



ANZCA
FPM

Bulletin

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

AUTUMN 2021



ANZCA now has a Māori name

Perioperative
medicine case study
How Sydney's Westmead
Hospital developed its own
model of care

Going global
Helpful tips on how to
apply for an overseas
anaesthesia training
position

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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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Cover: A powhiri welcoming conference participants on to the Waitangi Treaty Grounds opened the Cultural safety and leadership hui on 26 February in the Bay of Islands. Kai kōrero/speaker Brian Stephenson (husband of ANZCA President Dr Vanessa Beavis) accepted the challenge and answered on behalf of ANZCA.

Photo: Claire Gordon – Flash Gordon Photography.

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Our Māori name gives new meaning to breath of life

IT IS NOT easy to find an upside to a pandemic, but at least it has reminded first-world nations that it is bad policy to treat good healthcare as just another one of the benefits of being rich. The coronavirus is egalitarian about who it infects. Until disadvantaged nations are protected from it, no one is protected from it. As in the Māori saying, He waka eke noa – we are all in the same canoe.

That saying came to mind constantly as I listened to speakers at the ANZCA Cultural Safety and Leadership Hui at Waitangi recently. As Associate Professor Elana Curtis put it, “Being pro-equity is fundamental to assist all groups to achieve positive health outcomes!”

The hui marked the ANZCA Council's formal adoption of a name for the college in te reo Māori – Te Whare Tohu o Te Hau Whakaora. While there is a modern Māori word for anaesthetist (kaiārai mamae, one who blocks out pain²), the work of ANZCA specialists, embracing other specialisations within pain medicine, is much wider than just giving anaesthetics. Hence the choice of a broader Māori name, invoking the imagery of the breath of life.

Coming after several COVID-19 lockdowns, the hui at Waitangi felt like a rare privilege. It was a three-day conference on leadership, with a focus on cultural safety. What made it rare (apart from being able to meet in person) was the sense of deep connection that continued to develop between Māori and Pākehā colleagues, strengthened by participation in the traditional ceremonies of encounter, involving speeches, songs and the sharing of food.

The hui was particularly meaningful for its venue, entirely within the grounds of the Waitangi Treaty House. Here, in 1834, local chiefs chose a flag to identify New Zealand ships in international maritime law, in effect declaring Aotearoa New Zealand a sovereign nation governed by its Indigenous people. Six years later, the Treaty of Waitangi (recognised now as the modern nation's founding document) was signed here³. Nearby was the commercial and political capital, Kororāreka/Russell, until it was moved to Auckland a year later and subsequently to Wellington. Waitangi epitomises the natural beauty of the Bay of Islands, in the north of the North Island of Aotearoa New Zealand. Many of you on both sides of the Tasman will have been there.

Since 1840, the Treaty of Waitangi has journeyed from a pragmatic measure to solve immediate problems perceived by Britain and Māori, to a judicial pronouncement that it was “worthless” and “a simple nullity⁴”, to the nation's founding document, incorporated into more than 40 statutes⁵ and interpreted as the source of constitutional principles by the superior courts⁶.

The spirit of Waitangi permeated all the sessions at the hui. Difficult and confronting issues were openly discussed and debated. The themes centred on equity, but did not skirt around the ugly consequences of institutional racism. One of these is the disparity in health outcomes between colonisers and Indigenous people all over the world. The figures are distressingly similar for Aboriginal Australians and Torres Strait Islanders.

The causes of the disparity are complex and elusive. Well-intentioned societies set out to design healthcare systems that are agnostic as to ethnicity, culture and language. Repeatedly, they run aground on the reefs of assumptions. The dominant culture may try determinedly to achieve the best for everyone, but may struggle to escape its own hard-wired belief that the European model is the closest there is to perfection.

“As in the Māori saying,
He waka eke noa – we are
all in the same canoe.”



This insight challenged the assumption that the pathway to understanding the “other” people is to study the ways of the “other” people. While understanding the culture of the “other” people is essential, so also is an understanding by the “non-other” people of themselves – their ethnic, cultural, linguistic and historical default settings, which are the key determinants of their intuitive responses to the ethnic, cultural, linguistic and historical default settings of the “other” people.

In other words, know oneself. Self-knowledge, especially about unconscious bias, is the start of cultural safety.

Dr Vanessa Beavis
ANZCA President

References:

1. See elsewhere in this *Bulletin* “Equity is the new black” by Adele Broadbent. See page 10 in this *Bulletin*.
2. *Reed Dictionary of Modern Māori*, P M Ryan, Reed/TVNZ, 1995.
3. *The Treaty of Waitangi*, Dame Claudia Orange (1938-), Bridget Williams Books, 2011.
4. *Wi Parata v The Bishop of Wellington* [1877] NZ Jur Rp 183; (1877) 3 NZ Jur (NS) 72 (SC); 1 NZLRLC 14 (17 October 1877).
5. For example, the Treaty of Waitangi Act 1975, 1975/114; and the State-Owned Enterprises Act 1986, 1986/124.
6. For example, *New Zealand Māori Council v Attorney-General* [1987] 1 NZLR 641; (1987) 6 NZAR 353.

Australia Day honours

Several college fellows were recognised in the Australia Day honours list:

Member of the Order of Australia

Dr David Edward SCHUSTER, AM, from NSW
For significant service to medicine as an anaesthetist, and to the community of Dubbo.

Dr Bruce Gregory LISTER, AM, from Queensland
For significant service to paediatric intensive care medicine, and to professional societies.

Medal of the Order of Australia

Dr Judith Carmen LYNCH, OAM, from NSW
For service to medicine, particularly to anaesthesiology.

Dr David Mickle SCOTT, OAM, from NSW
For service to medicine, particularly to anaesthetics.

College embraces change in time of COVID-19



DUE TO THE ongoing impacts we all face in relation to COVID-19, I was disappointed not to have been able to travel to Aotearoa New Zealand in February to attend the Cultural Safety and Leadership Hui in Waitangi where the college's te reo Māori name – Te Whare Tohu o Te Hau Whakaora – was launched.

The name will be introduced to college collateral produced for use in Aotearoa New Zealand, and is a combination of two options considered.

As you'll see elsewhere in this edition of the *Bulletin*, the name speaks to the importance of the role of anaesthetists and pain medicine specialists in restoring the breath and "life essence/mauri" of their patients.

Our Aotearoa New Zealand office's Executive Director Kiri Rikihana (Te Ati Awa, Ngāti Toa, Ngāti Raukawa) has created a video that shows how the new name is pronounced – www.anzca.edu.au/about-us/our-culture/te-whare-tohu-o-te-hau-whakaora.

There is a synergy between this name and the Latin motto on the college coat of arms – *Corpus curare spiritumque* – which was developed more than 25 years ago and means "To care for the body and its breath of life".

A number of people have asked if there should also be an Aboriginal and Torres Strait Islander name for the college and as Aboriginal fellow Dr Dash Newington says on page 7 the First Nations people of Australia and Aotearoa New Zealand have very different histories and cultures and the reconciliation journeys for each nation is very different.

Aboriginal and Torres Strait Islander Australia – the world's oldest surviving culture – is made up of many different and distinct groups, each with their own culture, customs, language and laws. As the Australian Institute for Aboriginal and Torres Strait Islanders Studies says, the nations of Indigenous Australia were, and are, as separate as the nations of Europe or Africa.

I am pleased to be a member of a working group comprising fellows, trainees, staff and community representatives which has started the development of our first Reconciliation Action Plan. Our inaugural meeting was in March.

While in 2018 the college developed an Indigenous Health Strategy and associated action plan, the Reconciliation Action Plan will be a formal and public document that lists the initiatives the college will undertake to play our part in reconciliation with Australia's First Nations peoples. We've made some great progress over the past few years but we know we still have a long way to go.

Meanwhile, our work to support our colleagues in the Asia Pacific and beyond is continuing through our Global Development Committee (GDC). With the COVID-19 pandemic limiting the amount of travel to developing nations that we would normally do, the college has developed the Pacific Online Learning and Education program (POLE) in collaboration with the Australian Society of Anaesthetists, the New Zealand Society of Anaesthetists and the Society for Paediatric Anaesthesia in New Zealand and Australia (SPANZA).

POLE, supported by our Policy and Communications team, is a series of live online learning and education sessions to support colleagues in the Pacific, and the first meetings have been an overwhelming success with strong multinational turnout.

The working group comprises representatives of Australia's anaesthesia bodies as well as the Papua New Guinea (PNG) Society of Anaesthetists, the University of PNG, the Pacific Society of Anaesthetists, Hospital Nacional Dili, Fiji National University and Micronesia Society of Anaesthetists.

The sessions cover a broad range of topics (as requested by local Pacific representatives) and target a range of anaesthesia providers including consultants, junior doctors, trainees, anaesthesia nurses and anaesthesia scientific officers.

We are closely watching developments in PNG which is struggling to manage the COVID-19 outbreak there. The college's GDC has strong links to the anaesthesia and broader health community in PNG and is in regular contact to support colleagues there.

Dr Arvin Karu, President of the Society of Anaesthetists of PNG and a member of the GDC, reports that major hospitals are beginning to be swamped.

Through our GDC, the college recently made a donation of £2500 to a World Federation of Societies of Anaesthesiologists' (WFSA) appeal supporting hospitals in Nigeria and Zimbabwe.

The WFSA Uniting for Oxygen appeal aims to raise £100,000 (\$A180,000) to deliver oxygen concentrators, pulse oximeters, generators, emergency bags, associated training and ongoing maintenance support to a number of hospitals in Nigeria and Zimbabwe.

The WFSA is matching all donations, doubling the value of our contribution to £5000.

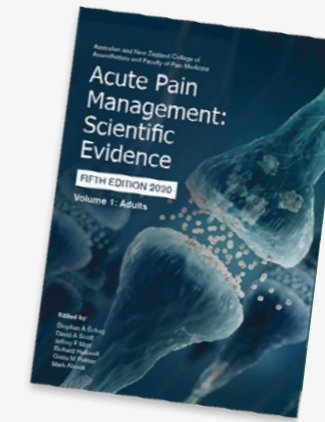
While the appeal is for African hospitals and hence outside our GDC's usual area of focus, we continue to support worthy causes beyond the Asia Pacific region where possible.

All of this work would not be possible without the incredible volunteer efforts of our fellows and trainees who contribute to our GDC – thank you.

Finally, we are working closely with the Royal College of Anaesthetists who is leading the development of the International COVID-19 Conference to be held in June. This virtual event aims to share vital lessons learned and help clinicians better prepare for coronavirus or similar future respiratory pandemics. More details will follow as the conference gets closer.

Nigel Fidgeon
ANZCA Chief Executive Officer

Acute Pain Management: Scientific Evidence



The fifth edition of the internationally-renowned *Acute Pain Management: Scientific Evidence* was launched late last year and covers a wide range of clinical topics, combining a review of the best available evidence for acute pain management.

It's the result of many years' hard work by a large number of people, particularly the editorial working group – Professor Stephan Schug, Associate Professor Greta Palmer, Professor David A Scott, Dr Mark Alcock, Dr Richard Halliwell, and Dr Jeff Mott.

As part of our commitment to promoting environmental sustainability, we designed this edition to be read digitally, and we would encourage you to access this publication electronically if possible. It's available on our website – www.anzca.edu.au/news/top-news/apsme5.

At 1300 pages, this edition is double the size of its predecessor, and when it's printed it weighs nearly 2.5 kilograms, and comes in two volumes.

We understand some fellows, trainees and specialist international medical graduates will want a hard copy and a limited number is available at a small cost for postage and handling. For those based in Australia and New Zealand this is \$A30 and for those elsewhere overseas the cost is \$A80. Please email us at communications@anzca.edu.au if you are interested in purchasing a hard copy.

Corrections

Number of candidates

An article on the primary and final exams in the Summer *ANZCA Bulletin* ("Running exams in a pandemic" page 19) had the incorrect number of candidates who sat the primary and final exams in 2020. The college examined 331 primary exam candidates and 310 final exam candidates in 2020.

White Island/Whakaari

An article on the one year anniversary of the White Island volcano tragedy ("Frontline anaesthetists reflect on the Whakaari tragedy one year on" page 28) had the Māori name of the island incorrectly spelt as "Whaakari". It should have been spelt "Whakaari". We apologise for the error.

Te Whare Tohu o Te Hau Whakaora

ANZCA has a Māori name



Haumi ē-I Hui ē-I Tāiki ē-I | To draw together as one, progress our common purpose. Rito Tapuke (Taranaki, Te Ati Awa, Ngāti Mutunga) and the Hui organising committee leads the blessing of the new te reo Māori name for ANZCA – Te Whare Tohu o Te Hau Whakaora.

ANZCA HAS ADOPTED the Māori name Te Whare Tohu o Te Hau Whakaora.

The name was launched at the Cultural Safety and Leadership Hui held at Waitangi in the Bay of Islands on 28 February by ANZCA New Zealand National Committee Chair, Dr Sally Ure.

Te Whare Tohu o Te Hau Whakaora is phonetically pronounced:

Teh / Far- re / Tor- who/ Or / Teh / Hoe / Far-car-or-rah

Our Aotearoa New Zealand office's Executive Director Kiri Rikihana (Te Ati Awa, Ngāti Toa, Ngāti Raukawa) has created a video that shows how the new name is pronounced – www.anzca.edu.au/about-us/our-culture/te-whare-tohu-o-te-hau-whakaora.

The name is a combination of two options presented to the Māori Anaesthetists Network Aotearoa (MANA):

- i. Te Whare Tohu denotes the status of a college, or literally a "significant house";
- ii. o means "of"
- iii. Te Hau Whakaora means The Life-Giving Breath, the words "hau" and "whakaora" have multiple meanings including:

Hau – breath, wind, gas, vital essence of life, aura, prestige, eminence.

Whakaora – revive, revitalise, rescue, restore to health, cure, healing.

The name Te Whare Tohu o Te Hau Whakaora speaks to the importance of the role of anaesthetists and pain medicine specialists in restoring the breath and "life essence/mauri" of their patients. This name infers the more holistic and sacred work of anaesthetists and pain medicine specialists to preserve the quality of life of their patients.

The motto on the college coat of arms is "Corpus curare spiritumque" and means "To care for the body and its breath of life". There is a synergy between the meaning in ANZCA's Latin motto, coat of arms and this name.

Many people have been involved in the journey to this point where ANZCA joins most other New Zealand health, government, education, training, and private businesses in recognising Māori as one of the country's three official languages (English and New Zealand sign language being the other two). However, it was former ANZCA President Dr Rod Mitchell who put his name and his enthusiasm behind the quest during his time as the head of the college. "This [the Māori name] strikes me as being a very important step forward for our college. We officially acknowledge that New Zealand, as one of the two nations that define who we are, is a bilingual nation. This is all the more so when te reo is so intimately related to New Zealand's national identity."

Dr Arihia Waaka FANZCA (Te Arawa) of Rotorua Hospital at Lakes District Health Board is the inaugural chair of the MANA who were integral in the gifting of this name. She sees the importance of the move.

"It is encouraging to see ANZCA acknowledging the value of te reo Māori, and the special contribution that Māori knowledge provides to mainstream doctrine. Many experts, (including linguists, horticulturalists and as we have all learnt recently, astronomers) have long recognised the benefit that a Māori world view can have on our population."

Dr Waaka says she was heartened to see ANZCA go through a non-appropriation process to acquire this name including recognising the value of a qualified translator (tena koe, e te Whaea). "I am hopeful that this is another step forward in our collective journey towards anti-racism. And I hope that our Aboriginal cousins across Te Tai o Rehua can also find a symbol that acknowledges their special contribution to our college."

And across the ditch...

IT'S GREAT TO see the college adopt a te reo Māori name recognising Māori as one of Aotearoa's three official languages (in addition to English and New Zealand sign language) and the contribution Māori knowledge makes to people's health and wellbeing in Aotearoa.

During the considerable period of consultation and development of this name, some have questioned whether there should also be an Aboriginal and Torres Strait Islander name for the college.

While great to see a Māori name for the college, First Nations people of Australia and Aotearoa have very different histories and cultures and the reconciliation journeys for each nation is very different. The fact is that Indigenous Australia is multicultural – visit aiatsis.gov.au to view a map of the many language, social or nation groups of Aboriginal and Torres Strait Islander Australia. The nations of Indigenous Australia were, and are, as separate as the nations of Europe or Africa.

The college recently commenced the development of our first Reconciliation Action Plan, with a working group comprising fellows, trainees, staff and community representatives holding its inaugural meeting in March.

While the college developed an Indigenous Health Strategy and associated action plan in 2018, the Reconciliation Action Plan will be a formal and public document which lists the initiatives the college will undertake to play our part in reconciliation with Australia's First Nations peoples.

Reconciliation action plans must be approved by Reconciliation Australia – a national, independent organisation charged with leading the nation's reconciliation journey. Regular progress reporting to Reconciliation Australia is also a component of the plan.

Over the remainder of 2021, we'll share with you major developments in the college's reconciliation journey. In the meantime, there are lots of ways you can make a difference – search "Indigenous issues can be daunting – here are 10 positive ways to engage" for a fantastic read on little things you can do to make a difference (number one is educate yourself!).

Dr Dash Newington, FANZCA
Member, Reconciliation Action Plan Working Group

Dr Stuart Walker (second from left) with ANZCA fellows and attendees at the NZNC Hui.



Dr Stuart Walker farewelled from Indigenous Health Committee

Dr Stuart Walker (Whakatōhea), stepping down from his place on the ANZCA Indigenous Health Committee, was honoured for his work with a gift and a waiata at the NZNC Hui dinner on 27 February at Waitangi.

ANZCA President Dr Vanessa Beavis spoke of Dr Walker's legacy and wise counsel before presenting a gift.

Dr Walker replied with a story about attending a protest at Waitangi with his father, famous writer and academic,

Dr Ranginui Walker. He said he left the protest knowing his future was not as a warrior but as a doctor.

His son, Dr Curtis Walker, chair of the Medical Council of New Zealand, led a moving waiata to his father.

Earlier both father and son had been honoured by a traditional Māori challenge in the grounds of Waitangi. Dr Curtis Walker described it as a special moment for them both.

Equity is the new black

ANZCA New Zealand National Committee Hui touches hearts and minds.

THE ANZCA NEW ZEALAND National Committee Cultural Safety and Leadership Hui at Waitangi in the Bay of Islands wrapped up with the launch of the Māori name (see page 6) on 28 February. This was just hours after COVID-19 restrictions were reintroduced across the country following a community outbreak of the coronavirus.

The hui was postponed last November so the privilege of gathering to share and, as one speaker said, “suck up the wairua (spirit) of this place” (Waitangi Treaty Grounds) was not lost on the 90 or so participants.

Among those presenting was the chair of the Medical Council of New Zealand (MCNZ) Dr Curtis Walker who took us on a journey using the story of the great Dame Whina Cooper. In 1975 at the age of 80, Dame Whina started to walk to parliament protesting Māori land rights with just two people. She ended at parliament flanked by thousands who had joined the Hikoi. Dr Walker likened this to the journey of medical colleges into equity and real inclusiveness: “Medical colleges need windows so they (students) can see into the specialty; mirrors so they can see themselves and doors so they can walk through them.”

The Powhiri



Dr Walker spoke about equity making its way into all policy and being boosted by the Black Lives Matter movement over the past year. “Black lives matter and equity is the new black,” he said.

When asked what an affirmative pathway into specialist medical colleges would look like Dr Walker said leaving things to happenstance was not the right way: “Affirmative pathways may be necessary to get the diverse workforce we need.”

Later in the conference, Associate Professor Elana Curtis renamed affirmative pathways as social justice for equity pathways. Dr Curtis is a public health physician working as a senior lecturer medical at Te Kupenga Hauora Māori, University of Auckland. She was on the panel with Dr Maxine Ronald, a consultant breast cancer surgeon from Northland, and Dr Rachelle Love, an ear, nose and throat surgeon from Christchurch.

Both surgeons work closely with their college on equity issues. There was some powerful korero (discussion) as three leading women in their fields pulled no punches with what they believed needed to change.

Dr Curtis’ message was strong and simple. “Being pro-equity is fundamental to assist all groups to achieve positive health outcomes.”

But, she says, this is not the same as cultural safety. “Being anti-racist is central to building a socially just society and understanding personally mitigated and structural racism. It is still not cultural safety. Cultural safety is about a critical consciousness, knowing yourself, your power, your culture and bias and assumptions. Asking what is the impact of these on fundamental human dignity in the care of patients and the delivery of services? That is cultural safety.”

Throughout the conference speakers explored cultural safety and the fight for health equity. But they also spoke of substance abuse – using personal stories that discussed burn-out and the need to keep colleagues safe. Tears were shed in sessions as presenters shared their personal stories about how departments cope with a suicide of a colleague and how a doctor lives with the death of her doctor husband.



Clockwise from top: The Powhiri; from left, Associate Professor Elana Curtis, Dr Maxine Ronald and Dr Rachelle Love; Dr Nigel Robertson Waka Paddling.

Many spoke of this being a watershed conference on issues of equity and strength for the journey now being taken by medical colleges to become more representative of the patients they care for.

These and other issues that were discussed at the hui including research into Māori patients and recovering from substance abuse as a specialist will be examined by the *ANZCA Bulletin* in future editions.

Adele Broadbent
Communications Manager NZ, ANZCA

“Being pro-equity is fundamental to assist all groups to achieve positive health outcomes.”

College provides expert input

Australia

College provides advice on COVID-19 response

Since the beginning of the SARS-CoV-2 pandemic 12 months ago, the college has sought to engage constructively with governments at all levels to inform and contribute to the development of information and actions to address the spread and the treatment of COVID-19.

As the first iteration of the college’s statement on personal protection equipment (PPE) was being drafted, then-President Dr Rod Mitchell established direct lines of communication with Australian government officials, in particular the Deputy Chief Medical Officer, Dr Nick Coatsworth and Chair of the Infection Control Expert Group, Professor Lyn Gilbert. This assisted greatly for subsequent revisions of the statement led by Associate Professor Leonie Watterson, Dr Nigel Robertson and Professor David Story.

In late March 2020, as Australians were coming to grips with life in lockdown and efforts to flatten the curve, a diverse coalition of peak health bodies united to focus on clinical care across the country through the National COVID-19 Clinical Evidence Taskforce. ANZCA presidents Dr Rod Mitchell and subsequently Dr Vanessa Beavis have represented the college on the national steering committee, and Professor Paul Myles, Associate Professor Nolan McDonnell and Dr Simon Hendel have contributed to the panels of clinical experts that are reviewing the evidence and making recommendations.

Professor Story, an ANZCA councillor and now chair of the college’s Safety and Quality Committee, joined a National Clinical Taskforce established by the Australian Commission on Safety and Quality in Health Care to advise on amendment of the National Safety and Quality Health Service Preventing and Controlling Healthcare-Associated Infection Standard (the HAI Standard). The process for review of the HAI Standard was undertaken with particular reference to transmission-based precautions, environmental and other controls in relation to SARS-CoV-2.

In October, past chair of the Safety and Quality Committee, Dr Phillipa Hore was appointed as co-chair of the new Australian Infection Prevention and Control Panel. The panel was formed to address calls from the clinical sector to strengthen capacity for emerging evidence and frontline clinical experience to inform national infection prevention and control guidance for healthcare workers. The 17-member panel draws on some of Australia’s foremost experts in evidence-based clinical practice, infection prevention and control, occupation and environmental health, occupational hygiene and clinical engineering.

In a recent letter to Australia’s Chief Medical Officer Professor Paul Kelly, and a subsequent letter to the Australian Technical Advisory Group on Immunisation, ANZCA President Dr Vanessa Beavis requested clarification on the COVID-19 vaccine and whether anaesthetists were considered frontline workers and prioritised for receiving the vaccination. Dr Beavis also wrote to New Zealand’s Director-General of Health Dr Ashley Bloomfield seeking clarification on the vaccination roll-out plan. We will continue to be at the forefront of discussions and decisions that relate to SARS-CoV-2, COVID-19 and associated matters of healthcare workers’ safety and standards of practice as they arise through 2021.

Draft National Medical Workforce Strategy released

In 2019 the Australian government Department of Health announced that it was developing a 10-year National Medical Workforce Strategy to guide long-term medical workforce planning. In December 2020 the department presented the draft strategy to the Council of Presidents of Medical Colleges. The National Medical Workforce Strategy aims to clarify how the work of the Commonwealth, states and territories, health

services, specialist medical colleges, universities, regulators and other local planning bodies can deliver the optimal medical workforce for Australia.

The draft strategy details dozens of actions to deliver on its vision to “work together, using data and evidence, to ensure that the medical workforce sustainably meets the changing health needs of Australian communities”. Five complementary priority areas guide the actions:

Priority area	Broad draft actions
1. Collaborate on planning and design	<ul style="list-style-type: none"> Establish a joint medical workforce planning and governance body. Develop a workforce planning framework that can be used at all levels. Develop and implement a National Medical Workforce Data Strategy. Further develop the Health Demand and Supply Utilisation Patterns Planning (HeaDS UPP) Tool.
2. Rebalance supply and distribution	<ul style="list-style-type: none"> Increase the number of trainees in undersubscribed specialties and decrease the number of trainees and oversubscribed specialties. Grow the Aboriginal and Torres Strait Islander workforce. Reduce barriers and improve incentives for doctors to work and train in rural and remote communities. Determine and monitor optimum use of locums. Align migration and distribution regulation. Establish a nationally structured service registrar model for service delivery.
3. Reform the training pathway	<ul style="list-style-type: none"> Medical training to occur primarily in rural Australia, wherever possible. Collaboratively set and fund the number and distribution of education, and training places through a national pool. Coordinated and visible training pathways. Reform regulation of vocational training programs. Culturally safe training, training in cultural safety, and expertise in Aboriginal and Torres Strait Islander health.
4. Build the generalist capability of the workforce	<ul style="list-style-type: none"> Support broader education and experience of generalist and rural and remote clinical practice during medical school and on training programs. Require doctors to develop and demonstrate generalist medical skills prior to entering specialty training. Support informed decision making for generalist career pathways and encourage rewarding of generalist experience in trainee selection. New fellows to demonstrate competence across full scope of practice. Implement and leverage innovation from the National Rural Generalist Pathway. Implement improved computerised clinical decision support systems.
5. Build a flexible and responsive medical workforce	<ul style="list-style-type: none"> Review COVID-19 from the lens of embedding more support and flexibility within the medical workforce. Increase flexible working arrangements to reflect the changing needs of the medical workforce. Establish portability of entitlements for doctors across different settings. Recognising and remodelling unsustainable and potentially unsafe employment models.

College's COVID-19 contributions in Australia

Group	College representative
National COVID-19 Clinical Evidence Taskforce Steering Committee	Dr Vanessa Beavis, President
Australian Commission on Safety and Quality in Health Care National Clinical Taskforce	Professor David Story, Chair Safety and Quality Committee
Australian Infection Prevention and Control Panel	Dr Phillipa Hore, member and former chair Safety and Quality Committee

Three cross-cutting themes overlay the priority areas and actions of the strategy, being:

1. Growing the Aboriginal and Torres Strait Islander workforce and improving cultural safety.
2. Adapting to changing models of care.
3. Improving doctor well-being.

Each of these themes will be influenced by success in each of the five priority areas.

The draft document argues that the COVID-19 pandemic highlights the potential for a national workforce strategy to provide agreed overarching goals and vision which can guide responses to emerging issues. Immediate COVID-19 issues include protecting the workforce from viral transmission, over-work and mental health impacts.

From a workforce planning perspective, the pandemic poses additional challenges in the way future demand for the medical workforce is assessed. In the face of border closures, the pandemic raises questions about the appropriate level of redundancy that should be built into a demand model (including domestic and international workforce flow), as well as policy questions about the extent to which Australia can contribute internationally to the rebuilding of depleted health systems and medical workforces.

The college has provided input into the development of the strategy with representation at strategy consultation forums in Melbourne, Sydney and Ballarat, in addition to participating in other face-to-face meetings and teleconferences with the department. The college has also provided written feedback to the draft strategy.

The National Medical Workforce Strategy is an ambitious document and while it will take some time for many of the proposed actions to demonstrate tangible benefits, it is important that the first steps to effect these long-term changes are taken now.

New Zealand

Health and Disability Systems Review in the spotlight

All eyes are on the New Zealand Labour government at the start of its second term as the health sector braces itself for a round of restructuring following recommendations by the weighty Health and Disability Systems Review. The review came out mid last year giving a strong direction for change in the country's health sector including the formation of a Māori Health Authority and a reduction of the 20 current district health boards (DHBs) to a recommended eight to 12.

A timeline has been released for the structural and culture change actions in the final report that can be found here – systemreview.health.govt.nz/final-report/download-the-final-report/. It's expected the reduction of the number of district health boards will be the first major reform off the block, however the management of that process will be complicated and take time. The government is expected to make their decisions on what part of the review to action during the first quarter of the year.

Former Director General of Health, Stephen McKernan is leading the Transition Unit for implementing the Health and Disability System recommendations. The unit is working out of the Department for the Prime Minister and Cabinet. The unit will carry out the detailed policy and design work for the changes. It is made up of experts from health services, the Ministry of Health, and other government agencies and it reports to a group of ministers led by the prime minister and the ministers of health and finance. Stephen McKernan is presented at the Council of Medical Colleges on 18 March, which was his first cross-sector meeting.

Submissions

The college prepares submissions and makes representations to government and other stakeholders on a range of policy initiatives and inquiries, many of these in response to requests for college feedback and input. Our submissions to public inquiries are available on the college website following the inquiry closing date. Note that some inquiries and requests for college input are confidential. For a listing of recent submissions visit www.anzca.edu.au/communications/advocacy/submissions.

Australia

- Australian Commission on Safety and Quality in Health Care: Public consultation on the 10th National Health Priority - Quality use of medicines and medicine safety (Phase 1: Aged care).
- Australian Commission on Safety and Quality in Health Care: Draft Acute Anaphylaxis Clinical Care Standard for public consultation.
- Royal Australian and New Zealand College of Obstetricians and Gynaecologists: draft Australian guideline for the diagnosis and management of endometriosis.
- Parliament of New South Wales: Health outcomes and access to health and hospital services in rural, regional and remote New South Wales.
- Department of Health: Draft National Medical Workforce Strategy 2021-2031.
- Australian Resuscitation Council: Final draft Australian and New Zealand Committee on Resuscitation guideline 4 – Airway.
- Therapeutic Goods Administration: Potential reforms to medicinal cannabis manufacturing, labelling and packing requirements.
- Therapeutic Goods Administration: Proposed amendments to the Poisons Standard.

