ANZCA
FPM

Bulletin

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

AUTUMN 2022

COVID-19:
How we're working and living with the virus two years on

Beyond city limits:
Twin cities provide regional opportunities for trainees

Into the deep with a breakthrough consciousness study

Contents

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: Professor Simon Mitchell taking a world first deep arterial blood gas specimen at 60 metres.

Photo: Pete Mesley. This photo has been reproduced from a video of the dive with the permission of the Journal of Applied Physiology.

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Disinformation the enemy of science and our pandemic recovery

MY TIME AS president of ANZCA is almost up. On 4 May 2020, Dr Rod Mitchell passed the baton to me. On 4 May 2022 I will pass it to Dr Chris Cokis, with my heartfelt wish that he will experience less tumult during his time in office than I have.

In my two years, the SARS-CoV-2 pandemic has been almost the only show in town. It has been extraordinarily disruptive of all human endeavours, all over the world.

One of its strangest features has been a seemingly well-funded and internationally co-ordinated disinformation campaign promoting bizarre conspiracy theories, attacking the advice of the world's experts in the science and practice of pandemic management, and attacking political leaders whose decisions have followed, successfully, the advice of the world's experts.

Conversely, those who have rejected expert advice have fared badly. Intuitively, one would think that wealthy, well-educated populations served by first-world medical practitioners would fare best. The data defeat that assumption. For a complex array of reasons, some rich and seemingly sophisticated countries have led the world in recorded deaths from COVID-19[1]. The internet-borne disinformation campaign has played a significant part. The "information super highway" doubles as a disinformation super highway. In that cosmos, everyone who is not a fellow conspiracy theorist is deemed a liar. Medical science cannot protect people who are impervious to facts and reason, and for whom anything they do not want to hear is dismissed as just another conspiracy.

Misinformation, often innocent, is common in times of crisis. In World War I, the word "furphy" entered Australian English, as meaning an unreliable rumour. It took its name from the Furphy horse-drawn water cart, serving army camps. At each stop the driver would be eagerly pumped for news from other military units. The accuracy of the news from such sources seems to have been an optional extra.

The war was closely followed by the 1918 flu pandemic, which killed 50 million people[2]. By 1920, at about the stage we are now with COVID-19, Americans were reportedly weary of restrictions and willing to downplay the seriousness of the disease. In its second wave, that disease killed more people than the combined total of world wars I and II, and the wars in Korea and Vietnam.

"Medical science cannot protect people who are impervious to facts and reason, and for whom anything they do not want to hear is dismissed as just another conspiracy."

In the Pacific, it killed 22 per cent of the population of Sāmoa, reportedly the highest mortality rate in the world[3].

Global deaths from COVID-19, at more than six million, are so far well down, in comparison with the 1918 flu pandemic. That can be attributed in large measure to the speed of development of vaccines and the breadth of vaccine coverage, as well as advances in medical practice. In that context, a worldwide propaganda attack against good science and good practice, and in particular against vaccination, is a worldwide threat to public health. It is a multi-faceted problem, calling for a multi-disciplinary analysis – a project worthy of the support of medical colleges and other learned institutions. A handful of our own fellows have unfortunately fallen victim to this disinformation. ANZCA has worked hard to counter it, and has succeeded in reaffirming its position as a steady, credible and trusted source.

In summary, the past two years for me and for ANZCA Council and staff has been a lively exercise in coping with uncertainty, as COVID's road continues to take unexpected twists and turns. As Wellington policy analyst Dr Jess Berentson-Shaw described it in a recent opinion piece: "In uncertain times, some people will try to insist on certainty from people in government, or workplaces, or scientists – people who cannot give it. However, the best responses I have seen to the pandemic, both individual and within institutions, involve finding ways to act with certainty where we have knowledge and an ability to do so, but not claiming false certainty where we don't."

Life is full of surprises. Some people who I thought were impervious to the pressures of dealing with uncertainty, were not – and some who I thought would break under the strain have shown tremendous resilience. The common theme seems to be that keeping away from negative, destructive opinions on social media (or people) is a sound principle. In the end survival and wellbeing is all about "he tangata" – the people.

To that end, I thank sincerely ANZCA Council for their support and friendship during the past two years. It would have been a struggle without their commitment, skills of analysis and humour. Likewise, my thanks go to all the staff for keeping the "good ship ANZCA" afloat. Particularly I thank our CEO, Mr Nigel Fidgeon, who has been a steadying hand in a tumultuous time.

Dr Vanessa Beavis
ANZCA President

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1. 950,490 deaths at 28 February 2022: Johns Hopkins University Coronavirus Resource Center.
2. https://www.cdc.gov/flu/pandemic-resources/1918-pandemic-h1n1.html.
3. https://nzhistory.govt.nz/culture/1918-influenza-pandemic/samoa.

Australia Day honours

Four of our fellows have been recognised in the 2022 honours list:

MEMBER OF THE ORDER OF AUSTRALIA

Professor Peter Thomas Morley AM, FANZCA, FCICM (Vic)

For significant service to intensive care medicine, to professional societies, and to tertiary education.

MEDAL OF THE ORDER OF AUSTRALIA

Emeritus Professor Laurence Edward Mather OAM, FANZCA FFPMANZCA (NSW)

For services to anaesthesia and pain management as a research scientist and educator.

Dr Deborah Simmons, OAM, FANZCA

For service to medicine through a range of roles.

CONSPICUOUS SERVICE MEDAL

Wing Commander Howard Roby, CSM, FANZCA

For meritorious devotion to duty in aeromedical evacuation for the Royal Australian Air Force.

Emerging to a new way of working

"EMERGING" IS THE theme of the 2022 ANZCA Annual Scientific Meeting, and even though this particular meeting was reluctantly moved to a virtual format, it is fair to say we are starting to emerge from two challenging years, overshadowed largely by the pandemic for many of us.

One of our goals in coming months is to reconnect people. While still ensuring our events are "safe", we are starting to plan for more face-to-face activities. There are a number of advantages in holding events online including saving attendees' time and travel costs, and reducing our carbon footprint through less travel.

But many do miss the opportunity to talk face-to-face – to be able to network and socialise. These activities are what make our events special.

We have committed to increasing the number of dedicated "Zoom rooms" in all our offices around Australia and New Zealand, including our new office in WA, and this work has now been completed.

Another of our aims, particularly when considering our budget processes, is to position the college for the future, improving the user experiences for our fellows, trainees, specialist international medical students (SIMGs) and staff.

Well under way is our Lifelong Learning project where we are uplifting the current technologies and systems within the college to better support the educational needs of our fellows, trainees and SIMGs.

This will enable us to continue to deliver and promote high-quality contemporary lifelong education and better position us to support new education offerings such as perioperative medicine and the diploma of rural generalist anaesthesia (DRGA).

The project involves reviewing our existing programs and systems, such as the continuing professional development portfolio, the training portfolio system, the training site accreditation system, the exams management system and Networks. We will also explore systems to enable the college to reduce reliance on paper processes with more online forms and improved payment functionality, such as online event registration.

Work on the two qualifications (rural generalist anaesthesia and perioperative medicine) is continuing.

Both projects involve strong collaboration with key stakeholders.

The DRGA project involves working with the Royal Australian College of General Practitioners and the Australian College of Rural and Remote Medicine.

Under our memorandum of understanding signed last year, the three colleges have agreed to work together to establish a diploma that will actively cultivate and maintain the highest principles and standards in the training, practice and ethics of rural generalist anaesthesia.

Significant work on the diploma's curriculum has been completed with the aim of producing rural generalist anaesthesia graduates who can deliver safe anaesthesia and perioperative care in rural and remote settings for patients classed as ASA 1, 2 and stable 3 undergoing elective surgery as well as patients requiring emergent surgery. This includes obstetric and paediatric patients (within scope of practice) and the resuscitation and stabilisation of patients for transfer when required.

The perioperative medicine diploma involves collaboration with the College of Intensive Care Medicine, Royal Australasian College of Physicians and associated societies, the Australian and New Zealand Society for Geriatric Medicine and the Internal Medicine Society of Australia and New Zealand, as well as the Royal Australasian College of Surgeons, Australian College of Rural and Remote Medicine, Royal Australian College of General Practitioners and the Royal New Zealand College of General Practitioners.

Work is continuing on the diploma where learning outcomes have been determined for the six topic areas that align to the recently approved Perioperative Care Framework.

Newly formed working groups will oversee the development of content and assessments and the development of a value proposition – or economic case – for perioperative medicine.

Credible data is essential in explaining to governments, hospitals and private insurers the financial benefits to organisations of perioperative medicine. It is also an essential promotional tool for potential diploma candidates, the media and a global audience.

This work will define and collect standard measures of quality patient care, and independent analysis into the value (outcome/cost) of a perioperative care model to demonstrate the value proposition for resource allocation by funders.

We still are facing challenges to get this work done. COVID-19 has managed to infiltrate locations that had been relatively unscathed by the virus and we've even had to contend with floods, with the Queensland Regional Office recently affected.

With changes to ANZCA Council to occur in May, this is my final opportunity to sincerely thank ANZCA President Dr Vanessa Beavis for her strong leadership from 2021-2022 before she hands over the presidency to Dr Chris Cokis . It has been a pleasure to work with Vanessa during these challenging times and I wish her all the best in her post-presidency plans.

Nigel Fidgeon
ANZCA Chief Executive Officer

Letters to the editor

HAMLET ANTICIPATES VAD?

"To die, to sleep, no more – and by a sleep to say we end the heartache and the thousand natural shocks that flesh is heir to, 'tis a consummation devoutly to be wished!

To die, to sleep – to sleep, perchance to dream! Aye, there's the rub! For in that sleep of death what dreams may come when we have shuffled of this mortal coil must give us pause!"[1]

We all want a good death, a peaceful death – distress free, pain free. Propofol in appropriate dosing fulfils all these requirements, (adding paralysis speeds the process).

Anaesthetists, however, dread awareness. What if, post-mortem, a patient subjected to voluntary assisted dying "awoke" in some realm beyond the reach of their compassionate colleague who dispatched them there?

Hamlet also suggests the possibility of post-mortem "awareness":

"Who would fardels bear, to grunt and sweat under a weary life, but that the dread of something after death, that undiscovered country from whose bourn no traveller returns, puzzles the will, and makes us rather bear those ills we have than fly to others that we know not of?"[2]

Hamlet then broods ambivalently on this intuition, apparently resenting the restraint it implies:

"Thus, conscience doth make cowards of us all. And thus, the native hue of resolution is sicklied o'er with the pale cast of thought, and enterprises of great pith and moment, with this regard, their currents turn awry, and lose the name of action!"[3]

Could there be forms of suffering we cannot see or mitigate? How can we reliably address this possibility? What might the consequences be for wrongly guessing or assuming incorrectly the answers to these questions?

Dr MP Burt, FANZCA, FCICM
Australian Capital Territory

References

1. Shakespeare W, "Hamlet" Act 3: Scene 1
2. ibid
3. ibid

HONORARY FELLOWS

It was very pleasing to see the brief article recognising the college's most recent honorary fellow (Associate Professor Lis Evered) in the recent *ANZCA Bulletin* for Summer 2021, and the short note on the college's 38 honorary fellows by Monica Cronin, the college's curator of the Geoffrey Kaye Museum of Anaesthetic History. These honorary fellowships acknowledge the appreciation that our college has for the contributions made by these recipients to anaesthesia, pain medicine or intensive care on the world stage and more particularly in our region of Australia and New Zealand.

There is however one small correction needed to the note on the 38 honorary fellows where there is a statement "In the almost 70 years of awarding honorary fellowships, only two have been conferred on non-medical recipients. The first was Michael Gorton (1998), ANZCA solicitor and the second was Joan Sheales (2005), first ANZCA CEO." This statement is incorrect as there have been four such recipients in the past, and now another one with Lis Evered. The two non-medical recipients who are missing from the note are Professor Douglas "Doug" Geoffrey Lampard (1976) who was an electrical engineer and Professor of Electrical Engineering at Monash University, and Sir Anthony Jephcott (1990) who was a manufacturer of anaesthetic equipment and philanthropist. Doug Lampard was elected largely for his contributions in physiology and physiological measurement to research in collaboration with a number of Melbourne anaesthetists in particular Noel Cass and John Mainland, and thus his contributions were somewhat similar to those of Liz Evered's. Sir Anthony Jephcott was elected to recognise his considerable involvement in anaesthetic equipment manufacture in the UK and New Zealand, most notably the production of the famous Macintosh laryngoscope.

Interestingly there has also been the election in 1983 to full fellowship of a non-medical researcher (Professor Laurence "Laurie" Edward Mather) which is the only occasion in the college's history when such an election of a non-medical person to a standard college fellowship has occurred. Again his situation is somewhat similar to that of Doug Lampard and Lis Evered, though this time for collaboration in pharmacology research particularly with Professor Michael Cousins. To my mind Mather's election should have been to an honorary fellowship which would also have allowed for a citation recording his contributions to be read when the honorary fellowship was awarded, as has occurred for all the other honorary fellows.

Professor Barry Baker
Honorary Historian, ANZCA
Emeritus Professor, University of Sydney

CALL FOR VIRTUAL MEETINGS

The latest report from the Intergovernmental Panel on Climate Change was described as a "code red for humanity" by UN Secretary-General António Guterres. The 2021 report of the Lancet Countdown on health and climate change, "code red for a healthy future", states that "the imperative is clear for accelerated action putting the health of people and planet above all else[1]."

With this in mind, I wish to suggest that a major action which ANZCA could take in response to the looming climate catastrophe is to permanently change our ASM and other major meetings to a virtual format. The ongoing COVID pandemic has already driven temporary changes from in-person to virtual conferences, as was the case with the highly successful 2021 ANZCA ASM and now also the 2022 meeting. It has been proposed that "carbon-neutral medical conferences should be the norm[2]." A recent detailed study, using full life cycle assessment analysis, showed that transitioning from in-person to virtual conferencing can substantially reduce the carbon footprint by 94 per cent and energy use by 90 per cent[3]. The authors also discuss ways in which the downside of virtual conferences can be reduced, such as asynchronous attendance practices.

I hope the 2022 ASM is a great success and that future meetings continue to be held in the virtual format.

Dr Richard Barnes, FANZCA
Victoria

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1. https://doi.org/10.1016/S0140-6736(21)01787-6
2. https://doi.org/10.1016/S2542-5196(20)30003-6
3. https://doi.org/10.1038/s41467-021-27251-2

MENDELSOHN'S SYNDROME

I read Dr Cay's letter regarding Mendelson's syndrome with interest.

Maternal morbidity and mortality associated with anaesthesia are a continual work in progress, for improvement, especially regarding pulmonary aspiration and Mendelson's syndrome.

However, I assert that rocuronium should absolutely be the preferred relaxant for obstetric anaesthesia, and that suxamethonium be retired to the museum for previously useful drugs, along with thiopentone, halothane and curare.

Dr Cay writes "In the past 10 years there were 47 cases of death due to pulmonary aspiration, and most involved the use of rocuronium".

This statement has no validity, without a numerical comparison to suxamethonium.

I laud Dr Cay's promotion of correctly applied cricoid pressure for obstetric general anaesthesia. But he writes "A modified rapid sequence intubation has become popular with the introduction of rocuronium". I agree – but removing "modified".

Judicious use of propofol and rocuronium, allows immediate post induction intubation, with conditions every bit as good as suxamethonium, without the complications of suxamethonium:

- Twice the rate of anaphylaxis.
- MH association.
- Suxamethonium apnoea.
- Fasiculation producing increased intragastric pressure and greater aspiration risk.
- Post op significant muscle pains.
- Further anaphylaxis risk with subsequent non depolariser.

Significant potential downside for no gain.

Rocuronium has been a game changer, and appropriately used, in my practice, provides intubating conditions every bit as good and rapid as suxamethonium, without the above mentioned downside.

I disagree with Cochrane's studies alluded to by Dr Cay in this regard – rocuronium was not used appropriately. A "normal" intubating dose of rocuronium is, in these days of sugammadex, enough.

Using propofol at 2-3 mg/kg, rocuronium 0.5-1 mg/kg, with 20 per cent pretreatment, Kipling's "60 seconds worth of distance run" is the maximum time from initiation of induction to the first cycle of the ventilator, and a CO_2 wave, not downtime waiting to intubate. Absolutely no need for 60 seconds wait as described by Dr Cay. Perfect intubating conditions – no BMV.

Since the introduction of the hyperangulated glidescope, I have used this exclusively for virtually all intubations, with the glidescope rigid introducer in the ETT. With correct technique, there is a learning curve, allied to the use of rocuronium I cannot remember the last time that I had a "difficult" intubation or needed to use BMV.

Sugammadex ensures 100 per cent reversal of rocuronium; the bad old days of partially reversed, squirming, potentially traumatised patients have gone. What's there not to like about rocuronium?

If you can keep your head...

Dr Stuart Skyrme-Jones, FANZCA
Anaesthetic Services, The Epworth Hospital, Victoria

Celebrate National Anaesthesia Day on 17 October

- **Mark Monday 17 October in your diaries.**
- **Book your hospital foyer space.**

National Anaesthesia Day is held each year to raise awareness of the crucial role anaesthetists play in healthcare. An ANZCA initiative, National Anaesthesia Day is usually held each year on 16 October to mark the anniversary of the day in 1846 that ether anaesthesia was first demonstrated publicly but this year we'll celebrate on 17 October due to 16 October falling on a Sunday.

ANZCA will send posters and other material to hospitals in September.

Please contact communications@anzca.edu.au for more information.

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ANZCA and FPM media coverage

Highlights since the Summer *ANZCA Bulletin* include:

"Josh drug shock will save lives"

(HERALD SUN 13 JANUARY)

The page 5 article included an interview with Jo Traikos whose personal account of her son Josh's case, which involved a reaction to propofol, featured in the Summer edition of the *ANZCA Bulletin*. Professor David Story, chair of ANZCA's Safety and Quality Committee told the *Herald Sun* it was a surprise when testing revealed Josh had an anaphylactic reaction to the drug in the same way other children do to nuts or eggs. The article reached more than 400,000 people.

"Autopsy reveals man most likely died as a result of vaping"

(ABC 7.30, 21 FEBRUARY)

ANZCA Councillor Dr Sean McManus warned about the long-term effects of vaping in interviews with several Australian media outlets after one of his patients died after a decade of vaping. The ABC *7.30* program featured an exclusive report on 21 February and the issue was also covered in an ABC online article. The ABC reports reached an audience of more than 800,000 people.

Dr McManus was also interviewed by ABC Radio Perth and Darwin and on the Nine Network's *Today Extra* program on 24 February.

"Pain patients left in lurch by Medicare cuts"

(THE DAILY TELEGRAPH, 25 FEBRUARY)

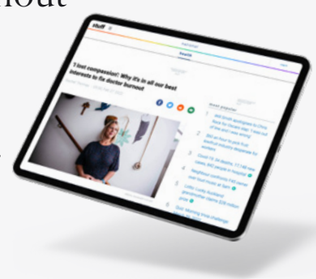
Faculty Dean Associate Professor Mick Vagg was interviewed for an exclusive news article "Medicare cuts to chronic pain care" by News Limited's national health reporter Sue Dunlevy. The article was syndicated to more than a dozen News Limited online and print mastheads.

