some decisions right, and others wrong, but our patients need us to always be prepared to keep plodding on with them.

Associate Professor Michael Vagg
Dean, Faculty of Pain Medicine

New fellows

We congratulate the following doctors on their admission to FPM fellowship through completion of the training program:

- **Dr Mahboubeh Adinehzadeh**, FRACGP, FFPMANZCA (Qld)
- **Dr Sami Ahmad**, FRACGP, FFPMANZCA (Qld)
- **Dr James Andrew**, FRCA, FFPMANZCA (UK)
- **Dr Glareh Arfaei**, FAFRM (RACP), FFPMANZCA (Vic)
- **Dr Irina Baleanu-Mackinlay**, FANZCA, FFPMANZCA (Vic)
- **Dr Anju Tessa James**, FRACGP, FFPMANZCA (Qld)
- **Dr David Sainsbury**, FANZCA, FFPMANZCA (NSW)
- **Dr Navid Amirabadi**, FRACGP, FFPMANZCA (Qld)
- **Dr Jennifer Dawson**, FRNZCGP, FACHPM, FFPMANZCA (NZ)
- **Dr Gloria Seah**, FANZCA, FFPMANZCA (Vic)

Election to fellowship pathway

With the development of standards for specialist pain medicine physicians and the increasing use of the specialist international medical graduate (SIMG) workplace-based assessments, as opposed to examination for assessment of SIMGs, the SIMG process has become less of an impediment to SIMG pain specialists considering moving to Australia/New Zealand. As a result, *By-law 3.2 Election to fellowship* has been retired.

2021 FPM Board election

The call for nominations for the 2021 FPM Board election will occur earlier than in previous years. To allow for the transition of the composition of the board as outlined in the revised *By-law 1: Faculty Board*, two positions will be designated as “co-opted” leading up to the 2021 Annual General Meeting (AGM).

The co-option process allows the board to ensure it has the skills and diversity required to progress its ambitious strategic goals. The call for nomination process is planned for November.

If a ballot is required for the elected positions, this will take place in January. The adjustment of the election process allows the time required to complete the co-option process ahead of the AGM in May. In 2021 there will also be calls for nominations for the new fellow position on board.

Procedures endorsement program

A KEY PIECE of work for the faculty over the past few years has been the development of standardised training leading to endorsement in procedural skills. Following the approval of a curriculum, by-law and handbook at the July Board meeting the *Procedures Endorsement Program* will be piloted in 2021. The program leading to endorsement of fellows with procedural skills builds on *PS11 Procedures in Pain Medicine Clinical Care Standard*, which identifies the optimum standards of practice in procedures.

FPM endorsement in procedural pain medicine is recognition of a practising FPM fellow's competence in providing safe and high-quality care, encompassing the selection, performance and follow-up of procedures within the sociopsychobiomedical paradigm.

Unlike other training programs offered by the college, the Procedures Endorsement Program does not lead to a formal qualification such as a fellowship or diploma. Rather, once the doctor has met the criteria for endorsement – that is, demonstrated proficiency in a specific procedure and adherence to *PS11* – they may be endorsed for that procedure. The program has no process for grandfathering: it is a principle of the program that every fellow seeking endorsement will have their procedural practice assessed, either in a training context or through peer review, prior to obtaining endorsement.

The Procedures Endorsement Program includes 21 procedures which have been broken into three categories based on increasing complexity. There is no requirement to seek endorsement in all procedures or all categories, and program participants may pursue one or more procedures that are relevant to their practice or interest. It is important to note that the endorsement is not mandatory and has no regulatory implication: the faculty does not suggest limiting the scope of practice to the procedures selected for endorsement, and endorsed fellows may practise and pursue training in other procedures as they wish.

The Procedures Endorsement Program includes the following two pathways:

- The Supervised clinical experience pathway for those wishing to be trained in procedural pain medicine, and
- The Practice assessment pathway for fellows who are already experienced at procedures.



Supervised clinical experience pathway

The supervised clinical experience pathway will be open to FPM fellows and trainees undertaking the Practice Development Stage. While FPM trainees can participate in the supervised clinical experience pathway they will not be eligible to be granted endorsement until they become Fellows of the Faculty. Completion of the pain medicine fellowship training program is not dependant on participation in or completion of the Procedures Endorsement Program. It is recognised that those undergoing the program may dip in and out of supervised clinical experience over several years as they build on their scope of endorsed procedures. The time frame of clinical experience expected to gain endorsement of all procedures in each category is:

- Category 1 procedures: 6-24 months FTE.
- Category 2 procedures: 6-24 months FTE.
- Category 3 procedures: 12-48 months FTE.

Inspired by apprenticeship-based surgical training programs, delivery of the supervised clinical experience pathway is not linked to accredited units but to accredited supervisors. This pathway is completely workplace-based, where learning is facilitated by multiple observational assessments and ongoing formative feedback from the procedural supervisor. The accredited procedural supervisor declares the participant as eligible for endorsement when they are satisfied that the participant can competently and independently perform the learned procedure within the context of the sociopsychobiomedical framework.

Applications have been sought from experienced procedural fellows to become accredited procedural supervisors to pilot the program and these are currently under review. All accredited procedural supervisors will first need to be endorsed themselves, under the practice assessment pathway, and will participate in workshops to prepare for delivering the program.