New Zealand

- Medical Council of New Zealand/Te Kaunihera Rata o Aotearoa: Musculoskeletal medicine (NZAMM) consultation.

Rural placements, COVID-19 and Australia Day honours top media coverage

ANZCA PRESIDENT Dr Vanessa Beavis was interviewed for a page 2 article about Australia's rural doctor workforce in *The Australian* on 15 February. The article "Calls for medical nashos in rural towns" reached an audience of 95,000 people. It noted that the country's peak medical colleges, including ANZCA, are almost united in their opposition to forcing aspiring specialists to undergo a mandatory placement in regional, rural or remote Australia.

ANZCA's Effective Management of Anaesthetic Crises (EMAC) course featured in an ABC Adelaide TV news report "South Australia gets state-of-the-art anaesthetic training centre" on 13 February (below). Adelaide fellow and EMAC co-convenor Dr Giresh Chandran and anaesthesia trainee Dr Brianna White were interviewed for the report which focused on the EMAC course at the University of Adelaide simulation centre from 10-12 February.

For decades, South Australian anaesthetists have had to travel interstate or overseas to complete their training in the specialty. The University of Adelaide has now opened a new simulation centre so participants can complete their training without having to travel interstate to other training facilities. Six local advanced trainees and provisional fellows were able to complete the EMAC training in Adelaide for the first time.

The FPM Choosing Wisely recommendation not to prescribe medicinal cannabis for chronic non-cancer pain in Australia attracted strong media coverage. *Sydney Morning Herald* health editor Kate Aubusson wrote the story as an "exclusive" for print and online on

23 March and it was syndicated to *The Age*, the *Brisbane Times*, and *WA Today* with a combined print and online circulation of more than 800,000 people. The article coincided with an opinion piece written by FPM Dean Associate Professor Mick Vagg for *The Conversation* "Medicinal cannabis to manage chronic pain? We don't have evidence it works" and this was syndicated to *Guardian Australia* (a circulation of nearly 800,000 readers) and *The New Daily*. The ANZCA/FPM media release led to media requests for radio interviews with Associate Professor Vagg for ABC Radio Sydney's breakfast program with hosts Wendy Harmer and Robbie Buck (90,000 listeners) and another interview with ABC Radio Adelaide's afternoon program host Sonya Feldhoff. An ANZCA/FPM media release was also distributed.

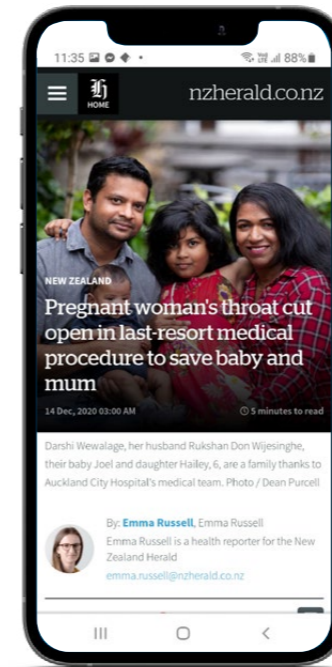
The chair of ANZCA's Safety and Quality Committee Professor David Story was interviewed by the *Herald Sun* about the aerosol spread of nebulisers and COVID-19 on 11 February following an outbreak of the coronavirus at a Melbourne quarantine hotel. Professor Story highlighted recent research by ANZCA fellow Associate Professor Forbes McGain which revealed that aerosol spread from a nebuliser was 10,000 times more capable of spreading a virus than a cough. Professor Story told the *Herald Sun* that intensive care unit specialists were very concerned about using nebulisers near patients who have known or suspected cases of COVID-19.

The article was syndicated to more than 30 online mastheads throughout Australia and reached an estimated audience of 500,000 people.

ANZCA fellow Dr Christine Ball featured in BBC coverage of the history behind the invention of the syringe. Dr Ball, honorary curator of the Geoffrey Kaye Museum of Anaesthetic History in Melbourne, was interviewed by BBC Scotland journalist Magnus Bennett for a 9 March online article about the history of the syringe "The invention that made mass vaccinations possible."

In experiments with dogs in 1656, Britain's Sir Christopher Wren – better known as an architect – administered drugs using an animal bladder attached to a hollow goose quill.

"He injected opium, alcohol and crocus metallodrug (a 17th Century emetic) into different dogs," Dr Ball explained.



Since the Summer 2020 edition of the ANZCA Bulletin, ANZCA and FPM have featured in:

- 6 print reports
- 70 online reports
- 3 radio reports
- 2 TV reports

"As we would expect, the first went to sleep, the second became very drunk and the third became very dead."

Melbourne anaesthetist Dr Andrew Huang wrote a first person account as a specialist in theatre for an organ retrieval operation on a healthcare worker on 8 February and this was published in the Insight section of the *Medical Journal of Australia*.

Retired Melbourne anaesthetist Dr Bob Smith featured in a Nine News Melbourne TV report on 21 March about a new exhibition featuring his paintings of some of his former colleagues in the operating theatre. The paintings will be sold to raise funds for the Western Health Foundation. Anaesthetist Dr Nicole Sheridan was also interviewed for the report which was viewed by more than 1200 people on the Nine News twitter feed.

Dubbo anaesthetist Dr David Schuster was featured in *The Dubbo News* and the *Daily Telegraph* on 26 January as a recipient of a member (AM) in the general division of the Order of Australia for significant service to medicine and the Dubbo community. *The Dubbo News* reported that the

former ANZCA supervisor of training and reserve medical officer with the Royal Australian Air Force had "put more than 100,000 people to sleep" during his 47 year career.

Dr Benn Lancman, an Australian anaesthetist working in San Francisco was interviewed by ABC Radio Hobart on 6 January about the spread of COVID-19 in California, his work in the department of anaesthesia at the University of California San Francisco, and what it felt like to receive the coronavirus vaccine. Dr Lancman has been living in San Francisco for several years.

Auckland anaesthetist Dr Jack Hill featured in a *New Zealand Herald* article on 14 December about the successful use of a rare emergency procedure to save the life of a pregnant mother and baby. Nearly 20 Auckland District Health Board staff had less than five minutes to prepare and complete an emergency surgical cricothyrotomy. Dr Hills said "as an anaesthetist, you train for it but you never think you will actually have to do it. It was an absolute last resort and no one knew if it would work".

Carolyn Jones
Media Manager, ANZCA

ANZCA Indigenous Health Awards

ANZCA is pleased to announce the launch of new Indigenous health awards.

As the college continues to implement actions from our Indigenous Health Strategy, the Indigenous Health Committee acknowledges that there are a number of individuals and groups across the college working to improve the health of First Nations peoples through various initiatives and projects.

The new ANZCA Aboriginal and Torres Strait Islander Health Award and ANZCA Māori Health Award aim to acknowledge and highlight this work. The awards offer a platform for sharing excellence and achievement in Indigenous health and to recognise strong partnerships and collaborative approaches to improving health outcomes for Australia and Aotearoa New Zealand's First Nations peoples.

The ANZCA Indigenous Health Awards recognise a college fellow, trainee, specialist international medical graduate, or a group of members, who have made a significant and sustainable contribution to Aboriginal, Torres Strait Islander or Māori health through a public health initiative or research project.

In line with the college's Indigenous Health Strategy, the selection criteria for the awards will assess:

- How the project aligns with the strategy's four pillars of governance, partnerships, workforce and advocacy.
- At what level the project engages and works in collaboration with First Nations peoples, community groups or organisations.
- The effectiveness of the project.
- How the project has demonstrated innovation.
- The sustainability of the benefits.

Nominations for the awards can be made by the nominee, a college fellow, trainee, specialist international medical graduate, ANZCA regional committee or Indigenous organisation or community group. Nominations are now open and will close on 31 December 2021. Selection criteria and forms can be found on the college website under Indigenous health.

We encourage you to nominate someone you know who is working to reduce inequities in health outcomes between Indigenous and non-Indigenous people in Australia and Aotearoa New Zealand.

Dr Sean McManus
Chair, ANZCA Indigenous Health Committee



COVID-19



College queries vaccination roll-out plans



Throughout the pandemic, anaesthetists and trainees have regularly been called on to intubate and resuscitate COVID-19 and suspected COVID-19 patients and play a vital role in primary and back-up resuscitation and intubation teams alongside intensive care and emergency medicine colleagues.

In March the New Zealand Government commenced a four-stage COVID-19 vaccination campaign using Pfizer-BioNTech vaccine, with border workers and their families the first to be vaccinated. Vaccination of frontline healthcare workers has commenced and will be completed by May. People over 65 years old and people with pre-existing health conditions in “high-risk settings” are also being vaccinated now, with others meeting these criteria in the rest of the country to be vaccinated from May. The remainder of the general population aged over 16 years will not begin to be vaccinated before July. Fifty community vaccination centres were in operation at the end of March to enable the rollout to proceed.

THE ROLL-OUT OF national COVID-19 vaccination programs in Australia and New Zealand has been a particular point of concern for many anaesthetists caring for COVID-19 patients, regularly undertaking aerosol generating intubation and also having to assist with providing care in intensive care units and emergency departments during the first and second waves of the pandemic.

ANZCA President Dr Vanessa Beavis has written to authorities in Australia and New Zealand seeking assurances that anaesthetists working with known and suspected COVID-19 patients and with critical care patients will be prioritised in the vaccination roll-out. Dr Beavis also spoke about the COVID-19 vaccination rollout with infectious diseases expert and Australian Department of Health adviser Dr Nick Coatsworth, who said all vaccinations being offered were effective, including the Oxford/AstraZeneca vaccine.

The Australian COVID-19 vaccination program commenced in February using Pfizer-BioNTech vaccine through upwards of 50 hospital hubs, with priority populations including aged care and disability care residents and workers, some frontline healthcare workers, and quarantine and border workers. More than 4500 accredited general practices will participate in the next phase of the rollout, supported by 130 respiratory clinics and over 300 Aboriginal Community Controlled Health Service sites. During this phase, all other healthcare workers, as well as elderly people, critical and high risk workers, Aboriginal and Torres Strait Islander people aged 55 years and over and adults with an underlying medical condition or significant disability will be vaccinated using Oxford/AstraZeneca vaccine. Subsequent phases of the rollout will extend to the remainder of the adult population and include delivery through community pharmacies.

New Zealand was ranked the best performing nation among almost 100 in an index by Australia’s Lowy Institute based on containment of the coronavirus, with Australia ranked 10th. Border closures and lockdowns in both countries have successfully contained the spread and work continues to establish a two-way travel bubble.

Dr Saul Judelman, an anaesthetist working at Royal Prince Alfred Hospital, receiving his first dose of the vaccine on Friday 26 February.

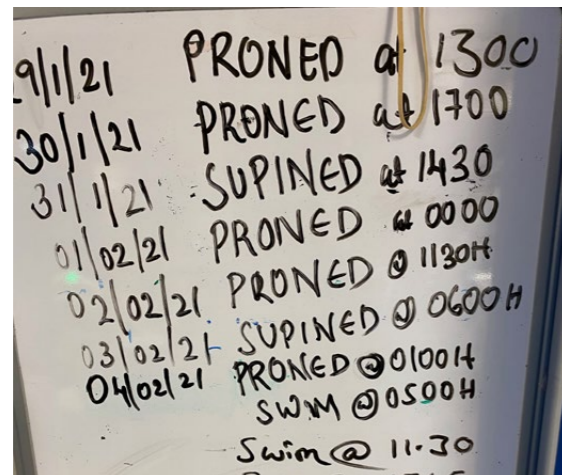


Helping out in a time of need

Earlier this year, Dr Simon Hellings returned to his former hospital in Manchester to help out with the COVID-19 response.



Dr Simon Hellings getting quantitative fit testing on his first morning.



A sign behind a bed giving timings of when the patient is proned, an indicator of how arduous it was.

AS COVID-19 SPREAD around the globe a year ago, my department at Sir Charles Gairdner Hospital in Perth was a hive of planning and innovation. In the end, relative isolation and rapid border closures mean that, thankfully, the anticipated surge never happened.

Unfortunately, the same could not be said for my previous hospital in Manchester in the UK, with successive waves of patients with COVID-19 over the year. Following a relaxation in social distancing at Christmas, Manchester was preparing for a “super-surge” in cases with modelling predicting a peak at the end of January.

With my General Medical Council registration automatically re-instated (part of UK COVID-19 response), a negative COVID-19 polymerase chain reaction (PCR) to get into the UK (slightly ridiculous) and permission from the Australian government, my department and family to leave, I found myself on an eerily empty plane back to Manchester. The timing could not have been better. Rapid preparations were being made to triple to 90 the number of ventilated beds. A paediatric HDU with an all-important separate oxygen supply, a general ward and a recovery area were all being re-purposed.

Sunday evening, after home quarantine in my Airbnb and another negative COVID-19 PCR test, saw me having my first vaccine. At 8am on an icy Monday morning I was at ICU handover.

My first impression was of a battle-hardened hospital with huge tubs of alcohol, security at the doors and every single staff member masked. The corridors were empty, devoid of any visitors.

Anaesthesia consultants and registrars introduced themselves as extra pairs of hands. They were invaluable in the daily assessment of patients, line changes and trips to scan. They managed airways during proning and during percutaneous tracheostomies (tracheostomies were increasingly done on ICU as confidence grew in the personal protective equipment (PPE) provided). A socially distanced handover proceeded in which patient after patient had the same diagnosis. Manchester is a diverse city, with around 190 languages spoken, but I was still struck by the preponderance of Asian and Afro-Caribbean patients. Many of these patients worked in supermarkets, as taxi drivers and cleaners, unable to work from home. I tried to make sense of some of the discussion. Had the patient had “toxi” (tocilizimab)?



A picture of staff getting ready to intubate a patient on a CPAP hood.

Were they in Recovery or REMAP-CAP? (two of the main trials) What day dexamethasone were they on? When were they due to be swum (head and arms re-positioned while prone)?

With handover finished, I had quantitative fit testing with a nurse educator and was good to go. It's important to have a range of N95 masks. Many people had a re-usable mask if they didn't fit the available disposable ones. Few anaesthetists and intensivists became seriously ill with COVID-19, but on the wards, where N95 masks and visors were used less often, it was a different story.

Some patients presented profoundly hypoxaemic to ED, while others deteriorated on the wards. I was grateful for the simulations we had done in Perth when intubating my first COVID-19 patient. A checklist was used for every intubation, particularly useful when working with the large number of less experienced nurses who had been re-deployed to ICU. Often, patients were critically hypoxaemic despite attempts at pre-oxygenation with continuous positive airway pressure (CPAP). It was necessary to carefully bag mask ventilate them post-induction whilst recognising the potential increased risk of aerosoliation.

I was fastidious with donning and doffing around patient contact, but this didn't stop me worrying in the first few days that I might get ill. My colleagues re-assured me that everyone had felt like this in the first wave and that the PPE worked well. The teamwork

and mutual support was incredible, and people were genuinely kind to each other. The high death rate in patients with COVID-19 in ICU, and the prolonged course of their illness, was an emotional challenge even for experienced staff.

The majority of patients who were intubated with COVID-19 required proning. I had the benefit of working with a team who had been doing this regularly for a year. Again, a checklist was utilised. The whole process would take around 10 minutes, often in obese patients, and there were minimal complications. Consultant resident night shifts (my first resident nights in quite a few years!) would often involve managing the airway whilst swimming the patient. Each patient was prone for at least 16 hours, often multiple times, with surprisingly few pressure injuries.

As COVID-19 admissions slowly declined post-lockdown the vaccination program accelerated rapidly. Tragically, several patients were admitted to ICU having declined the vaccine. Non-COVID-19 admissions began to outnumber COVID-19 admissions and elective work began to resume.

A pocket of peace and quiet

Mindful of how COVID-19 affected hospital teams everywhere the anaesthesia team at Brisbane's Princess Alexandra Hospital kept calm and carried on by creating their own special space. FANZCA Dr Agustina Frankel explains how they did it.

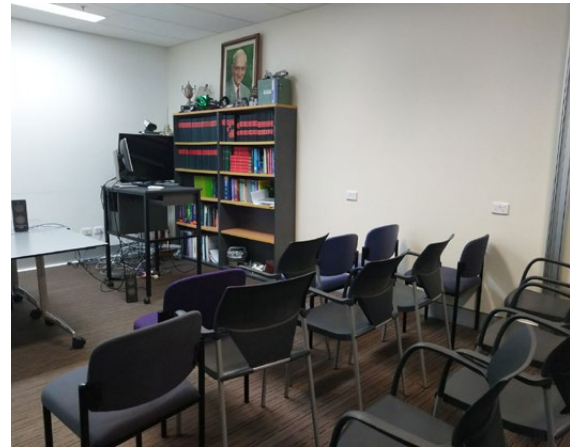
OUR WELLNESS CORNER in the department of anaesthesia was set up when COVID-19 struck in early 2020. Our forward-thinking deputy director Dr Francesca Rawlins, a cardiac anaesthetist, knew that wellbeing support would be key to helping our trainees through the pandemic.

The space was easy to create. It is marked out on the floor to delineate the space as a sanctuary. An arrow guides users to a table with hand sanitiser and an introduction to the purpose and rules of the wellness corner.

Posters of natural landscapes line the wall along with links to free online guided meditation. Exercise posters, sourced from the UK National Health Service, guide stretches and exercises that can be done in the work office – www.nhs.uk/live-well/exercise/gym-free-workouts/.

A bamboo water feature with trickling water provides a soothing sound and the IKEA chair is comfortable and easy to clean. Two IKEA lights cast warm light in a room previously dominated by fluorescent lighting.

Bookshelves are stocked with healthy muesli bars, porridge sachets, hot chocolate and herbal teas. There are also a few items of personal hygiene (for example free toothbrushes and toothpaste). The remainder of the shelves are stocked with textbooks donated by consultant anaesthetists to help registrars who are preparing for exams.



The space prior to becoming the wellness corner

We have also introduced indoor plants and encourage registrars to water them or contribute cuttings from their own gardens. One of our indoor plants is even being slowly trained into the shape of the propofol molecule!

There are often home-baked treats left at the wellness corner by keen bakers in our department, and these are much appreciated by registrars and consultants.

The space only requires once-a-week five-minute maintenance which involves wiping the surfaces, watering plants and restocking food.

The wellness corner is now one year old and continues to be used daily. Informal feedback from registrars is that it is not only valued but has also encouraged a more open acknowledgement of the need to look after ourselves and look out for our colleagues in our challenging but rewarding profession.

We hope that it inspires other departments to establish similar spaces. We would also be interested in hearing about wellness projects created at other hospitals.

Our wellness corner has become our own little pocket of peace and nature at work.

Dr Agustina Frankel, FANZCA
Department of Anaesthesia, Princess Alexandra Hospital, Brisbane



The wellness corner at Princess Alexandra Hospital.

Perioperative medicine



Work progresses on diploma

THE PERIOPERATIVE CARE

framework was presented to the Perioperative Medicine Steering Committee in March, the culmination of months of work by the multidisciplinary Perioperative Care Working Group led by Dr Jeremy Fernando.

The framework identifies the key steps in the surgical patient's perioperative care journey, outlining the key principles and responsibilities for each step, recommendations about how these may be operationalised (with examples and resources), and highlighting the evidence that supports these recommendations.

The framework will be circulated for feedback to the colleges and other bodies with representatives on the committee – the colleges of surgeons, physicians, rural and remote medicine, intensive care medicine, the GP colleges of Australia and New Zealand and of course FPM and ANZCA.

The framework will then be featured as an interactive tool on the ANZCA website.

To date, a curriculum framework has been developed by the Perioperative Medicine Educational Working Group, with further work to complete the six training modules needed as well as a plan for the delivery of the training program in 2023. The modules include:

- Perioperative impact of major disease.

- Planning for surgery.
- Optimisation.
- Intraoperative impacts on outcomes.
- Safe recovery in hospital.
- Discharge planning and rehabilitation.

Significant work will be completed in 2021 to describe the perioperative care framework and the competencies required in each part of the continuum of care.

Work will also be required to outline professional standards and continuing professional development requirements to support quality of care and patient safety.

The economic benefits of perioperative medicine will be explored to assist in the college's advocacy work, which will include engagement with government, the private health sector and partner medical colleges, so that healthcare systems can incorporate the perioperative care model.

Some economic benefits data was gathered as a result of the literature review that focused on which coordinated perioperative care models were effective in improving patient outcomes and cost efficiency.

The review found clearly that a coordinated and collaborative multidisciplinary and multifaceted model of perioperative care was effective in providing clinical benefits for patients and in reducing costs for health systems and providers.



The review also concluded that high-quality clinical care coupled with a coordinated team approach to the care of the patient improved long term patient outcomes.

An example of useful economic benefits data can be found in the 2011 study of "Perioperative Systems as a quality model of perioperative medicine and surgical care" by Lee et al* that showed that with a co-ordinated perioperative approach:

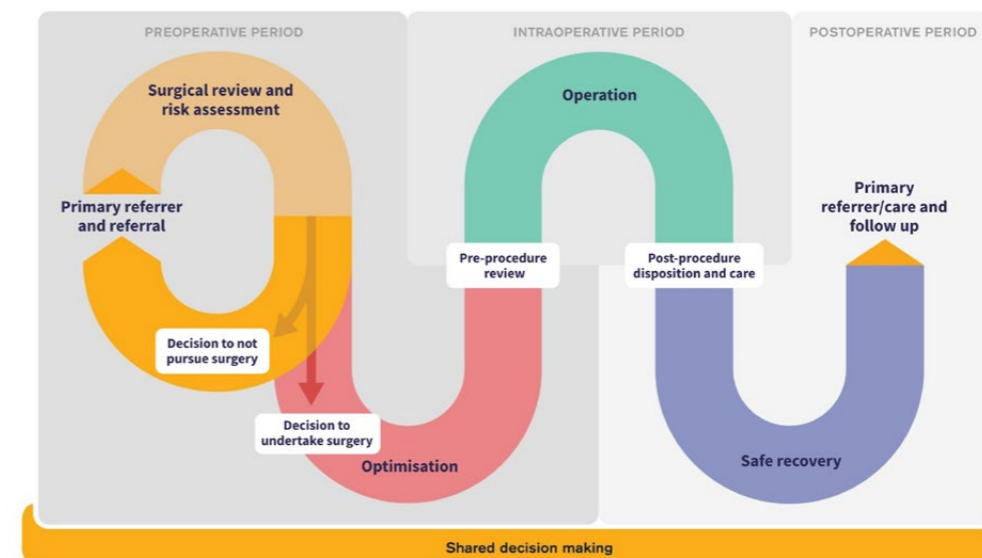
- Surgical volume and flow increased by 20-35 per cent.
- Preoperative length of stay dropped 0.2 days to 1.3 days.
- Surgery cancellations dropped 1 to 8 per cent.
- The number of pre-operative investigations dropped 23-55 per cent.
- The cost of pre-operative investigations dropped 40-59 per cent.
- Risk of wound infection dropped 22-78 per cent.

Further economic data showing the benefits of the perioperative model of care will continue to be gathered to support the implementation of the perioperative medicine model of care.

Dr Sean McManus
Chair, Perioperative Medicine Steering Committee

* Lee A, Kerridge RK, Chui PT, Chiu CH, Gin T. Perioperative Systems as a quality model of perioperative medicine and surgical care. Health Policyd 2011 Oct;102(2-3):214-222.

The perioperative care framework



Evolution of the Westmead Model

WESTMEAD HOSPITAL IS a major tertiary referral centre, with more than 16,000 surgical procedures performed annually. Highly complex patients classified as ASA IV or V make up approximately 10 per cent of these procedures, a significant patient load. The Westmead perioperative medicine service and fellowship were established in 2016 to specifically cater for the needs of these high-risk surgical patients.

Our aims align with the ANZCA perioperative medicine group “to provide an integrated, planned, and personalised approach to patient care.” It has taken us five years to firmly establish our multidisciplinary service comprising of perioperative anaesthetists, intensivists, physicians, geriatricians and surgeons.

Our model of care consists of planned medical and anaesthesia interventions during the preoperative, intraoperative and postoperative phases of the patient journey. The ultimate goals are to improve postoperative outcomes and reduce length of stay. The service also has a commitment to research and education, further strengthened with the integration of our 12-month perioperative medicine fellowship.

Preoperative care is provided by our High-Risk Perioperative Clinic which runs weekly. Referral criteria for our clinic include medically complex patients who require multidisciplinary optimisation and risk stratification. During the initial set up phase of our service, we identified surgical champions and outlined the referral criteria at multiple surgical subspecialty department meetings. These actions played a key role in the successful advertisement and promotion of our new service.

When a referral is received, we commence collation of the patient’s medical history, discharge summaries, specialist letters and investigations. This information is then summarised and emailed to the perioperative group for review. The clinic consultation involves an extended appointment time, and the application of screening tools including the STOPBANG

assessment and Edmonton Frailty Scale. Risk stratification for each individual is performed using the NSQIP risk calculator, supplemented by organ specific risk stratification tools such as MELD, and delirium screening. A comprehensive medical and anaesthesia assessment is thus undertaken. This is followed by discussion with the patient and their family to understand their values and expectations, the management choices available and the specific individual risks involved. The final decision to proceed with surgery or an alternative treatment is made after a face-to-face/teleconference meeting of the multi-disciplinary team (MDT) clinicians. These decisions are shared with the perioperative team via the Microsoft Teams application for review and feedback.

The perioperative medicine fellows play a key role within the perioperative team. They are assigned to the high-risk cases that proceed to surgery, thus providing continuity of care and intraoperative implementation of the perioperative plan. The combination of attendance at the high-risk perioperative clinic and the subsequent participation in

anaesthetic management form the core learning platforms for the fellowship. The fellows also review these patients in the postoperative period. This ensures early detection of any deteriorating physiological trends or suspected complications. The fellowship year also has dedicated clinical time for rotations to medical specialties. This not only reinforces the medical concepts relevant to anaesthesia but also helps build interdepartmental relationships and facilitates the exchange of new ideas and concepts in perioperative care.

The shared decision-making model of care adopted by our group has allowed us to develop and strengthen the relationship we have with our surgical colleagues. This has led to improved implementation of management recommendations from the group over the past five years. The patient care feedback loop is also enhanced by attendance at the surgical morbidity and mortality meetings, where the perioperative team member engages in clinical discussions about the referred patients and their outcomes. Annual audits of the service and outcomes are also presented at these meetings.

Figure: Westmead Perioperative Medicine Model of Care



Sitting from left: Shadi Gadalla, Farheen Ali, Rajdeep Basu Roy, Jessie Ly, Claire Kim, Hemal Vachharajani
Standing from left: Matt Rowe, Katherine Phillips, Madhav Pendyala, Katherine Chatten, Alfred Mahumani, Syed Huq.

In 2021, a retrospective review was conducted examining patients seen by the service between 2017 and 2020. Sixty-seven per cent of these patients proceeded with operative management. The remaining 33 per cent proceeded on a non-operative pathway. Predicted mortality, higher frailty score and dependence on activities of daily living (ADLs) were predictors of a shared decision for non-operative management.

Reversal of decision in both groups was reassuringly low, being less than 5 per cent. The 30-day mortality for the operative group was less than predicted which may indicate that the combination of preoperative optimisation and postoperative follow up is useful in reducing postoperative complications. Plans for a prospective study analysing patient reported experience and outcome measures (PREMS and PROMS) is under way pending ethics approval. We look forward to ongoing quality improvement and adaptation of our service, informed by future research and education.

As the quality and reputation of the service grows, so does the demand. The number of referrals to both the inpatient service and the high-risk perioperative clinic have been steadily increasing. Future prospects include expansion of the clinic, a new arm for cardiothoracic patients, and enhanced methods for the capture of a greater number of inpatients including emergency laparotomy surgery.

Our vision for the future is to pioneer a service that improves health outcomes in the sickest and most disadvantaged cohort of patients by excellence in clinical leadership, collaboration, teaching and

research. The integration of medical rotations with our fellowship training has further strengthened this vision for our perioperative medicine team. We look forward with enthusiasm to the next stage of evolution and growth of perioperative medicine at Westmead Hospital.

Westmead Perioperative Medicine Group
Dr Madhav Pendyala, Dr Farheen Ali, Dr Claire Kim, Dr Rajdeep Basu Roy, Dr Katherine Chatten, Dr Syed Huq, Dr Katherine Phillips, Dr Jessie Ly, Dr Alfred Mahumani, Dr Hemal Vachharajani, Dr Shadi Gadalla, Dr Matt Rowe, Dr Cristina Ciobanu.

Contact: Madhav.Pendyala@health.nsw.gov.au

Table. Summary of results. Westmead Hospital Perioperative Medicine Service – a Shared Decision-Making Model of Care: Retrospective Review of Outcomes for High Risk Surgical Patients.

Decision for Management	Operative	Nonoperative
Number	388 (67%)	191 (33%)
ASA 4	156 (40%)	141 (74%)
Partial or Full assistance with ADLs	155 (40%)	137 (71%)
Mod to Severe Frailty	25 (6%)	39 (20%)
Ave Predicted Morbidity	21%	27%
Ave Predicted Mortality	6%	13%
Reversal of Decision	3 (1%)	7 (4%)
30 Day Mortality	12 (3%)	12 (6%)

Shared decision making key for high-risk patients

New Zealand anaesthetist Dr Heidi Omundsen explains how a new process, the Complex Decision Pathway, is helping give patients the best possible information about the risks and benefits of surgery.

THE BAY OF PLENTY, located in the central North Island of New Zealand, is home to a growing and ageing population. Reflecting national population trends, patients presenting for elective surgery at the Bay of Plenty District Health Board (BOPDHB) are older and more co-morbid than they have ever been in the past. Surgery and anaesthesia are safer than ever before but, as the demographics of our surgical cohort have changed, we have faced new challenges.

In 2017 our multi-disciplinary perioperative team identified a gap in our preassessment processes. Patients were being offered surgery and progressed through streamlined assessment and optimisation pathways, which worked well for the majority of our patients. However, these pathways were ill-equipped to deal with cases where there was substantial uncertainty about the risk-benefit balance of the patient having an operation. When concerns were raised, these concerns were often at odds with already established patient expectations, and communication between clinicians over these issues was often less than ideal. We recognised the need to introduce a new shared decision-making arm to our preassessment model.