The dean was also interviewed for ABC radio news bulletins and these were broadcast on the 5.30am and 7pm morning news bulletins on ABC Radio Melbourne with syndications to regional Victorian ABC radio news broadcasts.

More than one million people were reached with the articles and broadcasts.

"I lost compassion": Why it's in all our best interests to fix doctor burnout"

(STUFF.CO.NZ, 27 FEBRUARY)



The Co-chair of ANZCA's Wellbeing Special Interest Group, NZ anaesthetist Dr Jo Sinclair was interviewed by stuff.co.nz on 27 February about the reality of burnout and how it is impacting on doctors. This was syndicated to the *Dominion Post* and the *Sunday Star Times* and was shared widely on social media.

A comprehensive media digest can be found in each edition of the monthly *ANZCA E-Newsletter* and on the college website.

emerging

ANZCA ANNUAL SCIENTIFIC MEETING

29 APRIL – 3 MAY 2022 | VIRTUAL

REGISTER NOW AT ASM@ANZCA.EDU.AU

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2022 ANZCA ASM adapts to a virtual meeting

Every session, every day, ASM your way!

What your registration gives you:

- Access to EVERY. SINGLE. SESSION of the ASM scientific program!
- 80+ hours of program content, watch live to engage or onDemand, in your own time.
- 24 knowledge and learning CPD points, auto-populated to your CPD profile (with opportunities to earn further points).
- Opportunities to engage and interact with your colleagues from near and far via the online discussion forum and meeting hub – it's the fashionable way to engage in the pandemic age.
- The chance to make it onto our onAIR leaderboard and win some great prizes, including bragging rights for beating your fellow colleagues.
- Access to a virtual healthcare exhibition, so you can stay in the know.
- Access to our "Get Social" webinars.

"We had hoped the 'emerging' theme would reflect the movement of people around Australia as we emerged from the pandemic. Little did we know it would be an 'emerging' variant of COVID that would change our plans! We will still deliver the full four days of the scientific program as originally promised, with exciting Special Interest Group STAT sessions, opportunities to interact with speakers through live Q & A and unique plenary sessions encouraging both inspiration and reflection."

Dr Neil Hauser,
2022 ASM Convenor

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ANZCA and government

College advocacy calls for action on key issues

AUSTRALIA

FPM urges government to reconsider MBS pain item number changes

The Australian government's Department of Health has advised the college of changes to item mapping in the Medicare Benefits Scheme (MBS) affecting both pain medicine and anaesthesia. The *MBS Online: Pain Management Services Changes* came into effect on 1 March 2022 and have significant detrimental implications for specialist pain medicine physicians and their patients.

The Pain Management Clinical Committee (with FPM representation) recommended to the MBS Taskforce that anomalies in the current system that were identified as particularly inhibitory of the provision of multidisciplinary team care outside hospital pain clinics be resolved. The recommendation was cost neutral with the $A40 million cost for pain specialists to access complex consultations recovered elsewhere.

While the 2021-22 federal budget included the anticipated savings of $40 million over three years, the recently announced changes to the MBS pain management items do not include the recommendations to make a complex consultation rebate available, further straining the already over-burdened public system. The decision is effectively a cut of $40 million to pain services and will impact some of the most marginalised patients in the community, the one in five Australians who suffer chronic pain. It is also a missed opportunity to improve the provision of pain services to the community.

FPM Dean Associate Professor Michael Vagg has written to the Minister for Health Greg Hunt requesting an urgent reconsideration of this matter. In late February the faculty launched a campaign to create awareness of the impact of the decision to the federal government and opposition parties, including the Parliamentary Friends of Pain Management Group (who later met with FPM), patients and the community, specialist pain medicine physicians and other stakeholders. The patient-focused campaign includes posters for waiting rooms which urge patients to contact their local federal member of parliament.

Associate Professor Vagg was interviewed for ABC news bulletins and an exclusive article on the issue by News Limited's national health reporter (below) was circulated widely in News Limited publications. ANZCA also distributed a media release about the faculty's concerns. Page 47: Dean's message.

Less relief of chronic pain

SUE DUNLEVY

THE federal government has slashed $40m from services for the one in five people living with chronic pain, exacerbating lengthy waits for specialist treatment.

And from March 1 people suffering from facet joint pain in their back and

care rebates for 35,000 people needing specialist pain treatment, dean of the faculty of pain medicine of the Australian and New Zealand College of Anaesthetists, Associate Professor Michael Vagg, said.

Migraines and back, neck and shoulder pain are four of the top 10 reasons people leave the workforce in prime

College calls for action on cosmetic surgery

On 25 October 2021 ABC TV's *Four Corners* program broadcast "Cosmetic Cowboys" an investigation that highlighted a range of concerns including hygiene and sterilisation protocols and unprofessional behaviours towards an unconscious patient undergoing a cosmetic procedure in a Sydney day surgery facility. One particularly disturbing segment showed practitioners dancing while performing a liposuction procedure.

Following this, ANZCA President Dr Vanessa Beavis wrote to all Australian health ministers calling for urgent action to establish a clear regulatory framework for doctors practising cosmetic procedures and to move to protect the titles of "surgeon" and "cosmetic surgeon" by law. Dr Beavis also wrote to the Australian Health Practitioner Regulation Agency (Ahpra) to raise similar concerns.

The college has been working to enhance patient safety and care in day procedure centres for many years. In September 2017, following the death of a NSW patient by overdose of local anaesthesia during a breast implant procedure, we wrote to all state health ministers, and subsequently met with them, to advocate for minimum standards in day procedure centres in relation to staff, facility, equipment and emergency planning. We worked closely with the then Victorian Department of Health and Human Services on updating the health services (private hospitals and day procedure centres) regulations.

Later in 2017, in conjunction with the Royal Australasian College of Surgeons and the Australian Society of Plastic Surgeons, we published a joint position paper on day surgery in Australia. In 2018, the college gave a detailed submission to the review of the Health Practitioner Regulation National Law, advocating that the title "surgeon" should only be used by those who have undertaken specialist training in surgery. Similarly, the term "cosmetic surgeon" should be able to be used only by those medical practitioners who have undertaken a well-defined, recognised cosmetic surgical training program and who also undertake continuing professional development within that specialty.

While much of the recent media attention has focused on the non-specialist cosmetic "surgeons" often performing these procedures, of equal concern are the standards of day procedure centres in terms of appropriate staffing, hygiene and sterilisation protocols and emergency planning and equipment.

Since the Four Corners program aired, two reviews into cosmetic surgery in Australia have been announced. One will encompass a review of the regulation of health practitioners in cosmetic surgery and is being undertaken by Ahpra. The other review is on the use of the title of "surgeon" by medical practitioners in the Health Practitioners Regulation National Law and is being undertaken by the Australian Government Health Council. The college is preparing submissions to both of these reviews.

National Medical Workforce Strategy and Aboriginal and Torres Strait Islander Health Plan released

The *National Medical Workforce Strategy 2021-2031* was released by the Australian government's Department of Health in January 2022. The strategy was developed during 2019-2020 and the college provided input into the development of the strategy with representation at strategy consultation forums, participation in face-to-face meetings and teleconferences with the department and submissions on the draft strategy.

The strategy details 25 overarching 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". Of the five complementary priority areas that guide these actions, priority area 2 – rebalance supply and distribution – is of particular relevance to our college. Actions under this priority include:

- Increasing the number of trainees in undersubscribed specialties and decreasing the number of trainees and oversubscribed specialties.
- Growing the Aboriginal and Torres Strait Islander workforce.
- Reducing barriers and improving incentives for doctors to work and train in rural and remote communities.

The college will continue to work with the department, other specialist medical colleges and the Council of Presidents of Medical Colleges and other stakeholders to progress these actions which align with those of our Indigenous Health Strategy, Reconciliation Action Plan and Regional and Rural Workforce Strategy.

The National Aboriginal and Torres Strait Islander Health Plan 2021-2031 was also recently released by the Department of Health. The plan is a comprehensive document that covers all determinants of First Nations peoples' health and wellbeing. There are 12 priority areas detailed in the plan and as a specialist medical college there are some where we can have a greater impact, in particular:

- Priority 1 – Genuine shared decision making and partnerships.
- Priority 3 – Workforce.
- Priority 8 – Identifying and eliminating racism.
- Priority 11 – Culturally informed and evidence-based research and practice.

The college provided feedback on the draft plan and is committed to increasing the number of Aboriginal and Torres Strait Islander anaesthetists and specialist pain medicine physicians. ANZCA is working closely with the Australian Indigenous Doctors' Association and their "Growing the number of Aboriginal and Torres Strait Islander medical specialists project" towards this.

Our Reconciliation Action Plan will also consider how the college can contribute to many of the priorities of the plan including:

- How to ensure Aboriginal and Torres Strait Islanders have a genuine voice in college decision-making, governance and committees.
- Working with jurisdictional health services and trainee selection bodies to increasing the number of Aboriginal and Torres Strait Islander trainees.
- Ways in which the college can address racism in the health system and ensuring that ANZCA-accredited hospitals are culturally safe learning and working environments.

NEW ZEALAND

College meets with Pharmaceutical Society

In December a meeting was held with the Pharmaceutical Society to understand the changes to the schedule of medicines for pharmacist prescribers. The college had provided feedback to the Ministry of Health earlier in the year advising that the draft changes included medicines that would only be appropriate if used under the supervision of specialist anaesthetists. Although advice given to the Ministry of Health was similar to that of the New Zealand Medical Association and the Royal New Zealand College of General Practitioners, the ministry has instead chosen to take a similar approach to the UK and included anaesthetic medicines into the schedule changes which can now be prescribed by a pharmacist prescriber.

The chair of the New Zealand National Committee, Dr Sally Ure, met with the Ministry of Health Chief Advisor Pharmacy, Ms Andi Shirtcliffe, to ask for a review of the changes in consideration of the risk associated with prescribing anaesthetic medicines without the supervision of specialist anaesthetists. This is an ongoing discussion and will in the future include other organisations that have similar concerns about specialist supervision for some of the new medicines within the schedule.

Transition unit update

The transition unit has been approached to comment on questions received by college and faculty fellows to be able to understand the mid-year changes to the health system (See pages 14-15 for ANZCA's Q & A with the Transition Unit.). With the recruitment of chief executives to the interim Māori Health Authority and interim Health New Zealand, attention can soon shift to the movement from District Health Boards (DHBs) to a locality approach.

As one of the largest pieces of change in the health reforms, the unit had committed to "prototypes" being established from a current list of DHBs in early 2022. The sector is now being engaged to see in which location these prototypes can be confirmed. The impact on patient load, wait times and funding will be dependent on these localities as well as the original aim of equity and delivering to priority populations.

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 anzca.edu.au/communications/advocacy/submissions.

Australia

- Healthcare Management Advisors: Streamlining and expansion of the Rural Procedural Grant Program and the Practice Incentives Program procedural GP payments (consultation 2).
- Victorian Department of Health: Draft guideline for providers of liposuction.

New Zealand

- Ministry of Health/Manatū Hauora: Pae Ora (Healthy Futures) Bill.

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Have you got a story you'd like us to share? We're always looking for new content and we love sharing and celebrating what our members have been up to. Message us directly on your preferred platform, or email communications@anzca.edu.au.

Watershed health reforms aim to transform services

From left: Riana Manuel heads the new Māori Health Authority. Fepulea'i Margie Apa leads the Health New Zealand, which will be the country's largest employer on 1 July.

THE NEW ZEALAND HEALTH and Disability Review Transition Unit is leading the response to the reform of the country's health system due to take effect on 1 July. Established in September 2020, the unit is responsible for implementing the reforms by developing policy and the new operating model.

The reforms disband the 20 district health boards (DHBs) and replace them with two new entities – Health New Zealand and the Māori Health Authority. Health New Zealand will take over the planning and commissioning of services and the functions of the DHBs to "remove duplication and provide true national planning". The Māori Health Authority is to work alongside Health NZ to "improve services and achieve equitable health outcomes for Māori" according the department of the Prime Minister and Cabinet.

These changes are the most comprehensive health reforms the country has faced in at least 30 years. They will affect health institutions across the spectrum from primary health to secondary and allied health. Health New Zealand will become the largest employer in the country, with a workforce more than 80,000 people and an operating budget of upwards of $NZ20 billion a year.

For hospitals, they promise a step away from the devolved model of independent DHB cost centres. These were set up in 1993 during the short-lived but long-suffered Crown Health Enterprises' model of profit centres.

The *ANZCA Bulletin* asked the transition unit (TU) what NZ doctors can expect.

The unit declined an interview but provided written responses to our questions.

ANZCA: DHBs are disbanded on 1 July and hospital clinicians are still in the dark about how these reforms will look for them. What will change for hospital doctors on 1 July apart from the name on their salary slip? What plans are there for rationalising middle management between hospitals? If say, Wellington is in a hub with other regional hospitals, could specialists find their lists are spread between more than one site?

TU: For frontline health workers, the intention is for day one (1 July) to provide as little disruption to core business as possible. This will mean for most people, where they work and the services they provide will be relatively unchanged.

For people employed by DHBs, public health units and shared service agencies, their employer will become Health New Zealand or Māori Health Authority from 1 July.

The new high-level organisational structure is being developed, and positions for second-tier and some third-tier leadership roles will be advertised soon to ensure that reporting lines can be updated ahead of 1 July.

The transformation will take place over a number of years, starting with getting the right structures in place, which will happen from 1 July.

ANZCA: How will the new "mandatory services" be decided and monitored? For instance, under the present system, the provision of chronic pain services is not mandated despite one in five Kiwis suffering from chronic pain combined with the Accident Compensation Corporation's high expenditure on chronic pain, The Ministry of Health (MoH) is also working on a chronic pain management national model of care. When will we find out what mandatory services our hospitals are being charged to deliver?

TU: In the future health system, we will move to a more nationally consistent approach, with a particular focus on addressing inequities of outcomes across various groups, and in particular Māori. Investment across the board will need to be prioritised where the biggest equity gains can be made, and where there is significant variation in access to services.

The interim Government Policy Statement will include a revised Service Coverage Schedule, setting out system expectations for the services, which people will have access to regardless of where they live. From here, the interim NZ Health Plan and subsequent operational guidance and frameworks will provide increasing specificity about the expectations for where services should be delivered consistently to national expectations and guidelines, and where services can be flexibly configured to meet local needs. Those accountability documents are expected to be available from July 2022.

> "Health New Zealand will become the largest employer in the country, with a workforce of more than 80,000 people and an operating budget of upwards of $NZ20 billion a year."

ANZCA: Can you give a timeline as to the release of these new commissioning arrangements?

TU: The transformation of the health system will take place over a number of years. Getting the right structures in place from 1 July is a first step. Transforming the way services are designed, planned and funded will take time – we will prioritise transforming commissioning where the biggest gains in equity lie.

The New Zealand Health Plan will be delivered in 2024/25, and will be the first full New Zealand Health Plan to be underpinned by the new ways of working through the system. An interim health plan is being developed to guide the first two years.

ANZCA: Late last year during the TU roadshow, it was mentioned in passing that Heath New Zealand will take over workforce planning from the Ministry of Health (MoH). Despite being vital to the country's health system already under pressure (before the pandemic) there is little being said about workforce planning. What is being planned to identify the demand side of the equation?

TU: The interim NZ Health Plan will outline immediate actions to tackle challenges facing our health workforce – including opportunities to make better use of education and training pathways and models of care to match supply and demand pressures on our workforce. From there, Health NZ will lead working with the Māori Health Authority and the Ministry of Health to plan to address workforce gaps and needs over time, including taking a more active role in managing both supply and demand pressures. It will take time to address critical workforce shortages.

ANZCA: You have been asked at your information roadshows around the country, whether the reforms are just "rearranging the deckchairs on the Titanic" or "UK NHS light". What do you say to doctors who have worked through several iterations of the health system and are cynical about reforms? How do you answer those concerned about the disruption of the reforms on core business in hospitals?

How do you answer senior doctors' concerns about the interruption of their core business and the need for their input?

TU: COVID-19 is putting pressure on a health system that was already under strain. The pandemic has forced us to work differently, and we have seen some benefits from being more collaborative and integrated in the way healthcare gets delivered. We do appreciate that people have not had as much time as they might have wished to input to the health reforms, but can confirm that there will be ongoing opportunities as changes are introduced over time.

This year's focus is on getting the foundations right to transform the health system, and we are committed to minimising disruption to the workforce, including for 1 July. We aim to remove some of the blockages to consistent effective decision making in the health system, and to reduce the number of entities with boards, CEOs, etc.

ANZCA: What does success look like in the first six months of implementation?

TU: Over the first six months, success looks like a smooth transition to the future system, including:

- Consolidating DHBs into Health NZ.
- More consistency across functions currently carried out by DHBs including corporate support, data and digital and procurement.
- Establishing cultures of collaboration and co-working between Health NZ and the Māori Health Authority.
- Greater working at regional levels for delivery of services.
- An interim NZ health plan that describes priorities for the first few years.

We will also see the start of Māori Health Authority commissioning and continue to ensure that New Zealanders can continue to access high-quality care while these reforms are delivered.

ANZCA: Can you tell our doctors what the key performance indicators are for 2022/23?

TU: An accountability framework for the health system will be part of the interim New Zealand Health Plan, which will outline key performance and accountability expectations for the wider health system in the first two years.

Adele Broadbent
ANZCA Communications Manager, New Zealand

BEYOND CITY LIMITS

For Dr Barbara Robertson, who spent 20 years as an anaesthetist in Shepparton, Victoria before moving to Albury Hospital in 2015 where she is now head of department, training and mentoring the next generation of clinicians is key to the future of the specialty in regional areas.

Dr Robertson has lived and worked mostly in rural and regional locations. Born on a farm near Dunkeld in Western Victoria she speaks candidly about the workforce issue that she and others in her department are increasingly concerned about.

"One of the big challenges facing anaesthesia departments in regional centres such as ours here in Albury is the ageing of the anaesthesia workforce," she explains.

"Some of our anaesthetists are at the tail end of their careers and the fact is we need to attract a more diverse and younger group of trainees and anaesthetists." It is hoped that incentives such as the Integrated Rural Training Pipeline (IRTP) program, by attracting trainees and younger specialists to the regions, could help reverse this trend.

Dr Robertson and Dr Michael Bulman, one of the hospital's two anaesthesia supervisors of training (SOT), have effectively become de-facto ambassadors for the program that helps regional hospitals and health services such as Albury Wodonga Health to fund trainees. Their current IRTP trainee, 30 year-old anaesthetic registrar Dr Jason Kong, is in his fourth year of training having just returned to Albury, 320 kilometres north-east from Melbourne, after his metropolitan year at St Vincent's Hospital in Melbourne. He and his wife Megan, a lawyer, have two young children. They have embraced the local lifestyle and have bought a house in Albury.