Practice assessment pathway

To allow faculty fellows who are already experts in procedural pain medicine gain endorsement without having to undergo further training, a practice assessment pathway has been established. This pathway will be open from late 2021 until the end of 2026 and consists of a comprehensive application, a paper review by the nominated committee and a potential onsite review by nominated peers who have already been granted endorsement. Similar to the supervised clinical experience pathway, endorsement does not have to be granted for all the procedures listed in the curriculum, but those performed proficiently by the fellow.

In preparation of opening the practice assessment pathway in 2021 the current focus is on progressing a small number of fellows through this process over the next few months. These fellows will then take part in the review of those seeking endorsement.

Regardless of the pathway taken to obtain initial endorsement, endorsement will be maintained mainly through undertaking professional development related to the endorsed fellow's procedural scope of practice, to ensure ongoing competence in pain procedures and adherence to the Clinical Care Standard (*PS11 (PM)*). Consideration of appropriate CPD activities and requirements for endorsed fellows is currently work in progress, and will be communicated to fellows early next year.

There has been an enormous effort contributed by many fellows to progress this body of work so quickly and comprehensively. We would like to thank all those involved in leading the faculty into this new area.

The Procedures Endorsement Program will be seeking feedback throughout 2021 to allow for adjustments to be made and processes to be streamlined. Those interested in being involved in the pilot program are encouraged to contact the faculty team via fpm@anzca.edu.au.

Better Pain Prescribing: Clarity and confidence in opioid management

An important educational initiative from FPM and Therapeutic Goods Administration (TGA) supporting safer opioid prescribing.

WITH THE FACULTY'S June launch of a dedicated Better Pain Management (BPM)/Therapeutic Goods Administration (TGA) e-learning package, we look forward to further supporting this strategic, safer opioid prescribing educational project. Not only does this recently-awarded TGA grant to FPM provide important revenue during challenging times, but it serves to further extend the faculty's position as a reliable and authoritative source of advice for regulators and government.

FPM fellows have successfully adapted six BPM (project-specific) modules, in alignment with TGA regulatory opioid reforms – further helping Australian prescribers support the appropriate use of prescription opioids. This is a perfect learning opportunity for department, clinic or hospital practitioners involved in managing patients living with pain. A no-cost course for Australian residents, and 10,000 BPM program licenses have been made available. The faculty's aim is to allocate all licenses as soon as possible, during 2020.

The faculty has prepared a user information page (one including an identical QR code and product link, below). Designed for easy scanning from a printed A4-page (placed on a staff room noticeboard) or directly from a desktop/mobile device screen (if the information page is sent electronically – via email/intranet). Please make sure to let the faculty know if you have any questions via fpm@betterpainmanagement.com.au.

Learning outcomes include:

- Developing sustainable techniques for delivering clinically-responsible outcomes for those experiencing persistent/chronic pain.
- Improving patient results with the use of alternative treatment options that provide clear pain management choices.
- Recognising complex pain management needs, critical for use prior to opioid therapy.

Course modules (each one takes around one hour to complete, and is self-paced):

- Module 1:** Making an effective pain diagnosis: a whole person approach
- Module 2:** The impact of management of psychological pain factors
- Module 3:** A whole person approach to chronic pain
- Module 6:** Opioids in pain management
- Module 7:** Pharmacology of pain medicine
- Module 11:** High-dose, problematic opioid use

This Better Pain Management e-learning package is free for Australian residents. Simply commence your registration by scanning the QR code on the right or visit <https://www.betterpainmanagement.com/product?catalog=TGA-BPM>.



Alternatively, email us at fpm@betterpainmanagement.com.au or telephone +61 3 9093 4930.



Opportunity to contribute to the development of professional documents

The faculty produces professional documents on a number of subjects, in the forms of policies, position statements and guidelines. The development and revision of such documents is undertaken by a document development group (DDG) made up of fellows with relevant interest and expertise. DDG members collaborate via email and Zoom according to a process outlined in *AP01 Policy for the development and review of professional documents*.

We are seeking expressions of interest from fellows to contribute to the development of two documents:

- Revision of a position statement
The background paper for *PS01 (PM) Statement regarding the use of opioid analgesics in patients with chronic non-cancer pain* requires updating and alignment with the recently revised foreground paper that responded to the regulatory changes to opioid prescribing in Australia.
- Development of a policy document
The faculty needs to devise policy on return to practice for those specialist pain medicine physicians who have incurred significant absence from clinical pain medicine practice.

To find out more or to express an interest in these opportunities, please contact Penny McMorran at fpm@anzca.edu.au. Please advise your interest by 20 October.

Senior editor role at *Pain Medicine*

For more than a decade, the journal of the American Academy of Pain Medicine (AAPM), *Pain Medicine*, has been the official publication vehicle for the faculty. In addition, the editorial board of the journal established a senior editor position for a fellow of the faculty, a position currently held by Professor Milton Cohen.

We are seeking expressions of interest to take over this position of senior editor. The duties are not onerous and may suit a mid-career academic fellow of FPM who is interested in enhancing quality in the pain literature.

The functions of that senior editor include:

Management

- Direct liaison with the editor-in-chief and the managing editor of the journal.
- Contribution to the operation of the editorial board.
- In consultation with the faculty ED, (re-)negotiation of arrangements with AAPM.