In 2018, our preassessment team began developing and testing a multi-specialist assessment and shared decision-making pathway for very high-risk patients contemplating surgery. This has culminated in the development of our Complex Decision Pathway (CDP).

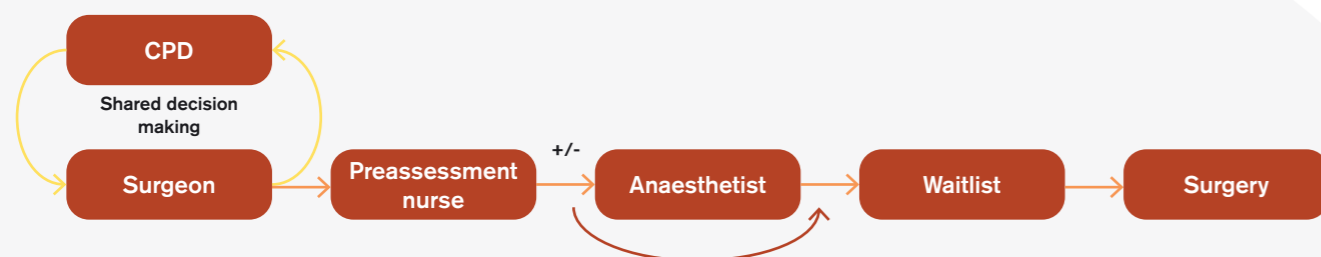


Tauranga Hospital is the main hospital for the Bay of Plenty District.

The key features of the CPD are:

- Initial identification by surgeons of patients for whom the decision to undergo an operation is complex, and communication of this to the patient. Uncertainty about surgery can be identified by other clinicians (for example, primary care physician, geriatrician, or anaesthetist) but this must be directed back to the surgeon, who then discusses this uncertainty with the patient. We have found this to be a crucial step in engaging patients effectively with the CDP.
- Consultant to consultant referral to the CDP including information on proposed surgery, expected outcome, surgical risks, alternatives, and the likely outcome of not operating.

Complex Decision Pathway



- Triage of referrals with investigations and input from multiple specialists as necessary, with clear communication between those specialists.
- An information leaflet is sent to the patient with examples of questions that will be asked at the clinic appointment. The patient then has the opportunity to consider responses with whanau/friends and to identify appropriate support persons to accompany them.
- Māori patients are offered an appointment that includes support from our cultural advisory service, and a Tikanga Māori framework for their appointment. Te Toi Ahorangi is the Māori health strategy for BOPDHB and the first of its kind in Aotearoa New Zealand. Offering this pathway for Māori is a commitment to equity in alignment with Te Toi Ahorangi.
- Patients attend an appointment at the CDP clinic with an anaesthetist and an intensive care specialist. For each patient 30 minutes is allowed for clinician case-conferencing, one hour to meet with the patient and their whanau, and 30 minutes for documentation. This appointment is patient-centred and includes a goals of care conversation (facilitated by the Serious Illness Conversation Guide (SICG) tool) as well as a standard medical assessment.
- The patient and surgeon are given a recommendation consistent with the patient's goals. Where surgery is likely to proceed, this recommendation often includes perioperative advanced care planning.

We aim with effective communication and specialist assessment to provide the patient and their whanau with the best possible information about the risks and benefits of surgery, and to support them in shared decision-making that is consistent with their goals. Early feedback suggests that the process is highly valued by patients and staff alike.

Since commencing in August 2018, we have seen 88 patients through the CDP, from numerous specialties. We have consistently found that a little over half of our patients choose a non-operative course. Early audit data from the CDP was published in *Anaesthesia and Intensive Care* in 2020¹.

As part of this new pathway we have piloted using the SICG to support



BOPDHB Intensivist Dr Suzanne Farrell (left) with anaesthetist Dr Sophie Van Oudenaaren discussing a patient.

perioperative shared decision-making, and we have found it a useful tool. The SICG was developed initially by Ariadne Labs² and adapted for use in New Zealand by the Health Quality and Safety Commission (HQSC)³. It is essentially a checklist that helps clinicians elicit patients' goals and fears, and make a bespoke recommendation using this additional information.

The SICG provides clinicians with questions and prompts using patient tested language. Feedback from local clinicians using this tool has been positive and early research results have reassured us that it is also well-received by patients.

As part of our continual efforts to improve this service we want to learn more about our patients' experiences after they progress through this pathway and choose either an operative or non-operative course. In May 2019 we commenced a prospective, observational study following our patients for one year after their assessment in order to better understand their experiences, decisions and outcomes.

Dr Heidi Omundsen, MBChB, FANZCA, MBHL
Clinical Director, Anaesthesia and Pain Medicine Department, Bay of Plenty District Health Board

References:

1. Omundsen HC, Franklin RL, Higson VL, Omundsen MS, Rossaak JR. Perioperative shared decision-making in the Bay of Plenty, New Zealand: Audit results from a complex decision pathway quality improvement initiative using a structured communication tool. *Anaesthesia and Intensive Care*. 2020, Vol 48(6) 473-476
2. Ariadne Labs. Serious Illness Care. <https://www.ariadnelabs.org/areas-of-work/serious-illness-care>
3. Aotearoa serious illness conversation guide (SICG), adapted with consumers in New Zealand, August 2018

Tips for trainees

THE SAFETY AND quality of care that we provide in theatre is now so great that we are likely to achieve greater incremental benefits from improving perioperative care outside of the operating suite. In order to maximise the benefit we can provide for our patients, advancing our knowledge and skills in perioperative medicine is a logical pathway. For trainees looking to get more involved in perioperative medicine, and potentially become perioperative specialists, there are a number of steps you can take:

- Gain broad clinical experience across medicine, surgery and ICU. Consider spending some time with a geriatrician interested in perioperative medicine as they have a unique and valuable insight into perioperative care of the elderly (delirium, pain management etc.)
- Attend pre-anaesthesia clinics to gain insight into the patient pathway and why specific investigations are done.
- Use risk estimation tools in your clinical practice (for example, the American College of Surgeons (ACS) National Surgical Quality Improvement Program (NSQIP) surgical risk calculator).
- Follow your patients postop on the ward or ICU to better understand their perioperative journey and how we can influence it. If your hospital has a periop team then join their postop rounds.
- Learn how to have difficult conversations – particularly around shared decision-making, goals of care, resuscitation and futility.
- Keep up-to-date with perioperative medicine literature (for example, using Read by QXMD, available through the ANZCA Library).
- Listen to perioperative medicine podcasts, such as TopMedTalk and the Monash PeriopMed Podcast.
- Get involved in quality assurance and quality improvement (QI) projects – these are key elements of perioperative medicine.
- Pursue a course in perioperative medicine (for example, the Perioperative Medicine Short Course or Masters through Monash University, or the UCL Perioperative Medicine in Action free online course).

Note that ANZCA is developing a formal perioperative medicine qualification. (See link below).

- Attend perioperative medicine events (for example, the Annual Australasian Symposium of Perioperative Medicine, the Peter MacCallum Cancer Centre and Austin Health Perioperative Medicine Symposium, or the Perioperative Medicine Special Interest Group meetings). If you've done any relevant research or QI projects then try to present them.
- Join the Perioperative Medicine Special Interest Group (SIG)
- Join trainees with an Interest in Perioperative Medicine (TRIPOM!).
- Undertake a fellowship in perioperative medicine (more details are below).

Follow people on Twitter who are active in the perioperative medicine sphere, such as @jdfvan6, @VBeavis, @Katy_Gibb, @montymythen, @rmoonesinghe. This may reveal opportunities such as the UK-based Evidence Based Perioperative Medicine (EBPOM) which held its annual conference online for the first time in 2020 with free early bird registration. This was a great chance to hear both live and pre-recorded talks from eminent experts in the field.

Fellowships

A number of fellowships are available in perioperative medicine for anaesthesia trainees in Australia and New Zealand. These vary considerably in the proportion of time available for clinical and non-clinical perioperative medicine activities, case mix, service provision requirements, and other aspects. It's worth contacting the program directly to find out more and to help decide if it's the right fit for you.

With assistance from Dr Bronwyn Posselt, Dr Ravi Mistry and Dr Amanda Siu, a list of perioperative medicine fellowships for anaesthesia trainees has been created. Hopefully this will be a useful resource for trainees looking to undertake fellowships in this field. If you know of any other fellowships, or to update the details for those listed, please get in touch through the website.

Resources

- **ACS NSQIP Surgical Risk Calculator** riskcalculator.facs.org/RiskCalculator/
- **ANZCA – Perioperative Medicine Qualification** www.anzca.edu.au/education-training/perioperative-medicine-qualification
- **ANZCA Library – Perioperative Medicine** libguides.anzca.edu.au/perioperative
- **Evidence Based Perioperative Medicine (EBPOM)** ebpom.org/
- **Monash PeriopMed podcast** www.periopmedicine.org.au/index.php/periopmed-podcast
- **Perioperative Exercise Testing & Training Society** poetts.co.uk/
- **Perioperative Medicine Fellowships** accessanaesthesia.com/periop-med-fellowships/
- **Perioperative Medicine in Action Course (University College London)** www.futurelearn.com/courses/perioperative-medicine
- **Perioperative Medicine MSc (University College London)** www.ucl.ac.uk/prospective-students/graduate/taught-degrees/perioperative-medicine-msc
- **Perioperative Medicine Short Course (Monash University)** www.periopmedicine.org.au/index.php/pm-sc-home
- **Perioperative Medicine Special Interest Group** www.acecc.org.au/Article.aspx?A=10397
- **Read by QXMD** read.qxmd.com/libguides.anzca.edu.au/apps/read
- **TopMedTalk** www.topmedtalk.com/
- **Trainees with an Interest in Perioperative Medicine (TRIPOM)** tripom.org/

Dr Richard Seglenieks

Provisional fellow in anaesthesia and perioperative medicine, Western Health, Melbourne

Reference:

1. Seglenieks R. Trainees with an Interest in Perioperative Medicine (TRIPOM). ANZCA Bulletin. 2018 September; 70-71.

Anaesthesia-related deaths analysed

Anaesthesia-related deaths analysed in report

The Safety of Anaesthesia (2015-2017) is the 11th triennial report produced by the ANZCA Mortality Sub-Committee. For the first time, data from every state and territory in Australia has been included, whereas past reports were limited to those jurisdictions participating in the uniform reporting of anaesthesia-related mortality.

The report contains data on 239 anaesthesia-related deaths (categories one, two and three) that were reported within Australia. Only 35 cases (14.6 per cent) were classified as category one where it was considered “reasonably certain” that death was caused by anaesthesia factors alone. In 29 cases there was “some doubt” (category two), and in the remaining 175 cases, “medical, surgical and anaesthesia factors were implicated” (category three).

The percentage of category one deaths has been relatively stable over the last four triennial reports. In 2006-08, category one cases were 15 per cent of the total anaesthesia-related deaths, 14 per cent in 2009-11, 12 per cent in 2012-14 and now 15 per cent in 2015-17.

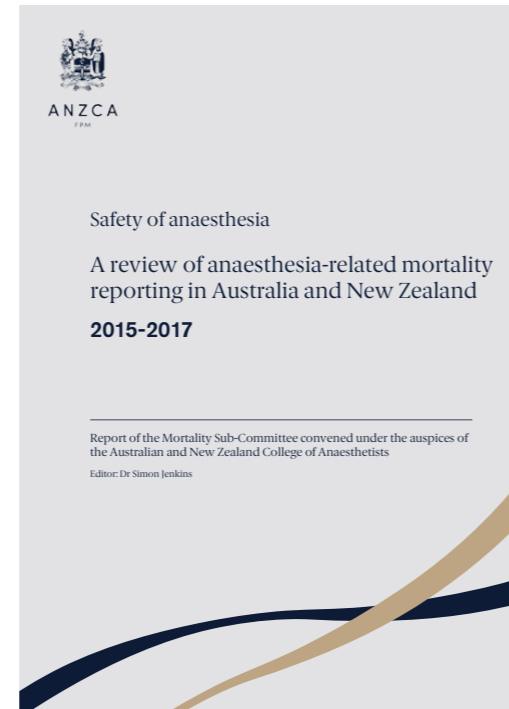
During the 2015-17 triennium, the combined population for Australia was 24.4 million thus the anaesthesia-related mortality rate was 3.29 per million population per annum. The anaesthesia-related mortality rate per million population is very similar in all triennial reports since 1997-99.

During the triennium, there were about 13.65 million anaesthesia procedures performed across Australia. This figure was obtained from the Australian Institute of Health and Welfare (AIHW), with data obtained from coders at all public and private hospitals. Using this denominator, the anaesthesia-related mortality rate was 1:57,125 in Australia. This is consistent with previous triennial reports since 2000-02.

Only a very small proportion of the deaths (7.5 per cent) occurred in patients considered low risk (ASA-P 1-2), with 92.5 per cent occurring in higher risk patients (ASA-P 3-5). This number has plateaued over the past three triennial reports, falling from 26 per cent in 1991-93 to 7 per cent in 2009-11 and 2012-14.

The majority of anaesthesia-related deaths occurred in older patients, with 17 per cent in patients over 90 years, 57 per cent in patients over 80 years, 79 per cent in patients over 70 years and 89 per cent in patients over 60 years of age.

Emergency surgery remains a major risk factor for anaesthesia-related deaths, with 72 per cent occurring in procedures considered urgent or emergent (compared with 70 per cent in 2009-11 and 73 per cent in 2012-14.



The report also includes a brief clinical summary of 18 of the 35 deaths classified as category one (where it is “reasonably certain” death was caused by anaesthesia or other factors under the control of the anaesthetist). Unfortunately, 17 category one deaths were unable to be reviewed in more detail.

However, of the 18 cases reviewed in detail, there were eight deaths due to anaphylaxis, seven cases involving pulmonary aspiration, one cardiac arrest, one hypoxic arrest due to difficult airway management and one case where the cause of death remains unclear.

Process

Through the ANZCA Mortality Sub-Committee, members from each jurisdiction collect mortality data over the triennial period, applying the same, uniform classification system in order to allocate cases to various categories. This data is then collated by the college to inform the development of the *Safety of Anaesthesia* report.

Data on the number and types of procedures is sought from the AIHW and analysed with the mortality data received from the states and territories. The data is then analysed, compiled and edited by the chair of the Mortality Sub-Committee with the assistance of college staff.

A detailed description of the data collection methods, criteria and analysis can be found in the full report.

ANZCA assumed responsibility of the *Safety of Anaesthesia* report in 1990. Prior to 1990, a national Working Party on Anaesthetic Mortality constituted by the National Health and Medical Research Council (NHMRC) coordinated the first two reports during the 1985-87 and 1988-90 trienniums.

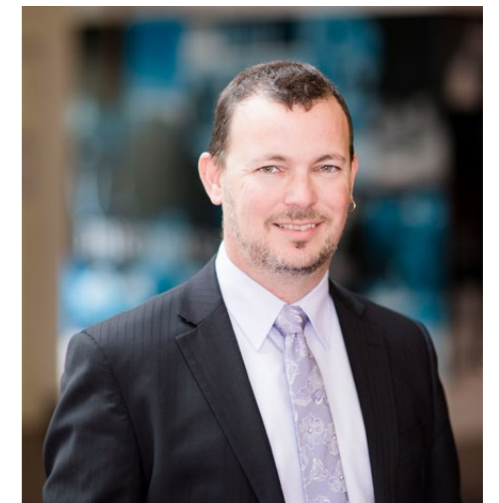
Acknowledgements

Thanks to members of the Mortality Sub-Committee who have overseen the collection of data within each jurisdiction during the 2015-17 triennium.

Thanks also to our New Zealand fellows who assisted in developing and reviewing the report. Anaesthesia-related mortality data in New Zealand is collected within the scope of perioperative mortality thus could not be analysed with the reporting templates used by Australian jurisdictions. However, the committee continues to work towards developing datasets that will allow for binational comparisons in future reports.

Efforts to produce a valid and uniform reporting system is no small effort and thanks must go to all those who have contributed to previous editions of the report, forming the basis on which this report is founded on.

Dr Simon Jenkins
Chair, Mortality Sub-Committee



Access the mortality report

The 11th *Safety of Anaesthesia (2015-2017)* triennial report is expected to be available on the ANZCA website by the end of April 2021

ANZCA Mortality Sub-Committee

- **Dr Simon Jenkins**, Chair Mortality Sub-Committee and South Australian Anaesthetic Mortality Committee
- **Professor David Story**, Chair, ANZCA Safety and Quality Committee
- **Dr Jennifer Bruce**, Chair, Anaesthetic Mortality Committee WA Council on Anaesthetic Mortality and Morbidity
- **Dr Andrea Kattula**, nominee, Victorian Perioperative Consultative Council
- **Dr Carl D'Souza**, Chair, Special Committee Investigating Deaths Under Anaesthesia in NSW
- **Dr Margaret Walker**, Tasmanian Audit of Anaesthesia Mortality of the Tasmanian Audit of Surgical Mortality
- **Dr Kerry Gunn**, Chair, New Zealand Perioperative Mortality Review Committee
- **Dr Carmel McInerney**, ACT Audit of Surgical Mortality, representative
- **Dr James Troup**, Chair, Queensland Perioperative and Periprocedural Anaesthetic Mortality Review Committee
- **Dr Philip Blum**, Northern Territory Audit of Surgical Mortality representative
- **Dr Peter Roessler**, Director of Professional Affairs Policy
- **Dr Vanessa Beavis**, ANZCA President (ex officio)

Anaesthesia registry enhanced

THE DAYCOR (Day Care Anaesthesia Outcomes Recording) Registry is about to be bolstered with a new version of the DayCOR adult survey which has already received 100,000 responses. The enhanced survey includes new features.

With healthcare issues an ongoing challenge for 2021 DayCOR can provide assistance on a range of measures such as:

- An updated general survey with an option of recording degree of frailty and the reason for requesting urgent assistance in the first 24 hours.
- A survey for assessment of complex day stay cases, for example, arthroplasty.
- Assistance with bundling outcomes through a short stay care outcomes recording survey (ShSCOR) survey.
- Convenience for noting variance (for administration statistics).
- Indication of the quality of patient reported outcome measures (PROMS) style responses and the high frequency of positive remarks.
- Quantification of negative observation factors.
- Identification of issues which may relate to the use of inexperienced staff for evening waiting list reduction strategies: prolonged time taken for a standard case, prolonged recovery times.

Healthcare issues for 2021 include:

- The delayed diagnoses of serious surgical diseases are yet to be comprehended and fully measured.
- Bundled payment models are confusing and in need of a great deal of discussion before their acceptance.
- Many elderly people are planning on staying at home with appropriate government funding, and the numbers expecting to do this are far in excess of those contemplated a year ago.

DayCOR provides 24-hour post discharge information for the patient's anaesthetist, surgeon/proceduralist, hospital administration and nursing staff through:

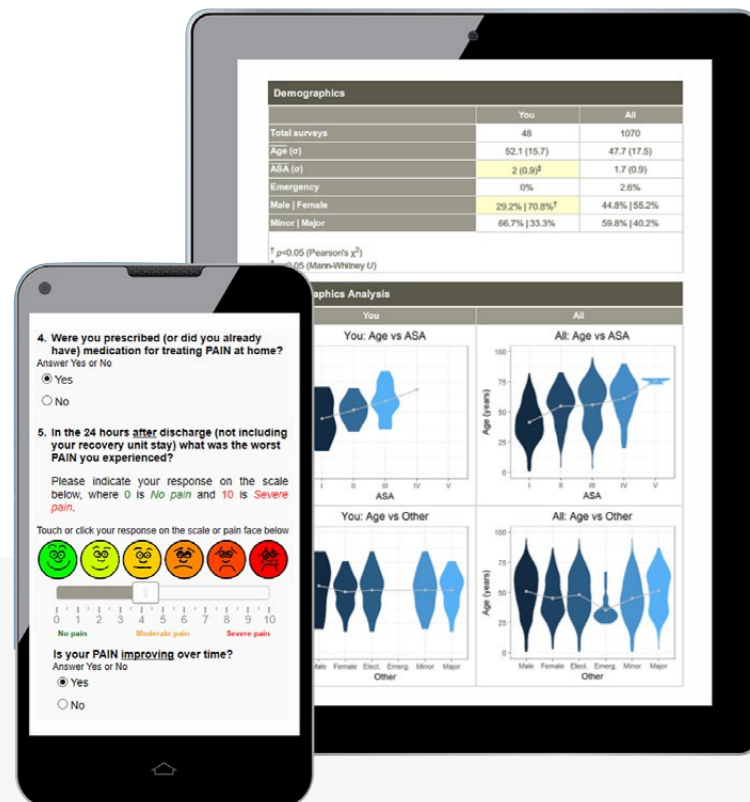
- An alert emailed to the anaesthetist and hospital/day care centre for problems identified in the survey.
- An early warning to the surgeon/proceduralist following receipt of an appropriate alert.
- Accurate satisfaction data through responses to three questions: positive comments, negative comments and observations.
- The structure of the above questions allows free, and if desired, flowing comment in each of the boxes far exceeding the value of selecting the "best" answer from a number of predetermined answers.
- Requirements for the recording of variance.
- Publication of the answers of 61 per cent of surveys with positive comments are a great morale builder for a busy service.
- Publication of the 7 per cent of surveys with a negative comment provide an excellent opportunity for education of all participants involved in a patient's care.
- Suggestions can be of great value – from a considered negative comment to a completely new thought on the experience.

A short stay care outcomes recording survey (ShSCOR) is available and can easily be modified to suit individual groups. The survey will cover short stay outcome activity, helped by patients understanding the process.

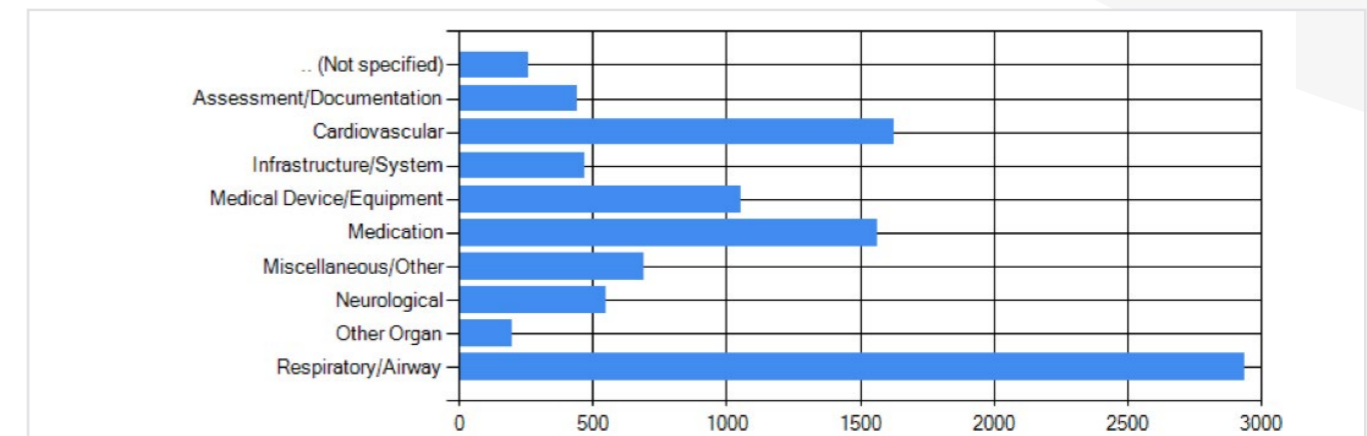
In addition to providing better evidence for day case outcomes and their improvement where necessary, there is an abundance of suitable material being collected which would satisfy research opportunities.

DayCOR Registry II Ltd is a not-for-profit company and recognised for research activities through Bellberry Health Research Ethics Committee approval.

Dr Ken Sleeman MB BS(Hons) FAMA FANZCA
Clinical Director and Chairman DayCOR Registry II Ltd
www.daycorregistry.com.au



WebAIRS update



Medication error

MEDICATION IS THE third most common category of incidents reported to webAIRS and forms 16 per cent of all the incident reports. However, while many of these are related to errors of commission, such as look-alike-ampoules, syringe swaps and distraction, there are still a number that are errors of omission. The Australian and New Zealand Tripartite Anaesthetic Data Committee (ANZTADC) Publications Group have recently added a case to the Advisory Notices for Anaesthetists (ANA) – Alerts, on the webAIRS website where, following an uneventful intravenous induction of anaesthesia, the anaesthetist inadvertently failed to turn on the vapouriser. After a few minutes, the patient moved as the suxamethonium started to wear off, and atracurium was given. Fortunately, this prompted the anaesthetist to check the vapouriser before the surgery commenced. Propofol and midazolam were given to rapidly deepen the anaesthesia and after the procedure there was no explicit recall.

The contributing factors reported included fatigue, the absence of a bispectral index (BIS) monitor, the absence of a physical vapouriser, that two anaesthetists were present, and that the use of volatile anaesthesia might be declining with the increased use of total intravenous anaesthesia (TIVA). The latter factor in turn means that an automatic cross check of volatile anaesthetic levels might be declining.

The anaesthetist submitting the report asked a question regarding the best medication for achieving retrograde amnesia. Midazolam and propofol are both associated with anterograde amnesia, but the degree of retrograde amnesia is either short or absent. The possible use of ketamine was also mentioned and would appear to have short retrograde amnesic effects in an animal study (see reference). However, although ketamine can be used as a sole anaesthetic drug providing both analgesia and dissociative effects, it does have a number of side effects, which have limited its suitability for widespread use.

In conclusion, incidents of this nature are probably quite frequent, although not commonly reported to webAIRS. Fatigue, distraction, and multiple anaesthetists in the team are some of the possible contributing factors. In order to avoid similar incidents in the future, a structured approach should be applied to induction of anaesthesia and then the maintenance of anaesthesia. This could be accompanied by a mental checklist at the various stages of anaesthesia, as well as regularly scanning the monitors, the ventilator settings, and the anaesthesia delivery system.

ANZTADC Case Report Writing Group

Reference

Ketamine induces anterograde and retrograde amnesia in rats (PDF) Ketamine induces anterograde and retrograde amnesia in rats (researchgate.net)

Implementation of small bore neuraxial connectors

The Australian Commission on Safety and Quality in Health Care is co-ordinating a process to develop guidance and support on the implementation of neuraxial connectors. Representatives from states and territories have been nominated to participate in the neural connector device working group (NCDWG).

The introduction of the neuraxial connector devices has been slowed by the COVID-19 pandemic as evident from jurisdictional feedback on the availability of device components to complete end-to-end procedures.

Latest clinical indicator report released

THE AUSTRALIAN COUNCIL on Healthcare Standards (ACHS) has released the 21st edition of its *Australasian Clinical Indicator Report* (ACIR).

Published annually, the ACIR summarises clinical indicator (CI) data submitted to the ACHS Clinical Indicator Program for the previous eight years.

Data are submitted by healthcare organisations (HCOs) in New Zealand, in every Australian state and territory, and member organisations in Asia. Public and private sector HCOs are represented, as well as those from metropolitan and non-metropolitan regions.

The ACIR highlights important trends or variations in the data over time, which may help HCOs identify areas of potential practice improvement. The report also provides commentary from medical colleges, associations, specialist societies and other clinical organisations, in order to provide context to the trends and variations in the data.

Expert working parties developed the CIs. These working parties included practising clinicians, representatives from relevant medical colleges, associations and societies, consumer representatives, statisticians and ACHS staff.

Associate Professor Joanna Sutherland, deputy chair of the college's Safety and Quality Committee, headed up the ACIR Anaesthesia and Perioperative Care CI working party for this latest edition (2012-2019) and provided the expert commentary which forms the introduction to the chapter on anaesthesia and perioperative care CIs.

Associate Professor Sutherland comments that the process of developing and implementing clinical indicators is not necessarily straightforward. "The ideal indicators that are useful to clinicians who wish to drive change and improvement will be evidence-based, sensitive, specific, patient-centric and easy to collect. For perioperative care, such indicators are surprisingly difficult to identify, and may range from unidimensional process measures, to more complex measures reflecting organisational culture and ability of organisations to learn and to self-transform."

The ACIR identifies eight CI sets that showed improvement "in at least two-thirds of all significantly trended CIs". These included anaesthesia and perioperative care, as well as day patient, emergency medicine, gynaecology, hospital in the home, hospital-wide, infection control and intensive care (p.10).



Associate Professor Joanna Sutherland

In relation to trends in anaesthesia and perioperative care, Associate Professor Sutherland notes that indicators that better reflect team-based performance (rather than the performance of individual anaesthetists) are likely to be more useful, and better align with patients' expectations of high quality care.

"The input of patients/consumers to the process of indicator selection is an important feature of the work of ACHS. The perspective of patients always brings the focus of the working party back to what is important to patients, rather than primarily to what is of interest to clinicians. On the best days, the two will coincide!"

Further information and a full retrospective report for each clinical indicator set is available on the ACHS website.

References:

Australian Council on Healthcare Standards (ACHS). *Australasian Clinical Indicator Report: 2012-2019: 21st Edition*. Sydney, Australia; ACHS; 2020.

Leaps -AND- Bounds

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"I am so proud of the 2021 ASM ROC, their ability to adapt and keep striving forward in what was, IS an uncertain time to be planning meetings has been nothing short of inspirational!"

Associate Professor Chris Ball,
2021 ASM Convenor



"Be sure to tune in for the final session; Anaesthesia Hypotheticals will see Dr Simon Hendel guiding a multidisciplinary panel of experts as they negotiate an ethically and morally difficult scenario set in the middle of the COVID lockdown."

Dr Lachlan Miles, Scientific Convenor

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"Our SIGs have embraced the new world of online meetings – live fast paced 60-minute Q & A sessions with your chance to engage in real time with leading experts."

**Associate Professor Lis Evered,
Deputy Scientific Convenor**



"We're really grateful to all the workshop facilitators who have donated their time and expertise to bring this program together. There's been some real innovation from the team to make this happen."

**Associate Professor Stuart Marshall,
Workshops Co-Convenor**



"Welcome to the Melbourne ANZCA ASM... 2021-style! Our innovative presenters have generously given their time and expertise to work with us in producing workshops we hope will engage and inspire delegates. We look forward to hosting a reimagined ASM that embraces online learning in Leaps and Bounds!"