Speaking to the *ANZCA Bulletin* on a recent visit to Albury, Dr Robertson and Dr Bulman say the program is giving the anaesthesia department a much needed boost as Dr Kong is now mentoring first year trainees.

"The recruitment of anaesthetists to the region is a critical issue because of our ageing consultant cohort but programs such as the IRTP can go some way to helping," Dr Robertson explains.

"Before we had access to the IRTP program we had rotating registrars through the Western anaesthesia rotation scheme and the ACT. It's quite a difference now having a fourth year trainee in the mix with the junior trainees," Dr Robertson explains.

"It means we now have a fourth year trainee like Jason who can mentor our first year trainees. Jason has now taken on a real leadership role and that benefits the department as a whole."

Dr Bulman, who spoke to the *Bulletin* at the hospital during a break from emergency theatre cases, says there is sometimes a perception among trainees and specialist anaesthetists that working in a regional hospital can be limiting in terms of clinical opportunities.

"But that is far from the truth as we have a full range of procedures here that are by no means simple. There are wide varieties of cases so you are able to apply your trade across all specialties.

"The program gives the department and the trainees a viable training pathway that they may not have been able to access before," Dr Bulman says.

"SOME OF OUR ANAESTHETISTS ARE AT THE TAIL END OF THEIR CAREERS AND THE FACT IS WE NEED TO ATTRACT A MORE DIVERSE AND YOUNGER GROUP OF TRAINEES AND ANAESTHETISTS."

TWIN CITIES OF ALBURY AND WODONGA PROVIDE REGIONAL OPPORTUNITIES FOR TRAINEES

Above: View of the nearby snowfields from Albury NSW; a couple cycling over the Rail Trail Bridge.

"IT'S A PICTURESQUE AREA AND WE'RE CLOSE TO THE SNOWY MOUNTAINS, THE SKI FIELDS, THE WINERIES AND THE HUME WEIR."

Clockwise from top: Fishing by kayak on the mighty Murray River; Moving the herd for milking on a dairy farm in North East Victoria; the region's cafe culture is thriving.

"Before this program we were regularly losing excellent junior doctors to Melbourne as there was no actual pathway for specialist training but now there is a real incentive for them to stay in the region."

The hospital's two campuses in Albury and Wodonga cater for a population of about 250,000 with patients travelling from Wagga Wagga in the NSW Riverina and the Victorian towns of Mansfield and Yarrawonga. The hospital is due for a major upgrade, requiring a new hospital on one site, an initiative that has the support of the Independent federal member for Indi, Dr Helen Haines.

As an SOT Dr Bulman is keen to promote the region to anaesthesia trainees. He's a local from the area who, after completing his specialty training including a year at Addenbrooke's Hospital in Cambridge in the UK, returned to Albury to take up a role in the hospital's anaesthesia department.

Albury Hospital Supervisor of Training Dr Michael Bulman.

"I grew up here and now live on a small farm with my family 15 minutes down the road from the hospital. There are a lot of pluses living here. It's a picturesque area and we're close to the Snowy Mountains, the ski fields, the wineries and the Hume Weir. The cost of housing is a lot less than in the big cities."

Dr Bulman says the IRTP program is a welcome and effective initiative that gives trainees an opportunity to move out of metropolitan areas and experience living and working in a regional centre, often for the first time. Some trainees, like Dr Kong, end up loving the lifestyle and work arrangements by buying a home and settling there. As an IRTP trainee he receives three years of training at a rural site and one year of metro training.

When the *Bulletin* visited the Albury team Dr Kong was working on an all-day urology list that included radical prostate surgery. He had spent the previous year in Melbourne at St Vincent's Hospital and returned to Albury for the start of the 2022 hospital year.

Albury Hospital has seven staff anaesthetists and 15 visiting medical officers (VMOs). The department has also established links with three local private hospitals. Two anaesthetists are on call across the two campuses seven days a week although only the Albury campus has an ICU. (The hospital's Wodonga site has more day surgeries and handles caesareans and obstetric cases.)

Dr Bulman says because Dr Kong had previous experience at the hospital as a medical intern he developed an interest in pursuing anaesthesia as his training specialty after working with local anaesthetist Dr Eric Moyle, an expert in simulation education, perioperative medicine, intensive care and training. Dr Moyle was awarded the Albury 2021 Citizen of the Year for his innovative work developing ventilators for the hospital at the start of the COVID-19 pandemic.

Carolyn Jones
Media Manager, ANZCA

THE IRTP PROGRAM

The Integrated Rural Training Pipeline (IRTP) is a subset of the Commonwealth-funded Specialist Training Program, and provides 100 positions from 2022-2025 across all specialist medical colleges. ANZCA receives funding to support up to eight full-time equivalent positions under the program.

Twenty-six regional training hubs have been established under the IRTP to work with local health services to help stream students through the medical training pipeline.

Each IRTP post is designed to support one trainee over several years. The funding enables a specialist trainee to complete at least two thirds of their fellowship training in a rural or regional setting, with only limited metropolitan rotations.

The IRTP-STP funding contributes to salary support of the trainee, rural loading, private infrastructure and clinical support.

From top: Gourmet home cooked pizza at the Wodonga Community Pizza Oven; morning walk at Sumsion Gardens; live music at The Cube Wodonga Arts Precinct.

Photos: Peter Charlesworth.

DR JASON KONG

Anaesthesia registrar, Albury Wodonga Health

Dr Kong, 30, was born in Perth and moved to Melbourne to complete his medical degree at Monash University. He didn't realise it at the time but it was a connection through three very different circumstances that helped forge his path to Albury.

"I had been doing a bit of teaching and tutoring as a medical student and one of my clients was a family of five kids who were from Albury and were talking it up. At the same time one of my best friends from medical school had taken a job in Albury as an intern and a hospital medical officer so I thought why not do my medical elective in Albury.

"I was interested in critical care so I did my final year elective rotation in the Albury ICU/Anaesthesia Department in 2016 and got to know Dr Eric Moyle, a "triple threat" anaesthetist, pain specialist and intensivist. He's a former department head and is quite an amazing guy. I loved the rotation and the enthusiasm that Eric brought to education and all the skills I learnt doing my elective. That experience formed the basis for me seriously considering working in Albury long term. The more I thought about it, the more I realised that it ticked the three main boxes for me – great for the kids, affordable housing, diverse and interesting work, and amazing people to work with.

"I returned to Melbourne for internship and residency. I knew at that stage that I would end up in the country but there wasn't an Integrated Rural Training Pipeline (IRTP) program that I knew of. I was pursuing the Victorian Anaesthesia Training Scheme, working at Eastern Health and working on my resume. My PGY2 year was a bit of a rollercoaster. The normal pathway is to get a critical care year somewhere for PGY3. Unfortunately, I got zero offers for jobs, and I wasn't quite sure what was missing because I worked very hard on my resume and I had presented at the ANZCA Annual Scientific Meeting.

"I was staring down the barrel of doing a year of emergency department locums or maybe taking some time off. I then came across an ad on Seek for the IRTP program for Albury Wodonga Health. I applied and by some miracle got the job and started in 2019. I had the first year in Albury, a year in Wagga Wagga, a year in Melbourne at St Vincent's Hospital and now my fourth year back in Albury. There's now an option for a provisional fellowship year in Albury too. The goal for me is to be able to finish my anaesthesia training and to be able to go and do any of the lists here, and feel comfortable doing it. We do obstetrics, paediatrics, large combined plastics cases, amputations, joint replacements and major general surgery – pretty much everything except vascular, neurosurgery, cardiac and thoracics.

"It really is the greatest job in the world. It's so rewarding but it also has unique challenges.

"The hospital has a close relationship with St Vincent's in Melbourne. All heart and neuro surgery referrals go to St Vincent's. I saw a thoracic patient there while I was doing my metro year there last year and then when I came back to Albury earlier this year I saw the patient here."

Dr Kong and his wife Megan, a lawyer, have two children – Isaac, who was born in Albury in 2019 and Zoe, born last year in Melbourne.

"One of the painful parts of the program is having to move your family around but we have made it work. We bought a house in Albury and feel settled here.

"What makes or breaks my work for me has always been the people. As long as you are working with great people that you respect and get along with you are going to have fun anywhere. Albury Hospital is certainly one of those places that you get along with everybody and have fun but everyone takes the educational aspect pretty seriously. They really are motivated to make sure you get the most out of your training.

"We're lucky that we're close to the ski fields, the Snowy Mountains, wineries, the lake, and there's no traffic compared to Melbourne. Housing is affordable relative to the city and there are a lot of couples like us with young families. It only takes 40 minutes to fly to Melbourne and the airfield is just a 10-minute drive from the centre of town. There are some things that you would have to be motivated to figure out in your life like being away from parents and school considerations but the pros in my mind far outweigh the cons.

"At the end of the day you know that while you won't be doing world-leading anaesthesia for neurosurgery, you will come here and provide an excellent anaesthesia service of high quality, contribute to the department, and really enjoy your life here."

"IT REALLY IS THE GREATEST JOB IN THE WORLD. IT'S SO REWARDING BUT IT ALSO HAS UNIQUE CHALLENGES."

What would you do?

Dr Peter Roessler explains ANZCA's professional documents using practical examples. In this edition he explores the definition of guidelines, polices and standards.

WELCOME TO 2022, the Year of the Tiger. This is in reference to the Chinese New Year and not the Australian Football League!

In our first scenario for this year, you have been invited to provide anaesthesia services to a new standalone private facility. As is your customary practice, you visit the facility to ensure that it meets your requirements for staffing, and equipment, which are guided by ANZCA's professional documents. On doing so, you discover that there is no monitor for end-tidal capnography.

You bring this to the attention of the administrator and cite PG18(A) *Guideline on monitoring during anaesthesia* indicating that the standard demands use of capnography. The administrator responds stating that it is only a guideline.

WHAT WOULD YOU DO?

Would you accept that PG18(A) is only a guideline, or would you insist on a capnograph?

This perception of guidelines is, in part, a reflection of the confusion surrounding terms that are often erroneously used interchangeably, including standard, policy, and guideline. While ANZCA guidelines are essential tools that serve to foster attainment of standards, they are not of themselves standards. The recognition of ANZCA professional documents as essential and of utmost importance will be cemented following the current development of standards in anaesthesia, and further enhance their national and international standing.

The value of setting standards is that they are a means of identifying specifications that can be used as benchmarks of performance. ANZCA's *Document Framework Policy* (DFP) includes a glossary of terms in appendix 2, which defines standards as "Documents that define levels of quality or achievement against which activities or behaviours can be measured." It is worth noting that on their own, standards are voluntary and are not laws. Consequently, there is no general requirement to conform to a standard, unless there is a law that demands compliance.

ANZCA professional documents are not infrequently referred to as policies. The DFP glossary defines policies as "Documents that formally state principle, plan and/or course of action that is prescriptive and mandatory." Policies are the conduit for implementing college regulations derived from the ANZCA Constitution. Within the category of professional documents, the only policies are those relating to corporate and non-clinical issues including policies for developing and reviewing professional documents and endorsement of externally developed guidelines.

Guidelines are defined in the DFP glossary as "Advice on a particular subject, ideally based on best practice recommendations and information, available evidence and/or expert consensus. Guidelines are not prescriptive ….". This accords with the National Health and Medical Research Council definition and in the context of healthcare, guidelines are statements that include recommendations intended to optimise patient care.

To digress a little, my role as a defender playing soccer was to prevent the opposition from scoring goals. My performance correlated closely with my ability to meet or exceed various benchmarks, such as the number of tackles I made during the game, the number of times I was dispossessed and the number of effective passes to teammates. These were the standards that I endeavoured to meet. By following my coach's guidelines regarding positioning myself to anticipate my opponent's moves, timing my tackles, and looking to pass to a teammate in the clear, I was able to match the benchmarks, which resulted in the coach patting me on the back as an indication of his satisfaction with my performance. His advice allowed me to achieve the standard, although I did have to deviate on one occasion and adapt to accommodate the specific need.

In general, coaches have a broader overview of the game than players, and wider responsibilities, which adds value to their advice. ANZCA's professional documents may be viewed in a similar vein.

In returning to the original scenario above, to suggest that "this is only a guideline" detracts from the value of good advice. It fails to recognise the importance of sound advice and misses the point that although not mandatory, ANZCA professional document guidelines are the essential tools for attaining or exceeding standards with the goal of optimising patient care. We are bound ethically, professionally, and vocationally to pursue this goal. It is the evidence/consensus-based recommendations aimed at safety and quality of patient care that makes ANZCA's professional documents so important.

Setting standards facilitates the ability to gauge our performance against benchmarks, thereby providing feedback about the level of our patient care. This is a key component of professional development and emphasises the importance of practice evaluation in continuing professional development.

Standards provide a defined focus for guidelines, which allow the purpose of each guideline to be clearly defined.

Maybe my response to the administrator above might be along the lines of "Have you conferred with your indemnifier to confirm that they will cover you in the event of a mishap related to the absence of an item deemed essential by a nationally recognised guideline, which you refused to follow?"

Dr Peter Roessler
Director of Professional Affairs, Professional Documents

Our new guideline on surgical patient safety and COVID-19

IN FEBRUARY 2022 we were pleased to announce the publication of the first edition of our new professional document *PG68(A) Guideline on surgical patient safety for COVID-19 infection and vaccination*. This guideline provide current advice to our fellows, trainees and specialist international medical graduates on navigating surgical patient safety concerns in the rapidly changing environment of the COVID-19 pandemic.

This document has been produced by a small group of fellows via a rapid review of best available clinical evidence and of relevant health sector, regulatory and government body guidance. We consider it living guidance, and will review and update it frequently. Before making use of it, please always check you have the latest version, via the college website www.anzca.edu.au.

Some key recommendations are summarised below.

SAFEST TIMING OF ELECTIVE SURGERY AFTER A CONFIRMED COVID-19 INFECTION

After a polymerase chain reaction (PCR) test–confirmed COVID-19 infection, and after patient has return to baseline function and is symptom free, we recommend:

- Non-urgent elective major surgery in adults: Delay at least eight weeks.
- Non-urgent elective minor surgery in adults: Delay at least four weeks.
- Non-urgent elective surgery (major or minor) in children: Due to lower risk, delay as if for other acute respiratory illness.
- Urgent or time-sensitive surgery such as cancer: Individual risk-benefit analysis, noting that:
  - Outcomes improve after two weeks mostly for asymptomatic patients.
  - Best outcomes are after seven weeks for both asymptomatic and symptomatic patients with resolved symptoms.
  - Worst outcomes are for patients still symptomatic at seven weeks.

DETERMINING WHETHER PATIENTS ARE STILL INFECTIOUS

Persistent or recurrent positive PCR or rapid antigen tests (RAT) are common after recovery for up to 90 days. Prior to 90 days, use a time- and symptom-based strategy:

- Patients with mild/asymptomatic infection or break-through infection:
  - Pre-omicron variants: Consider infectious at least 10 days from onset of symptoms and/or first PCR positive test, and at least 24 hours since resolution of fever without the use of antipyretic medications and improvement in respiratory symptoms.
  - Omicron variant: Consider infectious for at least seven days, as above.
- Severely ill hospitalised patients: Consider infectious after 20 days from onset of symptoms and/or first PCR positive test and at least 24 hours since resolution of fever without the use of antipyretic medications and improvement in respiratory symptoms.

PATIENT HEALTH ASSESSMENT AND OPTIMISATION FOR SURGERY AFTER COVID-19 INFECTION

Patients should have a formal clinical review prior to surgery, especially if they have not returned to their baseline function, to assess the state of the cardiorespiratory system and other potentially affected systems. Potential investigations include N-terminal-pro hormone B-type natriuretic peptide and B-type natriuretic peptide (NTproBNP/BNP), ferritin, and possibly transthoracic echocardiogram (TTE) if indicated.

Due to the increased risk of deep vein thrombosis or pulmonary embolism after COVID-19 infection, we encourage discussing these patients with Haematology to create a perioperative thromboprophylaxis plan.

OPTIMAL TIMING OF COVID-19 VACCINATION BEFORE OR AFTER SURGERY

Before surgery

The maximum level of vaccination before surgery that time permits should be encouraged.

Our recommended time gap between preoperative vaccination and surgery depends on the goal of the delay:

- To avoid confusion between vaccine-related side effects and surgical complications: At least one week's gap.
- To ensure optimal immunological response and better protection from COVID-19 infection: At least two weeks' gap.
- To optimise outcomes of transplant surgery: Up to four to six weeks' gap, in consultation with a specialist immunologist and the transplant team.

After surgery

- After major surgery, delay vaccination for at least two weeks.
- After minor or intermediate surgery, consider a shorter delay, especially if patient is at risk of loss to follow up.

MAJOR KNOWN SIDE EFFECTS OF COVID-19 VACCINES

Myocarditis and pericarditis are rare adverse events post COVID-19 messenger ribonucleic acid (mRNA) vaccination (Pfizer-BioNTech/Comirnaty and Moderna/Spikevax) with an onset usually within seven days of vaccination.

Vaccine Induced Thrombosis and Thrombocytopenia (VITT) is a severe prothrombotic syndrome associated with thrombocytopenia, which has been described in a small number of patients exposed to the COVID-19 AstraZeneca/Covishield or Vaxzevria and Janssen (Johnson & Johnson) vaccines.

For details on incidence, symptoms and treatment of both these side effects, please refer to the full guideline document.

Dr Peter Roessler
Director of Professional Affairs, Professional Documents

We thank the COVID-19 Surgery Living Guideline Working Group members Dr Vanessa Beavis, ANZCA President, Past ANZCA President Professor David A Scott, Perioperative Medicine Special Interest Group Chair Dr Jill Van Acker and Dr Joreline (Jay) Van Der Westhuizen for developing this document, and Professor Paul Myles, ANZCA's nominee on the Australian National COVID-19 Clinical Evidence Taskforce – National Guidelines Leadership Group, who will be joining the working group for subsequent editions.

This summary of the recommendations of PG68(A) Guideline on surgical patient safety for COVID-19 infection and vaccination *was current at the time of writing, but this guideline is updated frequently and may have changed by the time of reading. We remind readers to check the ANZCA website – www.anzca.edu.au – for the latest version before making use of this information.*

We invite your suggestions and contributions for future versions, via email to sq@anzca.edu.au.

Safety and quality

Medical gas pipeline systems

Commissioning and involvement of an anaesthetist

INTRODUCTION

Australia is unique in that the national standard for Medical Gas Pipeline Systems (MGPS) requires an anaesthetist to be involved in the final stage of commissioning of the system, specifically for the identification of the gas at the terminal units (TU).

A revision of the standard, AS 2896:2021 *Medical gas systems – Installation and testing of non-flammable medical gas pipeline systems* was published in 2021. The previous version AS 2896:2011 was confusing regarding the role of anaesthetists. Wording in the new version clarifies the involvement of the anaesthetist. An additional task in the revised standard is that an anaesthetist now is required to check that TU have the correct gas-specific connection and labelling.