Editorial

- Solicitation of papers from fellows.
- Advice/mentoring to prospective authors.
- Proposals for special articles/features/editions (optional).
- Management of reviews:
 - Triage of submitted papers.
 - Appointment of reviewers and overview of reviews.
 - Reviews per se (if desired).

To find out more or to express an interest in this opportunity, please contact us via fpm@anzca.edu.au. Please advise your interest by Friday 30 October.

Steuart Henderson Award

This award recognises a fellow who has demonstrated excellence and provided outstanding contribution, scholarship, and mentorship to medical education in the field of anaesthesia and/or pain medicine.

THE AWARD IS named after Dr Steuart Henderson who served as an ANZCA councillor from 1992 to 2004, working particularly in education and training and as assessor. He also served for 12 years as a member of the Panel of Examiners and has had a long-standing interest in the applications of simulation to training and professional development. He was instrumental in establishing New Zealand's first simulation-based clinical training centre in New Zealand.

The award recognises the profile of educators within the college and honours Dr Henderson for his past efforts and contribution to medical education.

The award takes the form of a medal, certificate and grant of \$A1000 for educational or research purposes.

Nominations for the 2021 award will close on 15 January. For further information visit anzca.edu.au/about-us/our-culture/recognising-excellence/steuart-henderson-award.

DR DAMIAN CASTANELLI was awarded the 2020 Steuart Henderson Award for his contribution to medical education in anaesthesia. Dr Robert Marr, Deputy Chair, ANZCA Educators Sub-Committee met with him to discuss his achievements.

What led you to an interest in medical education?

I was doing lots of caudal anaesthetics and I tried to teach the trainees how to do them. The trainees weren't very proficient and on reflection, I realised it was because I wasn't very good at teaching them. This led to me to learn how to teach technical skills properly. Doing formal study in medical education encouraged me from there.

After being a supervisor of training (SOT) for five years and then seeing transitioned consultants was so fulfilling – that's what's encouraged me.

What difficulties have you faced when advocating for medical education?

Rather than spend time learning about it, we are often satisfied with superficial knowledge – "tips and tricks". If you want to do something properly, then you need to understand the principles of what you're doing to do it well. It's integral to being a specialist. Doctors think that anyone can teach or assess learners, whereas people spend a lot of time learning about how to do these things properly.

What has been your most interesting role in medical education to date?

Both the Education Development and Evaluation Committee (EDEC) and Curriculum Redesign Steering Group were amazing experiences to be a part of. They involved a lot more work than I thought, but both were very interesting and have made big improvements to training.

On EDEC we've been involved in nearly 100 education projects, including the ANZCA Educators Program, Fundamentals of Feedback and Scholar Role resources. It's been a really productive period.

What education projects are you working on at the moment?

I'm doing research for a PhD on the impact of assessment for learning, as an educational principle, within the ANZCA training program.

I'm also working with other fellows on workplace based assessments (WBAs), using research to improve them for the future.

Where would you like to see medical education at ANZCA in the future?

There should be more professionalisation of the education roles with a designated skillset, set qualifications and allocated time and money. The human resourcing of this should be part of hospital accreditation, in order to provide quality formal

education for a department and so that people are better equipped to take on roles such as the SOT.

We should be using educational expertise more and producing more educational scholarships in order to help others contribute to the medical educational community. The ANZCA research grants are a great resource and many educational projects get supported by them which is really good. We need to continue to use the expertise that fellows are developing in our educational design and governance.

What advice would you give to a trainee interested in a career in medical education?

There's always work in this field, so volunteer for something and get some experience. If you're interested, then you need to learn the way people think and talk and join the community. You can start with a Graduate Certificate in Medical Education, which you can then develop into a Masters.

How do you feel about being awarded the Steuart Henderson Award?

It's amazing to get the award and get recognition from fellows and colleagues. It's nice to think I've had an impact on improving education and training.

Successful CTN virtual workshops

THE ANZCA CLINICAL TRIALS NETWORK (CTN) has wrapped up a series of three free virtual workshops: Anaesthesia Research Coordinators Network; Emerging Investigators; and New Proposals, in lieu of our annual Strategic Research Workshop held in August each year. All workshops were successfully executed using the Zoom platform due to the careful preparation and testing by the convenors and organisers.

The CTN new proposals workshop is core to developing research proposals into large multicentre trials. The presentation and discussion of research ideas at the CTN workshop is the start of the pipeline for many CTN-endorsed studies. It is part of the success stories for recently completed or published trials, for example, Balanced Anaesthesia Study, RELIEF and PADDI trials.

The CTN New Proposals virtual workshop was held over two sessions on 13-14 August and included a range of presentations from emerging and experienced researchers including Professor Kate Leslie presenting on a new trial examining sugammadex, neostigmine and postoperative pulmonary complications; Dr Tim Coulson presenting on a pilot trial of synthetic angiotensin II in cardiac surgery for prevention of acute kidney injury, and; Dr Justin Nazareth presenting on a pilot trial of midodrine for the prevention of perioperative hypotension. All presenters were given strictly five minutes to present their project and issues they wanted to troubleshoot with the delegates and keynote statisticians, Anneke Grobler and Francesca Orsini, from the Murdoch Children's Research Institute.