Dr Jane Anderson Workshops Co-Convenor



"Not only do you get 95+ hours of scientific content, you can also get social at an ENGAGE hub and in the virtual world... be sure to register for an optional activity and open the door to all Melbourne has to offer"

**Dr Rabb Salarzadeh, 2021 ASM Social
Convenor**



"We'll celebrate the evolving art which is pain medicine and the nexus between overlapping specialties. We'll aim to showcase different concepts in pain and what we can learn from other specialties who approach their patients in a similar, holistic manner."

Dr Noam Winter, FPM ASM Scientific Convenor



"A total of 183 submissions were received for the 2021 ASM call for abstracts. The review committee was very impressed with the high quality of submissions and research undertaken in anaesthesia and pain medicine during the past 12 months. We are excited to be able to share this research with delegates and encourage them to attend moderated prize sessions and check out the ePosters"

Dr Marissa Ferguson, ePoster Convenor



"The ANZCA ASM being virtual this year is a great opportunity for those of us that work further away from a city to be part of the main event. If you work in a small department it can be difficult for more than one person to attend the ASM, this year you can even have an evening "watch party" and gather together without hitting the highway."

**Dr Helen Roberts, Rural representative and
HCI liaison**



"The Q&ANZCA live panel sessions are not to be missed – surgical oncology, publishing what and why, and the highly anticipated COVID-19 operational responses and challenges. Be sure to be online to ask your questions."

Dr Tuong Phan, Deputy Scientific Convenor



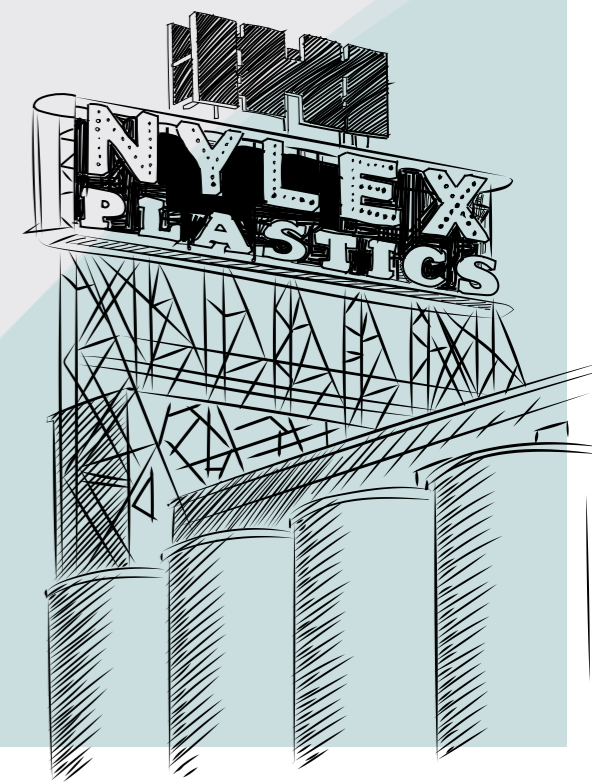
"Full Registration equals an automatic knowledge and skills 24 credit upload to your ANZCA CPD portfolio. Easy. Targeted interests viewed online post meeting will bundle in extra credits, add that content manually. Simple. A cornucopia of adult learning at your fingertips. Invaluable."

**Dr Debra Devonshire, ANZCA Councillor,
Chair CPD Committee**



"The 2021 ANZCA ASM promises to be an exciting and innovative event. As the trainee representative I'm particularly looking forward to the ANZCA and FPM trainee evening where Dr Nick Coatsworth will discuss leadership and communication in medicine and his own wide-ranging career path. Register and book your attendance now"

Dr Peter Stark, Trainee Representative



ANZCA's prof docs

What would you do?

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



The SARS-Cov2 pandemic led to the imposition of many and harsh restrictions, and emerging from those has presented ongoing challenges. During this time, our college demonstrated leadership in relation to developing its position statement on personal protective equipment (PPE). This is not an isolated instance of such leadership as evidenced by the college's commitment to promoting standards through the development of professional documents and publications, some of which are referenced by other international colleges as well as regulatory authorities.

At the individual level, as anaesthetists we are exposed to situations where leadership is required, whether it be in clinical settings, advocacy roles, research, or professional activities. Leadership skills are essential in order to be effective leaders.

Scenario

You walk into your theatre where you find your anaesthesia trainee demanding an item of equipment from the anaesthesia assistant who is unable to locate the item, whereupon the discussion gets a little heated. You intervene and defuse the issue. However, after commencement of surgery you notice the trainee and anaesthesia assistant staring "daggers" at each other as well as occasionally exchanging cutting remarks (not referring to the surgery). This eventually gains the attention of the surgeon who looks up.

What would you do?

Clearly, this is a setting in which distractions can compromise patient safety. It raises the question as to the roles anaesthetists play and in particular, that of leadership. While proceduralists need to be free to focus on skilful performance of procedures, anaesthetists are required to maintain vigilance and in that role are better placed for situational awareness.

We like to think of ourselves as leaders. My take on leadership is that it is both an attribute and skill desirable in all players/members (medical, nursing, and community) of any team that comes to the fore at times of need. Leadership training is included within the ANZCA Training Program section 1.4 Leader and Manager. It is also one of the many criteria considered when assessing specialist international medical graduates (SIMGs).

Reflecting on anaesthesia and perioperative medicine as careers it is evident that leadership skills are advantageous across a range of activities including roles within organisations as well as those involved with direct patient care. As anaesthetists we do not work in silos – we engage with the community at varying levels. Nor do we work in a vacuum. We function within theatre teams and multidisciplinary teams.

The term leadership has been defined in many ways including "the ability of an individual, group, or organisation to 'lead', influence, or guide others"; or "the art/skill of motivating people to act toward achieving a common goal".

However, a couple of my favourite quotes that capture the principles of leadership include:

"Of all the things I've done, the most vital is co-ordinating those who work with me and aiming their efforts at a certain goal." – Walt Disney, founder of Disney

"The pessimist complains about the wind. The optimist expects it to change. The leader adjusts the sails." – John Maxwell

These two epitomise the essential characteristics of leaders in bringing out the best from their team working towards a shared common goal while remaining calm and effective no matter what the circumstances. Feedback from medical and nursing colleagues about an anaesthetist's performance affirms the positive impact of such behaviour and ability.

In my days of playing soccer, whenever we faced opponents with clearly better skills, I would point out to my team that a champion team can defeat a team of champions. Evidently, there were times when my side was not a champion team!

Good leadership promotes standards, which in turn guides safety and quality. Clinical performance, cultural safety, and environmental issues are all areas where anaesthetists can demonstrate leadership.

Self-evaluation of contributions as leaders can be challenging. Fortunately, continuing professional development (CPD) provides opportunities for ongoing development and evaluation of leadership skills. The audit section of CPD Practice Evaluation facilitates this ability.

PS58 Guideline on quality assurance and quality improvement in anaesthesia (2018) provides a framework for developing quality assurance and quality indicator programs, the outcomes of which can then be compared against a benchmark/standard.

In addition to professional documents fostering the aspect of leadership, ANZCA's booklet *Supporting Anaesthetists' Professionalism and Performance – A guide for clinicians* provides examples of good and poor behaviour relating to leadership in the "Leader and Manager" section.

In returning to the scenario presented above, how would you have demonstrated leadership in that instance? It might be illuminating to compare your actions/behaviour with that of some of your colleagues.

As a final thought, the two words springing into my mind that reflect core actions of leaders are "Inspire" and "Empower". What are yours?

New document on minimum facility requirements

THE DIRECTOR OF your anaesthesia department has asked you to co-ordinate the relocation and activation of a new endoscopy suite for gastroscopies and colonoscopies. You have to work out the appropriate anaesthesia staffing, the equipment and to make sure all the emergency medications are available. Where do you start?

The new professional document *PS55 Position statement on minimum facilities for safe administration of anaesthesia in operating suites and other anaesthetising locations* and the accompanying background paper (*PS55BP*) are now available for guidance to help with situations like this.

The document was produced not only to outline the services required for the safe functioning of an operating theatre but to reflect the fact that an increasing volume of anaesthesia workload is "off the floor". These locations such as endoscopy and radiology suites are away from the traditional anaesthesia environment and pose unique challenges depending on the intended type of activity.

Anaesthesia staffing is the first consideration, ensuring that an adequate number of staff with anaesthesia experience are present. Furthermore, there should also be consideration of the number of people needed to move the patient should an emergency occur. Our patients vary in size from under 1 kilogram to well over 100k kilograms, they may have complex injuries, invasive monitoring or other requirements that make positioning difficult. These complexities need to be taken into account when deciding how many people will be needed. In some settings, more than one consultant anaesthetist may be required because of the unique skill sets needed to manage the case.

The physical set up of the location including electrical supply, temperature management and exits are key

considerations. Apart from adequate access to telecommunications to call for assistance when needed, *PS55* now strongly suggests that mobile phone reception and internet access should be available everywhere that anaesthesia is delivered. Because guidelines and emergency protocols may change frequently and medical knowledge is doubling at a rapid rate, it is important that access to up-to-date information is always readily available.

There is a minimum set of equipment that will be needed in any clinical setting where anaesthesia is provided. These items relate to airway management, intravenous access, monitoring, personal protective equipment and management of emergency situations. The purpose of the location must also be taken into consideration when identifying what additional stock is included. In our example of the endoscopy suite, it may be decided that volatile agents and muscle relaxants are not to be given routinely, therefore an anaesthetic machine might not be required. However, if intravenous anaesthesia is to be given, it is advisable that a programmable pump is available.

Similarly, in our example, the medications and equipment required for an endoscopy suite are unlikely to include items relating to obstetric, cardiac or major vascular procedures. For example, uterotonic drugs will not need to be stocked. Chest tubes may also likely be unnecessary. One substantial change to previous guidelines is that dantrolene does not need to be stocked when triggering agents such as volatile anaesthetic agents and suxamethonium are not routinely used. The risk of malignant hyperthermia is likely to be exceedingly rare in locations where these drugs are not in use such as in a gastrointestinal endoscopy suite.

Other emergency drugs that should be present are listed in appendix 1 of the position statement. The medications



are representative of medications found in endorsed guidelines for the clinical emergencies listed. As noted, some of these may be omitted if not deemed appropriate for the cases performed in the clinical setting. Where dantrolene is kept, the document is now prescriptive in how much must be available and within what timeframe. Not all of the dantrolene need be present in the one location as long as there is a strategy to access it as required.

After using the position statement to identify what should be in the new clinical area, simulation testing of different emergency scenarios should be undertaken to ensure there are no unforeseen problems. These should include urgent movement of the patient out of the facility in an emergency if required for ongoing management. It is ideal if simulation can be performed as early as possible in the design process, but this is rarely the case.

Position statements are designed to set expectations and drive change within the profession. We hope the new *PS55* position statement helps guide fellows and departments to provide, safe and effective environments for the provision of anaesthesia.

Dr Stu Marshall, FANZCA
ANZCA Councillor and *PS55* Document Development Group - Lead

Difficult airways equipment guidelines updated

Scenario

You have just induced your patient for an elective laparoscopic cholecystectomy. She is a healthy, slightly overweight patient without any significant past medical history.

She is difficult to ventilate using the face mask and you ask for an oro-pharyngeal airway. Unfortunately, it does not significantly improve your ability to ventilate. You quickly run through the cognitive aid and attempt alternative methods. You call for help, and the difficult airway trolley (DAT). A senior registrar arrives, but it takes some time before the DAT arrives. When it finally does, the anaesthesia nurse frantically searches its contents but cannot find the device requested.

PS56 Guideline on equipment to manage difficult airways was previously released in 2012 and was based on recommendations from an expert panel that was established in 2008.

While this guideline has been shown to be highly effective, its weakness, like all guidelines, is that over time it becomes outdated. Airway management has witnessed fundamental changes since its publication. New devices and technologies are continually emerging, while previously recommended devices are being withdrawn or are no longer considered to be first line.

The importance of human factors and the application of cognitive aids have been recognised and influence anaesthesia practice in all aspects of airway management. The newly updated guideline is a living document with the intention of being contemporary and forward-looking towards new developments.

The scope of the guideline applies to adult, paediatric and obstetric DAT requirements across all critical care areas, in all healthcare settings. One aim of updating *PS56* was to simplify and standardise airway equipment across clinical areas. Such standardisation addresses the human factors concerns arising during crises. Nevertheless, while it is advised that equipment choice should be simple to assist quick decision-making processes in a crisis, it is equally important not to oversimplify and potentially omit essential devices.

A critical aspect of the updated guidelines is the sub-classification of equipment into essential and non-essential components. This separation recognises location-specific nuances and ensures that DATs are fit for purpose for each area.

Recommendations for design features and labelling and the attachment of difficult airway management algorithms and cognitive aids complement the guideline.

Development of such a vital resource requires effort, time, expertise and collaboration. A committee



of acknowledged airway experts from all critical care areas, including intensive care medicine and emergency medicine across Australia and New Zealand was established to review the literature published between 2009 and 2019. Difficult airway guidelines and recommendations from established organisations worldwide were included. An extensive review of the evidence was undertaken, and recommendations were based on the level of evidence. It was considered important to ensure, as much as possible, that recommendations were suitable for all clinical applications ranging from rural hospital, private centre to tertiary centre in Australia and New Zealand.

Experts, organisations, committees and special interest groups were consulted during the review including paediatric and obstetric anaesthesia, intensive care medicine, emergency medicine and airway leads across Australia and New Zealand.

PS56 and its accompanying background paper (*PS56BP*) are in their pilot phase until May 2021 during which time feedback is invited.

The final version should serve as a valuable resource in forming the foundation for all DATs. The collaborative approach taken across all relevant specialities and geographical locations should ensure this.

After all, regardless of the site, it is paramount that patient safety has priority and that we provide the highest standard of care and equipment wherever airway are managed.

Dr Yasmin Endlich, FANZCA
Chair, Airway Management Special Interest Group
PS56 Document Development Group - Lead

*The author wishes to acknowledge Dr Peter Roessler and Dr Phillipa Hore for their assistance in co-editing the final pilot version of *PS56*.*

Remembering a fellow who made a global impact

BERNARD BRANDSTATER WAS born in Perth where his father Roy was a pastor. His family were originally from Tasmania with his great grandfather settling there after coming from Prussia in the 1870s.

In 1945 Bernard was accepted into medical school at the University of Adelaide on a full scholarship. In 1952, after graduation and internship, he was awarded a Fulbright scholarship for post-graduate study in the United States, undertaking his residency training in anesthesiology at the University of Pennsylvania in Philadelphia, with further training at St Thomas' Hospital and Eastman Dental Hospital in London. Later he spent a year as a research fellow in the Cardiovascular Research Institute at the University of San Francisco. In the 1960s he published on volatile anaesthetic agent MAC with Ted Eger and Lawrence Saidman and did work on cerebral blood flow at altitude with John Severinghaus.

In 1956 he joined the department of anesthesiology at the American University of Beirut in Lebanon, later becoming the founding chair at age 29. He started their residency program, founded their obstetric epidural service doing the first 1000 epidurals himself and also designed, made and implemented a new multi-orifice disposable epidural catheter, which is what we use today. Bernard was the founding editor of the *Middle East Journal of Anesthesiology* in 1966 and this journal is still published. He also organised the first international anesthesiology conference in Beirut and was a personal physician to the King of Saudi Arabia.

One of Bernard's pioneering contributions in Beirut was to develop prolonged endotracheal intubation in neonates and infants with respiratory failure, often secondary to tetanus. This was ground-breaking work as infant tracheostomy had a high complication and mortality rate. His first paper was published in 1962 and discussed the management of 12 infants having prolonged intubation for up to seven weeks. They used a Harvard piston-pump that was originally designed to ventilate small animals with room air for research. He also published on the effects of tracheal suction on lung mechanics in these infants. This work was followed on by the pioneering research of Tom Allen and Ian Steven at the Adelaide Children's Hospital and Ian McDonald and John Stocks at the Royal Children's Hospital, Melbourne.

In 1969, Bernard became professor at Loma Linda University in California and chair of the newly formed department of anesthesia in 1971. He subsequently built a strong department with an emphasis on research as integral to its residency training. This was expanded to include post-graduate dentists and nurses. He was fully engaged with other faculty on campus serving in various roles, all with the vision of promoting a broader spiritual vision of the church and University.

Bernard was one of a small group of Australians by birth who have made international contributions to our specialty throughout their overseas working life. However, he never forgot his antipodean origins and always maintained contact with Australia and attended



Dr Gwen Wilson and Dr Bernard Brandstater in 1994.

meetings here. He attended the Australian Society of Anaesthetists meeting in Canberra in late 1962 and sat and passed the FFARACS exam in February 1963 being fellow number 229. This later converted to FANZCA in 1992 upon the founding of the college.

Bernard had a love of medical history and archaeology and spoke at the first annual scientific meeting of the college in Tasmania in 1994. Here he presented our college with a 1558 edition of Hippocrates. This 800-page Latin translation from the Greek is titled *Hippocratis Coi Medicorum Omnium Longe* and was published by Frobenius in Switzerland.

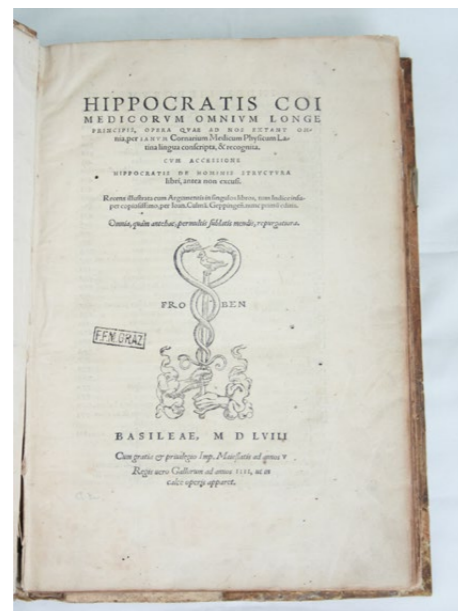
Dr Brandstater returned to Sydney in January 2013 to attend the 8th International Symposium on the History of Anaesthesia, presenting on his work of prolonged infant intubation 50 years later. He also gave a talk titled "Hippocrates come to ANZCA" at the subsequent Geoffrey Kaye Symposium at the college in Melbourne.

Bernard was accomplished in many areas. He loved music, playing several instruments, he wrote poetry and used Hamlet's words as the motto for the anaesthesia journal he founded, "For some must watch, while some must sleep". He was adventurous, serving as camp manager of an archaeological excavation in Jordan. He climbed mountains including the Matterhorn and Aconcaqua in Argentina; and he crewed on one of the tall ships during the First Fleet re-enactment in 1988 from England to Australia. Bernard's later years found him still practicing anesthesia part time as he never lost his love for teaching students his tried-and-true techniques.

Bernard Brandstater will be remembered as a hard-working, resourceful and committed leader, a bold visionary and articulate public speaker. Much of his success was due to his personal qualities of warmth, compassion and his constant cheerful disposition. Bernard was outgoing and enjoyed engaging with people in storytelling. Most of all he was known for his love for life and sharp Australian wit. He is survived by his wife Beverly, four children and seven grandchildren.

Bernard admired Oliver Wendell Holmes, physician and poet who coined the word "anesthesia". His words capture Bernard's personality and spirit. "It is required of a man that he share the passion and action of his time, at peril of being judged not to have lived." Bernard Brandstater lived well.

Dr Michael Cooper, FANZCA
Sydney



This 1558 edition of Hippocrates was donated by Bernard Brandstater to ANZCA in 1994.

“Bernard Brandstater will be remembered as a hard-working, resourceful and committed leader, a bold visionary and articulate public speaker.”

Structured return to work guidelines are key to a successful transition

South Australian provisional anaesthesia fellow Dr Julia Cox describes how structured, return to work guidelines helped her transition back to the frontline after the birth of her second child.

RETURNING TO WORK after maternity leave presents a series of confounding challenges for the working mother, perhaps even more so for the working medical mother.

During my training in anaesthesia, I have experienced these challenges on two occasions – once as an advanced trainee prior to the final exam, and more recently, as a provisional fellow, so I can certainly attest to these challenges firsthand.

Crucially, I have been fortunate to be the beneficiary of a comprehensive, structured return to work guideline which has been thoughtfully developed by the Department of Anaesthesia at Flinders Medical Centre in South Australia and this has made a significant difference to my transition back to full-time work after a second round of maternity leave.

This guideline was developed by consultant anaesthetist Dr Marni Calvert with Deputy Director of Anaesthetics Dr Anthony Guterres, and is based on a survey Dr Calvert conducted in 2019 (“The Experience of ANZCA Fellows and Registrars Returning to Work Post-Maternity Leave”, unpublished), and the ANZCA *PS50 Guideline on return to anaesthesia practice for anaesthetists*. Importantly, the Flinders Medical Centre Anaesthesia Return to Work Guideline and PS50 are equally applicable to anaesthetists returning to work after any period of absence.

My return to work was accompanied by a number of cognitive, physiological, emotional, physiological and social concerns. I was worried about my capacity to return to work at my prior capability, and indeed when I actually returned to work, I felt that I had regressed from an “unconscious competence” level of practice to a “conscious competence” level.

“Although “it takes a village to raise a child” it also takes a village to raise a mother”

I found I was thinking sequentially rather than in parallel, which had consequential impacts on my situational awareness, my efficiency and my confidence. Additionally, the COVID-19 pandemic unfurled while I was at home so I felt I had missed out on the opportunity to adequately prepare and upskill accordingly. My training trajectory (in particular the final exam) was delayed by my first maternity leave, and the timing of my second maternity leave had a disappointing but unavoidable influence on my fellowship pathway. I worried (and remain so) about the impact that maternity leave (and raising my family) might have on my training and career progression.

Physiologically, I was battling severe sleep deprivation and fatigue as a consequence of frequent overnight wakings. I was still breastfeeding and had to consider how to negotiate expressing breastmilk while at work. Emotionally, I was torn between the “duality of motherhood” where the desire to return to work and my own independent sense of identity was counterpoised with the regret of leaving my babies and the potential for missing milestones.

In terms of social challenges, I was concerned about the capacity for workplace flexibility when it came to organising childcare arrangements due to shift work, and what perceptions work colleagues might have when I needed to take carer’s leave for unwell children. There is also the underestimated burden for any mother returning to work of the so-called “invisible workload” – the responsibility of remembering (and in most cases performing) the bulk of the intellectual, cognitive and emotional work of childcare and household maintenance. And finally, outdated negative workplace perceptions about mothers returning to work persist, so the pressure to “prove one’s worth” is high.

Although “it takes a village to raise a child” it also takes a village to raise a mother, and the structured work plan developed by the Department of Anaesthesia at Flinders Medical Centre provided a strong scaffolding to support me on returning to full-time training. The components to this scaffolding were simple, yet comprehensive and effective.

I was allocated a dedicated support person (in fact, as the first beneficiary of this program, I was fortunate to be allocated two). I nominated these mentors from a list



Dr Julia Cox (left) and Dr Marni Calvert.

of enthusiastic and committed volunteer consultants who had expressed interest in this role. These relationships have been invaluable keystones for guidance, advice and support on returning to work.

There was a carefully planned, graded return to work. Immediately before, my official return-to-work start date began with three weeks of “keeping in touch days”, which is a federal government mandated provision designed to enable employees on unpaid parental leave (on negotiation with their employer) to access up to 10 flexible days of paid work for the purposes of staying connected with the workplace, refreshing or updating skills, or facilitating transition back into work.

I used these days to re-familiarise myself with the theatre environment, and “gently” return to clinical work without the pressure of holding sole responsibility for the care of a patient. There was genuine one-to-one supervision, with a mandated minimum of 10 “buddy shifts” upon returning to work. These buddy shifts involved identification of clear goals (for example obstetrics, paediatrics, airway skills) and as I was not on the visible roster, I was considered truly “supernumerary”. These keeping-in-touch days also provided an opportunity to re-skill and upskill for emergency scenarios. I underwent simulation training,

focussing on advanced life support skills, Can’t Intubate Can’t Oxygenate course training and specific COVID response training.

My apprehensive request for flexibility of work days was welcomed and easily accommodated, with Fridays becoming a weekly allocated rostered day off. This proved invaluable in facilitating childcare arrangements. I was offered the option to return to work part time with the provision that if I did opt for part-time training, my access to teaching opportunities would be protected and preserved. However, on balance, I felt returning to full-time work would enable a more efficient completion of my training with flow-on benefits for my family.

I received a thorough re-orientation on returning to work (even though I had previously worked there on multiple occasions). For the first four weeks after my official return, the rostering system was carefully arranged to minimise my exposure to after-hours shifts, and I subsequently re-commenced night shifts shortly after resuming a full roster of after-hours work. Consultant anaesthetists in the department transition back on to the on-call roster two to three months after returning to work. Finally, I was supported with my efforts to continue breastfeeding, with access to an appropriate expressing

We’d like to hear from you

ANZCA wants to hear 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.

environment (including all essential equipment – one of the perks of working in an obstetric hospital) and allocation of breaks to facilitate this.

Returning to work after maternity leave is complex and challenging on multiple levels. From my perspective, the keys to facilitating this transition include understanding and empathy as part of a thoughtful, structured return-to-work program.

Dr Julia Cox, provisional fellow
Flinders Medical Centre

**If you would like further information on the structured return to work program developed by the Department of Anaesthesia at Flinders Medical Centre, please contact Dr Marni Calvert at Marni.Calvert@sa.gov.au.*

- The ANZCA *PS50 Guideline on return to anaesthesia practice for anaesthetists* can be found on the college website.
- Information about keeping in touch days: www.fairwork.gov.au/leave/maternity-and-parental-leave/when-on-parental-leave/keeping-in-touch-days.
- Information on how to create a workplace that is supportive of breastfeeding: www.breastfeeding.asn.au/workplace.

Making the most of your offshore experience

Taking the plunge to apply for an overseas training position can be daunting. Here, four anaesthesia fellows explain what's involved and provide some useful and practical tips for the UK.

OVER THE PAST decade medical regulators and immigration restrictions have progressively made this reciprocal experience more difficult to undertake, and the process for spending some time training overseas may now seem quite daunting.

The number of anaesthetists that spend some time training outside of Australia is relatively low. For example, the number of approved overseas provisional fellowship trainees (PFTs) in anaesthesia over the past few years is shown below. Some anaesthetists may undertake overseas training after completion of FANZCA, which won't be captured below.

- 2020: Nine trainees (15 trainees planned for training overseas but six of them withdrew due to COVID restriction).
- 2019: 18 trainees (out of 302 new fellows for this calendar year, this is just 6 per cent of cohort).
- 2018: 17 trainees
- 2017: 18 trainees
- 2016: 29 trainees

Sub-specialised anaesthesia training usually requires at least one year of post-fellowship experience to gain exposure to complex cases and develop independent practice. While this is usually undertaken at the hospital where one wants a consultant post, there is a lot to gain from spending that year abroad, and for most of us will be the only time in your career where this may be feasible.

Applying for overseas fellowships

Ideally, we recommended making contact with the overseas fellowship coordinators 18 months ahead of your intended start date. Most hospitals in the UK have a well-established pathway for the recruitment and training of fellows. In the UK, positions are advertised on the www.jobs.nhs.uk/ website with job offers being advertised approximately six-12 months ahead of the start date. The Royal College of Anaesthetists (RCoA) has some guidance for international medical graduates at <https://rcoa.ac.uk/about-college/global-partnerships/international-medical-graduates-working-or-training-uk>.

In general, if you have already gained FANZCA, you will need to apply for "Full registration with a licence to practice with a postgraduate qualification" through the medical regulator, the General Medical Council (GMC). If undertaking training in the UK as part of PFT, extra exams in medical knowledge and skills (PLAB test) may

"It is easy to see that after a year enjoying your experience in London one may be tempted to spend a second year abroad."

need to be undertaken as part of your GMC registration. These need to be factored in as extra time is needed and further expenses are incurred.

The UK working visa is organised separately from the GMC application pathway and requires you to have a confirmed position so the hospital can start the process from their end. Having British dual-citizenship helps with not needing to go through this visa process. Below is a timeline of the main steps to complete once your application is successful. This is a simplification of the process so please use the "Find Your Route" questionnaire at www.gmc-uk.org for a more comprehensive description. {insert timeline here}

After completing a year fellowship in the UK, the options are to go back to Australia/New Zealand with new international experience and contacts, undertake another fellowship or progress to a consultant post in the UK. For some of the authors, this involved more than one overseas fellowship (for example, in paediatrics, liver transplantation and cardiac). If you end up staying as a consultant in the UK, you will need to apply for equivalence with the RCoA (known as Certificate of Eligibility for Specialist Registration, or CESR), a lengthy and onerous process.

Hurdles to application and life in the UK

One of the main hurdles we have encountered is delays in visa processing by the UK Home Office. Hospitals are usually accommodating when these issues have arisen but it is important to plan early for these. COVID-19 has placed the UK in a state of uncertainty and created additional hurdles in accessing fellowships. The NHS is currently overwhelmed managing COVID-19 patients and most training positions have been put on hold. Those undertaking overseas fellowships with partners or families also have added challenges (one of the authors and his wife even had their baby born here!).



Clockwise from top: Consultant thoracic surgeon Mr. Kelvin Lau (left) with Dr Lloyd Kwanten at Barts Heart Centre in London; Dr James Preuss; Dr Adi Prabhala.

Pay for senior clinical fellows in the UK is around £47,000 base salary, from this an on-call allowance (up to 50 per cent) and a "London weighting" is added, and there may be the ability to pick up extra shifts on your days off. As expected, the cost of living is generally higher in London than in Australian cities especially when including rent, and for some of us having a good bit of savings before coming over helps with the initial set-up.

Life in London is incredibly vibrant and a world-class city to live in. Offering great food, coffee, nightlife, cultural activities and is great to escape to parts of Europe for long-weekend getaways. It is easy to see that after a year enjoying your experience in London one may be tempted to spend a second year abroad.