ANZCA PG66(A) *Guideline on the role of the anaesthetist in commissioning medical gas pipelines*

ANZCA PG66(A) and its accompanying background paper PG66(A)BP have been developed to assist anaesthetists in MGPS commissioning.

COMMISSIONING MGPS

After installation or alterations to MGPS, commissioning is required before it can be used.

The initial stages of testing are undertaken and signed off, usually by a healthcare facility biomedical engineer. An anaesthetist is required only for the final commissioning step, however they may engage in testing at earlier stages if interested and confident so to do.

FINAL TESTING AT TERMINAL UNITS

Verification of the final tests performed on TU of the identity and concentration of the gas and of gas-specific connectors and labelling, requires a clinical practitioner "experienced in administration of medical gases to patients" to be present and witness the test results.

MGPS works are classified as either "Level 1" or "Level 2".

- Level 1 works are those performed on any part of a MGPS in a special care location or where asphyxiant gases are reticulated.
  (Special care locations are defined as "locations where patients are dependent on specific gases such as oxygen, nitrous oxide, medical air, medical suction, for example, anaesthetising area, recovery room, coronary care unit".)
- Level 2 works are those performed on any part of a MGPS where the only reticulated gases are a combination of either oxygen, medical air, surgical tool air or suction and where there are no special care locations.

Anaesthetists are required for testing Level 1 works. For Level 2 works, an alternative experienced clinical practitioner can be involved in TU testing.

The tests are usually performed by a testing engineer and the role of the anaesthetist is to witness the tests, confirm the results as recorded and sign the form. The anaesthetist must only sign off those tests they have themselves witnessed.

Often testing of flow and of pressure at TU is done at the same time as gas identification. Although anaesthetists are not required, anaesthetist participation in these tests expedites the process and anaesthetists are encouraged to assist if comfortable and confident. If not happy to be involved in this part of testing, anaesthetists are advised to decline.

IMPLICATIONS FOR DEPARTMENTS AND ANAESTHESTISTS

- The anaesthetist in charge should be aware of any works on MGPS, to determine if an anaesthetist is required for final testing.
- The anaesthetist in charge should ascertain the extent of testing and expected timing and duration of the exercise.
- The testing day should be scheduled in advance to assist in commitment to the task, noting that the schedule may be disrupted by unexpected events.
- The anaesthetist in charge may delegate the testing duty to another anaesthetist. It is preferable that the same anaesthetist is involved for the project.
- Healthcare facilities in remote locations may need to engage an anaesthetist from a larger centre. This should be anticipated in advance.
- The anaesthetist should be familiar with ANZCA PG66(A) & PG66(A)BP and may wish to take a copy with them.
- Testing equipment will be supplied by the testing engineer and includes various gas monitors and terminal unit connector probes.
- A copy of "as installed" plans of the MPGS will be provided to confirm which TU are affected by the MGPS works and require testing.
- Although the anaesthetist is not required to be involved in testing other than for TU gas identity, gas-specific connector and labelling, they are encouraged, if comfortable, to do so to assist in the commissioning process.
- The testing form may be electronic or hard copy. Results must be entered at the time of testing and personally witnessed by the anaesthetist.
- If any of the TU tests fail, the record must indicate that the TU has not passed. The cause of failure must be determined and the MGPS must be recommissioned and TU retested.

Dr Phoebe-Anne Mainland FANZCA
ANZCA representative, Standards Australia Committee HE-017

ANZCA and the coroner

A coronial finding emphasises end-tidal carbon dioxide detection and capnography for endotracheal tube placement in a difficult airway.

The Victorian coroner recently released a finding on the death of a patient undergoing an elective hernia repair.

The patient presented with a medical history including asthma, diabetes, and obstructive sleep apnoea. The patient had been assessed as having a potentially difficult airway due to poor dentition, bull neck and full beard, and a Mallampati score of 3.

Following induction, the patient was intubated after administration of suxamethonium. Correct placement of the endotracheal tube was visually confirmed at the time of intubation as well as the presence of end-tidal carbon dioxide on capnography. However, resistance to inflation was extreme. This was deemed to be due to bronchospasm and/or anaphylaxis and was then accompanied by rapid desaturation, followed by cardiac arrest, despite bronchodilators.

Although tube dislodgement had been contemplated, attempts to assess tube placement were hampered during cardiopulmonary resuscitation. Once return of spontaneous circulation occurred and the position of the tube was able to be checked, it was found to have dislodged. Sadly, the patient succumbed to cerebral hypoxic damage.

As with all these cases, the coroner endeavours to establish the cause of death and processes leading up to such tragic outcomes, with a view to lessons that can be learnt from them and to make clinicians aware of them.

The coroner's findings are available by searching "COR 2019 1998" on the Coroners Court of Victoria website at www.coronerscourt.vic.gov.au/inquests-findings/findings.

The coroner recommended improvement opportunities for the hospital, which included ensuring capnography is available on all crash carts, as well as crowd control and communication issues during the Code Blue and ensuring all theatre technicians are assessed in basic life support. The coroner also recommended ANZCA "consider the establishment of guidelines emphasising the use of End Tidal Carbon Dioxide in Endotracheal Tube placement." ANZCA responded advising the coroner of the existing presence of this material in our professional documents *PG18(A) Guideline on monitoring during anaesthesia*, its associated background paper *PG18(A)BP*, and in *PG56(A)BP Guideline on equipment to manage difficult airways, Background Paper*. These documents are available on the ANZCA website.

The college's mission to foster safety and quality is enhanced by coroners and jurisdictional courts engaging with the college in such tragic circumstances, which impact adversely on families as well as fellows.

ANZCA typically receives several coroners' findings per year from the range of Australian and New Zealand jurisdictions that the college represents. Responses are considered in the first instance by our Safety and Quality Committee Chair, Professor David Story, and our Director, Professional Affairs – Professional Documents, Dr Peter Roessler, with subsequent referral for consideration to the Safety and Quality Committee or other fellows with special expertise where needed. We thank all contributing fellows for their time and expertise.

Safety alerts

Safety alerts appear in the "Safety and quality news" section of the *ANZCA E-newsletter* each month. A full list is available on the ANZCA website: www.anzca.edu.au/safety-advocacy/safety-alerts.

Recent alerts:

- New Zealand recall: Carestation 750/750c Anesthesia Delivery Systems, O_2 low-pressure alarm malfunction.
- Co-prescription of gabapentinoids and opioids.
- Reissued: Accuracy of pulse oximeters at low oxygen saturation.

Anaesthesia-related deaths

Example case from SCIDUA's 2018 Special Report

The New South Wales Special Committee Investigating Deaths Under Anaesthesia (SCIDUA) has been reviewing deaths associated with anaesthesia and sedation since 1960. Example cases from the 2018 report are being reproduced in the *ANZCA Bulletin* in an effort to enhance reporting back to the medical community.

EXAMPLE CASE 4 – GENERAL SURGERY

A 50-year-old male presenting for laparotomy for small bowel obstruction. He weighed 80 kilograms.

Background history:

Gastrectomy and oesophageal – Jejunal anastomosis. Preoperatively the patient had abdominal distention with no nausea or vomiting. A nasogastric tube (NGT) was advised against by the surgical team given the patient's prior surgery.

Anaesthetic details:

Modified rapid sequence was undertaken with Midazolam 3mg, Fentanyl 100mcg, Propofol 130mg and Rocuronium 50mg.

Almost immediately a large volume (> 1L) of gastric fluid regurgitated into the patient's mouth. He was turned lateral and suctioned.

He was intubated in the lateral position, and a y-suction catheter used prior to ventilation. There was significant soiling of the trachea with gastric contents.

The case was undertaken on 100 per cent oxygen, arterial and central venous access was obtained. By the end of the case the patient was noted to be in pulmonary oedema and requiring inotropic support. His ventilation was becoming increasingly difficult and was transferred to another facility for consideration of extra corporeal membrane oxygenation.

His condition unfortunately worsened over the next day and he died.

Learning points:

- The committee continues to see aspiration events contributing to death. While aspiration events can be unpredictable, this patient was at risk.
- A rapid sequence induction was indicated in this case. If suxamethonium was deemed unsuitable to be used in this patient, a recommended dose of 1.2mg/kg of Rocuronium should have been used.

Source:

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

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

Fellows are encouraged to read the SCIDUA report in its entirety. The detailed cases and data analysis presented are paving the way forward to a more informative and educational mortality analysis in New South Wales.

WebAIRS incident reporting in 2022

"We cannot fix what we do not know".

Anaesthesia has a long history of advocating for patient safety. Sir Robert Macintosh, a New Zealander based in Britain and the first professor of anaesthesia outside the US, first drew attention to fundamental failures in anaesthetic practice in the 1940s.

In an open letter published in the *British Journal of Anaesthesia*, he recommended that an independent anaesthetist with suitable qualifications analyse every anaesthetic death as soon as possible after its occurrence. Macintosh recognised that knowledge and investigations of such events would create a wealth of valuable information and ultimately would improve patient care and safety.

Since then, there have been many improvements in anaesthesia to which incident reporting has contributed. These include the development of alarms for disconnection and low inspired oxygen, advances in the gas piping and rotameters of anaesthetic machines, the use of pulse oximetry and end-tidal CO_2 measurement, anaesthetic agent measurement and alarms, N_2O safety measures, colour-coded syringe labelling and the introduction of the World Health Organization (WHO) Surgical Safety Checklist.

Incident reporting is based on learning from adverse events, ranging from near misses to catastrophic patient outcomes. Learning from experience is an essential part of every anaesthetist's training, but individual events may be less informative than information amalgamated from several similar incidents. In addition, the more reported events, the more likely detection of rare incidents becomes.

A near miss is an event that did not cause patient harm but had the potential to do so. Under reporting of near misses might lead to missing out on important information and opportunities to learn from these events and prevent some of this harm before it occurs. Near misses also happen much more often than events causing severe injury. Therefore, it follows that there is a much greater opportunity to detect and learn from the precursors of patient harm than from the small number of events that actually result in serious harm.

WebAIRS was created in 2009 and is the first web-based voluntary anaesthetic incident reporting system in Australia and New Zealand. Registered anaesthetists have the opportunity to voluntarily report incidents that occur during their care to the database.

Almost 10,000 incidents have been reported since 2009, and multiple case series and summaries of the webAIRS incidents have been published in both peer-reviewed journals and in the magazine articles of ANZCA, the Australian Society of Anaesthetists and the New Zealand Society of Anaesthetists. Links are available on the webAIRS website. While this is a significant number of adverse events, one may assume that many incidents are not captured. In their latest report on safety and incident reporting in healthcare, WHO described underreporting of incidents as a particular concern. They assume that only 7-15 per cent of events are ever reported. Our own experience suggests that in Australia and New Zealand this might be close to 0.15 per cent.

While most of the incidents reported to webAIRS involve airway and respiratory issues, webAIRS provides a platform to collect incidents involving any aspect of anaesthesia care.

The main categories include assessment/documentation, infrastructure/system, medication, respiratory/airway, cardiovascular, neurological, other organ, medical device/equipment and miscellaneous/other. WebAIRS recognises that one incident may fall into more than one category – therefore, multiple category allocations per incident can be assigned to one incident. In addition, each category has further sub-categories, of which the reporter can choose all that apply for the incident.

Data entry is collected via tick boxes and non-mandatory narrative fields – therefore, the depth of the data analysis depends on the information provided by the reporters.

Over time it has been shown that most of the valuable information is found in the narrative fields. WebAIRS provides four different narrative boxes for each incident reported. The narrative field on the first page allows the description of the incident, and at the end of the reports, there are narrative fields to allow for reflection on contributing factors, alleviating factors and any additional information the reporter would like to add.

As all incidents are reported anonymously, the analysers cannot contact the individual reporter should the information be missing or unclear. It is therefore important to include as much detail as possible.

Anaesthesia colleagues across Australia and New Zealand are encouraged to use all webAIRS functions and report incidents ranging from near misses to major events across all areas of anaesthesia practice. Each reported incident collects continuing professional development points for the reporter. These incidents can also be used on an individual level for a personal audit, a departmental level for morbidity and mortality meetings, and a bi-national level to improve patient safety.

Dr Yasmin Endlich on behalf of the ANZTADC Case Report Writing Group

Framework underpins our diploma

OUR PERIOPERATIVE CARE Framework – an outstanding piece of work – is now a live document on the ANZCA website.

The framework, approved at the December 2021 ANZCA Council meeting, underpins our diploma in perioperative medicine and is a key milestone in the diploma development.

The framework – which comes in the form of a downloadable document and an interactive graphic – is the result of many hours' work by Dr Jeremy Fernando and his Perioperative Care Working Group.

Thank you to Jeremy and Dr David Alcock (ANZCA), Dr Su Jen Yap (ANZCA), Associate Professor Arthas Flabouris (ANZCA/CICM), Professor Guy Ludbrook (ANZCA), Dr Simon Reilly (ANZCA/ASA), Dr Katie Thorne (RACP – geriatrician), Dr Aisling Fleury (RACP – geriatrician), Professor Alison Mudge (RACP – general), Dr Rachel Aitken (RACP – geriatrician), Dr Margot Lodge (RACP – geriatrician), Dr Kathy McDonald (RNZGP) and Dr Matthew Burstow (RACS).

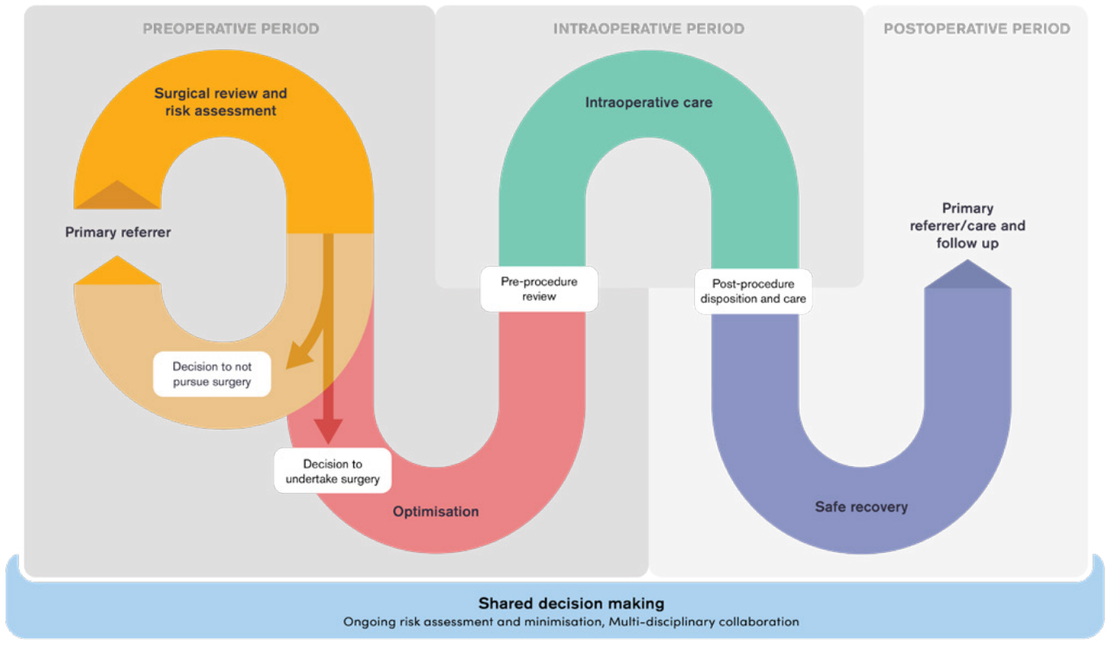
It has been designed as a practical resource for anyone considering developing a perioperative medicine service, encompassing the surgical patient journey from contemplation of surgery through to optimal outcome. The framework:

- Identifies key steps and principles in the surgical patient's perioperative care journey.
- Provides recommendations about how these principles might be operationalised in practice.
- Provides resources that support the evidence behind these recommendations and/or their implementation in practice.

This framework can also help guide training, service development and improvement, and research in perioperative medicine.

The Perioperative Care Framework

From the contemplation of surgery to an optimal outcome



THOUGHT LEADERS AND FACILITATORS

The development of our "grandparenting" process is also nearing completion. It has been approved by the ANZCA Council with some updates from the College of Intensive Care Medicine to come.

Our grandparented diploma holders will be those practitioners who will receive the diploma based on their experience and past involvement in perioperative medicine.

They will become our course facilitators, supervisors and thought leaders in this emerging field. The points-based application system ensures there is clear justification for who qualifies.

ADVOCATING FOR CHANGE

We are in the midst of forming our Perioperative Medicine Economics Working Group. I will be chairing this group and I am delighted to have the eminent Professor Guy Ludbrook as the deputy chair.

This group includes some outstanding individuals who will guide the work of health economists to conduct economic modelling and the development of a cost-benefit analysis for perioperative medicine.

This work will be critical to the success of our advocacy activities.

Between December and February we undertook stakeholder planning work in preparation for the development of an economic case for perioperative medicine.

This focused on:

- Updating the perioperative medicine literature reviews completed in 2018 and 2019.
- Establishing systems to identify and influence critical decision makers in Australia and New Zealand health systems.
- Establishing additional consultative mechanisms in addition to the Perioperative Medicine Steering Committee.
- Establishing what is required to develop an economic case, including the modelling that needs to be undertaken to support the economic case.

The results of this work will be essential in attracting candidates to the diploma and for persuading governments, hospitals and private health insurers of the financial benefits of perioperative medicine.

Coupled with the obvious benefits of perioperative medicine to our patients and practitioners, we will have a very strong argument for change.

Ultimately, we plan to be able to demonstrate and defend the case for investment, resource allocation and organisation reform to embed perioperative medicine.

CURRICULUM DEVELOPMENT

Joel Symons and the curriculum development team have finalised the learning outcomes and have commenced working on the curriculum content.

Aligned to the Perioperative Care Framework, the six topic areas are:

- Pre-operative assessment.
- Pre-operative planning.
- Optimisation.
- Intraoperative impacts on patient outcomes.
- Postoperative assessment and management
- Discharge planning and rehabilitation.