Delegates at the new proposals virtual workshop held on 13 August.

Developing research proposals that may lead into large multicentre clinical trials that have potential to attract large funding is at the very core of the CTN's mission. The aim of the new proposals workshop is to provide a forum where researchers can get constructive feedback about their research proposal. This is achieved in a number of ways. Firstly, delegates had the opportunity to post a number of questions and continue the discussion using the online chat feature of Zoom that the moderator could then ask the presenter. In line with the face-to-face meeting, delegates also had the opportunity to complete an online Google research evaluation form to leave additional comments and assess the research proposal for feasibility as a CTN study, scientific merit, originality and design and methods. The online chat transcript, research evaluation feedback and any other important discussion points raised during the meeting is passed on to the researcher in a report prepared by a designated expert in the field of research.

The network would like to thank all convenors, moderators, speakers, organisers, ANZCA communications and events teams, and the Monash University IT team for making the virtual workshops a huge success during a very challenging environment.

Tips for running virtual workshops via the Zoom platform

No one can deny the benefits of meeting face-to-face to ignite collaborations and continue the discussion of research themes throughout the annual strategic workshop. However, running virtual workshops came with a raft of benefits including greater accessibility to trainees, fellows and research coordinators who often can't afford the time or cost to travel. Anyone who has attempted to run a virtual meeting understands that technology can get the better of us, so for those who are planning to run a virtual conference, the organisers have these tips to share with you:

- Preparation is key: Test all functions of the Zoom platform that you're planning to use well ahead of time and prepare a full run sheet for organisers, convenors and presenters.
- Allow for at least 10 minutes at the start of the meeting while people connect and for technical troubleshooting. We used this time to run fun Zoom polls.
- Encourage delegates to use the Zoom chat function and have a moderator for the online discussion.
- Assign Zoom co-hosts to the meeting who can help mute, unmute, turn videos on and off as required, and change the names of delegates to an identifiable name as required. Having

videos turned off during the main presentation minimises distractions and protects the stability of the bandwidth.

- Ensure presenters are on a stable internet connection – test video and audio well ahead of the meeting for all presenters, moderators and convenors. The Zoom co-hosts had a copy of presentations as a back up in case they had to screenshare on behalf of the presenter.
- Have a back-up plan for presenters and convenors. The moderators and convenors served up a back up for one another in case of a technical difficulty.
- We asked delegates to have the Zoom app on their phone as a back up and also gave the presenters the Zoom dial in numbers that they could use instead of the Zoom app.
- Circulate presentations to delegates ahead of time in case delegates can't see video.
- Provide the program to the delegates in their time zone.
- Ensure all presenters, organisers, host and co-hosts are connected through group phone messaging to allow for fast communication and troubleshooting during the meeting. We used WhatsApp.

Dr Neil Eastwood Street

AM MB BS (Hons II) M App Sc FANZCA

1954-2020

NEIL STREET TRAINED at Royal Prince Alfred Hospital and accepted a fellowship in paediatric anaesthesia at the Children's Hospital at Camperdown in 1985 before undertaking further paediatric anaesthetic training in the UK at Great Ormond Street. In 1987 he returned to consultant positions at the Children's Hospital at Camperdown and Westmead Hospital, before taking on a full-time consultant position in 1995 at the Children's Hospital after it moved to Westmead. He was deputy head of the anaesthetic department from 2005-15 and head from 2015-19.

In 2001, on a very limited budget, Neil developed the malignant hyperthermia (MH) testing facility at the Children's Hospital, eventually providing from 2003 a testing service for NSW and Queensland patients and their families. Together with the CHW biomed team, Neil designed and built his own testing laboratory and continued to use it until recently, trouble-shooting its aging components and repairing it as only a true scientist and outstanding technician could. He was internationally recognised in the MH field and became one of the elders to whom others could turn to get advice and information. He gave many, many hours, much of his own personal time, to managing the MH unit, fielding questions and offering advice to the numerous anaesthetists (and indeed physicians and others) who contacted him with their concerns.

Neil was the epitome of an anaesthetist to which all could aspire. He was kind and respectful to patients, their families and staff at all levels. He was a superb technician with superlative skills. He could and did manage every case that came his way and was free with his advice, which was constantly sought. His special interests included anaesthesia for paediatric cardiac surgery, liver transplantation and spinal surgery, but there was no paediatric sub-specialty that he couldn't manage with dexterity, knowledge and expertise. He was in demand by surgeons who recognised his calm experience, his exceptional skills and his wonderful sense of humour that could defuse the most tense moment. Neil understood the importance of caring for all patients to the highest standard, be they the sickest pre-term neonate with complex cardiac disease or a robust child with a broken arm.

In 2006 Neil joined the volunteers of Open Heart International and over the years made many trips to Papua New Guinea (and one to Myanmar) to provide cardiac services to sick children who would otherwise have remained untreated. He not only helped provide anaesthesia in circumstances which would stress anyone, but at the highest level and with an attitude that drew instant respect from those with whom he worked. He was a much-loved regular team member on these annual trips, and he was recognised for

“Neil was the epitome of an anaesthetist to which all could aspire. He was kind and respectful to patients, their families and staff at all levels.”



his contribution to the training and development of the local anaesthetists and staff, who beautifully acknowledged this in a letter sent to his colleagues and his family after his passing.