Dr Lloyd Edward Kwanten
Cardiothoracic Anaesthetist and Lead for Quality Improvement, Department of Perioperative Medicine, Barts Heart Centre*

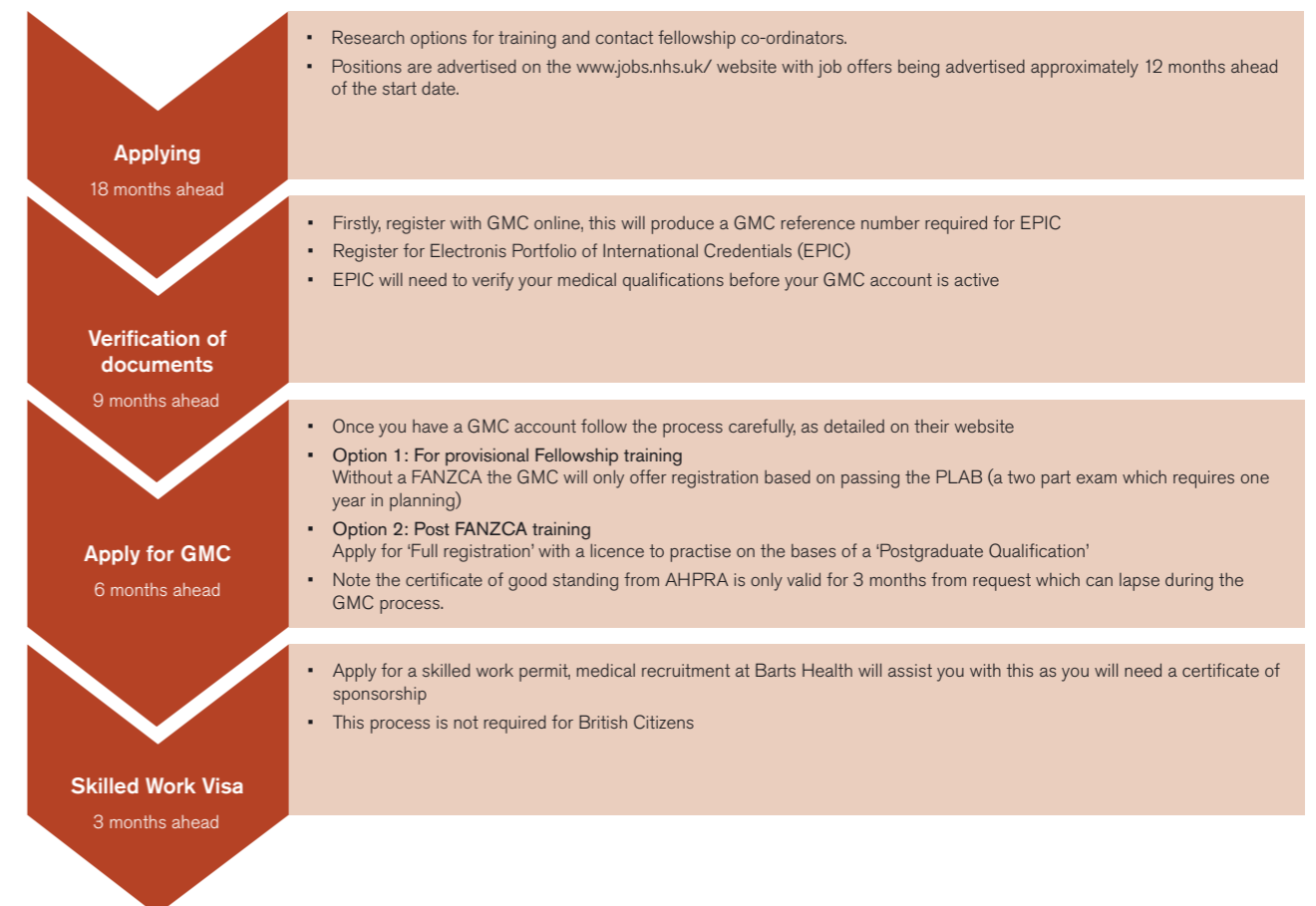
Dr Adi Prabhala
Senior Clinical Fellow in Cardiothoracic Anaesthesia, Barts Heart Centre

Dr Ali Coowar
Consultant Cardiac Anaesthetist, Royal Adelaide Hospital

Dr James Preuss
Consultant Cardiac Anaesthetist, Sir Charles Gairdner Hospital

*Corresponding author: lkwanten@nhs.net

Application timeline – what to do and when



Unforgettable experience at Barts

Dr Lloyd Kwanten, Dr Adi Prabhala, Dr Ali Coowar and Dr James Preuss write about their provisional fellowship year at Barts Heart Centre in London.

MOST OF US have become aware of Barts Heart Centre (“Barts”) through word of mouth. Barts is on the site of St Bartholomew’s Hospital, one of the oldest hospitals in the UK, founded in 1123, and is the only major hospital in the “City of London”.

Barts is one of the newest dedicated cardiothoracic centres in Europe, and it performs more cardiac interventions than any other centre in the world, providing elective and emergency tertiary and quaternary interventional, critical care, and extracorporeal services.

Per year, the centre performs more than 2000 cardiac cases, 1200 thoracic cases, and the most TAVI and EP procedures in Europe. In addition, being the main heart attack centre in London, one is involved routinely in acute coronary interventions.

Sub-specialised training in cardiothoracic anaesthesia is one of the most difficult to undertake with a steep learning curve to gaining independent practice. It may involve exposure and training for congenital heart disease (CHD), thoracics and regional anaesthesia, cardiac and lung transplantation, robotics and minimally-invasive surgeries, aorto-vascular surgery as well as extracorporeal membrane oxygenation, perfusion, cardiac critical care and echocardiography.

Barts offers exposure to a wide variety of complex cardiovascular cases including regular adult congenital heart disease (ACHD) surgeries, a new program for complex aortic interventions and frequent exposure to high-risk surgeries and rare conditions. Emergency cases can include aortic dissection repairs and other emergency cardiac procedures. Barts also performs a large amount of robotic thoracic work, an area of increasing development in Australia and New Zealand. Skills in this area will be very useful in the returning fellow. There is no emergency department or maternity services, which makes this a truly dedicated cardiothoracic site.

The ACHD service at Barts serves the whole of Greater London covering a population of more than six million, typical cases include pulmonary valve replacements in tetralogy of Fallot patients, double chambered right ventricle, partial anomalous pulmonary

vein drainage and double and triple valve surgeries. While a Ventricular-Assist Device (VAD) service has been developed, Barts does not have a heart and lung transplant program. It is worth bearing in mind that most transplant centres in Australia often have a specific way of conducting transplant anaesthesia and, as such, anyone joining these centres will need some upskilling at these centres regardless of fellowship training.

Training in transoesophageal (TOE) and transthoracic echocardiography (TTE) are essential components for a career in cardiothoracic anaesthesia, and there are many avenues to obtain accreditation. The most widely used qualifications are the British Society of Echocardiography (BSE), European Association of Cardiothoracic Anaesthesiology (EACTA) and the US program run through the National Board of Echocardiography Inc (NBE). Accreditation through the EACTA program for example, requires three components – an examination, logbook of 125 cases and five video echo cases. Melbourne University also offers the Graduate Certificate, Graduate Diploma and Masters in Clinical Ultrasound which provides a good basis of clinical knowledge for echo, however there is no practical component.

To ensure competence in TOE it is also essential to gain experience in a variety of cardiothoracic scenarios including complex congenital heart surgery, valve replacement surgery, emergency surgery and assessment of the clinically unstable cardiac patient. Barts provides an excellent environment to obtain a vast and comprehensive skill set through its case mix and excellent teaching program. Obtaining enough logbook cases, even for the US full qualifications, is easily obtained at Barts and there are many quality improvement and research opportunities to get involved in.

It’s not only the clinical skills that assist with obtaining consultant posts back in Australia. There are many opportunities that allow development of non-clinical roles of become a consultant. Barts has a well-established quality improvement and research team, opportunities in managing junior staff rosters, as well as organising the regular and popular “fellows club” teaching

afternoons. The access to many UK and European conferences gives you many opportunities to present posters, reports and research.

Barts anaesthesia fellowship program director, Dr Elizabeth Ashley, is an affable recruiter who is familiar with foreign fellows and the processes. Nine cardiothoracic clinical fellowship positions and one research fellowship are offered each year. These are in six-12 month appointments normally commencing February or August, in line with their clinical year. The majority of international fellows come from the European Union, and so far, four Australian fellows have come for 12-month positions.

Undertaking an overseas fellowship may seem like a daunting undertaking at the beginning. Seeking out and speaking to consultants that have spent some time overseas, you will hear very positive professional and personal stories that are well worth the efforts. You may end up working with the anaesthetist who “wrote the book” in your field.

Not only do you take back to Australia or New Zealand skills and experience, but also contacts from around the world. These connections are important for future research collaborations and can come in handy for the odd piece of advice (“How do you manage anticoagulation in your antiphospholipid syndrome patients on bypass?”). There are many hurdles to undertaking a fellowship overseas, yet there are so many benefits to be gained from shared-learning systems and a transfer of knowledge and skills between countries. We all feel that the personal and professional benefits you will gain by the end of it are invaluable.

Dr Lloyd Edward Kwanten

Cardiothoracic Anaesthetist and Lead for Quality Improvement, Department of Perioperative Medicine, Barts Heart Centre

Dr Adi Prabhala

Senior Clinical Fellow in Cardiothoracic Anaesthesia, Barts Heart Centre

Dr Ali Coowar

Consultant Cardiac Anaesthetist, Royal Adelaide Hospital

Dr James Preuss

Consultant Cardiac Anaesthetist, Sir Charles Gairdner Hospital

Successful candidates

Primary fellowship examination

2020.1 Exam

A total of 122 candidates successfully completed the primary fellowship examination:

AUSTRALIA

Australian Capital Territory

Fabio Longordo

New South Wales

Terrence Desmond Alfred
Hayden Alicajic
Jessica Lee Barry
Mitchell Blake Brooks
Tristram Owen Brown
Daniel Christopher Chilton
Clara Melanie Chung
Michael Peter Connolly
Julian Arie de Jong
Elif Fatma Durur
Kathleen Margaret Fixter
Felicity Annabelle Charlotte Fletcher
Alexander James Garner
Cheng Fai Hui
Jason Bob Kong
Sarah Xin Kong
Deahne Christine Levas
Christopher Sam Long
Christine Huanyi Ma
Belinda Jayne Mahoney
Daniel Crawford Moore
Grant William Moore
Anthony Peter Notaras
Kelly Elizabeth O'Shea
Erica Lee Sanderson
Keshan Savinda Selvarajah
Siobhan Rachel Stone
Patrick Chee Kong Teo
Michael Sebastian Wesley Truelove
Rosie Elizabeth Trumper
Alex Wang
Julia Victoria Whitby
Chloe Una Won
Lukasz Zdanowicz

Queensland

Patrick William Abbott
Anthony David Brown

Robert Henry Burnett
Samuel Joseph Butler
Benjamin Lewis Cahill
Ryan James Devlin
Elizabeth Ann Forrest
John Alan Ham
Leah Andrea Hatton
Esmond Qing Hii
Thomas Joseph Holmes
Samantha Howard
Luke Yao-I Huang
Nathan Robert James
Tyson Byrne Kevin Jones
Tarrant Blythe Kenman
Chia Yuan Lee
Laura Giovanna Panizza
Nicholas David Pawula
Thomas James Pearson
James Henry Phillips
Michael Stuart Quinn
Andrea Senesi
Anthony David Shepherdson
Laura Elizabeth Staples
Casey Luke Steele
Zi Ping Tong
Kathleen Marianne Turner
David Graham Walker
Garry Yang

South Australia

Hayley Marie Adams
Andrew Thomas James Chong
Alexander Dai Ishimaru Dean
Timothy David Hall
Joel Michael Krause
Daniel Hoang Minh Ly
Emma Jane Panigas
Henry David Upton
Kevin Wei Yu

Tasmania

Stuart Maurice Paterson
David Edward Somerville-Brown

Victoria

Craig Robert Beaman
Edward William Bender
Jason Robert Bishop
Charles Martin Chilvers
Alexander Brown Courtney
Laura Mary Elliot-Jones
James Mark Hulls
Yasmeen Kalam
Anthony Leonard Kavanagh
Teck Hock Khoo
Siak Khui Lee
John Chang-Chuan Leou
Curt Jason Peterson
Queennie Faye Reyes
Thomas Lloyd Smith
Anurag Vijay
Lucas Wheat
Julia Jiewen Zhu

WA

Lip Yong Choo
Thomas David Cordery
Clinton Dillon Ellis
Hamish William Johnston
Claudia Marcelle Lagrange
Jolene Shu Ning Lim
Ross McNaught
Declan Charles Jolley Sharp
Elliot Karl Smith
Katherine Pixley Smith

NEW ZEALAND

Wee Choen Ang
Siddhi Gopal Ayyar
Alec Marshall Beresford
Lee Sean Gribbon
Richard Alan Hamilton
Natalie Irving
Alice Mary Jones
Jad Jurji
William Zhang Weiling Law
Jae Hyun Lee
Clare Louise McConnell
Thomas Kenneth Gordon Milne
Kamil Patel
Katharine Elizabeth Plant
Elizabeth Ann Robinson
Adam George Tiley
Robert William Milnes Walker
Daniel Wansong

2020.2 Exam

Seventy-one candidates successfully completed the primary fellowship examination:

AUSTRALIA

New South Wales

Christina Shan Cheng
Yuanjing Cheng
Sophie May Connolly
Sheridan Louise Frisby
Lucien Joel Hackett
Edward Bing Kee Ho
Mari Koyanagi
Patrick Barry Kroek
Varahini Kumar
Thomas Charles Lang
Simon Paul Minns
Varun Nanda
Eliza Hannah Jean Patterson
Ravi Senegal Shankar
Simon Trevor Thomas
Jireh Tsun
Boris Waldman
Annabel Whitaker
Sarah Hui Xin Wong

Queensland

Jordan Rita Rose Casey
Victor Xin Yun Chen
Graham Wesley Coupland
Jasmin Ellenberger
John Bernard Jones

Polly Clare Marshall-Brown
Eavan Margaret O'Brien
Alexander Charles O'Donnell
Anastasia Bridget Pearce
Davina Christel Louise Seidel
William John Turck

South Australia

Ryan Christopher Breslin
Julia Faye Rouse

Tasmania

Sneha Ann Ancheri
Edward Vern Khan Lim
Sally Christina Perks
Divya Rattan
Benjamin Arthur Rose

Victoria

Imogen Louise Ackerly
William Thomas Birkett
Angus Elliot Brown
Arno Crous
Alexandra Louise Drucker
Gregory David Evans-McKendry
Margaret Ellen Forbes
Gerard Kenneth Harrop
Lisa Jane John
Dustin Viet Anh Le

Austin Yong-Sheng Lee
Luke Daniel Nelson
Darren Yong Ooi Ong
Thomas Robert Scodellaro
James Leigh Sgroi
Bernard Liyang Shan
Alexander James O'Mullane Stevens
Andrew Harald Talman
Annie Xin

Western Australia

Yannick Yves Cucca
Eileen Linlin Zhang

NEW ZEALAND

Rose Cameron
Abhishek Charukonda
Leanne Rebecca Connolly
Philip M. Dabrowski
Aisling Marie Gormley
Alice Louise Hickey
Nicholas Ivan Instone
Charlotte Elizabeth Legge
Harriette Rose Helen Mulcaster
Saleimoa Bill Sami
Phillip David Tarrant
George Paterson Wallace
Chooi Ling Wong



Clockwise from top left: Brisbane examiners, New Zealand examiners, Sydney examiners and Melbourne examiners.

Renton Prize



The Court of Examiners recommended that the Renton Prize for the half year ended 30 June 2020 be awarded to:

Laura Elizabeth Staples, Queensland

“After graduating from ANU Medical School, I quickly realised that I wanted to pursue a career in critical care medicine. I initially started ICU training, then changed to anaesthetics training. I commenced training in Queensland but have just moved back to Canberra this year to start advanced training.

I’ve been incredibly fortunate to work in encouraging and supportive departments, and I hope that I can have the same positive influence on future trainees that my colleagues have had on me.

I have an extremely understanding partner and family and am looking forward to being able to spend more time with them. I’m very interested in trauma and retrieval medicine, and my goal now that the exam is over is to start flying lessons!”

MERIT CERTIFICATE

The Court of Examiners recommended that merit certificates at the 2020.1 sitting of the primary examination be awarded to:

- Joel Michael Krause, SA**
- James Henry Phillips, Victoria**



The Court of Examiners recommended that the Renton Prize for the half year ended 31 December 2020 be awarded to:

Boris Waldman, NSW

“I have always felt fortunate to have grown up in Sydney and to have received so many opportunities and so much support in my academic pursuits. That feeling has never been stronger than amid this global pandemic.

My family emigrated from Russia when I was three. My mother completed her Australian Medical Council exams, physicians’ exams and cardiology training while I went through school. I studied medicine at the University of Sydney, where I met a lovely group of friends. Several are now ANZCA trainees, and became my exam coaches and study buddies. St George Hospital kindly accepted me to anaesthetics training in 2020 and has provided a friendly, nurturing environment. My fiancée Anna has been incredible, riding the highs and lows of exam preparation, and occasionally politely nodding as I tried to explain pH or the pharmacology of propofol.

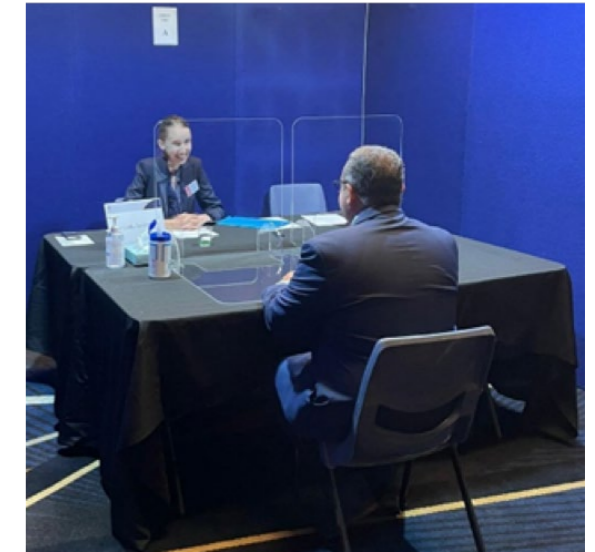
I am grateful to the college and examiners for running the exam, something which seemed highly unlikely in April 2020. Post exam, I have enjoyed a summer of swimming, diving and learning to surf. I look forward to getting back into clinical research, which I’ve been passionate about for many years, and making the most of a specialty which offers such a unique combination of science, procedural medicine and patient care.”

MERIT CERTIFICATE

The Court of Examiners recommended that a merit certificate at the 2020.2 sitting of the primary examination be awarded to:

- Alexander Charles O’Donnell, Queensland**

ANZCA Final Examination



Due to the impacts of the COVID-19 pandemic, the 20.1 anaesthesia vivas were postponed until Friday 20 November and Saturday 21 November 2020. These were planned to occur in eight separate regions – WA, SA, Victoria, Tasmania, NSW, Queensland, the ACT and Auckland, New Zealand.

At the last minute, the South Australian candidates had to sit their vivas in NSW due to a lock down in Adelaide.

The examination was held over two days in Queensland, NSW and Victoria and one day in the other regions – WA, Tasmania, the ACT and New Zealand.

Candidates in the ACT and Tasmania were examined in the usual face-to-face setting as well as in a videoconference setting. In WA, Victoria, NSW, Queensland and New Zealand the vivas were held as usual with no videoconferencing.

Extensive logistical planning and preparation was undertaken to confirm that each exam venue had the appropriate safety measures and that all venues met government guidelines and Covid-safe requirements.

The considerable efforts of the chair, final examination team, examiners and regional office staff ensured that the high standards of the examination were upheld regardless of the unusual setting.

A total of 149 candidates successfully completed the examinations.

Thank you to all who ensured the examination was a success.

**Final fellowship examination
March/November**

A total of 149 candidates successfully completed the final fellowship examination:

AUSTRALIA

Australian Capital Territory

- Nikhil Patel
- Nicole Elizabeth Somi

New South Wales

- Kathryn Marie Brooker
- Ritchie Jacob Cherian
- Alex Man Ho Chua
- Laura Elizabeth Connell
- Anuk Ruwanka Cooray
- Paul Anthony Heatley
- Gregory Kalogeropoulos
- Adam Michael Kelly
- Nicole Kemp
- Peter John Langron
- Lawrence Yeow-Chung Law
- Rebecca Elizabeth Lewis
- Andrew Gregory Little

- Andrew William Maccioni
- Laura Marie Massouth
- Benjamin Ross McAlpin
- Mark Edward McDonald
- Francoise Naeyaert
- Mylene Nassif
- Erin Mary Nelson
- Ryan Oliver Mark Pedley
- Natalie Pfund
- Aaron James Pym
- Kartik Venkat Ramesh
- Christopher William Sadler
- Michael John Scerri
- Patrick Vincent Sheehan
- Natalie Anne Sim
- Oliver John Snellgrove
- Brendon Jonathan So
- Samuel Weka Stewart
- Michael James Tobin
- Rheily Paige Ward

- Mitchell Allan Warren
- Samual Bradley Welsh
- Darin David Westaway
- Samuel Charles Wotherspoon

Queensland

- Alexandra Mary Anderson
- Joseph Michael Bauer
- Catherine Jane Bella
- James Edward Lloyd Booth
- Vicnaesh Chandra Segaran
- Larissa Maree Cowley
- Rian James Crandon
- Nicholas John Egerton
- Karl Alexander Eisner
- Alice Jean Goldsmith
- Courtney Lee Jones
- Benjamin John Yi-Hua Hew
- Seng-Wei Ho
- Lada Kordich
- Jun How Low
- David MacGarty
- Antimony Ashley Mar
- James David Marckwald
- Linden James Lucas Martyr
- Genevieve McCreanor

Danielle Louise McPherson
 Rajesh Pachchigar
 Danielle Rebecca Scott
 Jai Sharma
 Carling Ann Tills Simmons
 Shaiyla Sivakumar
 Vaishnavi Vasanthi Sridhar
 Benedict Francis Stephen
 Stewart Ure
 Benjamin Peter Warlow

South Australia

Jeremy Liam Duke
 Matthew Armando Matto
 James Richard Murtagh

Tasmania

Alice Elizabeth Mulcahy
 Dheeraj Sharma
 Jana Ludmila Vitesnikova

Victoria

Daniel Reece Alban
 Christopher Jake Douglas Barlow
 Matthew Jonathan Bolland
 Louise Caroline Boyle
 Stewart James Brown
 Brian Nee Hou Chee
 Tristan Mark Coleman
 Reece Raymond Cordy
 Daniel Philip Creely
 Luis Ruben Cuadros
 Asha Simon D'Arville
 Linden Anton De Ridder
 Jane Thu Doan
 Brendan James Flanders
 Ron Glick
 Charles Alexander James Harding
 Alexandra Lee Hill
 Shravya Karna
 Jessica Louise Kay
 Michael Hua Gen Li
 Vivian Liang
 David Yuan Yue Loo
 Vaughan McCulloch
 Alice Louisa Moore
 Nicole Muir
 Mark Gerard O'Donnell
 Benjamin George Peake
 Alan James Richard Peirce
 Anthony Anis Almendra Qureshi
 Inamul Rahiman
 Priya Rao
 Ambujaan Raviendran
 Richard Seglenieks
 Anna Elizabeth Steer
 Ya-Chu Tsai
 Genna Louise Verbeek

Geoffrey Julian Wigmore
 Thomas Yang
 Xianglin Yeaw
 Beiye Rebecca Zhao

Western Australia

Samantha Bonnington
 Louisa Ann Corr
 Alicia Louise Cullingford
 Owen Patrick Gray
 Rhyon Johnson
 Gregory Leeb
 Xiao Liang
 Sneha Neppalli
 Grant Damien O'Brien
 Ray Paramalingam
 Jam Sadullah
 Darren Paul Sherwin

NEW ZEALAND

James Edward Bickley
 Chen Chen
 Kerryn Anne Cook
 Rachel Holly Edmond
 Carole Ann Gillespie
 Sophie Elizabeth Gormack
 Stephen Duncan Hillier
 Melanie Gina Hwang
 George Syek Meen Lim
 Bridgette Irene McKenzie
 John Edward Shepherd
 Jennifer Stephens
 William Geoffrey Osborne Tomkins
 Peter Yang Xiang

SIMG examination

Eight candidates successfully completed the specialist international medical graduate examination:

AUSTRALIA

New South Wales

Jan Marinus Dieleman
 Nisha Bindu Murali

Queensland

Leonie Johanna Elisabeth Roberts

South Australia

Laetitia Deknudt

Victoria

Pooja Agrawal
 Luis Andres Sierra

Western Australia

Ronithung Ovung

NEW ZEALAND

Gonzalo Andres Millan Montoya

CECIL GRAY PRIZE

No candidates were awarded the Cecil Gray Prize for the 2020.1 final examination.

MERIT CERTIFICATES

Merit certificates were awarded to:

Danielle Rebecca Scott, Queensland

Jana Ludmila Vitesnikova, Tasmania

Brendan James Flanders, Victoria

ANZCA final examiners



Clockwise from top left: ACT final examiners, WA final examiners, Old final examiners, NSW final examiners, Vic final examiners, NZ final examiners.

2020 Trainee Survey: Thank you for your feedback

The ANZCA Trainee Survey was conducted in October-November 2020 and asked trainees to comment on the preceding 12 months of training. The ANZCA Trainee Committee thanks all trainees for taking the time to share feedback on their training experience.

Despite the challenges posed by the COVID-19 pandemic, ANZCA training sites are to be congratulated on maintaining the positive trend of survey results in relation to trainee satisfaction with their workplace experience. The survey has also identified areas within the training experience where there may be room for improvement.

The survey was sent to 1591 ANZCA trainees and completed by 662 (42 per cent). The survey was managed by an external consultant and a suite of reports has been prepared for ANZCA to disseminate results to key

stakeholders, including ANZCA training sites. Training sites receive de-identified results of the survey relevant to that site. Results are also shared with ANZCA Executive Committees and committees that support trainees and the training program.

The Education and Research Department will be co-ordinating an action plan in consultation with the ANZCA Trainee Committee and relevant education committees from the results of both the 2020 ANZCA Trainee Survey and 2020 Medical Board of Australia Medical Training Survey that was conducted in late 2020. When the analysis is complete and themes and issues fully identified, the results will be widely shared.

It is anticipated that key results, issues and proposed actions to address the identified issues will be published in the next ANZCA Bulletin.

Studying for the part two exam? Take a deep breath

Whereas most anaesthetists walk away from their fellowship exams with a brow wipe and a long, well deserved exhale, two enterprising doctors are taking a deep breath and diving back in.

DR KATHERINE STEELE and Dr Kate McCrossin, both consultant anaesthetists from Brisbane, have created a podcast designed to assist registrars preparing for their anaesthesia part two exams.

Available free and out now, the podcast explores exam relevant anaesthesia in bite-sized 20-minute chunks.

Existing episodes include interviews with a former examiner and discussions on topical subjects such as SGLT2 antagonists, regional anaesthesia for fractured ribs and awareness under anaesthesia.

Dr Steele said that the idea for the podcast came about due to their own experiences studying for the fellowship exam.

“Studying for the final exam can be a daunting and complex endeavour,” said Dr Steele. “Now that we’re ‘out the other side’ with some experience under our belts, we want to create a free learning tool that’s accessible to everyone, regardless of where they work or what their roster is. Podcasts are a great tool for auditory learners, and for people who want to utilise otherwise ‘dead’ time for a bit of incidental study.”

The podcast is already making waves. Word-of-mouth alone saw it receive hundreds of downloads in the first few days, even before the official launch, and the first five episodes have attracted more than 1500 downloads.

Co-host Dr McCrossin said that neither of them were prepared for the popularity of their project. “We knew there was a gap in specifically Australian anaesthesia exam podcast content. But we are finding that it’s not just anaesthesia registrars who are interested in the podcast – fellow consultants are listening in for CME, as well as anaesthetic technicians and nurses. We have listeners all over the world – Australia and New Zealand, of course, but also Singapore and America. I mean, how does someone in Ohio even find out about this?” she said with a laugh.

The podcast is available on iTunes, Spotify, and Google Play.

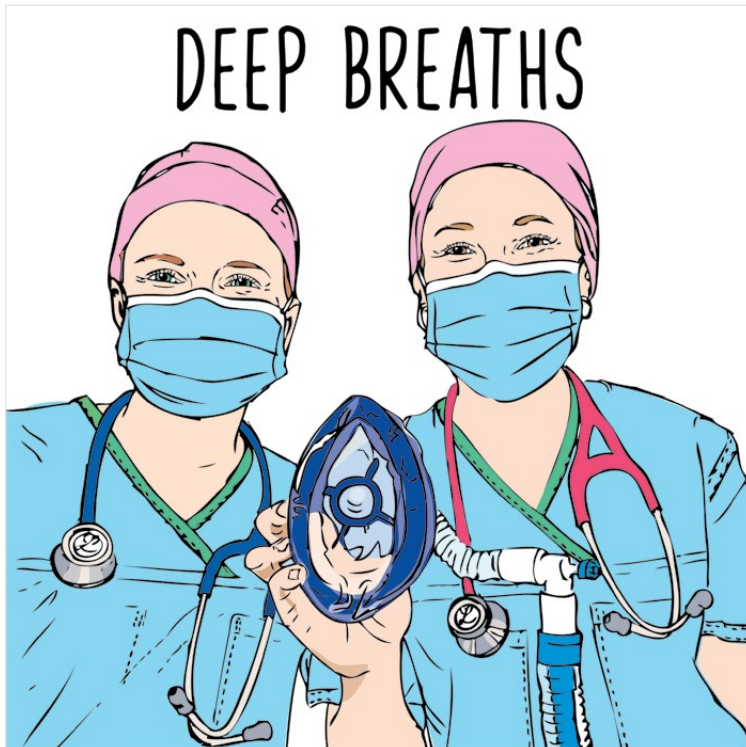
Episodes are designed to be easy to digest, for people to listen to while they’re doing other things – on their way to work, at the gym, or even when they’re just tired of didactic study or looking at a screen.

“Obviously the podcast is most relevant to registrars studying for their part two exam,” said Dr Steele. “But we hope it becomes a good resource for anyone interested in staying current. We invite all ANZCA *Bulletin* readers to take a deep breath and dive in.”

Dr Katherine Steele, FANZCA
Dr Kate McCrossin, FANZCA

You can find Deep Breaths at deepbreathspod.buzzsprout.com/ or by searching for “Deep Breaths” on most podcast sites. Season two of Deep Breaths has already started.

If you’d like to contribute to the podcast, Deep Breaths is always looking for experts on specialty anaesthesia and other exam related subjects! You can get in contact by emailing deepbreathspod@gmail.com.