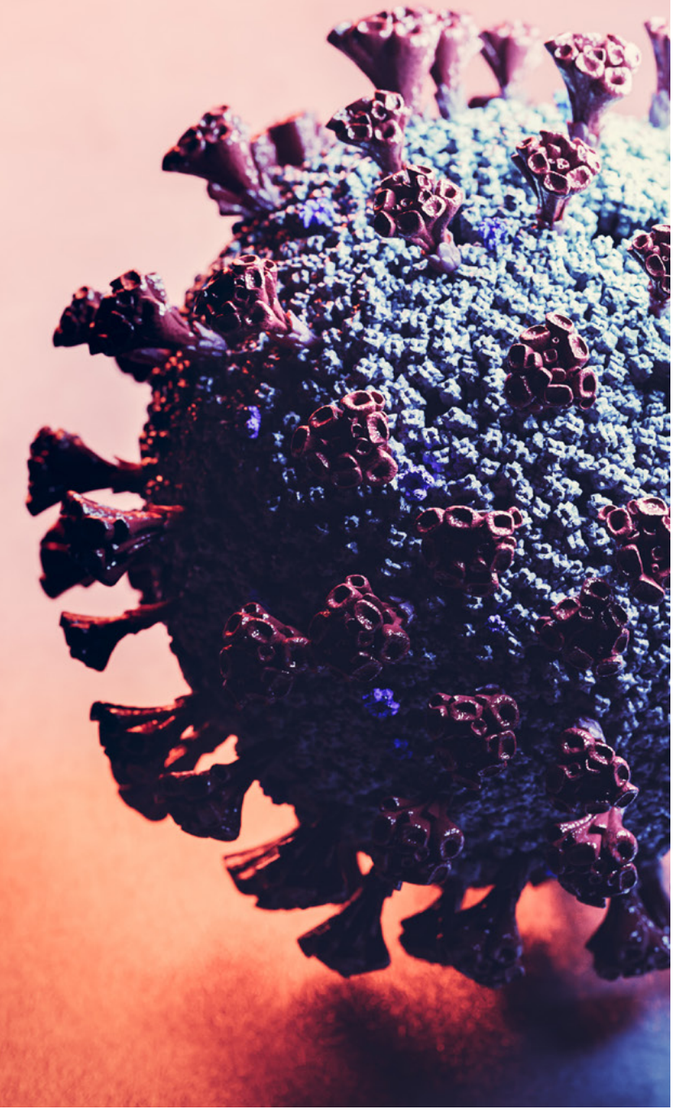
Each topic area includes access to an online module including suggested reading packages, resources, opportunities to network, assessments, as well as face-to-face workshops and opportunities to apply this knowledge in a clinical setting.

There is still much to do, but we are making good progress.

Dr Sean McManus
Chair, Perioperative Medicine Steering Committee

Reflections from the frontline, two years on

Since the onset of the global COVID-19 pandemic in early 2020 nearly 500 million cases have been recorded and more than six million people have died. The impact on clinicians and healthcare workers has been immense. We asked two ANZCA fellows and a trainee how they have coped.



Fellow leads COVID response protocol

Dr Louise Sweet, FANZCA is an anaesthetist at Sydney's Liverpool Hospital where she helped lead the introduction of COVID response protocols. She trained as an anaesthetist after a career in nursing in hospitals and aged care.

I had been a consultant anaesthetist for four weeks when COVID arrived, and as I watched the devastation which ravaged Europe in early 2020, I knew only too well it was on its way to Australia.

Two years on, Liverpool Hospital and the South Western Sydney local health district (LHD) where I am based, have borne the brunt of COVID.

As one of a few anaesthetists tasked with creating the original protocols to manage COVID patients, the burden of protecting ourselves and our staff weighed heavily on us in the early days of the pandemic. There was no precedence, no prior experience, and we were trying to prepare for something we had never seen, but with help from our emergency and ICU colleagues, we set about developing intubation guidelines, PPE and transfer protocols, and our 24 hour onsite anaesthetic VMO-led COVID intubation team that would continue successfully for 10 months.

A group of about 30 clinicians from around the hospital and from within the community formed the COVID Taskforce and met several times per week to identify and manage any issues as they emerged. This was an invaluable way of combining our collective expertise and ultimately bringing our departments closer together. Two years later we still meet every week and have a unique bond created by the challenges we have faced as a group.

The groundwork we did that first year held us in good stead for the challenges ahead. But 10 months of 12-hour shifts, seven days a week on the COVID intubation team, took its toll.

Despite the fact the pandemic would continue for many months, when I look back, this was the time I was most exhausted. Luckily, I was privileged to have the support of some incredible anaesthesia colleagues, whose resolve to finish the task at hand never faltered.

One of my most rewarding memories is of a paramedic in ICU who had caught COVID at work. He was a middle-aged man, who had been intubated for more than a week, and while we cared deeply for all our patients, he was special because he was one of us.

We followed his progress every day, hoping he would improve, and on one of my ICU shifts, I was asked to extubate him.

I remember holding his hand and explaining that he was somewhat of a celebrity even though he didn't know it. When he heard how many people had been asking after him every day, he started to cry, and once the endotracheal tube was removed, all he could say was "thank you".

I was so pleased to have been there at a time in his life when he felt so alone, but it was incredibly confronting, as we were all too aware this could easily have been us.

Even though this story had a happy ending, there were just as many others that didn't.

Whole families being intubated, young parents dying having never seen their newborn babies, and those that took their last breath without their families there to hold them one last time.

It's not been an easy road, but COVID has been a lesson of strength and resilience. Despite being asked to provide support in ICU, our anaesthesia registrars have worked tirelessly over the past two years, and not once have they complained. Watching the incredible work of the ICU and ED registrars and nurses, who continue to give everything to care for their patients, even when they are exhausted, is phenomenal. They are the true unsung heroes.

Those who know me know work life balance is not a particular strength of mine, but it's certainly a work in progress. I spend more quality time now with my long-suffering daughter Cassie, and have the pleasure of having a one-year-old Cavoodle named Lockie, who demands every minute of my attention when I'm home.

This year I plan on picking up where I left off before COVID, going back to running and spending time with my dearly missed friends.

The last two years have certainly been a rollercoaster ride. For all the tragedy and suffering that COVID bought with it, it has also been an incredible experience. I'll never forget the stories of those I have cared for, and I'll always be extremely proud to have worked with such an amazing group of clinicians who never once faltered in the face of adversity.

Fellow changes role to help colleagues during long, tiring days

Dr Bronwyn Webster, FANZCA is an anaesthetist in full-time private practice in Melbourne. She worked through Melbourne's six lockdowns as a frontline COVID-19 surge clinician in general and ICU wards at a regional hospital and a metropolitan private hospital.

"I had the opportunity to take on three different roles during the time elective surgery was reduced in Victoria due to COVID restrictions.

My worst moment was in my head – the realisation that things were going to change and that we were about to enter a period of instability and change. I think we all fear the unknown and want to cling to the safety of what is familiar. I am in my early 50s and had built a private practice over a long period of time which meant my professional life was predictable and something I felt I could control.

My best moment was realising that such fears are baseless and that it is possible to step away from what you know and experience new, rewarding and challenging things. Taking on different roles as a medical professional over the past two years was such a privilege and empowering experience.

My initial role was to relocate to South Gippsland and to help improve the COVID response capacity at Wonthaggi Hospital. It is a small regional hospital staffed by GP anaesthetists. We set up the theatres so we had the ability to treat ventilated patients in the event we were unable to transfer to Melbourne. We also ran drills and established protocols to deal with the anticipated surge.

A group of us staffed the hospital day and night, but it was not much fun returning to overnight shifts catching a quick snooze in a Jason recliner. I chatted and bonded with the staff during the many long shifts waiting for the surge that never really came.

My second role was working as a general ward doctor at Melbourne's Epworth Hospital looking after the nursing home patients. Here I had to learn to be a resident again – ward rounds, drug charts and doing whatever odd jobs came up. As a senior experienced doctor, it was such a pleasure to be able to trouble-shoot problems on the ward, talk to relatives with a perspective that only time can give you and to contribute in a meaningful way to the chaos of that time. That Melbourne lockdown in 2020 was long and boring and joyless, and I think it was exhausting trying to stay on top of things.

Being part of a team with social interaction, structure and doing something with substance helped me get through that time. My third role was in ICU at the Epworth assisting the team in the COVID pod with airway management and lines. This was an amazing learning and empowering secondment which my normal life would never had allowed. I updated my skills and knowledge in a supportive environment away from the usual time-pressured streamlined routine of my everyday practise.

The unsung heroes I encountered during the past two years were the almost invisible glue that holds hospitals together – the rostered staff who had little choice about whether they wanted to be there or not. I was filled with admiration watching cleaning staff join the rest of us and don full PPE before embarking on the endless deep cleaning that was required. I'm sure they found the environment much more frightening and challenging than those of us with experience in such an environment. And then there were the tireless physiotherapists who assembled a motley crew of nurses, techs, registrars, anaesthetists and intensivists to safely prone our ventilated patients or to hoist them out of bed and make them build muscle and recover.

So for me, the COVID pandemic offered an opportunity to turn the multiple skills of an anaesthetist into making a useful contribution to people in need in a new and challenging and ultimately rewarding environment.

The unknown is not something to be feared, and there is always a silver lining."

The challenges of training and young children during a pandemic

Dr Kirsten Long is an anaesthetic registrar who has been treating complex COVID patients at the Royal Melbourne Hospital.

"Rather than one moment, I'd say the pandemic has brought different challenges as it evolved through the months and then years.

Early in the pandemic when little was known about the virus, I was pregnant with twins and had a two-year-old at home. As a higher risk pregnancy I had to make decisions about what level of risk I was comfortable with.

Avoiding aerosol generating procedures in anaesthesia is difficult, and I was mindful of not missing volume of practice. PPE at that time was still a hot topic of contention. My supervisors of training were brilliant in checking in often, and we were able to switch up my duties when I felt necessary.

When I returned to work, Melbourne case numbers were taking off. Some positive patients who came through theatre became very sick very quickly. Managing rapid deterioration in full PPE while isolated inside a positive theatre led to some pretty steep learning curves!

As a registrar group we were intermittently redeployed to the COVID respiratory ward or intensive care unit. An unexpected challenge was treating patients who had been overwhelmed with misinformation and didn't believe the SARS-CoV-2 virus existed. Occasionally the patient would die, and the family would leave not believing or understanding the cause of death. That was quite a surreal experience.

I think most people would be able to identify definite positives that have come out of the past two years. My husband is also a shift worker. We often joke that having three kids under four was like being in stage-four lock down – pandemic or not. Life moving online has given me greater access to events that might normally be difficult for me to attend. Virtual meeting places have allowed me to attend out of hours meetings and viva nights. I can work out easily with friends online and have caught concerts and performances from my couch. Teaching from home means I can throw a load of washing on in the coffee break. It all adds up.

The period from 10 August 2020 when the twins were born until now has been exhausting. The pandemic has really challenged our family with ongoing day care uncertainty, long periods of isolation with recurrent toddler infections, and separation from major family supports interstate.

Having young children is often exhausting. Full-time training can be demanding. Having children while training full-time in a global pandemic is one way to find your limits. Exercise has always been my way to switch off. Previously I had been a long-distance runner, although these days I'll take what I can get. Usually that means squeezing in a run to work, or more recently a spin on the Peloton bike after the kids go to bed. I've been able to connect with some amazing groups of medical parents online which makes exercising from the loungeroom feel a whole lot more social.

My real heroes are those who have championed me and my potential as a trainee, regardless of my busy life away from the hospital.

Though not often, there have been times when I've felt being a parent – and in particular a mother – has factored into people's assessment of my capabilities such as my ability to sit exams or manage demanding shift work. Although I have felt overwhelmingly supported during my training, I believe those perhaps unconscious biases still exist as barriers in some areas. Opportunities to working parents shouldn't be limited by home circumstances, and access to rotations along with flexibility in training are areas that could still be improved upon. I'm lucky to have so many outstanding mentors in anaesthesia – I hope they know who they are!"

Continuing professional development

2019-2021 CPD End of triennium update

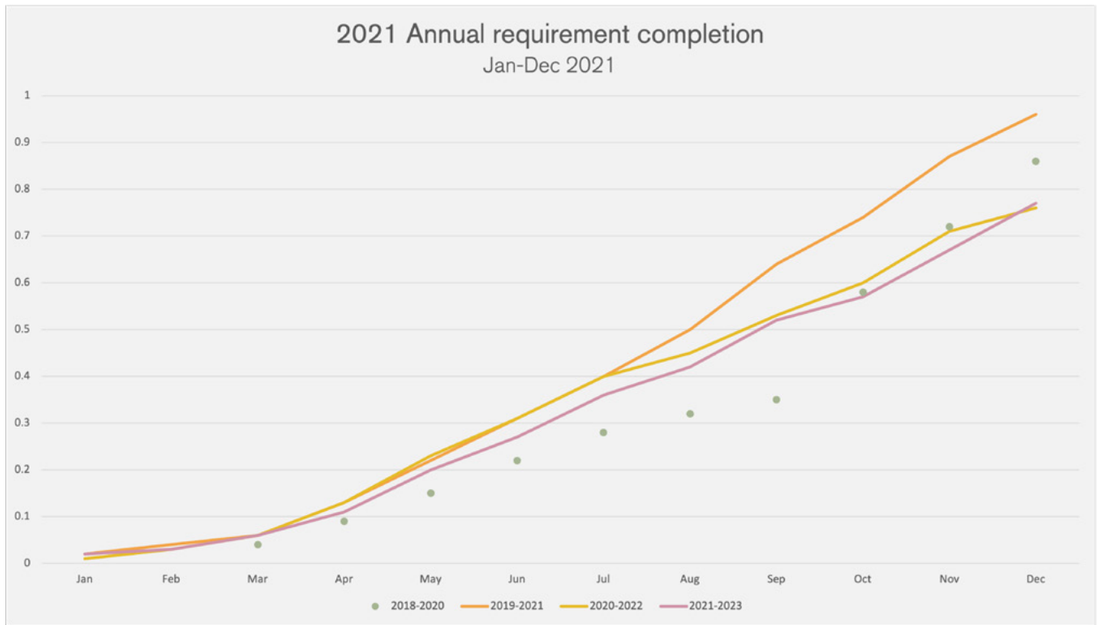
OUR CONGRATULATIONS TO over 1100 continuing professional development (CPD) participants who completed the 2019-2021 triennium. The pandemic and its restrictions continued during 2021, but you all continued to pivot during unprecedented disruptions. At the time of publication a 99 per cent completion rate demonstrates this dedication to your professional development.

Records continue to show participants across all trienniums have been actively updating their CPD portfolios. This builds on last year's results of 100 per cent successful completion for the 2018-2020 CPD triennium. Despite the COVID-19 pandemic restrictions affecting access to the usual channels of CPD activities, participants are still able to demonstrate their CPD compliance.

These entries are also on par with year on year completions. The graph below displays the CPD portfolio completions for the 2021 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.

This end of triennium process will be completed in April 2022, with full details shared on our website news item CPD end of triennium 2019-2021.



2021 CPD AUDIT UPDATE

The CPD team is actively working through the verification checks of the 2021 verification of CPD activities (audit). This process occurs between January to March, following the final submission date of 31 December 2021. Confirmation of selected participants' compliance status will be sent once all checks have been completed in early April 2022.

Thanks for your patience, we appreciate the time taken in preparing your CPD portfolio. The CPD committee and team are attempting to support those selected who require further CPD evidence. Full details are available on our website news item Annual CPD verification: your questions answered.

CPD REVIEW PROJECT UPDATE – STAGE 1 COMPLETE

The ANZCA and FPM CPD Committee have formed a CPD review project group (CPD-RPG) to support the review of our CPD program and standard.

The current program has been in place since 2014. Recommendations by the review group will align with the Medical Board of Australia's (MBA) Professional Performance Framework and revised CPD registration standard with an effective date of 1 January 2023, as well as the Medical Council of New Zealand's (MCNZ) recertification documents. We shared full details on our approach in our *ANZCA Bulletin* Spring 2021 article – New CPD standard: Our approach.

The project group has now finalised stage one of the project plan by determining the project scope and evaluating the CPD program. Full details on the stage one completion including tasks taken to support the CPD programs evaluation and next steps is available in our news item CPD review project update - scope and evaluate.

All CPD participant updates have been collated for members to view on the dedicated webpage CPD review project group.

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 plan, 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.

To complete your CPD plan, log into 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 so 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 you like to be involved in and when might they 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?

You will be unable 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 CPD 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.

NEW CPD RESOURCE FOR PFTS

All new professional fellowship trainees (PFT) are automatically enrolled in the ANZCA and FPM CPD program. This is to help with the transition from ANZCA training to your life-long learning through CPD once you become a fellow.

A new CPD PFT support document has been designed to help navigate this transition. This support document provides helpful information about navigating the online CPD portfolio, the connection between CPD and Training Portfolio System (TPS) and your CPD requirements.

CONTACT US

If you have any concerns about meeting your CPD requirements, the verification process, or any CPD-related enquiries please do not hesitate to contact the CPD team – cpd@anzca.edu.au.

A CPD triennium to remember

ANZCA and FPM Continuing Professional Development (CPD) Committee member Dr Michelle Castro, FANZCA, shares her experience of completing her first CPD triennium.

WHEN I STARTED my provisional fellowship (PF) year in October 2018, one of the aspects of the year I looked forward to was the CPD. This may seem strange, but I'd discovered a passion for attending conferences and courses during my training, and I was looking forward to forging my own path and pursuing interests such as medical education.

Things started well. By the end of my PF year, I had a graduate certificate in clinical education and had attended several conferences, including two emergency response workshops along the way.

Having managed to obtain a staff specialist position in January 2020 at one of the hospitals I trained in I had every intention of continuing my CPD triennium the way it had started. Unfortunately, as we all know, history had other ideas. Instead of attending conferences in person, I was viewing them remotely and claiming COVID-19 simulations completed with my theatre team. One of the most unexpected aspects of my CPD experience, however, was unrelated to the pandemic at all.

Towards the end of my training, I'd had a rather nebulous idea that I'd like to do some work for ANZCA but I really didn't have anything concrete in mind. I liked medical education, and attending courses and conferences, but I'm no good at organising events. So it seemed like a perfect fit when I noticed an advertisement in the *ANZCA E-Newsletter* for new ANZCA/FPM CPD Committee members. It was 2020, and I was still in my first year as a consultant, so I couldn't believe it when I was selected alongside two other new members.

While I hope I have added some value by contributing my perspective on issues, I have gained so much from being a member of the CPD committee. The other members of the committee, both clinicians and administrative, have always made me feel welcome and my opinions valued. I hope that conditions finally allow me to meet them in person!

CPD committee membership has also broadened my perspective in a way I hadn't anticipated. While I previously appreciated that being a FANZCA looked different for different people, I had no idea of the variability in lived experience, for example, the large proportion of FANZCAs who have no public appointment, and the difference this potentially could bring to their experience of meeting their CPD requirements.

Each potential change made to the CPD program is carefully considered, always trying to anticipate how such a change may affect as broad a range of program participants as possible for public and private, New Zealand, Australia, and elsewhere, different states, urban, regional, and rural, ANZCA and FPM. As the CPD review project ramps up, these considerations become even more important.

As a new consultant, and having now spent almost 18 months on the CPD committee, I believe that we have a great CPD program, but if I was asked what I would like to see in future I would suggest more guidance, particularly for provisional fellows, when compiling their CPD plan. When completing my first plan, I had already attended a number of conferences and courses, so I knew what was out there and achievable for me, but I am acutely aware that many trainees, for various reasons, enter their provisional fellowship never having attended an anaesthesia conference. Even so, I had very little confidence in filling in my plan. How much should I write? How much detail? Does this question mean what I think it means?