Neil was made a Member of the Order of Australia in 2015 for his significant contribution to paediatric anaesthesia, to malignant hyperthermia and to the people of the Asia-Pacific region through medical aid programs. He was almost –no, actually – embarrassed by this recognition and felt that he had always just been doing his job and no more – a manifest understatement of his contribution, as usual for Neil.

Neil, the person, was a wonderful man, friendly, funny, helpful, wise and perhaps above all, humble. His life reflected the values of irreverence and an understanding that every single person has equal value, instilled in him by his father, Fred Street, a paediatric surgeon, and his mother Gillie. He has been appropriately described as a polymath, equally at ease repairing a motor vehicle, welding up a grass catcher or installing electrical switches in his new caravan, or preparing a baby for complex cardiac surgery. He was a family man to the hilt with a wonderful love for his wife Cathy who had to deal with his huge commitment to his work over so many years. He was enormously proud of his children Philippa, Doug and Alice, their partners and grandson Freddie, and loved them unconditionally, not to mention his close and extended family. It is a great sadness to all that he became sick and eventually passed away at a time when he was planning to spend more time with his family and friends.

With Neil's passing, there has been an outpouring of both love and grief from all whose lives he touched. There is such a huge sense of loss which can only be countered by the recognition of the goodness and care Neil brought to the world. Those who knew him will remember him as the wonderful man he was, and he will live on in our hearts.

Vale my great friend.

David Baines AM FANZCA

New Zealand



Growing advocacy in the Council of Medical Colleges in New Zealand Te kaunihera o ngā kāreti rata o Aotearoa

SOME OF THE 15 colleges who make up the board of the New Zealand Council of Medical Colleges (CMC) have been interested in seeing the council use its collective voice more effectively in areas of health policy for a good while. However COVID-19 provided the environment where that became more a necessity than a “good to have”. It threw the need into sharp relief.

In March this year, the country moved quickly into lockdown as the first cases of the coronavirus reached our shores. Health professionals were scrambling to get health services fit for purpose for what could have been a “tsunami” of patients through primary and into secondary care. The Ministry of Health moved fast, the Director General of Health Dr Ashley Bloomfield admitting there was no time for normal consultation procedures.

Dr Bloomfield spoke to CMC on 28 May where he acknowledged that many health groups had felt left out of the COVID-19 response because of the speed with which it was set up. However, he encouraged colleges to lean in with advice and help. ANZCA and other colleges have “leant in” since, meeting with the director general and advising, and lobbying, on issues including PPE and drug shortages. Meanwhile CMC has been more publicly vocal on the response to COVID-19 supporting the government’s lockdown and elimination strategy against the calls of “but the economy”.

The council’s latest meeting on 27 August was an example of it flexing its advocacy muscle. There was a line-up of some of the most influential people in health. Among those to front was the chair of the million dollar, wide-ranging Health and Disability Systems Review, Heather Simpson. Ms Simpson has since been appointed to a group advising on border testing. The Ministry of Health’s Andrew Simpson, the Privacy Commissioner, the CEO and the chair of the Medical Council of New Zealand also came before the colleges and the list goes on.

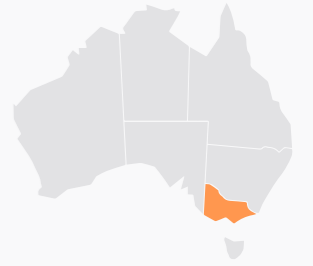
What the pandemic revealed was the need for medical colleges to be more nimble and flexible in terms of advocacy. It showed the necessity for the colleges to be able to respond as a collective voice and at speed to changing events, and the voraciousness of the 24-hour news cycle. CMC is the obvious vehicle for this as it represents more than 7000 medical practitioners working in a range of 37 specialties in the New Zealand health system.

The appointment of a new executive director with more hours and more funding may give the CMC the capacity it needs to be a relevant voice in policy and in the public at the time of ongoing health crises. Chair, Dr John Bonning says the council has seen collaboration between colleges during the pandemic. He points to the work between the colleges involved in critical care on issues of PPE and infection control; and also colleges working together on training and workforce issues. “Necessity is the mother of invention. The pandemic has given CMC focus. Universities and colleges were facing delays to training which would impact the workforce pipeline. CMC advocated for the Resident Medical Officer Rotation dates to be pushed out to January 2021 allowing more time for completing training requirements in 2020. Serendipitously, this also brings trainings dates across New Zealand and Australia into alignment.”



Chair of CMC Dr John Bonning outside the Beehive in Wellington

Victoria



Zooming through the year

Despite this year’s COVID-19 lockdowns and restrictions, the Victorian Regional Committee, Victorian Trainee Committee, FPM Victorian Regional Committee, along with the Victorian Anaesthetic Trainee Committee and Victorian Association of Directors Departments of Anaesthesia Committee have each been meeting regularly via Zoom and continue to work on making sure our important work continues. We would like to thank each of the members for their time and dedication to the committees, especially in these trying times.