Self matters

In this edition of my regular wellbeing column, I'm delighted to highlight work led by Dr Divya Sharma at Sir Charles Gairdner Hospital where I work. Dr Sharma's vision was a 24-hour roadmap on how to mobilise local resources to support colleagues who are distressed or unwell. Sharing the process of its development might serve as a useful model for other departments and practices.

Feedback along with ideas for future wellbeing topics and contributors are welcomed to lroberts@anzca.edu.au.

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

Supporting colleagues in distress: A 24-hour roadmap for on-call anaesthetists

Our profession has promoted comprehensive resources and frameworks on supporting colleagues who are distressed or unwell (see the box below). We describe development of a practical guide that supplements these excellent generic approaches with local resources and contacts. Our aim was a comprehensive, 24-hour roadmap for duty/on-call anaesthetists, supervisors of training and our head of department. We focused on steps when urgent responses were indicated, that any on-call anaesthetist could take, and that are feasible at any time, even after-hours when accessing advice is more challenging.

To that end, Dr Sharma initiated a collaborative process with experienced members of the departments of anaesthesia, psychiatry, and occupational health and safety (OSH), the senior clinical psychologist for our health service workforce wellbeing initiative, and representatives of hospital medicolegal services and the WA Doctors Health Advisory Service (DHAS WA).

Comprehensive resources and frameworks on supporting colleagues who are distressed or unwell

- Wellbeing SIG Resource Documents¹
- RD20 Substance abuse
- RD27 A manager's guide to the sudden death of a colleague
- Long Lives Healthy Workplaces toolkit²

Two experienced wellbeing advocates brainstormed possible scenarios. Following anaesthesia leadership feedback, the group agreed that pathways should address colleagues in the following situations:

1. Acute psychological distress.
2. Suspected theft or misuse of drugs.
3. Impaired or intoxicated requiring immediate work cessation.
4. Suicide/self-harm attempt at work.
5. Sudden death at work.

The interdepartmental team lent their expertise and knowledge of local resources. It took six months of iterative teleconferencing and emails to develop a consensus approach to each scenario. The resultant guide includes a brief overview of distress signs and what to do if worried about self or a colleague. Each scenario is addressed in terms of practical and psychological support. Notes to the guide include specifics on impairment and intoxication laws, patient safety concerns, mandatory notifiable behaviours (including timing), suicide risk, next of kin notification and tips on how to be discreet. The pathways are very clear on when to get professional psychiatric help.

As an example, scenario one is shown in figure 1. Practical measures such as simply listening to the colleague, organising shift cover, encouraging them to see their GP and sending them home with a follow-up phone call is usually enough. If the distress is severe, in our service, the emergency department duty psychiatrist is the professional most able to guide the supervising anaesthetist. For those issues that cannot be solved with a phone call, this psychiatrist can attend to encourage voluntary and discreet emergency department admission. During development, OSH reinforced employers' responsibility to care for their employees³. If required, they will manage support by either the employee assistance provider, in-house resources or an external consultant. In more severe cases, OSH will also follow up regarding fitness for return to work.

Figure 1

Colleague with Acute Psychological Distress
 Work-related: Includes critical incidents, interpersonal conflict, colleague death at work
 Not work-related: Includes relationships, exam stress, health issues

Practical support by DA / HOD / SOT¹:

1. Enquire about practical supports / GP / travel home
2. Offer break, send home & cover shift / upcoming shifts / theatre allocations
3. Allow leave to see GP in hours discreetly
4. Follow-up phone call by HOD to close loop
5. Consider obtaining advice from ED Psychiatry²
6. Complete OSH incident form³ if work related
7. HOD can request OSH to complete a Fitness to Work Assessment⁴

Psychological Support:
 Recommend Peer Support.⁵ Peer Supporter may offer:

1. Peer support / listening
2. Encourage GP appointment
3. If work-related, contact OSH to obtain their review
4. DHASWA 9321 3098
5. Converage 1300 687 327 or Lifeworks 1300 361 008

SCGH Anaesthesia: Supporting Colleagues In Distress, Version 1.

For psychological support, all pathways include the role of "peer supporter". This could be fulfilled either by a trained wellbeing advocate or within a formal peer support program, like that of the Royal Brisbane and Women's Hospital⁴. Notes to the pathways include information such as that DHAS WA, while being a phone advice provider, is not a crisis line, is only accessible in hours and that their database includes GPs and psychiatrists who will prioritise appointments for colleagues.

The value of our collaboration has been whole-hearted support for this guide from psychiatrists and physicians who provide 24-hour psychiatry cover for our emergency department. Currently, the guide is being implemented within our department. Education and training is not only essential for implementation but also a local OSH requirement. A planned online training session and resource has been supported by trainers, including the clinical lead for emergency psychiatry and an OSH representative. With time, peer supporters will be identified and trained. Anticipated benefits include destigmatisation of distress and help-seeking, along with briefing department members about issues that may occur in their workplaces⁵.

What have we learnt? Among other things, words matter; we needed to use the term "responsibility", rather than "duty", to achieve consensus. Knowledge of local resources was invaluable. It was fruitful to engage other departments and experts. We have forged productive relationships and increased awareness of anaesthesia-specific issues and context. In time, this guide may be adapted for broader use within our institution.

Effective teamwork and supportive work environments rely on departmental buy-in, executive sponsorship, interprofessional collaboration and co-workers acting on their responsibilities towards each other. Assistance provided by those "in the job" is also the most highly valued form of support^{2,5}. The pandemic has brought increasing recognition from administrators that supporting staff in distress supports high-quality patient care. We have much to do and these pathways are a practical step on our journey.

Dr Divya-Jyoti Sharma
Dr Lindy Roberts
 Department of Anaesthesia,
 Sir Charles Gairdner Hospital



Dr Divya-Jyoti Sharma and Dr Lindy Roberts.

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.

References:

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3. WA Occupational Health and Safety Act 1984. At: https://www.legislation.wa.gov.au/legislation/statutes.nsf/main_mrtitle_650_homepage.html. Accessed 3 Feb 2021.
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5. Greenberg. Nightingale mental health team standard operating procedure. At <https://www.healthcareworkerscarenetwork.org.za/images/pdf/nightingale-mental-health-support-plan-SOP.pdf>. Accessed 6 April 2020.



Faculty of Pain Medicine

DEAN'S MESSAGE

Challenges ahead in pain medicine



WITH A BELATED 2020 Fellowship Clinical Examination now out of the way, and our binational specialty beginning to deal with the possibility of a post-Covid recovery period, it's a good time to reflect on what the year may bring.

We survived 2020 in relatively good shape compared to many organisations, but we cannot take for granted the challenges ahead.

The first half of the year will be spent consolidating the plans made so far, and responding to requests for comment or guidance, particularly in opioid policy and cannabis policy. The launch of the Choosing Wisely recommendation six required plenty of advocacy to explain the nuances of our position. Given the tide of misinformation regarding medicinal cannabis and its purported benefits in chronic pain, our responsible, strongly evidence-based position will stand up to scrutiny, and I take reassurance from the results of our survey of the fellowship, which showed a support level of just over 80 per cent for the recommendation. The recommendation was launched in conjunction with the IASP presidential taskforce report, making the task for advocates of medicinal cannabis for chronic pain clear.

Not only do specialist pain medicine physicians need to see evidence of efficacy in chronic pain conditions, but we also need detailed information about the predicted and observed harms as well as the potential for making more evidence-based pain

management approaches less accessible or more difficult for the patient.

It is incredibly easy to offer passive relief of chronic pain, and we are very familiar with a raft of treatments which make claims to this end. Very few of them ever become part of our armamentarium, and we make no apologies for having high standards. In a complex field of medicine where in some cases, we may never have definitive randomised controlled trial evidence for some of our treatments, our recommendations should reflect a blend of astute scientific judgement, compelling arguments for the plausibility of the treatment, and conservative, cautious judgement regarding possible harms. Further to this already high standard, we favour active treatments wherever possible over passive ones, and comprehensive multidisciplinary care over fragmentation.

We will also have a strategic focus in the first half of 2021 on ensuring that our core educational offerings are up to standard. We will be undertaking a project to refresh Better Pain Management, the Learning and Development Committee will complete its review of the curriculum, and our assessments for the training program will continue to be reviewed for fitness of purpose in this new training landscape.

Our team has learned an enormous amount about online assessment, and some of these learnings will be able to generalise to our regular exam format. We will be attempting to increase the professional development of examiners, board members and supervisors of training through targeted workshops. We will be seeking to refresh membership of many of the committees of the faculty in the middle of this year, and I encourage any interested fellows to peruse the terms of reference of these committees and reflect on whether they feel able to make a contribution.

I'm delighted to report that our New Zealand National Committee has been asked by the Ministry of Health to participate as expert advisers in a process to completely re-envision the

model of how pain care is provided in Aotearoa New Zealand. This is a very consequential development that will potentially allow our fellows and their allies to reshape the agenda in their country for the next five to 10 years. It's a very exciting strategic development.

Our major project of the National Health Practitioner Pain Education Strategy continues to advance despite the continuing uncertainty. We hope that this will inform the implementation of a major plank of the National Strategic Action Plan for Pain Management, namely that of providing a health practitioner workforce that is more pain literate, and understanding of the complexities of the chronic pain phenotype.

Yet another recent study from the US confirmed that health practitioner bias against chronic pain patients begins in the training years, and we will never see useful progress or implementation of the evidence-based treatments that we already have if those who are meant to be our allies in the pain management project continue to feel uncomfortable or even hostile towards our patients.

We have the opportunity to advise governments about the ideal model of education for health practitioners to change this. We continue to work



Do not prescribe currently available medicinal cannabis products to treat chronic non-cancer pain (CNCP) unless part of a registered clinical trial.

with our colleagues at the Royal Australian and New Zealand College of Obstetricians and Gynaecologists to provide feedback and expert advice about the role of central and peripheral sensitisation in pelvic pain as they develop their national guidelines for the treatment of endometriosis. Focused effort by our dual fellows supported by the faculty will hopefully result in evolution of the disease-based paradigm of pelvic pain into an appropriately informed framework that will improve the lives of Australian women well into the future.

The other major event of the first half of the year will be the Melbourne annual scientific meeting. Dr Noam Winter has had an unenviable job in shepherding the program through several periods of extreme uncertainty, before finally undertaking the radical step of a fully virtual annual FPM Symposium. I hope that our fellowship around the country will embrace the sessions of the ASM by getting together at a local level in the hubs provided, or indeed in threes or fours around a colleague's computer or TV wherever

possible. Our scientific meetings invariably have content of a high standard, but until we are able to safely gather in large numbers again, we will continue to search for ways to bring our fellowship together and connected in meaningful ways.

For better or worse, online meetings are here to stay and we need to experiment with effective ways of maintaining our sense of community even if we can't meet in person.

Over the next few months, the faculty Executive Director, Ms Leone English and myself will be trying to dodge travel restrictions and get around in person to visit our units. As Leone grows into her job, it's important for her to meet the family! We look forward to these visits and to sharing the concerns, hopes and ambitions of our fellowship in person.

Associate Professor Michael Vagg
Dean, Faculty of Pain Medicine

FPM Annual General Meeting

The Annual General Meeting of the Faculty of Pain Medicine, Australian and New Zealand College of Anaesthetists, will be held on Sunday 9 May 2021 commencing at 2pm AEST, via Zoom.

Fellows are encouraged to attend to hear about the current strategic priorities for the FPM Board.

Please see below the agenda for the meeting:

1. Welcome and apologies.
2. To confirm the minutes of the FPM annual general meeting held on 3 May 2020.
3. To receive and consider the report of the FPM Board presented by the Dean.
4. To receive the annual financial reports.
5. To receive the declaration of the poll for election of members to the Board.
6. Other business of which due notice has been given to the executive director FPM, in accordance with the by-laws of the faculty.

Please indicate your availability to attend the AGM by sending an email to fpm@anzca.edu.au prior to the meeting. However if you are unable to attend, you may appoint a proxy, with further information to be found on the website shortly.

Election to fellowship pathway – reminder

A reminder that any fellows interested in applying for election to fellowship as outlined in by-law 3.2, should do so by 30 June 2021. No further applications will be accepted for consideration after this time.

The requirements for submitting an application are outlined in by-law 3.2. For any queries, please contact the executive director FPM via fpm@anzca.edu.au.

New fellows

We congratulate the following doctors on their admission to FPM fellowship:

- **Dr Eliza Beasley**, FANZCA, FFPMANZCA (Vic).
- **Dr Tze Chow Chow**, FANZCA, FFPMANZCA (NSW)
- **Dr Esther Dube**, FRACP, FFPMANZCA (Vic)
- **Dr Marcus Mina Gurgius**, FRACGP, FARGP, FFPMANZCA (Tas)
- **Dr David Hamilton**, FRANZCA, FFPMANZCA (WA)
- **Dr Ramsey Jabbour**, FRACGP, FFPMANZCA (Qld)
- **Dr Peter Keogh**, FRCA, FANZCA, FFPMANZCA (Vic)
- **Dr Antony Kodsi**, FRACP, FFPMANZCA (NSW)
- **Dr Michael Miu**, FANZCA, FFPMANZCA (WA)
- **Dr Trudi Richmond**, FAFRM (RACP), FFPMANZCA (NSW)
- **Dr Harridharshan Sivakumar**, FANZCA, FFPMANZCA (Vic)
- **Dr Benjamin Teo**, FRACP, FFPMANZCA (NSW)
- **Dr Candice Wallman**, FRACP, FFPMANZCA (NSW)

Crossing borders to advocate for better pain services in the ACT



Ms Leone English, Associate Professor Michael Vagg and Dr Romil Jain.

ON 17 MARCH our FPM Dean, Associate Professor Mick Vagg and FPM Executive Director, Leone English travelled to Canberra to meet with the ACT Minister for Health, Rachel Stephen-Smith. Accompanying Mick and Leone, and representing the faculty at the local level, was pain fellow Dr Romil Jain, Director of the ACT Pain Centre (Canberra Hospital).

In a positive meeting with the minister, her senior advisor Ben Tomlinson, and ACT Chief Medical Officer

Dr Dinesh Arya, the faculty proposed, for consideration, the potential of a public/private partnership model as a solution to the current lack of specialist paediatric pain services in the ACT and requested further funding for ePPOC activity in the state, which is something requiring a relatively small financial commitment by the government.

The minister was also interested in a concept put forward by the faculty for the establishment of a "transitional pain service" to provide targeted support for post-acute patients identified "at risk" of ongoing pain issues for a period of three months. The aim of this service would be to improve the management of patients post discharge and preventing the development of chronic pain problems, thereby improving patient outcomes, and reducing cost to the health system. If this transitional pain service was established, ACT Health would be at the forefront of best-practice.

Following the meeting Romil treated Mick and Leone to a visit to his ACT Pain Centre which has been purpose-built and is well supported by a broad multidisciplinary team of pain management professionals.

The faculty will maintain its engagement with the minister and further advocacy visits are planned to other state ministers over the coming weeks.

Ms Leone English
Executive Director, FPM

Developing a national pain management education strategy – stakeholder consultation workshops



THE FACULTY IS leading a federal Department of Health-funded project to develop a pain management education strategy for Australian health practitioners. In March 2021, the project team embarked on a roadshow of stakeholder consultation workshops across Australia.

Thankfully, open borders enabled the project team to travel to Adelaide, Melbourne and Sydney to hold three face-to-face workshops. To ensure the workshops were accessible to participants across the country we also held four Zoom workshops for those in the Australian Capital Territory, Northern Territory, Queensland, Tasmania and Western Australia.

The aim of the workshops was to inform the values, underpinning principles, goals, implementation considerations and recommendations for the national strategy. Workshop participants came from a diverse range of backgrounds and included health professionals, educators and consumers.

Feedback from participants has been excellent, with many appreciating the opportunity to engage with those from outside their own discipline. Group discussions at the workshops have produced a large amount of data, which will inform the project team when drafting the strategy. We would like to thank all participants for their time and contributions.

What's new in the library?

ANZCA Library at this year's ASM

ANZCA Library is running two workshops at the 2021 ASM for fellows and trainees who are interested in learning more about library services at ANZCA and undertaking their own literature searches.

Beyond Google: An introduction to the ANZCA Library

An introduction to the wide range of library resources available to fellows and trainees, with a focus on the primary and most useful tools, products, and services. After attending the webinar, participants will have a greater awareness and understanding of the resources and services – including the library discovery service – and tips and tricks for using them.

Advanced searching in MEDLINE: Tips and tricks to getting the best out of your search

This workshop will focus on literature searching in the MEDLINE databases using Ovid and PubMed, and is an ideal introductory session for emerging investigators. After attending the webinar, participants will have a greater understanding of the use of MeSH headings, advanced search and filtering options, and a clearer idea of the key differences between platforms. Please note: Participants are expected to have some experience with searching and using library resources.



Better searching for anaesthesia-, pain- and perioperative-related articles

Every year the National Library of Medicine (NLM) update the Medical Subject Headings (MeSH) to include new topics that can be searched in the Medline/PubMed database.

In 2021, a number of new terms have been added that are relevant to anaesthesia, pain medicine, perioperative medicine and COVID-19, including the following:

Caregiver burden

The stresses or associated emotional responses experienced by caregivers when caring for the mentally or physically disabled.

Chain of infection

A sequence of infection transmission from infectious agent leaving disease reservoir or host through a portal of exit, conveyed by some mode of transmission, and entering through a portal of entry to infect a susceptible host.

COVID-19

A viral disorder generally characterised by high fever; cough; dyspnea; chills; persistent tremor; muscle pain; headache; sore throat; a new loss of taste and/or smell (see ageusia and anosmia) and other symptoms of a viral pneumonia. In severe cases, a myriad of coagulopathies often correlating with COVID-19 severity is seen (for example, blood coagulation; thrombosis; acute respiratory distress syndrome; seizures; heart attack; stroke; multiple cerebral infarctions; kidney failure; catastrophic antiphospholipid antibody syndrome and/or disseminated intravascular coagulation). In younger patients, rare inflammatory syndromes are sometimes associated with COVID-19 (for example, atypical kawasaki syndrome; toxic shock syndrome; paediatric multisystem inflammatory disease; and cytokine storm syndrome). A coronavirus SARS-CoV-2 in the genus betacoronavirus is the causative agent.

COVID-19 testing

Diagnosis of COVID-19 by assaying bodily fluids or tissues for the presence of COVID-19 antibodies, SARS-CoV-2 antigens or the VIRAL RNA of SARS-CoV-2.

COVID-19 vaccines

Vaccines or candidate vaccines containing SARS-CoV2 component antigens, genetic materials, or inactivated SARS-CoV-2 virus, and designed to prevent or treat COVID-19.

N95 respirators

Respiratory protective devices designed to achieve a close seal around the nose and mouth to maintain efficient filtration of aerosolised particles and droplets. They are often fitted for the prevention of the spread of infections (for example, COVID-19) or to administer inhaled anaesthetics or other gases.

Opiate overdose

Accidental or deliberate use of an opioid in excess of normal dosage. It includes overdose for prescription and illicit opioids.

Preoperative exercise

Various physical exercises implemented before a surgery designed for better treatment outcome.

SARS-CoV-2

A species of betacoronavirus causing atypical respiratory disease (COVID-19) in humans. The organism was first identified in 2019 in Wuhan, China. The natural host is the Chinese intermediate horseshoe bat, *rhinolophus affinis*.

Teleworking

Arrangement under which an employee performs the duties and responsibilities of such employee's position, and other authorised activities, from an approved worksite other than the location from which the employee would otherwise work.



AusDI Update

Due to an increase in usage, some users have recently been experiencing access issues with AusDI. Additional user access has been purchased to help alleviate these issues.

AusDI (Australian Drug Information) contains more than 80,000 pages of Australian medicines information, a product identifier tool, and interactions and safety modules.

- Access AusDI via the Library Databases & collections page: <https://libguides.anzca.edu.au/databases>



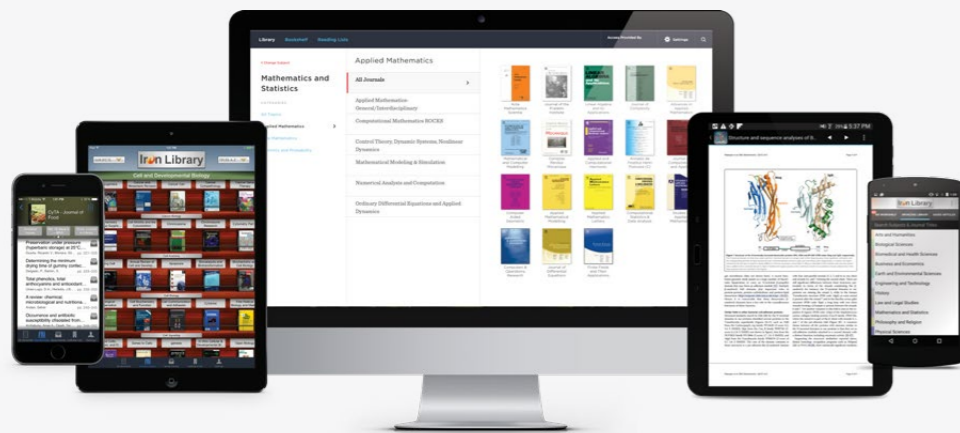
Have you tried BrowZine?

BrowZine is a mobile app for tablets and smart phones that allows you to browse and access the entire ANZCA e-journals collection all in the one simple interface.

It is easy to set-up, defaults to PDF format for reading purposes, and journals can be browsed by both title and subject categories. Includes full-text access to all subscribed ANZCA journal content, and allows users to save their authentication credentials for instant access.

It's the perfect "armchair-reading" app for catching up with your favourite journals. Users are also able to create a user profile and save PDFs for offline use/bookmark articles for CPD purposes.

Learn more about BrowZine, including how to set up at libguides.anzca.edu.au/apps/browzine.



AIRR | ANZCA Institutional Research Repository

All issues of the ANZCA Bulletin now in AIRR:

Work on adding past issues of the ANZCA Bulletin to AIRR is now complete. You can now access and download all issues in PDF format – all the way back to 1992.

Full details for the project (including how to search the Bulletin) can be found in the Spring 2020 ANZCA Bulletin.

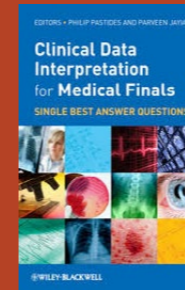
Recent contributions to AIRR:

- Gong J, Merry AF, Beyene KA, Campbell D, Frampton C, Jones P, McCall J, Moore M, Chan AHY. Persistent opioid use and opioid-related harm after hospital admissions for surgery and trauma in New Zealand: a population-based cohort study. *BMJ Open*. 2021 Jan 19;11(1):e044495.
- Loughnan TE, Wake PB. Dr Himson Tamur Mulas, the first national specialist anaesthetist in Papua New Guinea. *Anaesth Intensive Care*. 2020;48(3_suppl):39-43.
- Haridas RP. David John Thomas and the first operation under etherisation in Melbourne. *Anaesth Intensive Care*. 2020;48(3_suppl):14-20.
- Cronin M. Anarcha, Betsey, Lucy, and the women whose names were not recorded: The legacy of J Marion Sims. *Anaesth Intensive Care*. 2020;48(3_suppl):6-13.

New titles in the library

New exam books

A number of primary and exam prep titles are available online for the first time: libguides.anzca.edu.au/training-hub



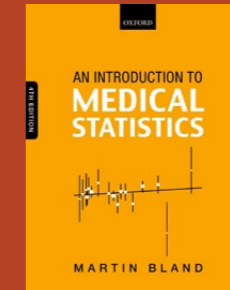
Clinical data interpretation for medical finals: single best answer questions

Jayia P, Pastides P [eds]. Oxford, UK: Wiley-Blackwell, 2012.



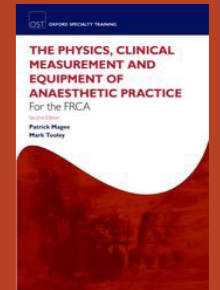
Get through final FRCA: single best answers

Rangarajan D, Patel P, Wroe V, Bahal N. London, UK: CRC Press, 2015.



An introduction to medical statistics, 4e.

Bland M. Oxford, UK: Oxford University Press, 2015.



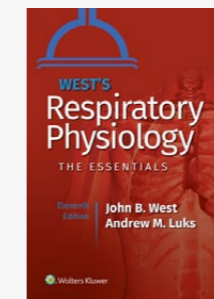
The physics, clinical measurement and equipment of anaesthetic practice for the FRCA, 2e

Magee, P Tooley M. Oxford: Oxford University Press, 2011.

New books for loan

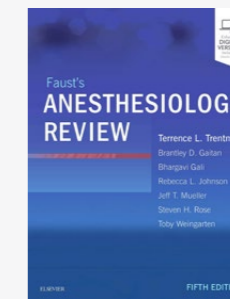
Books can be borrowed via the ANZCA Library catalogue:

libguides.anzca.edu.au/borrowing



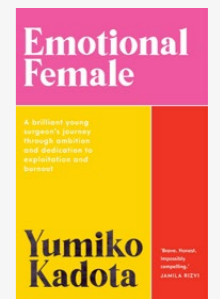
West's respiratory physiology : the essentials, 11e

West JB, Luks A. Eleventh ed. Philadelphia: Wolters Kluwer; 2021.



Faust's anesthesiology review, 5e

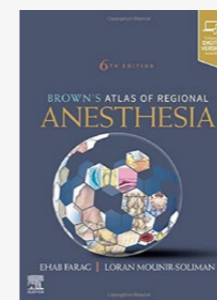
Trentman TL, Gaitan BD [eds]. 2020. Amsterdam: Elsevier, 2020.



Emotional female

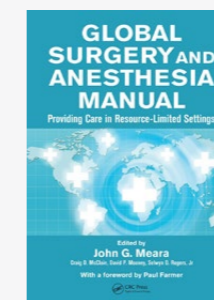
Kadota Y. Australia: Vikings, 2021.

New eBooks



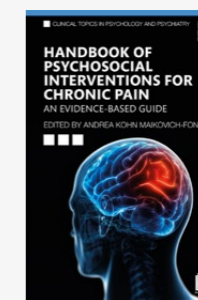
Brown's atlas of regional anesthesia, 6e.

Farag E, Mounir-Soliman L, Brown DL. Philadelphia, USA: Elsevier, 2021.



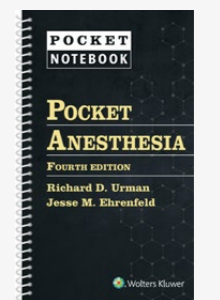
Global surgery and anesthesia manual

JMeara JG, McClain CD, Rogers SO, Mooney DP [eds]. Boca Raton, USA: CRC Press, 2015.



Handbook of psychosocial interventions for chronic pain

Maikovich-Fong AK [ed]. New York, USA: Routledge, 2019.



Pocket anesthesia, 4e

Urman RD, Ehrenfeld JD [eds]. Philadelphia, USA: Lippincott Williams & Wilkins, 2021.

Contact the library:

+61 3 9093 4967

library@anzca.edu.au

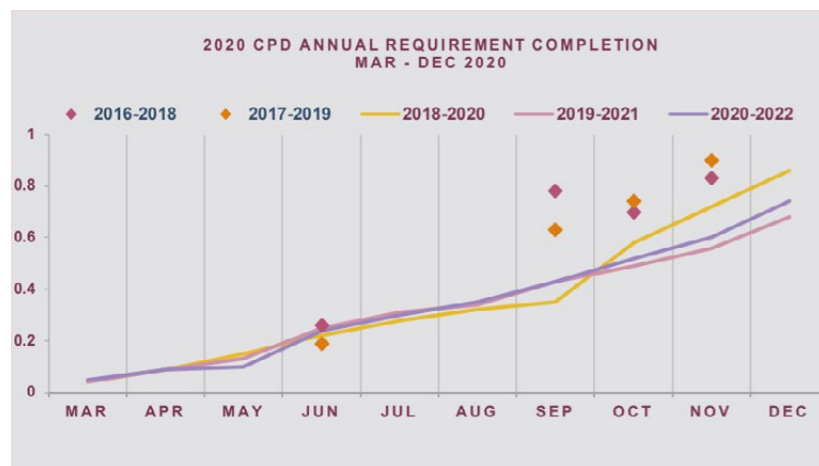
anzca.edu.au/resources/library

Supporting your professional development

2018-2020 end of triennium update

Our congratulations to more than 1800 continuing professional development (CPD) participants who completed the 2018-2020 triennium. While 2020 was certainly an unusual year, the 99% completion rate demonstrates the strength of your program and the dedication you have to your professional development. Importantly, the learnings gained in 2020 will continue to support better patient care.

Records show participants across all trienniums have been actively updating their CPD portfolios. This is even though the college did not conduct a 2020 annual verification (audit) and the COVID-19 pandemic restrictions affected access to activities. These entries are also on par with previous years' completions. The graph below displays the CPD portfolio completions for the 2020 annual requirement across our three active CPD trienniums and in comparison for those previously completed. We commend all CPD participants for their dedication to their professional development and reflecting this in their CPD portfolios.



The CPD committee and team are attempting to support the remaining 2018-2020 CPD participants in updating their CPD portfolios and encourage all members to contact the CPD team at cpd@anzca.edu.au when support is needed.

Planning your CPD

"Planning" seems near impossible during a time of so much change. However, as many of us have learnt, having an integrated pandemic preparedness and response plans, supported by the existing medical emergency strategies, have ensured we can respond to this pandemic. Taking a moment to plan your CPD is helpful in assuring that activities undertaken are meaningful and relevant to your needs. Your CPD plan, within the CPD portfolio, has been designed to support this consideration with helpful prompts and questions. It can be updated at any time during your active triennium to reflect changes to conferences, workshops, scheduled department meetings or peer reviews, and so on.

To complete your CPD plan, log in to your CPD portfolio and click the tab "CPD Plan". Once in your CPD plan click the purple button "edit" and respond to the seven listed boxes and "save" your responses. Please note: The page will automatically time out after 60 minutes, we recommend you save as you go, if you intend to exceed this time.

Example CPD plan questions

- What practice evaluation activities will you or would like to be involved in and when they might be completed?
- Are there any particular topic areas in which I need to update my knowledge?
- Are there any skills I only use from time to time, or in an emergency, that I need to practise so I can respond appropriately when needed?
- What activities will I undertake to develop a greater understanding of my own health and wellbeing over the next three years?

From 2021, you will no longer be able to add or confirm any new activities to your CPD portfolio until your CPD plan has been fully completed. This measure is to avoid CPD plans being overlooked, and stopping some CPD participants from transitioning into their new triennium.