I believe more guidance, such as an example plan, may improve the confidence of provisional fellows, FANZCAs and FPM fellows (particularly non-FANZCAs navigating a new CPD system) in filling in their plan, and potentially improve the utility of the plan as well. Luckily, a guide to the CPD program aimed at provisional fellows has recently been developed.

I have now completed my first CPD triennium, as both a participant and a CPD committee member. I would not hesitate to recommend to all fellows that they become involved in their college's activities, particularly the newer fellows.

It really is never too early, you'll meet some great people, and it broadens your perspective of the specialty in ways you couldn't imagine.

Dr Michelle Castro, FANZCA
ANZCA and FPM CPD Committee member

CPD RESOURCES

- The COVID-19 information for CPD participants' webpage has helpful information about CPD activities that can be considered in response to the pandemic, including COVID-19 simulations and team training scenarios.
- There are many ways to get involved at the college, including applying for a committee role or joining a specialist interest group. Full details are available on contributing to your specialty webpage.
- Full details on the CPD review project group can be found on our website.
- A new CPD PFT support document has been developed to help with provisional fellowship transition to the CPD program, providing helpful information on how to navigate the CPD portfolio and requirements.

Self matters

The importance of maintaining connections

Over the past few years, many of us have experienced prolonged separation from family and friends. It feels like we have missed so much in the lives of those we love. I was concerned to hear a close colleague describe herself as "broken" in response to recent border decisions that prevented anticipated travel. Somehow, we need to find ways to manage separations and maintain connections that nurture and support us. I was really pleased when Dr Tanya Selak suggested inviting ANZCA fellow Dr Mary-Ann Fox, an Adelaide-based anaesthetist, to write about her experiences of support from friends and colleagues on Twitter – a charming and deeply personal piece. As always, please send ideas for future columns to lroberts@anzca.edu.au.

Lindy Roberts AM
Director of Professional Affairs, Education

Nigella Lawson, Twitter, and me

WHY WOULD I want to use Twitter and how could it help me personally interact with Nigella Lawson, the British food critic, writer and TV chef?

My journey on Twitter began in 2010. Naturally I chose my schoolgirl nickname @maffygirl. I did not really engage much until I saw my fellow anaesthetists Tanya Selak @GongGasGirl and Scott Ma @scrufff888 live tweet conferences, which I enjoyed. "There might be something in this for me," I thought. But my live tweeting was awful and so I continue today to leave that to the experts.

In November 2019 I asked on Twitter where I should go in London. Kate Prior @doctorwibble whom I had only engaged with on Twitter, met me two weeks later in London and took me to an exhibition at the Tate Gallery. She even bought me a cheese toastie and a beer. "This Twitter thing is amazing," I thought.

At a World Airway Management Meeting in in Amsterdam that same month, my opinion of Twitter suddenly changed. During the first session on airways, a speaker put up a still from a movie of a female actor being strangled and clearly terrified. All around me people laughed, and I felt sick and scared. Who were these colleagues who thought this was appropriate? A delegate left the hall and complained on Twitter. I echoed her sentiment and tweeted my displeasure. In Australia it quickly went viral. It was not the attention the organisers wanted. Apologies followed and all talks were pre-scrutinised.

I could actively change things that I thought were wrong, and this opened a new door for me on Twitter.

In January 2020, I joined 10 Twitter followers to bid for a white glove tour of the Victorian State Library as a fundraiser. We won and formed a message group to plan the trip. We were doctors, a teacher, and a lawyer and most of us did not know each other. "I do not give money to strangers on the internet," one said as she paid her share.

Then COVID changed our society. Six weeks after our first meeting these people became a source of comfort and friendship. We supported each other with regular interactions, and we still chat daily, with members jumping in and out as they please. I call them my #RaftOfOtters. I do not know how I would have coped without these diverse people for support. I also met An Leavy @an_leavy, a retired anaesthetist, who diligently summarised all the state government's pressers, saving me time and providing great advice.

During a terrible time in April 2020 when my beloved aunty died and a friend was killed in a tragic accident, Twitter friends reached out and comforted me. I will never forget that kindness. In 2021 when I returned to the ward after an emergency appendectomy, the first flowers to arrive came from my Twitter friend Tanya Selak, with a sneaky bottle of gin.

I have engaged widely on Twitter, promoting the compulsory mask fit-testing of South Australian public hospitals, producing the hashtag #BeLikeUs. If we could mask fit the hospital chaplain, surely all hospitals could get their staff fit-tested. I support equality and highlight the "untitling" of female doctors. I am a staunch vaccination promoter and find like-minded people on Twitter. Through my activity on Twitter, I have made networks that I could not have made otherwise.

I love cooking and I especially love my airfryer. I was excited to see Nigella Lawson comment on fellow #MedTwitter photos of food. I was absolutely thrilled when she said my mango trifle was "splendiferous". (By early March my tweet with the trifle had 44,000 interactions). Her kindness in commenting (and yes, it is her) brought such hope and joy during the darker times of this pandemic.

I asked Twitter followers recently what they thought of my contribution, and one reply stands out as a summary of what I hope I am on this platform:

> *"You're a kind & welcoming doctor on Twitter, your attitude is inclusive & as a sensitive person with a history, I'm able to recognise in you an anti-discrimination ally. I also find you deeply reflective. It's been a joy to know you in a less than joyful world." @VSTMMJJ*

I have made wonderful friends on Twitter who have helped me emotionally. I have learnt so much about COVID from colleagues all over the world. I am much more knowledgeable about all things academic, and I have learnt to respect others' opinions even if I do not agree. If you are at all unsure, give Twitter a go. We are a welcoming inclusive group. You might be pleasantly surprised who you meet.

Finally, there is always something to explore and words of wisdom and kindness amongst the chatter. Thanks to @genderqueerwolf for permission to use the following.

> *"When you find yourself scrolling Twitter in the middle of the night, because the trauma is too much or the dreams are too hard or your mind refuses to be quiet: I hope you see this, and you know that you are loved. That I love you. That trauma lies. You are not useless, or alone".*

Dr Mary-Ann Fox, FANZCA
Anaesthetist, Adelaide
@maffygirl

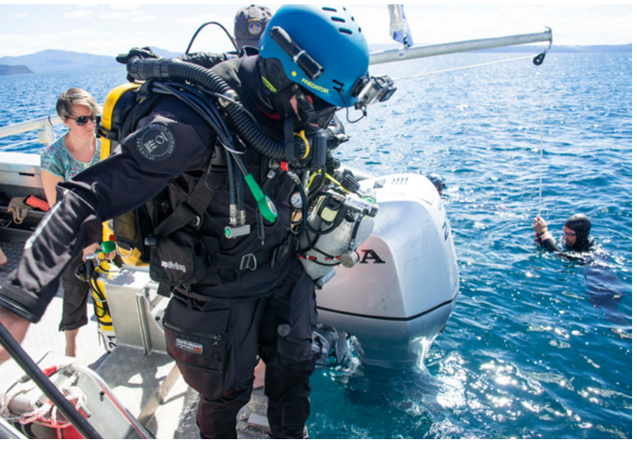
Acknowledgments to Ronni Salt, Karen Magraith, Tanya Selak and Lindy Roberts for assistance in preparation of this article.

Diving deep into physiology with a world first at 60 metres

In 2010 Professor Mike Grocott from the UK was the first to take arterial blood gases in air breathing subjects on the summit of Mount Everest. This remarkable feat inspired Professor Simon Mitchell, an anaesthetist and well-known diver from the University of Auckland and Auckland City Hospital, to contemplate a study in similarly extreme circumstances – taking blood gas samples from a breath-hold diver at very deep depths, and then again at the surface before breathing on the same dive.

Professor Mitchell explains how he and his team proceeded with the study that marks another world first.

Clockwise from above: Professor Simon Mitchell taking the deep arterial blood gas specimen; Dr Tom Scott just after taking specimen at the surface.



From top: Dr Tom Scott with arterial catheter inserted and during waterproofing test in a pool; Professor Simon Mitchell entering the water prior to descending to 60 metres depth.

THE AIM OF the study was to explore the pathophysiology of hypoxic loss of consciousness that may occur as a breath-hold diver nears the surface when ascending, particularly from a deep dive.

The accepted pathophysiological explanation was that during descent, despite the diver being apnoeic and metabolising oxygen, the alveolar and arterial PO_2 would actually increase as the lungs were compressed. The resulting high arterial PO_2 would provide a degree of "apnoea-comfort" at depth especially if the diver had hyperventilated and lowered their arterial PCO_2 prior to the dive. However, oxygen would be removed from the lungs at depth, and during the subsequent ascent, the alveolar PO_2 would fall precipitously as the lungs expand. The oxygen content in the arterial blood would also plummet during ascent and if the diver had spent too much time (and metabolised too much oxygen) at depth, this could result in loss of consciousness when nearing the surface. Many breath-hold divers have died under these circumstances.

This "received pathophysiological wisdom" had never been formally investigated due to the obvious challenges in doing so. The rapid pressure changes and deep depths of an extreme breath-hold dive cannot be simulated in a hyperbaric chamber. Relevant research would have to be undertaken in water. In 2018, an Italian group inserted an arterial catheter in humans performing breath-hold dives in a 40 metre deep, warm water pool and obtained blood gas specimens either at depth or at the surface before breathing, but not both in the same dive. Their study also did not address real-world dives in cold open water conditions, in true competition format, to more extreme depths.

Over the years since Grocott's Everest study, I had suggested the idea to a number of registrars looking for research projects but the first to "run" with it was Dr Tom Scott, a basic anaesthesia trainee from Auckland City Hospital and a keen breath-hold diver.

Dr Scott designed and hand-built an ultra-low dead-space splitter device to allow simultaneous connection of two syringes to an arterial line. In true Edgar Pask spirit, he allowed this to be tested on himself in an Auckland swimming pool prior to its use in the study. He recruited one of only two New Zealanders capable of comfortably performing breath-hold dives to 60 metres using fins with constant weight. This diver was happy to have an arterial line inserted with specimens taken at 60 metres and the surface on the same dive. We also convinced an ethics committee that all this was a fine and safe idea. The plan involved the breath-hold diver descending to 60 metres where I, breathing a helium-nitrogen-oxygen mix via a rebreather system, would draw the deep specimen, leaving the syringe attached. The breath-hold diver would then ascend to the surface where Dr Scott would take the surface specimen before the diver breathed.

> "The rapid pressure changes and deep depths of an extreme breath-hold dive cannot be simulated in a hyperbaric chamber."

The plan was executed over two days at Lake Taupo, New Zealand in January 2021. On day one, a complete practice run, including a dive to 60 metres, without the arterial line was successfully undertaken. On day two, the full experiment took place with two breath-hold dives to 60 metres completed while the mixed gas divers waited at 60 metres for 36 minutes, subsequently completing two hours of decompression. The deep and surface specimen collection went flawlessly on both dives and the specimens were immediately processed using an iStat Alinity analyser on the boat. Everyone involved agreed that watching this incredible athlete execute these dives (twice, 25 minutes apart) was extraordinary.

Despite the fact that he was apnoeic and consuming oxygen over the minute it took to descend, the diver's arterial PO2 increased from 15 kPa (after hyperventilation) at the surface to 43 kPa at 60 metres. However, over the course of a one minute ascent, it fell from 43 to 8 kPa, confirming the previous predictions. All participants returned home safely.

This adventure in applied physiology represented a world first in the field, and detailed results are available in the related publication[1]. We have received ethics approval for a follow-up study that will look more closely at the changes we saw in arterial CO_2. We are planning dives of up to 80 metres for the next study.

Professor Simon Mitchell, FANZCA
Auckland City Hospital

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Ditching desflurane – four steps to success

With the goal of net zero emissions by 2050 and the increasing recognition of the importance of sustainability in healthcare, anaesthetists in Western Australia have significantly reduced desflurane use in public hospitals.

THE HEALTHCARE SECTOR is responsible for seven per cent of CO_2 emissions nationally[1]. With the planet facing a climate change crisis, and the Australian government finally committing to achieving net zero CO_2 emissions by 2050, it is time for those working in the healthcare sector to do their bit.

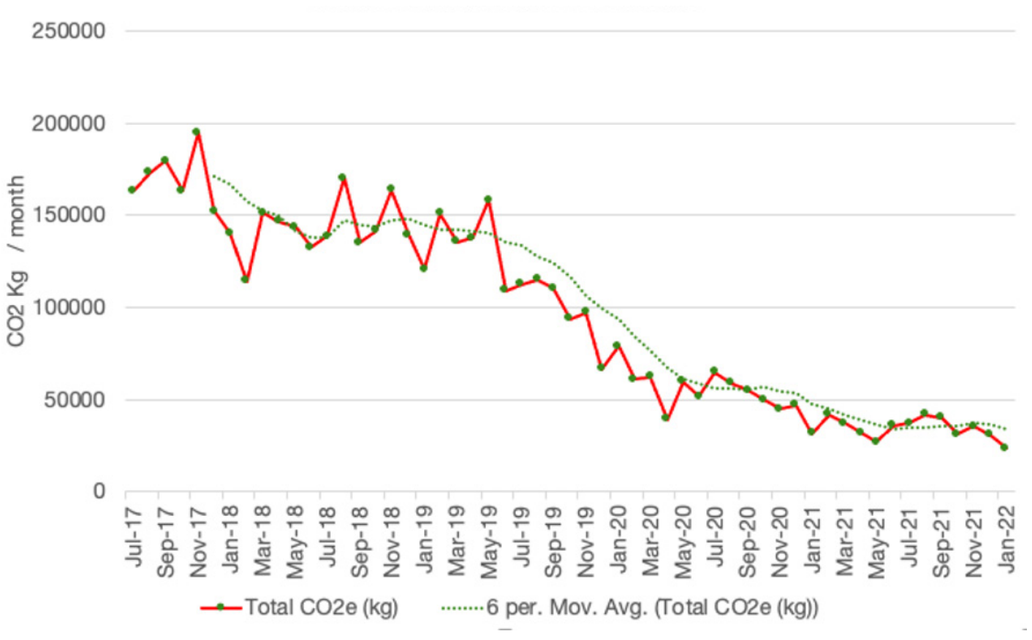
Volatile anaesthetic agents are environmental pollutants. Of these, desflurane is the agent with greatest global warming potential, due to its ability to retain heat and its longevity in the earth's atmosphere[2]. One 240mL bottle of desflurane is equivalent to 893kg of CO_2 emissions (this equates to driving a Volkswagen Golf for 5900 kilometres)[3].

The good news is we have excellent alternatives with a much lower carbon cost.

Sevoflurane, MAC for MAC, is 50-60 times less harmful than desflurane[4]. Total intravenous anaesthesia (TIVA) with propofol has approximately 1:10000 of the environmental cost[5,6], and the advantages of smoother emergence and less postoperative nausea and vomiting. Furthermore, experience has demonstrated no compromise to either patient safety or list turnover, across all patient cohorts.

Anaesthetists in Western Australia have recognised that reducing the use of desflurane is one of the "lowest hanging fruits" to target in order to mitigate the global warming impact of their practice. In recent years, they have achieved remarkable success. As illustrated in the graphs below, the total usage of desflurane across all public metropolitan and country hospitals in Western Australia has fallen from a monthly average of 162 bottles in January 2018 to just six bottles in January 2022. This has resulted in a staggering reduction of 110,000kg of CO_2 equivalents per month, as well as saving the health service $A40,000 a month.

MONTHLY TOTAL OF CO_2E (KG) PRODUCED BY WA HEALTH FROM DESFLURANE AND SEVOFLURANE



Left: Dr Chris Mitchell with the Desflurane vaporisers taken out of the theatre in store room.
Above: Dr Laura Wisniewski.

The lessons to be learned from this remarkable reduction of desflurane use may be distilled into four key steps to success:

1. Measure the current volatile and propofol use in your department as a baseline. Start a simple database to track your department's progress. This is easy to do using pharmacy purchase data as it bypasses the complexity of determining individual theatre usage (and pharmacy staff are generally keen to help when they are presented with the potential financial savings).
2. It is critical to raise awareness, empower and educate people who are willing to champion the cause in their department. Most anaesthetists are willing to change their behaviour and practice when presented with clear evidence and scientific reasoning. Those who have had reservations regarding the change have often been surprised to see that, in practice, their concerns were unfounded. There are a number of existing organisations (for example, TRA2SH https://www.tra2sh.org[7]) which can assist in providing information and resources to support the phasing out of desflurane.
3. Sequentially institute physical changes to reduce the usage and availability of desflurane. For anaesthesia machines with end tidal control, set a default low-fresh gas flow (for example, 0.55l/min on the GE Aisys machine). After educating the department and anaesthetic assistants, start storing the desflurane cassette in the anaesthetic trolley (rather than installing in the machine). This physical reminder to desflurane users that the department was trying to decrease usage assisted in a significant change. The next step is removing the desflurane from theatre and storing it in theatre pharmacy. This balance between availability, but inconveniently so, results in many of the "devout" users exploring the acceptability of alternative agents. The final step is to remove desflurane from the hospital. This has occurred at different times in various hospitals, depending on the leadership style of the head of department. In some instances, it has been by simple autocratic removal, in others, it was put to the consultant group vote.
4. Ongoing cycles of monitoring and education are vital in order to effect the required change. In parallel, aim to gradually ramp-up barriers to accessing desflurane. It must be recognised that change will not be immediate. The Green Theatres Network, as well as the TRA2SH group, have both been involved across WA in raising awareness and providing ongoing education.

It is relevant to note that public sector reductions have been easier to achieve than private – however, as many consultants work across both sectors, the flow-on effects mean there has also been significant change in the private sector. Two private hospitals have now ceased using desflurane altogether, and the three largest private metropolitan hospitals have moved storage of desflurane out of theatre to the theatre pharmacy. Of the remaining hospitals, those using the cassette system have moved desflurane to the anaesthetic trolley.

So – how to initiate the change in your institution? Become the local champion, and start by obtaining the cost/usage figures from your friendly theatre pharmacist. Follow the four-step process we have outlined. With persistence, and a little help from your colleagues, the results will follow.