Events and courses

Unfortunately we have experienced many cancelled events and courses due to the pandemic but we did deliver some online central exam prep webinars alongside the Education department to our trainees which were well received. We have also rescheduled the annual Melbourne Winter Anaesthetic meeting, and now with Victoria’s extended lockdown our events and courses that were due to be held towards the end of the year, we are planning for next year.

The Melbourne Winter Anaesthetic Meeting will now be held next year on Saturday 31 July and Emergency Response Workshops will be held on Sunday 1 August, at the Sofitel Melbourne on Collins.

Due to the Victorian VIVAS being postponed until the end of November, new dates are being scheduled for both our trial oral courses in October and early November. Each of these are usually held on Monday

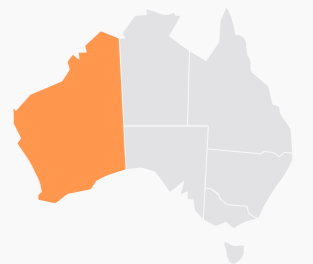
and Wednesday evenings at the various hospitals but depending on restrictions may need to be delivered online. Details will be confirmed via email with eligible Victorian trainees.

A popular meeting held each year in November, the Victorian Registrars’ Scientific Meeting is being postponed until Friday 22 January 2021. The decision was made to avoid clashing with VIVA exams, and we are mindful that trainees should be focussing on their friends and families at the end of the year, after a crazy year. Hopefully it will be a nice start to the year for our trainees – both those wanting to present and those to support their fellow trainees that are presenting their research, clinical or audit topics.

Our two-week Primary Refresher Course scheduled in November unfortunately cannot be held face-to-face at the college and presentations will now be delivered online. Given that it would be too intense to have an online delivery eight hours per day, five days per week for the two weeks, we are looking at recording the sessions to be viewed at any stage for those registered. Details will be confirmed via email to trainees.

We understand that it has been a stressful time for our trainees around exam prep and we will continue to focus time on bringing together courses to support and help assist as best as possible.

Please contact us should you have any queries and/or to express interest in attending either of our courses/events at vic@anzca.edu.au or phone +61 3 8517 5313. Trainees can contact the Victorian Trainee Committee members directly via email: vicananaestheticregistrars@gmail.com.



Western Australia

The WA Continuing Medical Education Committee has rescheduled the CME Conferences for 2021. The Autumn Scientific Meeting will be held on 20 March at the University Club, UWA. The Country Conference will be held from 22-24 October at the Pullman Resort in Bunker Bay, it is convened by the Perth Children’s Hospital.

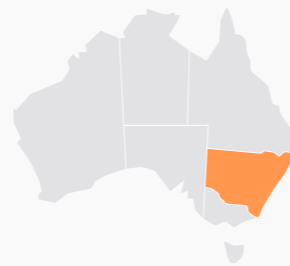
There have been several committee meetings held via Zoom which the committee members have quickly

become accustomed to. The primary and final exams have been held in August, and the Part 2 long course is continuing.

Thank you to the fellows and trainees who have put in extra time and resources into supporting college activities over the past six months.

We look forward to returning to some sort of normalcy in 2021.

New South Wales



Primary Refresher Course in Anaesthesia

This is a fulltime revision course, run on a lecture/interactive tutorial basis and is most suitable for candidates presenting for their primary examination in the first part of 2021.

Date: Monday 30 November – Friday 4 December 2020
 Venue: Northside Conference Centre, Corner Pole Lane and Oxley Street
 Crows Nest NSW 2065
 Fee: \$A660

Applications close on Monday November 16, 2020, if not already filled. The number of participants for the course will be limited. Preference will be given to those candidates who will be sitting the primary examination in the first part of 2021. Late applications will be considered only if vacancies exist.

For further information email Tina Lyroid at nswcourses@anzca.edu.au or phone +61 2 9966 9085.

Part Two Refresher Course in Anaesthesia

The course is a fulltime revision course, run on a lecture/interactive tutorial basis and is open to candidates presenting for their final fellowship examination in 2021.

Date: Monday 7 December – Friday 11 December 2020
 Venue: Northside Conference Centre, Corner Pole Lane and Oxley Street
 Crows Nest NSW 2065
 Fee: \$A825

Applications close on Monday 23 November 2020, if not already filled. The number of participants for the course will be limited. Preference will be given to those candidates who will be sitting for their final fellowship examination in the first part of 2021. Late applications will be considered only if vacancies exist.

For further information email Tina Lyroid at nswcourses@anzca.edu.au or phone +61 2 9966 9085.

Part Zero Course

The ANZCA NSW Regional Committee are pleased to announce that the Part Zero Course will held on Saturday 14 November 2020. The venue will be confirmed soon. The course is specifically aimed at basic trainees in their first year of training or those doctors about to take up training positions in 2021. The course covers many topics, from how to deal with clinical errors, to what to expect in anaesthetic training and how to look after your own welfare, all delivered in a short and informal format. The session has been such a success in previous years that many departments have made it compulsory for new trainees. Look out for the flyers soon to be sent to anaesthetic departments across the state.

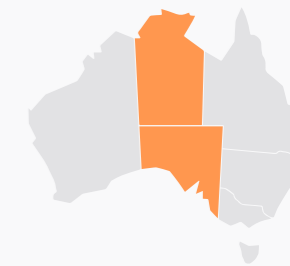
Register your interest for this free course by emailing nswcourses@anzca.edu.au before Saturday 6 November.