While the main driver for completion of your CPD plan is to support preparation for your professional development, the CPD plan must also be completed to receive annual statements of participation and a triennial certificate of compliance. For more information, please refer to the CPD Handbook, Appendix 17.

Growth of the CTN

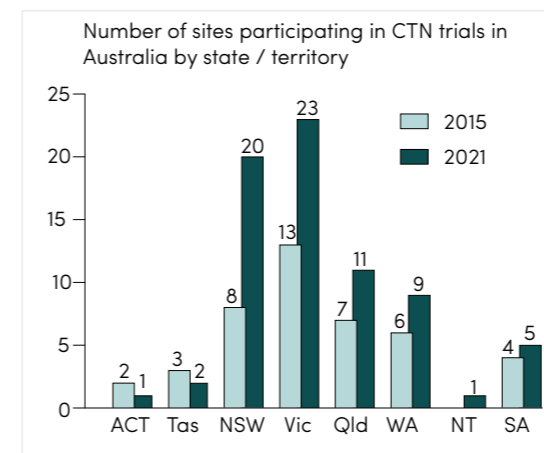
The ANZCA Clinical Trials Network (CTN) has enjoyed nearly 50 per cent growth in hospitals participating in CTN-endorsed trials across Australia and New Zealand since 2015.

A SURVEY ON research capability of all ANZCA-accredited training hospitals in 2015 showed that 52 accredited training hospitals in Australia and New Zealand were participating in CTN trials (Goulding et al. *Anaesth Intensive Care* 2017, *ANZCA Bulletin* March 2017), or 54 hospitals including those that were not identified as training sites at the time.

Five years on, the net growth of the CTN sites across the network in Australia and New Zealand is 48 per cent growth with 80 sites now participating in current trials (PADDI, HAMSTER, TRIGS, ROCKet, ITACS, POISE-3, T-REX, VAPOR-C, Chewy, DECS-II, MASTERSTROKE, NATO – see anzca.edu.au/ctn).

A large proportion of this growth has occurred in NSW which has experienced a 150 per cent growth or an additional 12 new sites coming on board and Victoria which has seen 10 new sites or 77 per cent growth.

Although there has been a decline in the number of hospitals participating in CTN trials in New Zealand since the Balanced Anaesthesia Study finished, a number of new sites are completing the ethics and governance processes for current trials.



The growth of the network reflects the substantial efforts made by fellows, trainees, research co-ordinators, trial project teams and the CTN Executive, Anaesthesia Research Co-ordinators Network (ARCN) Sub-Committee and CTN office. Some of the reasons behind the growth of the network are:

- There has been an increase in the number and diversity of CTN trials running due to the success of investigators in securing major grant funding. This has led to a greater opportunity for sites to participate in trials due to feasibility in terms of resources and research capability, and also access to suitable patient populations.
- Strong leadership by the CTN Executive, ARCN Sub-Committee and CTN office to implement the strategic plan to engage with more sites including private and rural and regional sites. This has resulted in 10 private, rural and regional sites coming on board.
- The strong growth and engagement of the ARCN and the formalisation of the ARCN Sub-Committee in 2016 to represent 160 research co-ordinators facilitating anaesthesia research. It is recognised that research co-ordinators underpin the success of the network. They drive patient recruitment and are vital to the sustainability of research departments. Our data from the PADDI trial shows that sites with full-time research co-ordinators recruited five times more patients than sites without co-ordinators.
- The enthusiasm and drive from fellows and trainees to lobby for departmental support to participate in clinical trials and to build a case to employ a research co-ordinator.
- The dedication of trial project teams to teach new investigators and research co-ordinators the ropes of clinical trials.

- The annual strategic research workshop to engage and mentor fellows, trainees and research coordinators as well as to develop new research proposals ensuring a pipeline of clinical trials.
- The relocation of the CTN strategic research workshop in 2016 from Queensland to NSW by the executive to engage with more sites in NSW. This included a number of site visits at the time by the executive to meet with leaders and emerging leaders to discuss CTN trials.
- Support from the ANZCA Research Foundation to provide seed funding for clinical trials as well as support from the ANZCA Communications and Events teams to continue to deliver high quality services to CTN and college members.
- The PADDI trial was pivotal for many new sites to come on board due to the accessible patient population, the relative ease of the trial to recruit patients to and support from the project office.
- Paediatric sites are now included in the network of CTN sites due to the CTN endorsement of the T-TREX, HAMSTER and Chewy trials.
- Promotion of the network through web and social media platforms, newsletters, bulletins, and presentations by investigators on the outcomes of the trials.
- The support of investigators and research coordinators to teach the ropes of clinical research to their peers at other hospital departments.

Inspiration and motivation

With 12 trials under way, there has never been a more important time to continue to engage with ANZCA and FPM fellows, trainees and research co-ordinators to grow research capability across the network so we can conduct more trials and complete our trials

on time and within budget. This ultimately improves patient care and safety in the perioperative setting.

Thank you to all our hard working sites participating in our trials, and to the sites that are about to come on board with our trials. We are calling for new sites to join the CTN especially rural and regional sites and the private sector.

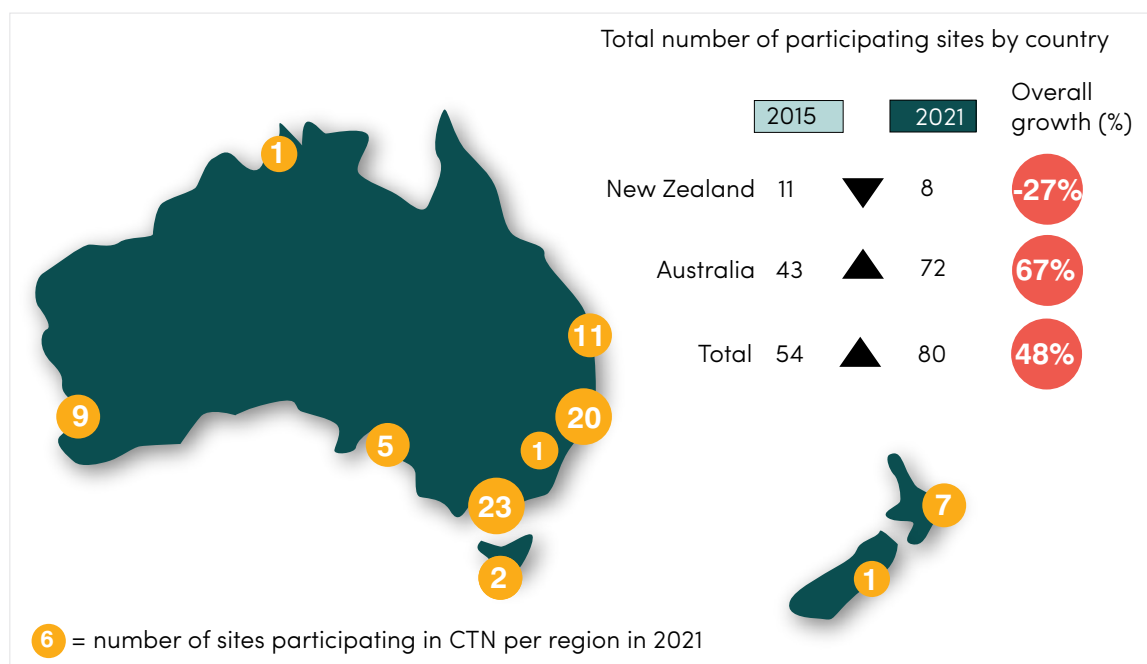
To learn about our clinical trials that are under way and how you can become involved in the world leading clinical trials network in anaesthesia, pain and perioperative medicine, visit us at www.anzca.edu.au/ctn.

Karen Goulding
CTN Manager

Gillian Ormond
ARCN Sub-Committee Member

Professor Kate Leslie AO
CTN Executive Member

Professor Andrew Davidson
CTN Executive Chair



Trainee research networks

SQUEEZE: A prospective multi-centre international observational study of postoperative vasopressor use

Data collection commenced in November across seven sites within Australia, and the second of two cohorts is almost complete for Australia. Trainees from Royal Perth Hospital, Sir Charles Gairdner Hospital, Fiona Stanley Hospital, QE II Jubilee Hospital, Metro South Hospital, Logan Hospital and Sunshine Coast Hospital have been working hard over the past 18 months to make this a reality.

This achievement was a direct result of a lot of hard work from a large cohort of anaesthesia trainees and fellows across the country. Involvement in large multi-centre trials offers significant learning opportunities for emerging researchers, while contributing to high quality research. I'd like to thank all of those involved for their contribution, and look forward to the publication of SQUEEZE in the near future.

Dr Simon Bradbeer MBBS (Hons) FANZCA
SQUEEZE National Co-ordinator Australia

Research support bounces back

Russell Cole and Darcy Price memorial awards

The 2021 Russell Cole Memorial ANZCA Research Award and Darcy Price ANZCA Regional Research Award were both conferred by the ANZCA Research Committee on 1 March 2021. While ANZCA grants for 2021 were deferred due to COVID-19, the grant round for 2022 is progressing.

The Russell Cole Memorial ANZCA Research Award was awarded to chief investigators Professor Andrew Somogyi, Professor Jennifer Philip and Dr Aaron Wong of Adelaide Medical School, Adelaide University, for the project "Personalising pain relief for people with cancer – the right opioid for the right person at the right time". The investigators will receive \$A49,598 for this important study.

Associate Professor Alwin Chuan and Dr Benjamin Moran received the Darcy Price Memorial ANZCA Regional Research Award of \$10,000, for the project "Using virtual reality to teach simulation-based ultrasound-guided femoral nerve blocks: A randomised controlled trial".

The Russell Cole Award is generously provided by Mrs Ann Cole in memory of Dr Russell Cole. The Darcy Price Award is generously provided in memory of Dr Darcy Price by the Waitemata District Health Board in Auckland.

Professor Andrew Somogyi (left) and Associate Professor Alwin Chuan.

The research committee and the foundation are again deeply appreciative of the generosity and vision of both donors, and we warmly congratulate all of the recipient investigators.



Record giving to subscriptions appeal

Total giving from more than 540 foundation patrons and donors who included foundation gifts with their annual college subscriptions for 2021 has now exceeded \$75,000, another record high. A big thank you goes to all of the generous supporters who donated in this way, for contributing to the sustainability of the foundation and the vital work we support together.

Foundation patrons to be honoured

The ANZCA Research Committee has approved the creation of a new annual research award for emerging researchers, to be named in honour of the foundation's patron level supporters.

The new ANZCA Patrons Emerging Investigator Research Award, to be conferred every year along with the foundation's other named awards within ANZCA's annual research grant round, has been created to recognise the outstanding long-term support of foundation patrons.

Patrons are the foundation's most committed donors, due either to having committed to donate \$A1000 or more annually, or having reached total giving of \$A5000 or more.

Patrons will have the choice of directing their giving to support the new award, or just continuing to provide general support for the work of the foundation.

As well as increasing the recognition of our valued patrons, the new award provides emerging researchers with an exciting new pathway between ANZCA's Novice Investigator Grants, which provide up to \$A20,000, and ANZCA Project Grants providing up to \$A70,000. The award gives applicants the opportunity to further develop the skills and abilities they need to access larger grants, while competing with their emerging investigator peers at a similar level.

Providing a grant of up to \$A70,000, each year, the new emerging investigator award will be restricted to researchers who have not previously received a grant of more than \$A20,000, have not been principal investigator on more than two successful grants, and have not had more than five peer-reviewed publications as first author.

The first ANZCA Patrons Emerging Investigator Research Award will open for applications from 1 December 2021, when the guidelines and application form will be available on the college website.

AMEAR Award and AMER Scholarship

We are very pleased to announce that the ANZCA Melbourne Emerging Anaesthesia Research Award (AMEARA) for 2021 has been awarded to Dr Way Siong (Alex) Koh, for his study "A randomised controlled trial of dexmedetomidine to reduce pain after spinal fusion surgery (The SPADE Study)".

We are also very pleased to announce that the ANZCA Melbourne Emerging Researcher Scholarship (AMERS) has been awarded to Dr Ned Douglas, based on his PhD-related study "Postoperative hypotension: causes and consequences".

The foundation is grateful for the generosity of Dr Peter Lowe, the long-standing patron of these two awards.



Dr Way Siong (Alex) Koh.



Dr Ned Douglas.

Second COVID-19 study published

The "COVID-19 Risk in Elective Surgery During a Second Wave: A Prospective Cohort Study", funded in equal parts by Medibank Better Health Foundation (MBHF) through the ANZCA Research Foundation, and Safer Care Victoria, has been published in the *Australian and New Zealand Journal of Surgery* (ANZ J Surg.). The FANZCA authors included Professor Paul Myles, Professor David Story, Professor David A Scott, Professor Andrew Forbes, and Professor Andrew Davidson, Dr Andrew Jeffreys, Dr Niki Tan, and Dr Jade Radnor.

This study of the prevalence of SARS-CoV-2 infection in asymptomatic elective surgery patients across eight Melbourne hospitals found very low likelihood of transmission, and recommended consideration of elective surgery recommencement and a mandatory screening checklist for elective surgery patients.

The study followed another ANZCA fellow-led study on COVID-19 screening in two Melbourne hospitals completed earlier in 2020 with foundation-negotiated MBHF funding, published in the peer-reviewed *Australian Health Review* and in Melbourne's *Herald Sun*.

Reminder for bequestors

If you are considering or have already recently included the foundation in your will, please advise us so that you can be recognised if desired in our communications, and included as a member of the John Snow Society, which will be more prominently featured after planned revisions to the foundation's website pages.

Contacting the foundation

To donate online, search "GiftOptions – ANZCA" in your browser.

For general queries, contact:

- Rob Packer, general manager
+61 3 (0)409 481 295
rpacker@anzca.edu.au.
- Kayla Smith, Fundraising Administration Officer
ksmith@anzca.edu.au.

ANZCA research grant program queries:

- Susan Collins, Research and Administration Co-ordinator
scollins@anzca.edu.au.

Fellows or trainees interested in becoming involved in CTN-led clinical studies should contact:

- Karen Goulding, CTN Manager
ctn@anzca.edu.au.

Mentoring crucial to encourage new researchers

Dr Claire Rose, a junior doctor in Queensland with an interest in gastric ultrasound research, is hoping to pursue anaesthesia as her specialty. Here she explains the genesis of her first research study and how mentoring support from senior anaesthetists including FANZCA Dr Sarah Bowman has been crucial in helping her navigate her way through the research maze.

MY JOURNEY INTO research began when, after searching for a topic, Dr Sarah Bowman – FANZCA and Principle Investigator – suggested perioperative point of care gastric ultrasound. While gastric ultrasound is well researched and used as a point of care tool in the UK and other countries^{1,2} a review of the literature revealed that Australian studies are somewhat lacking and even fewer studies have looked at its utility in the endoscopy unit.

Gastrointestinal endoscopy harbors the greater risk for aspiration events occurring under procedural sedation³. Several factors contribute to this risk including attenuation of protective airway reflexes, patient positioning during the procedure, stimulation of the gag reflex and insufflation of air during upper and lower endoscopy respectively. Aspiration occurs reportedly in 0.16 per cent of colonoscopies and 0.19 per cent of upper endoscopies³. Fasting patients before endoscopic procedures is intended to mitigate this risk of aspiration. There are factors however that may affect the rate of gastric emptying such as obesity, diabetes, pregnancy, acute pain and certain medications⁴. Not every patient is the same, and therefore, can we always assume the patient's stomach is adequately emptied with the same length of fasting? This is what we set out to investigate through the use of gastric ultrasound.

Point of care gastric ultrasound is an emerging bedside tool that allows for assessment of gastric volume and contents to aid anaesthetists' decision-making on whether to proceed, delay or modify sedation or general anaesthetic².

We conducted a pilot study at Queen Elizabeth II Hospital in Brisbane that involved performing gastric ultrasound in 31 patients undergoing elective gastrointestinal endoscopy. The procedure is performed by using a curved array low frequency transducer (1-5MHz) probe placed in the patient's epigastric region in the sagittal plane. The gastric antrum is identified in both the supine and right lateral decubitus (RLD) position using nearby anatomical landmarks. The purpose of the RLD position is to empty any contents from the fundus of the stomach into the antrum. From here the contents of the gastric antrum can be qualified and quantified².

Clear fluids and gastric secretions appear as anechoic or hypoechoic whereas thick fluids are more echogenic¹. The consumption of solid food is associated with ingestion of air, which impairs sonographic visualisation and creates a "frosted glass" like appearance⁴. The stomach is empty when it is visualised as small and collapsed in both the supine and RLD position. This is classified as a grade 0 antrum and associated with a low pulmonary aspiration risk³. A grade 1 antrum also has a low aspiration risk and is present when fluid is only visible in the RLD position³. The grade 2 antrum is when fluid is visible in both the supine and RLD position and is associated with a high pulmonary aspiration risk². Two simple calculations can be used to calculate the antral surface area, and from this the gastric volume¹. For further quantification – a gastric volume of more than 1.5mL/kg of actual body weight is consistent with greater than baseline gastric secretions and is associated with an increased aspiration risk³.

Our data concurred with the literature that a grade 1 antrum correlates with less than 100mL of gastric volume and a grade 2 antrum greater than 100mL. Increasing antral surface area is also associated with larger volumes².

As expected, the majority of patients in this study had grade 0 or 1 antrums. The most surprising finding, however, was the higher than anticipated number of patients with grade 2 antrums. The literature reports the incidence of grade 2 antrums to be 3-5 per cent¹. Our data however found the incidence to be much higher – 19 per cent in fact, with half of these having more volume than what could be expected from baseline secretions. All of these patients were ASA 3 or higher, with multiple comorbidities such as type 2 diabetes mellitus. All of these patients were also fasted beyond the minimum requirements with none being required to consume further "re-do" bowel preparation on the day of presentation. Perhaps



Dr Sarah Bowman (left) and Dr Claire Rose.

an important enquiry for further research down this avenue is how might their gastric volumes have differed if this was not the case?

In the context of further research, it is hoped that this study will influence further larger studies to be conducted with the scope extended to emergency endoscopy or surgical patients in whom the risk of aspiration may be higher. The utility of gastric ultrasound may be of even greater benefit in this cohort. Anecdotal evidence of this is the emergency endoscopy patient with an upper gastrointestinal bleed – who was encountered during the course of this study. The patient was found sonographically to have a grade 2 antrum. Based on this, the senior anaesthetist made the decision to administer a prokinetic medication – intravenous metocloperamide. After a 40-minute delay the patient was found to have an empty stomach and proceeded to have an uncomplicated procedure.

Conducting a research project, especially for the first time, has definitely had its challenges. The process of obtaining ethics approval was certainly more lengthy and arduous than anticipated. There are certain things however that can only be learned by going through the process and troubleshooting along the way. This included working out the logistics of timing access to the departmental ultrasound machine when it was not in clinical use and the positive engagement of stakeholders such as the anaesthesia department, gastroenterologists and endoscopy nurses. The technical aspect of performing ultrasound on morbidly obese patients also required more practice than expected prior to data collection.

Perhaps the most important thing for anyone starting out in research is finding a good mentor; someone who can be both motivating and realistic. This is where the door really opened for me. Prior to this I felt daunted by the process. As such, senior anaesthetists have an important role in promoting involvement in research for trainees and junior doctors. Cultivating a culture of aspirations in research through the generations of anaesthetists is important for innovation and progression of the specialty as a whole.

Dr Sarah Bowman is a staff specialist at Queen Elizabeth II Hospital, Brisbane and a senior lecturer anaesthetics at the University of Queensland.

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Managing anaesthesia waste

Fellows Dr Yena Hwang and Associate Professor Kerstin Wysseusek reveal the results of a Queensland survey of anaesthetists about their hospital's theatre recycling practices.

THE HEALTHCARE SECTOR is one of the largest contributors of waste nationwide, with operating theatres generating up to 30 per cent of the total hospital waste^{1,2}. Anaesthesia waste accounts for a quarter of the operating theatre waste, of which 60 per cent can be recycled^{3,4}.

Anaesthetists have the power to affect the environment in our daily practice, through waste production and carbon emissions^{5,6}. To gain an insight into the opinions and recycling practices of anaesthetists in Queensland, a 14-question electronic survey was sent out to Queensland fellows, trainees and specialist international medical graduates (SIMGs).

Results

Via an ANZCA email list the electronic survey was sent to 1394 anaesthetists. Unidentified and anonymous data was collated from 216 responses within a four-week period (15.5 per cent response rate).

More than 90 per cent of respondents made an effort to recycle at home, with most recycling at least 75 per cent of paper, cardboard, glass and hard plastic. The rate of soft plastic recycling was more variable, with 21.8 per cent having not recycled it at all in the past year. The majority were aware of community recycling initiatives such as yellow-top bin home recycling, container deposit schemes and soft plastic recycling programs.

Fifty-three per cent of respondents stated there was a recycling taskforce in their hospital, but nearly a third were unsure. Seventy-two per cent were aware that operating theatre waste was recycled. Paper and cardboard were the most commonly recycled, followed by polyvinylchloride (PVC) and hard plastic.

More than 97 per cent and nearly 95 per cent of respondents were in agreement that more recycling should occur in the community and hospital setting, respectively. Lack of recycling facilities, staff attitudes and hospital culture were the most common barriers to recycling in operating theatres.

Recommendations

The responses to this survey show that anaesthetists are passionate and conscious of recycling, waste reduction and the environmental impact of healthcare, but there are many limitations that need to be addressed. A multi-faceted approach is essential in tackling our barriers to recycling, which includes:

- Engaging with stakeholders (governments, hospital management and recycling companies).
- Appointing hospital recycling champions and committees to increase education and awareness.
- Having dedicated, streamlined recycling stations in theatre with clear instructions.
- Quantifying cost savings for the hospital (reduced general waste, monetary incentives for recycling metals).
- Establish sustainable procurement processes.

Dr Yena Hwang

Staff Specialist Anaesthetist, Royal Darwin Hospital

Associate Professor Kerstin Wysseusek

Director of Anaesthesia and Perioperative Medicine, Royal Brisbane and Women's Hospital

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ANZCA
FPM

NATIONAL ANAESTHESIA DAY 2021

Save the date – Monday 18 October – and don't forget to book foyer space at your hospital!

Each year we celebrate ANZCA National Anaesthesia Day across Australia and New Zealand on 16 October, the anniversary of the day in 1846 that ether anaesthetic was first demonstrated in Boston. As 16 October falls on a Saturday this year we will celebrate National Anaesthesia Day on Monday 18 October.

Each year, many hospitals across Australia and New Zealand set up foyer displays to showcase the specialty with equipment and mannequins. Anaesthetists are also on hand to answer questions from the public and distribute patient information sheets. We also run a media campaign to highlight anaesthesia.

The 2021 theme is "Anaesthesia and having a baby".

More information will be coming soon – including a new patient information video.

Medical Board of Australia national medical trainee survey

The survey results of nearly 21,000 doctors in training (double last year's response and 57 per cent of Australia's doctors in training) provides a single, national snapshot of the state of medical training in Australia. Of those surveyed, 712 ANZCA trainees responded (more than half of the 1405 ANZCA and pain medicine trainees in Australia).

The key difference to last year's Medical Board survey which included responses on bullying, discrimination and harassment, are the additional questions about how COVID-19 affected medical training. Overall, ANZCA's training program seems to be highly regarded. ANZCA trainee responses on bullying, harassment and discrimination are similar to last year.

- Sixty per cent of ANZCA trainees surveyed in the Medical Board survey said COVID disrupted preparation time for exams because of unconfirmed exam/assessment dates. This compared to 34 per cent of the total cohort of trainees surveyed.
- Sixty-six per cent of ANZCA trainees said COVID created uncertainty for the remainder of the training year compared to 43 per cent of other trainees.
- Fifty-five per cent of ANZCA trainees said COVID had a negative impact on their training compared to 32 per cent of other trainees.

In the foreword to the report, Medical Board Chair Dr Anne Tonkin said: "Perhaps unsurprisingly, 80 per cent said the pandemic had impacted on their training. About one third of trainees overall (notably 37 per cent in Victoria) reported it having had a negative effect, nearly half said the impact on their training was mixed, and more than one third said it had led to innovative ways to learn."

Dr Tonkin said 34 per cent of doctors in training reported they had experienced and/or witnessed bullying, harassment or discrimination, consistent with 33 per cent in 2019.

Darcy Price ANZCA Regional Research Award



Dr Darcy Price with baby daughter Rita.

THE SPECIALTY OF anaesthesia is fortunate in having a legacy of clinicians who have made huge impacts on the lives of their patients, colleagues, peers, friends and family. When their lives end prematurely it can be challenging to know how best to remember their position in the greater anaesthesia community.

When our friend Dr Darcy Price died in 2018, we, as a department, chose to honour his name and place in our professional community by setting up an eponymously-named research prize.

While never seeking the limelight, Darcy was a leader in many areas of life. Those who knew him knew a man of integrity, humour and a passion for teaching. Darcy was a family man – husband and father to two fantastic daughters – and an outstanding sportsman who gained international recognition as an ocean kayaker and an active teacher in anaesthesia. He was involved in both primary and secondary teaching for FANZCA examinations. His physiology background allowed him to decipher the complexities of Wigger's diagrams and aortic flow-volume loops to generations of candidates.

Darcy particularly enjoyed both the teaching and research into regional anaesthesia. Clinically he gained national and international recognition for his regional anaesthesia teaching using university cadaver labs, clinical simulators and radiology to finesse his clinical practice and teaching methods. His office had its resident "skeleton" and he took great pleasure in navigating the intricacies of bony canals and surface anatomy to trainees and colleagues alike. Darcy's enquiring mind allowed him to undertake research into various aspects of regional anaesthesia and he developed an eponymously named block for shoulder

surgery – "The Block of Price". He developed new innovative techniques using combined high thoracic epidural anaesthesia and suprascapular nerve blocks for thoraco-scapular fusion.

The addition of ultrasound allowed Darcy to review traditional approaches to nerve blocks and suggest new approaches. To this end he reported new approaches for radial nerve block and extensively explored axillary nerve blocks to supplement suprascapular blocks for shoulder surgery.

He engaged in academic discussions over the optimal dose of local anaesthesia for brachial plexus blocks and challenged dogma over best practice for shoulder surgery regional anaesthesia.

When considering how we should remember our friend and colleague, it was obvious that his name should be associated with both clinical research and regional anaesthesia. The inaugural Darcy Price ANZCA Regional Research Award has been awarded to Dr Waiss Sekandarzad from The Alfred hospital in Melbourne to investigate the effect of erector spinae block on acute pain and respiratory function following rib fracture/s. This study epitomises the aspirations of the funding department (Department of Anaesthesiology and Perioperative Medicine, Waitemata District Health Board, Auckland) and Dr Price.

As a clinician who often undertook acute pain rounds, Darcy was active in placing intercostal blocks and Erector Spinae Blocks. He was pragmatic and always put his patients at the centre of his clinical world. As such this study reflects all the qualities we admired in Darcy. We hope that this research grant will attract new researchers with clinical questions which are patient-centred and utilise regional anaesthesia in new and effective ways.

The Waitemata department acknowledges the support of ANZCA in co-ordinating this grant and providing a high-profile platform to acknowledge an important figure in our lives.

Associate Professor Michal Kluger
Dr Amitha Abeysekera
Dr Vincent Fong
Dr Charles McFarlan
 North Shore Hospital, Waitemata DHB

ANZCA Prize for Best Quality Scientific Presentation

THE NEW ZEALAND 2020 Annual Registrar Meeting was held on 4 December at Auckland City Hospital. This year it was offered as a hybrid meeting with a face-to-face audience and a Zoom webinar broadcast due to the possibility that gathering limits may be required. This allowed participants to view the meeting virtually which opened it up to participants outside Auckland. There was also a virtual presenter. These options will continue to be offered in future events.

The judges this year were Professor Alan Merry, Dr Tin Chiu and Dr Kerry English.

The ANZCA Prize for the Best Scientific presentation was awarded to Dr Julius Dale-Gandar, anaesthesia fellow from Auckland, for his presentation "A retrospective review of postoperative

respiratory complications in patients undergoing elective colorectal and upper gastrointestinal surgery at Auckland District Health Board (ADHB)".

The New Zealand Society of Anaesthetists (NZSA) prize for the Best Quality Scientific Presentation was awarded to Dr Susanne Eadie, anaesthesia fellow from Wellington for her presentation "Shorter water: Reducing excessive fasting times for preoperative fluid intake". She delivered her presentation virtually from the United Kingdom in the early hours of the morning, having returned there after spending a year in Wellington as out-of-program experience from her British anaesthesia training.



Dr Julius Dale-Gandar with the ANZCA Prize for the Best Scientific Presentation.

Australian Capital Territory



2021 Art of Anaesthesia CME

Save the date for the 2021 Art of Anaesthesia CME – September 11 and 12 at the Hotel Realm, Barton ACT. The working title of this year’s meeting is “The Occasional Anaesthetist” and the focus for much of the lectures will be refreshers in the main anaesthetic disciplines. We have an exciting line up of speakers on offer this year including Dr Joanne Irons (RPA, Sydney), Professor Bernhard Riedel (Peter Mac, Melbourne), Associate Professor Forbes McGain (Western Health, Melbourne), Dr Peter Hebbard (Northeast Health, Wangaratta), and plenty of our best local speakers also. Pop the date in your diary now and we look forward to seeing you in Canberra in Spring. Registration will open shortly!

ACT Trainee Committee

In 2021 we welcome a new trainee committee and look forward to getting to know them over the next year. The committee members are: Dr Anneliese Kerr, Dr Michael Li, Dr Fabio Longordo, Dr Cameron Maxwell (Chair), Dr Dharan Sukumar (Deputy Chair), Dr Daniel Foong (co-opted), Dr Shruti Krishnan (co-opted), Dr Laura Staples (co-opted), Dr Kurt Zapasnik (co-opted), and Dr Mark Giddings (co-opted). We look forward to working closely with them during 2021.

Supervisors of Training Meeting

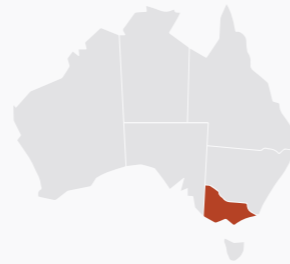
Following on from the SOT panel within the Introduction to Anaesthesia Course, we had a separate afternoon meeting on Friday 26 February for supervisors of training to join afterwards. The group was welcomed by Dr Alex Henry (EO), Dr Tim McIver and Deas Brouwer (Deputy EOs), along with Maurice Hennessey from the ANZCA Education unit who gave talks including online learning facilitation, assisting new and established SOTs in their role, and current challenges. It was a well-received meeting and a great introduction back after not having any meetings in 2020.