Dr Laura Wisniewski
Registrar, Department of Anaesthesia, Pain and Perioperative Medicine, Fiona Stanley Hospital

Dr Chris Mitchell, FANZCA
Consultant Anaesthetist, Sir Charles Gairdner Hospital

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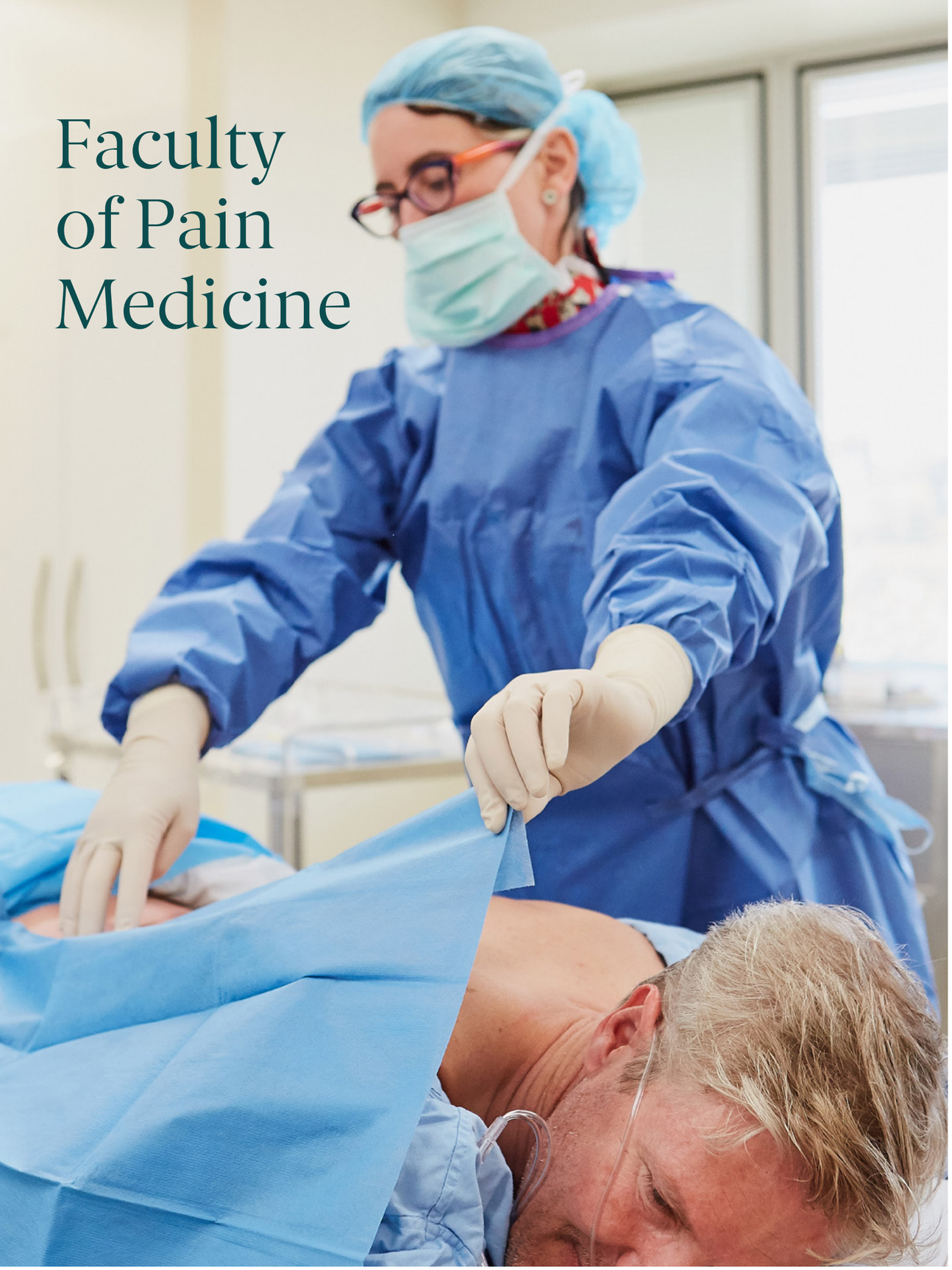


Faculty of Pain Medicine

Time to make our voice heard as Australia prepares to vote

"With an election in Australian due in May this is the perfect time to mobilise our voices in a simple and effective way"

THE START OF MARCH saw the implementation of the MBS Review recommendations for pain management. The failure of the Australian government to fully introduce all the recommended changes of the review taskforce represents the biggest lost opportunity in a generation to secure basic Medicare funding support for community-based pain services. The MBS Review process began in 2018 and after four years, to see the introduction of the new item numbers result in a projected $A40m reduction in Medicare spending with no reinvestment in the recommended new item numbers.

FPM has been front and centre with the entire process and has represented our disappointment to Australian Minister for Health and Aged Care Mr Greg Hunt on several occasions. To coincide with the 1 March implementation date we created some talking points to explain the situation to patients, and called on our fellows to make their patients and their supporters aware of the situation (details on page 48). A simple three-minute phone call to a candidate, sitting member or senator's office will be logged and added to the stats.

This is the single most effective way to change a politician's mind about the importance of an issue, especially if our patients begin sharing their stories of inaccessible or unaffordable care directly with the politician's staff. If we register this in enough offices around the country, it becomes impossible to ignore.

With an election in Australian due in May but not announced, this is the perfect time to mobilise our voices in a simple and effective way. We may have to wait another 20 years to have the chance to do this again, so please don't be shy about asking your patients and their support networks to do this one simple thing. Our consumer allies at Painaustralia and Chronic Pain Australia will also be asking their supporters to do the same.

Apart from our advocacy efforts, the core business of training and settings standards for specialist pain medicine physicians continues apace. The Practice Assessment Pathway of the Procedures Endorsement Program is now open, and I encourage all fellows with an established scope of practice in procedures to familiarise themselves with the requirements to obtain endorsement. In due course this will become the main way for hospitals, patients and others to identify providers as high-quality and well-trained in this field.

The annual scientific meeting and FPM symposium will again be virtual due to the predicted timing of the omicron peak in WA but I am looking forward to the Spring Meeting in Noosa being a welcome return to face-to-face conferencing.

The handover to dean-elect Dr Kieran Davis will be timed to coincide with the faculty's annual general meeting and I look forward to welcoming Kieran to the leadership role for his term.

Associate Professor Michael Vagg
Dean, Faculty of Pain Medicine

FPM campaigns for pain management rebate reforms

THE FACULTY HAS launched an advocacy campaign opposing the Australian government's new Medicare item numbers for pain management.

The latest MBS rebates were introduced on 1 March but the faculty is disappointed that the recommendations of the Pain Management Clinical Committee to the national Medicare Benefits Scheme (MBS) Taskforce were not fully implemented.

A co-ordinated campaign by the faculty's leadership team and ANZCA's Policy and Communications Unit involved media outlets, the faculty fellowship and letters to the federal Health Minister Mr Greg Hunt and senior health bureaucrats. The faculty is also engaging with all political parties in the lead-up to the federal election including the non-partisan group of MPs and senators in Canberra known as the Parliamentary Friends of Pain Management Group, and other key stakeholders.

The faculty is concerned that the 1 March rebates failed to extend eligibility for the 132/133 complex consultation item numbers to all specialist pain medicine physicians and do not allow specialist pain medicine physicians to create limited Chronic Disease Management (CDM) plans for their multidisciplinary teams. The changes also fail to provide reimbursement for team members and doctors to provide group therapy.

The federally-appointed Pain Management Clinical Committee (with faculty representatives) had been able to offset the costs of these extended services by reallocating Medicare funding from some of the less effective treatments in hospitals. The government has kept these savings without implementing the other recommendations – effectively reducing spending on pain services through Medicare by $A40 million a year.

A package of FPM resources has been uploaded to the ANZCA website. It includes a poster and talking points for practitioners to discuss with patients. Fellows are encouraged to download the materials, if appropriate, for their practice as a way to communicate the impact of the changes to the wider community. The posters encourage patients to phone or email their local member of parliament by demanding full implementation of the MBS Taskforce recommendations and an ongoing commitment to accessible and affordable pain care under Medicare. (A QR code on the poster links to the website with updates and more information).

FPM Dean Associate Professor Michael Vagg said the failure to implement the MBS Taskforce recommendations means "our ability to provide team care outside hospitals has been crippled, and the unfairness and lack of equity inherent in the funding model in the Australian medical system perpetuated."

"Our patients are the ones who will suffer when their care becomes less affordable and they are also the ones who will be listened to once they begin to make their voices heard as the election approaches."


FPM
Faculty of Pain Medicine
ANZCA

Chronic pain patients lose out in $40 million government cut to Australian pain services

From 1 March 2022 major changes to Medicare rebates for many pain services, especially procedures, will come into effect.

The result of these changes will be reduced Medicare funding available for pain services.

Last year, pain doctors worked with the Medicare Benefits Schedule (MBS) Taskforce to reallocate Medicare funding from some less effective treatments in hospitals to more effective community based pain treatment programs.

This would have given patients access to a much wider range of pain care services.

The government has chosen to go ahead with the changes that save them around $40 million without implementing the recommended changes which would have been better for patients.

We are now asking for your help in getting this decision reversed by phoning or emailing your local Federal member of parliament.

Name: _____ Electorate: _____

Email: _____ Phone: _____

Please ask them:

1. To fully implement all the recommended changes to the Medicare item numbers.
2. To commit to improving accessibility and affordability of pain management services overall.

If you or your politician needs more information, please scan this QR code.

The campaign received strong print, online and broadcast media coverage on Sunday 27 February and Monday 28 February with News Limited's national health reporter Ms Sue Dunlevy writing an exclusive news article about the issue based on our embargoed media release. The articles were syndicated in print and online articles including in the *Daily Telegraph, Adelaide Advertiser, Gold Coast Bulletin, Herald Sun, Hobart Mercury,* and *Courier Mail* with headlines such as "Hurting Aussies face more Medicare pain" and "Medicare cuts to chronic pain care".

Associate Professor Vagg was also interviewed for ABC radio news bulletins and these were broadcast on prime time morning news bulletins on ABC Radio Melbourne with syndications to several regional ABC Radio news broadcasts. More than one million people were reached with the articles and broadcasts.

Carolyn Jones
Media Manager, ANZCA

Fellowship examination

Following the written section of the fellowship examination held regionally on 30 September 2021, 27 candidates were invited to sit the viva voce on 27 November 2021.

The oral fellowship examination was once again held over videoconference at the Cliftons venues in nine regions across Australia, New Zealand, and Hong Kong.

The faculty acknowledges the contribution made by examiners in delivering the viva voce examination over videoconference and the additional preparation and consideration that were required again this year to deliver the content via this medium.

SUCCESSFUL CANDIDATES

The candidates who successfully completed the fellowship examination are:

AUSTRALIA

New South Wales
Dr Sibella Bentley
Dr Steven Bruce
Dr Supriya Chowdhury
Dr Rachel Angharad Halpin-Evans
Dr K M Mominul Hassan
Dr Claudia Higgs
Dr Tejas Kanhere
Dr Karen Wong

Queensland
Dr Yi-an Chou
Dr Poshitha De Silva
Dr Jin Hyuk (Robin) Kang
Dr Helen Claire Newman
Dr Robin Park
Dr Behnood Shahi
Dr Elaine Shek

South Australia
Dr Katie Rogers

Victoria
Dr Nathan Bruce Flint
Dr Pouya Hafezi
Dr Navid Hamedani

Western Australia
Dr Erica Remedios
Dr Hassan Zahoor

NEW ZEALAND

Dr Christopher Turnbull

HONG KONG

Dr Yiu Chung Lau

Two candidates were awarded merit awards:

- Dr Sibella Bentley (NSW).
- Dr Pouya Hafezi (Victoria).

NEW FELLOWS

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

- **Dr Ravi Agrawal,** FCAI, FFPMANZCA (WA).
- **Dr Anita Chou,** FAFRM (RACP), FFPMANZCA (Qld).
- **Dr Andrew Jarzebowski,** FANZCA, FFPMANZCA (Vic).
- **Dr Say Yang Ong,** MMed(Sing), FANZCA, FFPMANZCA (Singapore).
- **Dr Anthony Sayce,** FRACGP, FFPMANZCA (NSW).
- **Dr Jeremy Tannenbaum,** FRANZCP, FFPMANZCA (WA).
- **Dr Dana Weber,** FANZCA, FFPMANZCA (WA).
- **Dr Jie Xu,** FRACGP, FFPMANZCA (WA).

TRAINING UNIT ACCREDITATION

The following units have been accredited for pain medicine training in the Core Training Stage:

- Perth Children's Hospital (WA).
- Royal Children's Hospital (Vic).
- Sydney Spine and Pain (NSW).
- Townsville Hospital (Qld).

Global health

Dr Hilbert Tovirika with his partner Merissa and son Wilson after receiving his Masters in Medicine (MMed) in 2021.

PNG anaesthetist scores a "trifecta" with latest accolade

Dr Hilbert Tovirika received ANZCA's Garry Phillips Prize in 2020. The award is presented for outstanding achievement in anaesthesia within the masters of medicine program at the School of Medicine and Health Sciences, University of Papua New Guinea.

WHEN HILBERT TOVIRIKA'S critically ill father Wilson was medevacced from Port Moresby to Townsville in 2000 the then year 9 student was in awe of the medical flight crew on board the flight.

The flight doctor, Papua New Guinea anaesthetist Dr Duncan Dobunaba, assured Hilbert and his mother Melrose that his father, who was intubated, was in the best of care.

Hilbert, now 36, an anaesthetist at Port Moresby General Hospital (POM) has achieved the rare "trifecta" of receiving all three of ANZCA's PNG anaesthesia awards in recent years, capped off by the 2020 Garry Phillips Prize.

He says it was that Medevac flight when he accompanied his parents to Townsville that first started him thinking about pursuing a career in medicine in PNG. The family remained in Townsville for six weeks while Wilson Tovirika recovered.

"Back in 2000 there weren't specialist services in PNG. My father was unable to speak or walk and we thought he had had a stroke. He had to be transported to Port Moresby from Lae where we were living and then onto Townsville for treatment and care. He was intubated on the flight and I was scared. But when I looked at the doctor and the flight nurse they were really calm and that helped me deal with everything that was going on.

"When I met up with Dr Dobunaba 10 years later I had just received my first ANZCA prize for the best undergraduate medical student at the University of PNG. I introduced myself to him and he said 'you have to join us now.'

"That was a key point for me in my decision to train in anaesthesia. Seeing my father go through all that and watching him having to learn to walk again made me decide to take up medicine."

Dr Tovirika was speaking to the *ANZCA Bulletin* earlier this year during a break from work at POM. He lives in Port Moresby with his partner Merissa and their three-year-old son Wilson who is named after his grandfather. (Dr Tovirika's father died in 2017 before his grandson was born.)

"It was a quiet goal of mine for many years to train as anaesthetist so for me to be awarded the Garry Phillips Prize is a real honour," he explains.

The annual prize, presented as an engraved medal, is awarded by ANZCA for outstanding achievement in anaesthesia within the masters of medicine program at the School of Medicine and Health Sciences, University of Papua New Guinea.

The prize was established in 2012 to honour the contributions made by Professor Garry David Phillips to the Papua New Guinea anaesthesia community. The medal caps a series of ANZCA prizes for Dr Tovirika since 2010 when he received ANZCA's award "for the best overall performance in the anaesthesia module of the School of Medicine curriculum" and in 2015 when he was awarded "best overall performance in the Diploma of Anaesthesia to go into the MMed program at the University of PNG" . He was a resident in Kimbe in PNG when Adelaide fellow Dr Chris Acott presented him with his first ANZCA award.

"When I started training it also became a personal goal to pursue the ANZCA awards but I never told anyone. I first got the undergraduate award and then wondered if I could do more and get the others."

Dr Tovirika was recovering from a COVID-19 infection when the *Bulletin* spoke to him. PNG is now experiencing its fourth wave of COVID-19 but vaccine hesitancy among the general population is still high.

"It is quite frustrating for me when the general population doesn't see the importance of being vaccinated. There are many things driving this apprehension. Part of it is the misinformation and people are more inclined to listen to someone who is not a doctor or from the medical fraternity. A lot of cultural beliefs also lead to a fear of vaccination so trying to convince people is very difficult.

"Thankfully this time around the infections aren't as severe and most of those who are testing positive have mild symptoms. We have some intubated patients here at POM but they are mostly already in the hospital for other reasons and end up testing positive. We have a separate COVID ward but it is not full. The main thing is the lack of staff because everyone who works here is starting to test positive. We have been really short of staff. Nearly everyone has come down with COVID. It does put a strain on the staff who are here and it means we have to do alternate call rosters. And some of our staff are on recreational leave and have to be called back."

"When I started training it also became a personal goal to pursue the ANZCA awards but I never told anyone. I first received the undergraduate award and then wondered if I could do more ..."

Dr Tovirika with the medal awarded for the Garry Phillips Prize.

Left from top: Dr Tovirika receiving his first ANZCA prize in 2011 from Dr Chris Acott; Dr Hilbert Tovirika and Dr Pauline Wake in Port Moresby in 2017.

While still studying for his medical degree at the University of PNG's School of Medicine and Health Sciences Hilbert took a year off from his studies in fourth year so he could earn enough money to fund the rest of his degree. He moved to Bougainville, where his father was born, and became a farmer where he grew, harvested and dried cocoa beans.

Dr Tovirika is modest about his achievements but he decided to share his thoughts on a Facebook post late last year after he received the Garry Phillips Prize.

"I am not one to post regularly on Facebook and I do not wish to sound conceited or arrogant but this has been a quiet personal goal for some time now," he wrote.

"When I started Post Graduate (sic) training in Anaesthesia in 2014 I heard that there were similar ANZCA Academic Prizes for the best Post Graduate Diploma in Anaesthesia and the Gary Philips Medal for the best Anaesthesia Masters In Medicine (MMed) candidate. It became a quiet personal goal to see if I would be able to obtain all three. In 2016 I was presented with the ANZCA award for the Best Candidate in the 2015 Postgraduate Diploma in Anaesthesia and recently I received the Gary Phillips Medal for the Best MMed Anaesthesia Candidate for 2020 finally achieving that quiet personal goal after 10 long years.

"There were times I felt like leaving the program and doing something else, times when I doubted my ability to become a specialist let alone obtain an award. Thank you to those who have inspired me. Thank you to those who have taught and mentored me. Thank you to those who stood with me through the depths of my struggles. Thank you to those who have shared this journey with me as colleagues and friends. Thank you to the Australia and New Zealand College of Anaesthetists (ANZCA) for the acknowledgement and commendation. We all have our own personal stories, our personal struggles and our personal successes. This is part of mine. The trifecta complete."

"There were times I felt like leaving the program and doing something else, times when I doubted my ability to become a specialist let alone obtain an award"

Carolyn Jones
Media Manager, ANZCA

Anaesthesia training in Mongolia a priority for country's leaders

Melbourne FANZCA Dr Amanda Baric was recently awarded a prestigious Order of the Polar Star for her contribution to Mongolia's healthcare sector by advancing anaesthesia training in the East Asian country.

Dr Baric receiving her award at a ceremony in Canberra with Mongolian ambassador D. Davaasuren and anaesthetist Associate Professor Dr David Pescod.

IN THE 15 YEARS she has been travelling to Mongolia to run anaesthesia seminars and clinical teaching programs Dr Amanda Baric has seen the reputation of the specialty there come full circle.

"There were about 105 anaesthetists in the country when I first started going there (in 2006) but not everyone practiced anaesthesia. The attrition rate was very high at the time. Postoperative patient outcomes were poor, and mortality was so high that people just left the profession, and it became tough to recruit enough trainees to join the specialty," she explains.

"Now it has gone from the least popular specialty to the most popular. Anaesthetists command respect and influence in the health ministry, which is great. They are involved in decisions about training, examinations, and policy, including the delivery of emergency medicine and surgery around the country."