Dr Katherine Gough
 Convenor
katherinegough@live.com

Dr Rebecca Lewis
 Convenor
rebeccaecocco@gmail.com

Save the dates
 NSW Winter Meeting, Hilton
 – 19 June 2021
 NSW Anatomy Workshop
 – 27 November 2021
 NSW Spring Meeting, Leura
 – 20-21 November 2021

South Australia and Northern Territory



SA/NT registrar teaching

Trainees and ANZCA staff are extremely grateful to the Part 1 and Part 2 long course presenters who have enthusiastically adapted their tutorials to deliver engaging, informative and interactive tutorials to our trainees via Zoom. We especially thank the course convenors, Dr Agnieszka Szremska, Dr Nicholas Marks, Dr Adam Badenoch and Dr Oliver David for making these sessions possible.

SA/NT Regional Committee

The SA/NT Regional Committee is pleased to announce the appointment of five new regional committee members to the 2020-22 Committee. Dr Praveen Mamillopalli, Lyell McEwin Hospital, Dr Nicholas Harrington, Royal Adelaide Hospital, Dr Div Kumar, Royal Adelaide Hospital, SA/NT New Fellow representative Dr Heidi Robertshaw, Alice Springs Hospital and co-opted member Dr Rav Harish, Alice Springs Hospital. See the article on page 56 about the Alice Springs fellows joining the SA/NT committee.

SA/NT Regional Committee Chair, Dr Richard Church said the mix of new committee members' experience will be an ongoing asset to the committee and the committee is thrilled to have additional representation from the Northern Territory.

Dr Church thanked out-going committee members, immediate past chair Dr Perry Fabian and Dr Mahdi Panahkhahi for their expertise and contribution to the committee.

Australian Capital Territory



2021 Scan and Ski Workshop

After the unfortunate postponement of this year's event, we are excited to announce that the Scan and Ski workshop will take place in Thredbo from Thursday 22 July to Saturday 24 July 2021. The workshop will feature world-renowned ultrasound specialists Dr Ross Peake, Dr Alwin Chuan, Associate Professor David M Scott, Dr Peter Hebbard, Dr Andrew Lansdown, Dr Brad Lawther, Dr Bojan Bozic and Dr Chris Mitchell. Hands-on ultrasound scanning and instruction will be held during the morning and evening sessions, leaving the middle of each day free for skiing or sightseeing in the beautiful NSW Snowy Mountains. The workshop will cover upper-limb blocks, lower-limb blocks, trunk, and spinal blocks, among other topics. We are also pleased to announce the inclusion of a CICO (can't intubate can't oxygenate) workshop into the 2021 program, to be run by Dr Freya Aaskov. Head to the website for all the details and online registration.

ACT Regional Committee 2020-2022

In May 2020 we welcomed a new ACT Regional Committee and look forward to getting to know our new members over the next two years. The committee members are: Dr Natalie Marshall (chair), Dr Manasi Rai (deputy chair), Professor Thomas Bruessel, Dr Jennifer Hartley, Dr Girish Palnitkar, Dr Monika Tecsy, Dr Bibhuti Thakur, Dr Freya Aaskov, Dr Val Quah, Dr Igor Lemech, Dr Barbara Robertson, Dr Philip Morrissey, Dr Romil Jain, and Dr Nicole Somi. We look forward to working closely with the committee.

Tasmania



Above: Barnbougle, Tasmania

Below right: Royal Hobart Hospital anaesthetic simulation team

The new "Covid normal" is settling in Tasmania with the regional committee and CME planning re-starting, incorporating the new way of doing things. We are fortunate that Tasmania currently has no Covid-19 cases.

Covid-19 has brought significant change and challenges and our professional community has stood up well. Current outstanding issues include ongoing access to fit testing and continued support and advocacy for our trainees as resolution to the examination and training progression implications are sought. The regional committee will continue to work to support our fellows and trainees in Tasmania.

Like other committees, the Tasmanian Regional Committee have met twice via Zoom and were honoured with ANZCA president Dr Vanessa Beavis and ANZCA CEO Mr Nigel Fidgeon attending the last regional meeting on 23 July. The regional committee welcomes new members Dr Bruce Newman, Dr Joanne Samuel, Dr Joey Walsh and Dr Sam Walker (New fellow representative).

The Tasmanian Annual Scientific Meeting just squeezed in before Covid-19 restrictions and was held on 29 February and 1 March with the annual winter meeting that was to be held at Barnbougle on 27 August postponed until 2021.

Plans have begun for CME events for 2021 and you are invited to save the following dates in your diary so you don't miss out.

Tasmania runs two main events each year and intends to hold both of these in 2021. The Annual Scientific Meeting will be on 27 February 2021. The meeting comprises a scientific program and workshops and is under development. This meeting is preceded by

the annual trainee day which provides opportunities for trainees to come together and meet some great speakers in intimate, relaxed surroundings and share the day with their colleagues while being challenged by some great presentations that are relevant to exams, professional practice, as well as their private life.