The EO committee are planning two further full day meetings in 2021, tentatively scheduled for Thursday 3 June and Tuesday 11 November. These will include two educators workshops, updates from the Education unit along with other presentations and topics of discussion. A program will be emailed to all supervisors of training closer to the dates.

FPM VRC CME Evening meeting

Hosted by Dr Louise Brennan, the FPM VRC chair, this evening lecture was held online via Zoom on Wednesday 24 March. The topic of the lecture “Navigating the complaint process” was presented by Dr Sara Bird. It was a very well-received meeting with 45 registered and delegates that were not able to attend in person requesting slides and recordings of the talk. Our warm thanks goes to the FPM VRC Committee, our presenter Dr Sara Bird, and all participants.

Victoria



Final Refresher Course and Final Anatomy Course

Both of these courses are traditionally held onsite at the college but were delivered online via Zoom due to restrictions. The Final Refresher Course was a five-day course from Monday 8 to Friday 12 February, followed by the one-day anatomy course held on Monday 15 February. There was a total of 22 presentations given that were tailored to assist with preparation for the final exam and each were also recorded. Many thanks to all the presenters for their valuable contributions.

We had great attendance of about 100 trainees registering, some joining in for the live presentations each day and others opting to watch the recordings afterwards at their leisure. The recording have proven to be a valuable resource for our trainees to be able to access and watch these over again to study and refresh up until their exams. Registration in these courses gives access to online links to join and/or access to the recordings.

Introduction to Anaesthesia

The Introduction to Anaesthesia course was held online via Zoom on Friday 26 February. The whole day course was attended by a healthy balance of new Victorian introductory trainees and resident medical officers aspiring to be trainees and anaesthetists. The trainees were welcomed by co-convenors Dr Adriana Bibbo and Dr Aaron Paul. The presentations covered welfare of anaesthetists, introduction of TPS/WBAs, curriculum, updates on college resources, Victorian Trainee Committee, ASA, as well as stories from other trainees. A significant part of the course was run by trainees for trainees. There was also an interactive question and answer sessions with supervisors of training and the day finished with a CICO, regional anaesthesia, and Introduction to airways talk. Generally when held in person it is more interactive with group airway sessions aimed at teamwork and team learning, and the highlight for this course is also the opportunity for trainees to network and forge friendships. It was difficult to do this not being face-to-face however the day was well received overall. Many thanks to all the valued presenters, SOTs and workshop facilitators for their contributions, and also thank you for the support of the convenor, Dr Lucky De Silva, and co-convenors Dr Adriana Bibbo and Dr Aaron Paul for their help to bring this meeting together.

Upcoming events and courses – save the date and register online!

Melbourne Winter Anaesthetic Meeting – save the date/s

- Saturday 28 August 2021 (exploring idea of an online scientific meeting during the day, followed by a face-to-face dinner in the evening at the Sofitel)
- Sunday 29 August 2021 (Emergency Response Workshops to be held face-to-face) at the Sofitel Melbourne on Collins.

Further details to come, and in the meantime please save the date in your calendars.

Victorian Registrars’ Scientific Meeting

The Victorian Regional Committee invites you to join us on Friday 12 November from 1-6pm. Once again we are offering a prize for best presentation on the day in each of the following two categories: Scientific research project or audit. To participate please send in an abstract of 250 words in either category, and/or you can register to attend to support your colleagues online.

Exam prep courses dates:

- **Primary VIVA practice nights**
Monday 19 April, Wednesday 21 April, Wednesday 28 April, and Monday 3 May (possibly further dates).

Monday 6 September, Wednesday 8 September, Monday 13 September, and Wednesday 15 September (possibly further dates).
- **Final VIVA practice nights**
Wednesday 5 May, Monday 10 May, Wednesday 12 May, Monday 17 May (possibly further dates).

Monday 4 October, Wednesday 6 October, Monday 11 October, Wednesday 13 October (possibly further dates).
- **Primary Refresher Course**
Monday 17 to Friday 28 May
Monday 15 to Friday 26 November
- **Final Refresher Course**
Monday 19 to Friday 23 July
- **Final Anatomy Course**
Mon 26 July

Please contact us should you have any queries and/or to express interest in attending either of our courses/events via vic@anzca.edu.au or phone +61 3 8517 5313.

Attention trainees – You can contact the members of Victorian Trainee Committee confidentially!

If you have any queries or concerns that you would like to discuss with a member of the Victorian Trainee Committee you are welcome to contact them direct via their private email vicanaestheticregistrars@gmail.com.

South Australia and Northern Territory



SA Primary Exam Refresher Course

We were excited to deliver the inaugural SA Primary Exam Refresher Course from 8-12 February at The Lion Hotel, North Adelaide. This intensive course covered many of the core curriculum topics via tutorials, short answer questions, multiple choice questions and viva practices. The convenor, Dr Gary Tham, worked tirelessly in delivering this valuable program and his passion for giving trainees the best opportunity to pass the primary exam is outstanding. We wish to thank the course co-convenor, Dr Adelaide Schumann, for all of her input towards the course and trainee exam preparation, as well as all the consultants and viva volunteers who generously imparted their knowledge to attendees. We look forward to offering this course twice a year with the planning for the mid-year 2021 course already underway.

SA FPM webinar

FPM specialist pain medicine physicians and allied health professionals attended a “Medicinal cannabis – a clinical update” webinar on 15 February. The session was presented by Ms Tania Colarco, Clinical Pharmacist, Drugs and Therapeutics Information Service (DATIS), and Dr Meredith Craigie, FPM Immediate Past Dean. It was well-attended by local and interstate members and discussed issues relating to medicinal cannabis including risks, treatment, approvals, products and manufacturers.

SA March ACE Meeting

The South Australian Anaesthesia Continuing Education Meeting was held at the Lion Hotel, North Adelaide on 25 March. Delegates were out in force enjoying the opportunity to gather for the first face-to-face ACE meeting held in Adelaide for more than 12 months. Speakers Dr Indy Lin and Dr Brigid Brown presented “Novel fascia blocks of the lower limb – PENG and iPACK.

After the presentation, three scanning machines were available for delegates to get hands-on experience in the pericapsular nerve group (PENG) block, a novel regional analgesia technique of the hip and the iPACK block, a tissue plane block of the posterior aspect of the knee.

The CME Committee would like to thank Dr Lin and Dr Brown for their efforts in putting together such a successful meeting.

Adelaide’s state of the art EMAC course

Adelaide’s first Effective Management of Anaesthetic Crises (EMAC) course launched in February thanks to the efforts of a team of local fellows led by Dr Cameron Main and Dr Giresh Chandran.

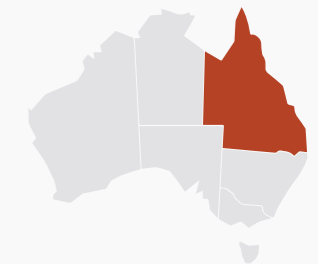
In a collaboration between local ANZCA fellows, ANZCA and the University of Adelaide, the two-and-a-half day high fidelity EMAC course was offered to SA-based trainees and facilitated by 10 Adelaide based instructors with Dr Stuart Marshall, Supervisor of EMAC, able to participate by Zoom link from Melbourne.

The course was held at Adelaide Health Simulation, a recently built state-of-the-art simulation centre which is accredited by the Society for Simulation in Healthcare. Running EMAC in South Australia provides the opportunity for local doctors to attend an EMAC course during this time of uncertainty due to COVID-related border closures.

Facilitators are now looking ahead to make this an ongoing, viable and sustainable course for South Australia and have commenced planning to run a second course in September 2021. To register your interest, please contact sa@anzca.edu.au.



Queensland



A busy start to the year

Despite the recent lockdowns and varying restrictions associated with COVID-19, we continue to focus on delivering courses to support our trainees as best as possible. In order to best meet the trainees’ learning needs we have adapted a number of courses to a hybrid format, offering both face-to-face and remote registrations where possible.

The annual Introduction to Anaesthesia course (formerly Part Zero), was held on Saturday 6 February 2021. This year we welcomed 45 new trainees, both in person and remotely via Zoom. The course is aimed at providing introductory trainees with information and tips that are relevant to them and their training, and is a great opportunity to meet other trainees and build friendships and connections. We would like to thank all the fellows and trainees who provided support and expertise during the course.

The primary lecture program is on offer again in 2021, with the course being opened up to trainees outside of Queensland for the first time. Participation continues to grow, with 21 trainees registering for series one in person, and 18 attendees joining remotely. Thank you to Education Officer Dr Robert Elliot and Course Convenor Dr Gamini Wijerathne for helping to make this happen.

The final exam refresher course was held on 16-19 February, with 29 trainees attending in person at the ANZCA Queensland regional office, and five trainees joining remotely. Thank you once again to convenor Dr Stuart Blain, and to all fellows who presented at this course.

Conjoint ASA NSC and Qld ACE meeting

We are pleased to announce that the Queensland ACE meeting will be joining forces with the ASA National Scientific Congress (NSC) in 2021. With COVID-19 impacting much of what we do and changing the way we deliver meetings and come together, this exciting initiative is sure to be a success. We trust you will be as eager as we are to attend.

The Conjoint ASA NSC & QLD ACE meeting will run from 23-25 July 2021 at the Brisbane Convention and Exhibition Centre. Retaining and enhancing elements from both the QLD ACE meeting and the ASA NSC, this combined event will deliver an extensive scientific programme including workshops and quality assurance activities, along with social events and opportunities to meet and reconnect with colleagues.

Further details will be announced over the coming months as our committees continue to work together. This will include a new look for the meeting, registration information and importantly CPD opportunities available.

We look forward to welcoming you to Brisbane in July 2021 as we showcase our regional experience, expertise and energy along with the broader ASA NSC.

Dr Ed Pilling and Dr Peta Lorrway
Co-Convenors

Course convenor Dr Gary Tham, centre, with course attendees



TQEH Barossa Valley Conference

The Barossa Valley Emergency Responses and Wellbeing Workshops Team-Building Conference was an idea conceived during the midst of COVID-19. Initially the conference was planned to ensure that consultants were able to maintain their CPD requirements, something that was challenging due to travel restrictions.

It started out as just an emergency response workshop, however, it became apparent there was an appetite for the inclusion of some wellbeing and team building activities. The constantly changing work environment and the uncertainty surrounding occupational, social and personal activities of 2020 had taken a significant toll on staff morale.

On a lovely sunny weekend in February, a group of 24 anaesthetists from the Queen Elizabeth Hospital, convened at the Novotel in the heart of the Barossa Valley. The stress of the morning CICO and anaphylaxis workshops was alleviated by an “Amazing Race” challenge which

saw the group divided into four teams and set against each other in a race around the picturesque township of Tanunda. The team-building activities were many and varied, including the construction of a human catapult, a grape stomping exercise and navigation around the town. Despite the intense rivalry, there was much hilarity and good-natured verbal jousting which extended to the winning team wearing their gold medals to the conference dinner at Hentley Farm that evening!

Sunday morning’s wellbeing workshop was run by Dr Andrew Czuchwicki, the Wellbeing Officer for our department and a qualified yoga and mPEAK instructor. It was a valuable session that yielded many useful insights and practical exercises for participants to incorporate into their daily routines.

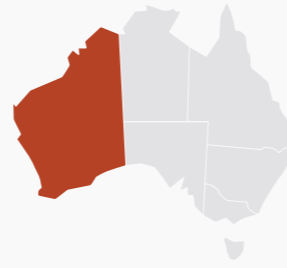
Thanks are extended to workshop facilitators Dr Nikki Dyson, Dr Louis Papillion, Dr Nagesh Nanjappa and Dr Andrew Czuchwicki.

Dr Zoe Lagana and Dr Faith Crichton
Conference Convenors



TQEH CICO workshop.

Western Australia



Introduction to Anaesthesia Course

The Introduction to Anaesthesia is run yearly in all regions and New Zealand to welcome new trainees into the ANZCA training program. The course is a face-to-face, full day event aimed at providing introductory trainees with information that is relevant to them and their training. It is also a fantastic opportunity to meet other trainees in the training program and build friendships and connections.

This year WA invited 16 new trainees to the course which was held via Zoom; we once again welcomed guest speakers including trainees, supervisors of training and consultants and to discuss professionalism and performance, ANZCA resources, the Training Portfolio System, welfare, mentoring and training. ANZCA WA would like to thank the fellows and trainees who provided support and expertise during the course. We would also like to offer our sincerest thanks to Dr Jay Bruce, Dr Kevin Hartley and Dr Annie Carlton for their time and efforts in facilitating the Introduction to Anaesthesia course, the extensive mix of experience they provided.

Anaesthetic Trainee Information Evening

Dr Kevin Hartley and Dr Jay Bruce have introduced an anaesthetic trainee information evening which was held on 15 March in the ANZCA WA office and will again be held on 7 April. Medical students and junior doctors are invited to learn more about the training program and what it is like to be an anaesthetic trainee.

Final Exam Preparation Course

The Final Exam Preparation Course is well under way. If you are a trainee studying for your final exam and would like some further tutoring please visit the ANZCA Calendar for the WA Final Exam Preparation Course registration page.

WA ACE conferences

The WA ACE Autumn Scientific Meeting 2021 will be held on 27 March 2021, themed "Reflect, reset, reconnect", which encompasses the normalcy to which we'd like to return after the last, very unusual, year. It is convened by Dr Archana Shrivathsa and Dr Charlie Ho with the WA ACE Committee.

The WA ACE Country Conference 2021 will be held from 29-31 October 2021 at the Pullman Resort in Bunker Bay, convened by Dr Chris Gibson and Dr Paddy Cowie from the Perth Children's Hospital.

Committee meetings

The EO/SOT Committee held their annual dinner meeting on Wednesday 10 February, at Mayfair Lane in Perth. The regional committee met on 16 February and the trainee committee had their first meeting of the year on February 9.

Voluntary Assisted Dying Training

The mandatory training for participating practitioners will be a series of online modules, estimated to take approximately six hours to complete. The training will include an assessment component which practitioners are required to pass in order to be approved as a VAD practitioner.

There is no specified role specifically for anaesthetists in the Act but they would be eligible to apply for access to the training to become an approved Practitioner.

From 1 July 2021, any medical practitioner who receives a request from a patient to access voluntary assisted dying must do three things:

1. Respond to the patient's request (immediately if they hold a conscientious objection or within two business days); and
2. Provide the patient with the "Approved information for a person making a first request for voluntary assisted dying" information sheet; and
3. Notify the Voluntary Assisted Dying Board by completing the first request form (typically completed and submitted online).

Information sheets under "Information for professionals" and "Information for the community" are on the Government of Western Australia Department of Health website: ww2.health.wa.gov.au/voluntaryassisteddying.

Tasmania



Another busy start to 2021 with the Foundation Day and Introduction to Anaesthesia Training Program occurring in Launceston on 19 and 20 February which was followed by the Trainee Day on 26 February and the Tasmanian ASM on 27 and 28 February in Hobart.

Introduction to Anaesthesia Training

The 2021 Introduction to Anaesthesia Training course was held on 20 February at the Silo Hotel in Launceston. The course was attended by 15 delegates comprising ANZCA Introductory Trainees and prospective anaesthesia trainees. Dr Joanne Samuel and Dr Rowena Lawson convened the meeting and were well supported by presenters from all three regions including Dr Martin Russnak, Dr Ryan Hughes, Dr Jeremy Sutton, Dr Greg Bulman, Dr Lia Freestone, Dr Gregg Best, Dr Lokesh Anand and a panel session consisting of all the supervisors of training in the state.

Overall feedback was positive with delegates valuing the location, catering and organisation of the day. One reviewer wrote "Good organisation of basic info related to training. The tips and personal advice from different anaesthetists was the most interesting/useful part". The course convenors were pleased with how the day went and thought that the day played an important role in guiding trainees on how to navigate the ANZCA training program in Tasmania. The convenors were

grateful to the presenters for donating their weekend to share their thoughts, experiences and pearls of wisdom with the trainees.

The Tasmanian Trainee Day

The annual Tasmanian Trainee Day is held on the Friday preceding the Tasmanian Annual Scientific Meeting. Tasmania is the only state that has a "trainee day" that provides registrars with an array of fascinating speakers that they otherwise wouldn't have been exposed to and includes an opportunity to hear from interstate speakers attending the Tasmanian ASM in an intimate and relaxed atmosphere.

Altogether 25 delegates attended the meeting which was followed by drinks and canapes in the hotel's lounge at the end of the day.

Interstate speakers included Professor Guy Ludbrook presenting on "Spending wisely – what we offer health in a COVID world" and Dr Jennifer Long on the acutely distressed pain patient and how to manage without more opioids.

The meeting was again well supported by Tasmanian presenters, including Dr Alicia Tucker (FACEM) on hyperbaric and space medicine and Dr Lucy Barnett who spoke on pre-hospital medicine and her time with Sydney HEMS. Local anaesthetist Dr Mat Yarrow gave a great update on allergy and anaphylaxis in anaesthetic practice with Dr Adam Mahoney showing the wide range of experience offer through the Australian Defence Force and Australian medical assistance teams. Dr Mark Reeves travelled from the north-west of the state and shared his wealth of knowledge on the ANZCA exams and how to do well. Dr David Alcock gave an update on ANZCA's upcoming perioperative qualification and on risk assessment preoperatively.

The presidents of ANZCA and ASA have traditionally been an important part of trainee day. Dr Vanessa Beavis planned to be present but wasn't able to attend and prepared a pre-recorded message for the attendees. Dr Suzi Nou also was unable to attend with Dr Vida Viliunas, the ASA Education Officer and Chair of the ASA Online Education sub-committee kindly representing her on the day.

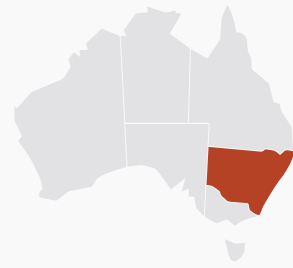
Co-convenors Dr Dylan Siejka and Dr Nicola Fracalossi were thrilled with how the day went and received a lot of very positive feedback from delegates and presenters on the day. They enjoyed each of the presentations and particularly valued the panel of speakers including Dr Lia Freestone; Dr Bruce Newman; Dr Adam Mahoney; Professor Guy Ludbrook and Dr Lucy Barnett with a wide range of topics discussed. Thank you to all involved in assisting with the ongoing education of Tasmanian trainees.

The Introduction to Anaesthesia Training (formerly Part Zero) course in Launceston on 20 February 2021.



Dr Alicia Tucker, Emergency Specialist, Royal Hobart Hospital Hyperbaric and space medicine.





New South Wales



Tasmanian Annual Scientific Meeting 2021

Tasmania has the unusual honor of holding the last ACE face-to-face meeting last February 2020 with our international speaker, Professor Meg Rosenblatt returning to New York on 2 March 2020 and in February 2021, we are the first to hold an ACE face-to-face meeting since COVID began.

All efforts were made to make the meeting as COVID safe as possible and meet both the state and University COVID safe guidelines. All people who entered the venue were temperature checked at the start of the day with sanitizing stations located around the venue.



A total of 81 delegates registered to attend (the maximum that the School of Medicine, University of Tasmania lecture theatres could take). The program was divided between the two lecture theatres with speakers presenting twice with starting and finishing times and break times all held at separate times to allow delegates the opportunity to social distance appropriately. Only seven trade were invited to participate which also allowed maximum opportunity for distancing and delegates were encourage to take their breaks sitting outside in the fresh air with individually packed healthy and delicious catering.

The theme of the meeting 'A New World' examined COVID; Acute Pain

From top: Regional Workstation with Dr Ranjita Sharma demonstrating techniques; a glittering dinner with stunning views provided an enjoyable and relaxed venue to finish the scientific program.

and Perioperative Medicine. The traditional president's address were pre-recorded and were followed by a panel discussion on 'Towards a new world in anaesthesia and perioperative medicine'.

The convenor of the meeting, Dr Shirin Jamshidi was pleased with the day and stressed that the success of the meeting included a bit of luck with no border closures, great timing by chairs and presenters and hard work by the organising committee. Shirin is grateful to the speakers for happily presenting twice and thought that the quality and standard of presentations was one of the highlights of the meeting.

A delightful three course dinner with 360 degree views of the city lights, mountain and water views finished the scientific program with a congenial and relaxed end to the day.

Sunday morning saw an array of hands-on COVID safe workshops available for delegates including Anaphylaxis; ALS; Regional Workshops and a mindfulness workshop. Dr Chris Wilde, the workshop coordinator was pleased with how the morning went and felt that delegates enjoyed the opportunity of doing hands-on face-to-face workshops again.

Dr Lia Freestone, the chair of the Tasmanian Regional Committee thought that the meeting went well and spoke with many of the delegates who were again happy to attend a face-to-face meeting and appreciated the collegial opportunity that such a meeting can bring.

The Tasmanian Winter Meeting – registrations opening soon

Join us for the 2021 Tasmanian Winter Meeting in Bambougle, Tasmania on Saturday 21 August 2021.

Cross off the date in your calendar as you won't want to miss this meeting at beautiful Bambougle where the theme explores "Links to the Future". Topics explore the challenges that the future holds in relation to paediatrics, the environment and sustainability, both on a personal and professional level.

This is a small meeting and registrations will fill quickly. Not only will delegates have the opportunity to expand their horizons with the scientific program but they will also have the opportunity for a game of golf the day before or after the meeting. The meeting concludes with delegates relaxing at the Lost Farm restaurant with their colleagues as the sunsets over Bass Strait.

Please e-mail tas@anzca.edu.au for more information.

The Tasmanian Regional Committee Annual General Meeting (AGM)

The Tasmanian regional committee (TRC) held it's AGM on Saturday 27 February. The chair Dr Lia Freestone noted the challenges of 2020, the resilience of our profession, particularly the Tasmanian trainees, and thanked the committee for its dedication, collaboration and advocacy. Particular thanks was given to outgoing committee members Dr Andrew Messmer, Dr Margo Peart, and Dr Joanne Samuel for their hard work and contribution to the committee and anaesthesia in Tasmania. The TRC is looking forward to a busy and hopefully more normal 2021.

Introduction to anaesthesia

The NSW Introduction to Anaesthesia course for new trainees was held at the Northside Conference Centre, at Crows Nest in November. It was the first time run as a hybrid course with very positive feedback. There were 49 participants in attendance and 47 via Zoom. The day program included sessions on training, navigating TPS, examination preparation, career options, welfare and ended with a session by partners of anaesthetists.

Many thanks to those trainees, consultants and non-anaesthetists who volunteered their time to take part. Thanks to the NSW Trainee Committee for organising a great day, which provided an opportunity for new trainees to meet and mingle with other trainees and consultants and especially to the convenors Dr Katherine Gough and Dr Rebecca Lewis.



Primary Exam Refresher Course

The Primary Exam Refresher Course was held from 30 November to 4 December at the Northside Conference Centre, Crows Nest. It was the first time run as a hybrid course, and was attended by 50 trainees in person and 58 via Zoom.

The course was designed to help prepare candidates sitting the primary exam in March. It included some didactic teaching sessions, which focused on areas which candidates commonly find difficult. Most of the course was taught in an interactive style, including the use of many practise short answer questions. Friday was entirely viva-focused using small groups of six.

There were 12 tutors from seven hospitals teaching on the course. A special thanks goes to all the tutors who devoted a huge amount of time and effort in assisting the candidates to prepare for their primary examinations, and especially to the course director, Dr David Fahey.

NSW Final Exam Refresher Course

The Final Exam Refresher Course was held in December at the Northside Conference Centre, Crows Nest. It was the first time run as a hybrid course, and was attended by 50 trainees in person and 60 via Zoom.

The exam-focused course included presentations and discussions on core topics, as well as preparation for the different components of the final examination. Speakers included many current and past examiners. There was also a trainee led session, providing advice and personal examination experience.

The team from 45 Productions provided great technical support and helped create an interactive space for all those attending.

A special thanks to all the speakers who devoted an enormous amount of time and effort in assisting the candidates to prepare for their final examination, especially convenors Dr Shanel Cameron, Dr Veronica Payne and Dr Sally Wharton.



COVID-19 webinar

The NSW ACE Committee conducted a successful two-hour interactive webinar in November.

It was the first NSW virtual webinar to include an international speaker, a short PPE donning and doffing video commissioned by NSW ACE and an interactive Q&A component with CPD accreditation. Post registration is available until November 2021. The webinar was well attended with positive feedback. A special thank you to all the speakers and the NSW ACE Committee who devoted a huge amount of time and effort to the webinar.

Supervisors of Training Meeting

The NSW Supervisors of Training Meeting was held at the Northside Conference Centre, Crows Nest,

in October as a hybrid face-to-face and Zoom meeting. Despite not being able to all meet in person, it was great to have the opportunity to all get together.

ANZCA Executive Director, Education and Research, Dr Robert O'Brien provided a college update and answered questions about training and education. Mr Maurice Hennessy (in Melbourne) and Dr Scott Fortey (in person) facilitated a module of the ANZCA Educators Program, which they had modified for a hybrid audience – the first time to be delivered in that way. Despite the challenges, there was much discussion and positive feedback from attendees.

We welcomed new supervisors of training and farewelled others. There was a special farewell to Dr Maggie Bailey (St George Hospital) in appreciation of her long contribution. She has provided great support to trainees and other supervisors of training, and our meetings will not be the same without her.



Upcoming events and courses

Save the dates!

- NSW Winter Meeting Hilton – 19 June 2021
- NSW Spring Meeting Leura – 20 and 21 November 2021
- NSW Anatomy Workshop – 27 November 2021

NSW Primary Exam Refresher Course

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 second part of 2021.

Date: Monday 5 July – Friday 9 July 2021

Venue: Northside Conference Centre, Corner Oxley Street and Pole Lane, Crows Nest NSW 2065

Fee: \$A660

Applications close on Monday 21 June 2021, 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 second 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.

NSW Primary Exam Refresher Course

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 2022.

Date: Monday 29 November – Friday 3 December 2021

Venue: Northside Conference Centre, Corner Oxley Street and Pole Lane, Crows Nest NSW 2065

Fee: \$A660

Applications close on Monday 15 November 2021, 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 2022. 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.

NSW Final Exam Refresher Course

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 2022.

Date: Monday 6 December – Friday 10 December 2021

Venue: Northside Conference Centre, Corner Oxley Street and Pole Lane, Crows Nest NSW 2065

Fee: \$A825

Applications close on Monday 22 November 2021, 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 2022. 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.

Dr Peter Edgeworth Lillie

1949-2021



FRIENDS AND COLLEAGUES have recently had many opportunities to recognise and honour this legend of a man. In 2019 Peter celebrated his 70th birthday and was made a Member (AM) in the General Division of the Order of Australia for his service to medicine in the field of anaesthesia. In 2020 he retired from Flinders Medical Centre (FMC) after 40 years of dedicated service, which coincided with him receiving an ANZCA Citation, acknowledging him as an outstanding person, clinician and leader.

After commencing his anaesthesia training in Sydney, Peter arrived at FMC as a registrar in 1978. He then worked at the Department of Anesthesiology, University of Washington School of Medicine Hospital Group in Seattle from 1979-1980. Peter returned to FMC as a staff specialist in 1980 and in 2001 was appointed head of the Department of Anaesthesia and Pain Management, which he held until his retirement.

During his tenure at FMC, Peter expanded the department to over four times its original size, managed the amalgamation of the Repatriation General Hospital and the implementation of SA Health's "Transforming Health" program. In addition to playing a key role in the development of the liver transplant

and cardiothoracic services, he also provided care to critically unwell and premature neonates and established the hospital's acute pain service. Always embracing progress and change in anaesthesia, he was quick to adopt innovations such as transoesophageal echocardiogram in cardiothoracic cases and the implementation of perioperative surgical pathways.

We will remember Peter for his enjoyment of life, intelligence and outstanding ability. His strong leadership and commitment to improving the department of anaesthesia attracted a highly skilled and dedicated group of anaesthetists. He fostered inclusive, flexible and fair workplace practices, including gender equity in the hiring of staff, long before this was the norm. His colleagues described him as incredibly loyal and supportive. They describe his legacy as most enduring in the department at the Southern Adelaide Local Health Network (SALHN) where his commitment to excellence and can-do attitude will be ingrained in its culture for years to come. He was a wonderful mentor and skilled anaesthetist who led from the front and was never afraid to stand up for himself or the department.

Peter was a committed teacher, serving as an ANZCA examiner for a full 12 year term from 1988-2000 and was a

coordinator and teacher on the Adelaide Primary Examination Course. He was a visiting speaker on many international courses and conferences and heavily involved in teaching nursing and medical students at Flinders University. (It's not clear how widely he taught his golden rules of anaesthesia: 1. Never panic; 2. Don't F**k it up; 3. If you break rule 2 refer immediately to rule 1!)

Peter served as federal treasurer to the Australian Society of Anaesthetists (ASA) between 1988 and 2003. He was presented with the ASA President's Award in 1993 and life membership in 2004. This award was celebrated at the 2004 annual general meeting where he was thanked for exceptional dedication and guidance in managing the society's financial direction for over 16 years. He was held in the highest regard by many ASA presidents and described as a true gentleman.

Peter also served as the chair of the South Australian Directors of Anaesthesia for 20 years and was a great advocate for anaesthetists, highlighting the importance of anaesthesia in South Australia and ensuring its recognition as an essential perioperative service.

Many colleagues have described Peter not only as their colleague and mentor, but also as a trusted friend who provided them with support and guidance during both professional and personal challenges. He has built not only a large anaesthesia department but one that has become like a family to many of its members.

Peter was forever calm in a crisis and handled every situation with expert skill, both in the operating theatre and in his administrative duties. His proficiency and knowledge of anaesthesia were beyond doubt, however it was his warmth and dry sense of humour which ensured there was never a dull moment at work.

He was a wonderful friend and colleague and will be missed by all who knew him.

Dr Brigid Brown, FANZCA
Flinders Medical Centre and Pulse
Anaesthetics
Chair, ASA SA/NT Committee

Dr Sophia Bermingham, FANZCA
Flinders Medical Centre
Vice Chair, ASA SA/NT Committee