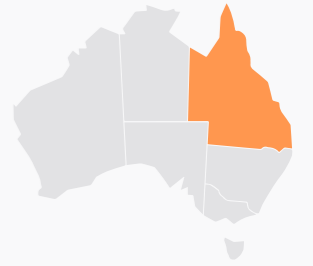
The second event, the winter meeting will be held at Barnbougle, northern Tasmania at one of the top links golf courses in the world. This will be held on Saturday 21 August 2021 and can only hold very limited numbers – so mark it in your diary. The theme "Links to the future" offers a range of interesting local and interstate speakers, on topics related to the challenges that the future holds, in relation to paediatrics, the environment and sustainability, within the workspace and on a more personal and professional level. The meeting will also offer for the first time a neonatal resuscitation breakfast workshop for all of those who feel slightly uncomfortable near the Resuscitaire.

The Chair of the Tasmanian Regional Committee, Dr Lia Freestone is aware of the challenges of organising events in the current climate but feels that it's important to provide high-quality professional development opportunities for fellows as well as a social occasion to relax together and believes flexibility in delivery is the key in successfully moving forward with these events. The regional committee is working towards good CME in 2021.

Finally, the regional committee recognises and thanks all our peers, colleagues and trainees for their professionalism and hard work in preparation and response to Covid-19. Please look after yourselves and each other.



Queensland



2021 Queensland ACE meeting

Due to the cancellation of the 2020 meeting, the Queensland ACE meeting "To infinity and beyond: hot topics for the 2020s" will be held at Brisbane Convention and Exhibition Centre on Saturday 24 July 2021.

Registration will open in March 2021. Keep an eye out for the events e-newsletter for further information.

We look forward to welcoming you back next July!

Courses

With the ongoing COVID-19 situation and restrictions in place we have been unable to hold our courses and lectures face-to-face. In order to best meet the trainees' learning needs we have adapted a number of courses to a virtual platform where possible.

The primary lecture program for Queensland-based trainees was held on Saturday 18 July via Zoom, with Dr Riaz Hooshmand delivering his talk from home and Dr Peter Iu presenting from the ANZCA Queensland regional office.

The final exam preparation course was held via Zoom on Thursday 23 and Friday 24 July 2020, in lieu of the face-to-face course previously held over five days. The new format of the course involved a combination of pre-recorded and live presentations, as well as live question and answer sessions.

Both courses were highly interactive and well received. We would like to offer our sincere thanks to the course convenors Dr Gamini Wijerathne and Dr Stuart Blain, and to all presenters for their time and commitment to these courses.



From top: Dr Andrew Souness delivering his talk on "Regional anaesthesia" via Zoom; Dr Stuart Blain presenting his talk "Paediatric anaesthesia" via Zoom.

Environmental sustainability role

The Queensland Regional Committee has responded to PS64 and taken up the challenge of addressing environmental sustainability by creating an environmental sustainability committee role. The responsibility of the officer will be to advocate for environmental sustainability in the activity of the college and anaesthetists in Queensland. I would like to congratulate Associate Professor Kerstin Wyssusek on being appointed as our inaugural Environmental Sustainability Officer.

In December 2019 Associate Professor Wyssusek, Director of the Department of Anaesthesia and Perioperative Medicine at the Royal Brisbane & Women's Hospital (RBWH) and former chair of the Queensland Regional Committee, received two Queensland Health Awards for Excellence:

- Winner: Individual Award for Outstanding Achievement.
- Second runner up: Minister's Award for Excellence.

The Queensland Health Awards for Excellence recognise initiatives and teams who have demonstrated a commitment to excellence when supporting or delivering health services to Queenslanders. She is very active in quality improvement activities and is passionate about environmental sustainability in healthcare.

Environmental sustainability in healthcare has been her interest for more than a decade. She actively promotes and enhances hospital waste management, specifically waste reduction and recycling in the operating theatre (OT). Her engagements started in 2009 with the introduction of waste segregation and recycling in the operating theatre complex. Annual savings of \$150,000 have been the result of this activity.

The introduction of PVC recycling in Queensland hospitals is based on her leadership in bringing this sustainability activity championed by Associate Professor Forbes McGain, the Vinyl Council Australia and Baxter to the Royal Brisbane and Women's Hospital as first hospital in Queensland. She has published in peer reviewed journals with the latest publication assessing the volume of polyethylene terephthalate (PET) plastic accumulated in the OT at the RBWH:

- The volume of polyethylene terephthalate plastic accumulated in one month of surgical operations at the RBWH: A prospective audit. *American Journal of Surgery*.
- Operating room greening initiatives – the old, the new, and the way forward: a narrative review. *Waste Management and Research*.
- The gold in garbage: implementing a waste segregation and recycling initiative. *AORN journal*.



Associate Professor Kerstin Wyssusek with Health Minister Steven Miles.

For a pilot project assessing feasibility of the PET audit, her team received the Professor William Egerton Award for Medical Research at the 2019 Herston Healthcare Symposium.

After championing waste reduction and recycling in Queensland hospitals for more than a decade, Associate Professor Wyssusek says she is very impressed by the many activities from anaesthetists interested and invested in sustainability in healthcare. She is planning further sustainability activities and consolidation of the many great ideas from colleagues across the state.

I look forward to the positive impact she will have on Queensland in the role of Environmental Sustainability Officer for the Queensland Regional Committee.

Dr Christopher Stonell
Chair, Queensland Regional Committee