The Melbourne fellow speaks from experience, having been a regular visitor to Mongolia and its capital Ulaanbaatar as part of a dedicated volunteer team of clinicians who have worked over many years to advance anaesthesia training there.

Such is the esteem Dr Baric is held in the country that she has been awarded the prestigious Order of the Polar Star for her contribution to Mongolia's healthcare sector. Dr Baric was presented with the honour at a ceremony in Canberra late last year at the Mongolian embassy by ambassador D. Davaasuren. Dr Baric is in good company – previous recipients of the country's highest honour include former US President Barack Obama and former US Secretary of State Hillary Clinton.

When the *ANZCA Bulletin* caught up with her after she had received her award, she was working with Northern Health's COVID community team at the end of a long day. In late 2021 Dr Baric was on long service leave, but she returned to Northern Health to help the COVID community team deal with the surge in COVID-19 infections in the north of Melbourne. By late last year, the team were managing between 1500-2000 COVID-19 patients at home every day. Dr Baric and her colleagues would regularly check in with these patients by phone, checking their symptoms, giving advice, organising home monitoring with oximetry, inhaled corticosteroids and antibody infusion for those who were eligible, and escalating to the virtual emergency department and ambulance care if required.

Dr Baric last visited Mongolia in 2018, having postponed her annual visit in 2019 to support her daughter during her VCE. While the onset of COVID-19 in early 2020 temporarily halted her team's yearly visits and face-to-face seminars in the country, she and her Northern Health colleagues have continued to maintain contact with their Mongolian colleagues and involved them in virtual education when possible. Most recently, her team, Interplast and the Australian Society of Anaesthetists (ASA) supported a group of young anaesthetists to complete the perioperative medicine short course at Monash University.

Dr Baric at a simulation session with anaesthesia trainees in Mongolia.

Anaesthetists from Northern Health have had a long association with Mongolia since the early 2000s. Dr Baric's friend and colleague Associate Professor David Pescod played a crucial role in developing a relationship between the ASA, the Mongolian Society of Anaesthesiologists (MSA), and ANZCA to advance anaesthesia training.

"By 2006, David had done several seminars and teaching sessions in Mongolia to bring them up to speed, and he was doing that on his own with a translator. I had done some obstetric anaesthesia training elsewhere, so he asked me if I was interested in visiting.

"At that initial visit, I realised they didn't have much going on in the way of anaesthesia training. Before 2006, training was limited to four months to increase the number of anaesthetists in the country. The MSA was responsible for training anaesthetists and recognised the need to improve, so they asked us to help them develop a training program. A memorandum of understanding between the MSA and the ASA was made, and we went to work. We borrowed the Fiji School of Medicine's successful modular training framework to help the MSA write their training program," Dr Baric explains.

By 2008 Dr Baric was working with Associate Professor Pescod and other Northern Health anaesthetists and trainees to develop an anaesthesia training program in collaboration with the MSA.

"The annual 'refresher' seminars we organised became the MSA's annual continuing medical education (CME) meeting, and we added other training initiatives such as life support and ultrasound skills teaching. Each year anaesthetists from the different provinces travel to Ulaanbaatar for two weeks to attend the seminars.

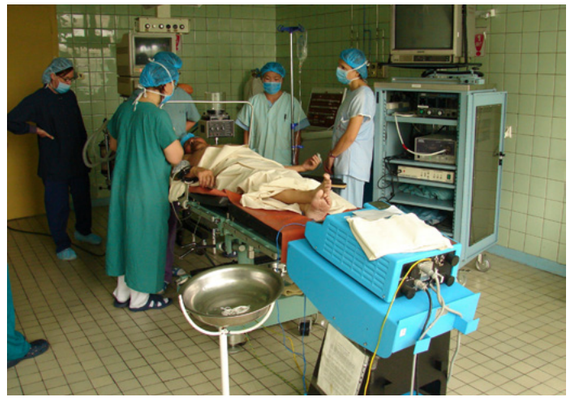
"We've made sure that we maintain our contact with them during the pandemic, and most recently, we have been trying to develop a letter of understanding between ANZCA and the MSA to improve their training program further and work with them on the development of their professional anaesthesia standards.

"In 2020, ANZCA's Director of Professional Affairs Dr Peter Roessler, met virtually with the MSA representatives and us to discuss how we could help them develop their standards of practice. The MSA has adopted the World Federation of Societies of Anaesthesiologists (WFSA) standards but wants something more concrete that they can work with and so have sought guidance to produce professional documents."

Mongolia has a population of three million, many of whom live in rural and remote villages. The climate is one of extremes. Winter temperatures can drop to minus 40, and while the summer season is short, daytime temperatures can reach 40 degrees celsius. The terrain is rugged, and the population is sparsely distributed.

Dr Baric says that while the Mongolian terrain makes healthcare challenging for medical teams, there have been noticeable improvements. There are 21 district areas (aimags) and a few larger regional hospitals. Many of the aimag hospitals are staffed by just two anaesthetists working long hours and sharing the on-calls, presenting a significant challenge for the delivery of care and continuing education. The demand for medical services is mainly for essential general surgical procedures, obstetrics, trauma, and paediatrics.

A traditional Mongolian Grand Ger dwelling.



A Mongolian hospital theatre scene.

> "Anaesthetists command respect and influence in the health ministry…They are involved in decisions about training, examinations, and policy, including the delivery of emergency medicine and surgery around the country."

"Getting patients to care is difficult because of limited transport. Mongolia has a universal healthcare model based on the Semashko system that was introduced during its communist era. The extensive infrastructure was difficult to staff and maintain, and was expensive to run. Vast distances across a sparsely populated country make the transfer to higher levels of healthcare lengthy and challenging.

"The regional hospitals that provide emergency services are often not that well-funded and frequently deal with medication shortages and shortages of basics such as electricity. The Mongolian government has done much work in recent years to improve access to surgery around the country. The health ministry has worked hard to meet the Millennium Development Goals and now the Sustainable Development Goals of ensuring access to urgent surgery within two hours for the entire population. Mongolia is close to this goal at over 80 per cent – so we must continue working with them to train their anaesthetists to achieve this goal."

Dr Baric says there are now about 200 anaesthetists practising in Mongolia while another 30 trainees complete their clinical training each year.

It is not clear when she and her colleagues will return to Mongolia. The country closed its borders early in the pandemic. While per capita, the country has one of the highest infection rates in East Asia, Mongolia has a good track record of implementing infection control measures when they have faced other infectious disease outbreaks.

"I am looking forward to going back, as there is still a lot more to do," Dr Baric says.

"There remains a need to maintain anaesthesia training basics and support their educators. They have a core group of new educators and leaders in the profession who were trained in Bangkok at the WFSA training centre. This group is leading the development of academic anaesthesia, basic research, and scholarly activity. It has been encouraging to see this emerging over the time we have been associated with the Mongolian anaesthesia community. The MSA has been instrumental in establishing an emergency medicine specialist qualification and has also supported other specialties such as intensive care.

"The next thing to work on is professional practice and expanding their research and quality improvement work."

Carolyn Jones
Media Manager, ANZCA

From top: Mongolian horses on the steppes; An ultrasound training session.

Anaesthesia simulation training a key tool for global collaboration

Participants in a recent VAST course in Tanzania celebrate their success.

CAPACITY BUILDING THROUGH education is one viable strategy to improve anaesthesia care in resource-limited settings. Vital Anaesthesia Simulation Training (VAST) was founded to overcome barriers that prevent delivery of simulation-based training in resource-limited and remote locations.

The three-day VAST course[1] was a collaborative development between partners at Dalhousie University, the University of Rwanda, the Scottish Centre for Simulation and Clinical Human Factors and simulation educators from both well and limited-resourced countries. The course is aimed at multidisciplinary learners and teaches essential clinical practices and non-technical skills for perioperative healthcare providers using immersive, low-cost simulation.

VAST courses focus on safe general anaesthesia and resuscitation for obstetrics, paediatrics, trauma, general surgery and pre- and postoperative care. In addition to simulated scenarios, there are discussions and skills stations on non-technical skills, primary trauma survey, pain management, neonatal resuscitation and complex decision making. The course is highly portable and deliverable across diverse settings. First piloted in Rwanda in 2018, the course has demonstrated capacity to improve participants' non-technical skills[2].

Endorsed by the World Federation of Societies of Anaesthesiologists and supported by the Canadian Anesthesiologists' Society International Education Foundation, the Australian Society of Anaesthetists and other partners, VAST's courses have been delivered in Rwanda, Ethiopia, Tanzania, India, Fiji, Canada and Australia. VAST courses are paired with the VAST facilitator course to develop local capacity for sustainable ongoing delivery of simulation training. VAST's activities are

Left: Simulation training in a VAST course in Tanzania.
Below: Simulation technology training for facilitator orientation participants at a session in India.

conducted by a globally distributed network of volunteers, anchored at the Dalhousie University, Department of Anesthesia, Pain Management and Perioperative Medicine in Nova Scotia, Canada.

Pre-pandemic, VAST's momentum was palpable. In January 2020, supported by an ANZCA Health Equity Project (HEPF) grant, VAST trained facilitator teams from Ethiopia, Sudan and Kenya with the goal of future implementation of VAST courses in their settings. A subsequent ANZCA HEPF grant funded a similar project for Darwin, aimed at disseminating VAST in Papua New Guinea, East-Timor and Fiji. The latter project was cancelled due to the pandemic. Planning was in place for translation of course materials into Spanish, with intended course delivery in Latin America. VAST was awarded a multi-year grant from the Royal College of Physicians and Surgeons of Canada International Development, Aid and Collaboration program for development of a competency-based framework for training and evaluating simulation facilitation in resource-limited and remote locations.

With the pandemic severely restricting face-to-face training, VAST's team has shifted focus to curricula expansion and organisational development. Extensive refinements were made to the VAST course and the VAST facilitator course. The VAST Foundation Year, a 48-week curriculum of simulation-based sessions for first year anaesthesia trainees is near completion. The team developed VAST Wellbeing, a one-day course to promote personal and professional wellbeing and to reduce workplace burnout for multi-disciplinary healthcare providers. An interview study was conducted to explore the qualities of effective VAST facilitators[3]. This study also provided a much-needed opportunity to connect VAST facilitators around the world.

In January 2020, Vital Anaesthesia Simulation Training (VAST) Ltd was registered as a not-for-profit company in Australia. VAST Ltd has an international Board of Directors from Australia, Canada and Rwanda. In October 2020, VAST Ltd was granted registration with the Australian Charities and Not-for-profits Commission. As the pandemic continued, the VAST team received permission from ANZCA to modify the Darwin project's HEPF grant, allowing it to explore delivery of online education. All VAST's courses are now offered in a blended format, with engaging pre-course and post-course resources augmenting VAST's face-to-face training. VAST's learning platform also allows for sharing of facilitator resources, monitoring of learner progression and evaluations. An integrated suite of management software has also been developed, enhancing VAST's operational and communication capability.

The VAST team is cautiously optimistic that courses can return in 2022. VAST's learning platform rollout will begin with the VAST Foundation Year for a new cohort of anaesthesia trainees in Rwanda. The pilot for VAST Wellbeing is scheduled for 2022, as is the inaugural VAST SIMposium, a conference aimed at uniting simulation educators from diverse global settings. Work is under way to develop a competency-based framework to support quality simulation facilitation in resource-limited and remote settings.

VAST's team is indebted and grateful for the encouragement and generous support provided by individuals and organisations.

Dr Adam Mossenson, FANZCA
Consultant Anaesthetist, St John of God Midland Public and Private Hospitals, Perth, WA

Adjunct Assistant Professor, Dalhousie University Department of Anaesthesia

VAST Founder and VAST Ltd Managing Director

Dr Patricia Livingston
Associate Professor, Department of Anesthesia, Pain Management and Perioperative Medicine, Dalhousie University, Canada

VAST Ltd Director

Above: Collaborative learning is an essential part of the VAST program.
Below: VAST facilitator training in Ethiopia.

TO FIND OUT MORE ABOUT VAST OR TO GET INVOLVED:

- Please visit vastlearning.org. If you are interested in getting involved, reach out via our "contact us" page.
- If you would like to support VAST, please donate via donate.vastlearning.org. Donations over $A2 are tax deductible.
- If you have an unused iPad or iPhone using iOS 13 or above that you would like to donate, please post it to PO Box 8691, Perth BC, Perth WA, 6849.

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Changing hearts and minds in your department

Taranaki anaesthetist Dr Duncan Brown.

For anaesthetist and environmentalist Dr Duncan Brown, trying to change people's behaviour can be like, "running at a brick wall". Dr Brown, from Taranaki Base Hospital, took a "mental sabbatical" from departmental politics last year and finished a certificate of climate change and health from Yale University. The course had a whole module dedicated to changing minds and here he explains how it helped him find more clarity.

THE SUMMER 2020 edition of the *ANZCA Bulletin* ran a story about Taranaki Base Hospital (TDBH) reducing theatre emissions from volatile anaesthetic use by 161 tonnes CO_2 emissions per annum over four years. This contributed to TDBH winning environmental awards from both the Taranaki Regional Council and the Taranaki Chamber of Commerce in 2021. It turns out this has very little to do with running at immovable objects and much to do with the social marketing strategy that those working here have serendipitously employed.

Knowledge is not activism. We all know that we should eat better and cycle to work but how many of us manage this for sustained periods of time? If knowledge by itself is not enough to change our own behaviour then it is unlikely to change the behaviour of others. In my experience of healthcare, the standard approach to targeting behaviour change is aimed at imparting knowledge and (often unconsciously) self-promotion by giving a presentation and championing change yourself. Every time I have tried to make a change this is pretty much what I have done. If we are lucky this might temporarily change the attitudes of our most dedicated admirers, but none of us have universal appeal and it rarely leads to long-term sustained behaviour change. Phil Knight (founder of Nike) did not get rich by modelling his own clothing.

Behaviour change requires social marketing, which is the use of commercial marketing principles to promote behaviours for greater social good. Social marketing is complex, laborious and resource heavy. It begins with analysing your target audience, subdividing them into groups based on their beliefs and attitudes, and identifying the perceived barriers and benefits to the change you want to make.

Once the market research is complete, the marketing strategy is like riding an elephant. It needs to target each group's attitude and conscious decision-making (the rider), motivate them (the elephant) and remove barriers to change (the path). If you can make the rider want to go in the right direction, get the elephant's inertia to follow the rider's intentions and make the path easy to follow then the desired behaviour change is more likely to result.

Marketing works. It is a $1.7 trillion industry that dictates how we spend our money and our time. It heavily influences our aspirations and self-image. Successful marketing strategies are the reason it is hard to pass up junk food when you are hungry and on-call. You are the rider and, despite knowing a McDonald's is unlikely to help your cause, you feel you deserve it. You are motivated by hunger and the memory of the taste or the seductive advert you have seen. And the path these days is very easy. There is Uber Eats or the drive-through on your way home. Companies that invest enough in marketing can make you do whatever they want.

In Taranaki, change was catalysed by the arrival of 11 new consultants in five years. Total intravenous anaesthesia (TIVA) is normal for those of us recently out of training so the education and examples set by environmentalists like Dr Michael Booth who has been tireless in gathering and publishing our anaesthesia emission data on a monthly basis since he arrived three years ago, and early-TIVA-adopters like Dr Charlie Brown have found fertile ground. Enthusiastic input from our award-winning sustainability officer Maria Cashmore and ongoing scrutiny of our volatile emissions by a carbon reduction program called Toitu have helped keep the rider on task.

> "I suspect that the majority of anaesthetists in New Zealand no longer consider routine use of desflurane to be acceptable practice."

Such a large increase in TIVA use has created a powerful descriptive norm that has provided motivation for continued change. A few years ago, the surgical team would accuse you of holding up theatre if you gave a TIVA. Now you will need to justify the use of volatiles to our trainees, technicians and recovery nurses who expect TIVA as standard. Even the surgeons (who now drive Teslas) take an interest when people deviate from the new norm.

As change occurs, new role models emerge. One of our senior consultants, Dr Joerg Heim, has been desflurane-free for more than two years having previously been a big proponent. These people are the real heroes of the campaign. The motivating effect on the rest of the department is substantial.

The path to change has involved investment in Bispectral Index (BIS) Monitors and TIVA pumps so that all of our theatres are properly set up and early morning squabbles over equipment are a thing of the past.

There are two main subgroups of anaesthetists still using desflurane on a regular basis in New Zealand and they have proven themselves resistant to climate change rhetoric or the allure of the enthusiastic young consultant trying to model change. Continuing to beat the same drum is of limited benefit.

If we want to continue to progress with desflurane reduction we need to evolve our strategies based on social marketing. We need to change the frame from environment to collegiality, acceptable practice and qualitative recovery from anaesthesia. I suspect that the majority of anaesthetists in New Zealand no longer consider routine use of desflurane to be acceptable practice.

Get to know colleagues that are particularly resistant to change, make them feel included in what the department is doing. Membership to a strong and progressive department is a good motivator and none of us want to be medical outliers.

It's time for those of us who have been championing sustainability for a long time to put our egos down, reframe the issue, and share the air time with people that resistant groups can identify with.

Dr Duncan Brown, FANZCA
Taranaki Base Hospital, New Zealand

Accessing the library

ANZCA LIBRARY AT THE 2022 ASM

Find out more about the ANZCA Library at the ANZCA Virtual Booth as part of the 2022 ASM Exhibition Portal. Library staff will be online during all breaks from Saturday to Tuesday and will be more than happy to answer any library-related queries you may have.

SYSTEMATIC REVIEW WEBINAR

The ANZCA research librarian is running a webinar on 10 May 2022 for ANZCA members who would like to learn more about the systematic review process.

Systematic reviews (SR) are a great stepping stone to research and publishing. This session will give you an overview of what is involved in an SR; how to evaluate if you need to do an SR or another type of review; as well as understanding the advice, support and resources available from the ANZCA Research Consultation Service and the library to enable you to perform your own systematic review.

The session runs for 60 minutes and members can register at anzca.libwizard.com/f/libwebinar.

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 2022, a number of new terms have been added that are relevant to anaesthesia, pain medicine and COVID-19 including the following:

Axial spondyloarthritis

A spectrum of chronic inflammatory conditions affecting the axial joints (for example, spine), characterised by pain, stiffness of joints (ankylosis), reduced mobility and inflammation.

Mast cell activation disorders

A spectrum of primary, secondary, and idiopathic disorders involving mast cells and characterised by an aberrant release of mast cell mediators which result in multiple and variable inflammatory and allergic symptoms. These disorders are associated with various mutations in tyrosine kinase kit (proto-oncogene proteins c-kit) and other genes, underlying conditions, and responses to allergic or non-allergic triggers of mast cell stimulation and degranulation such as local anaesthetics, lactam antibiotics, muscle relaxants, specific foods, environmental toxins, physical conditions such as vibration, cold, pressure, and stress.

Thromboinflammation

Thrombosis with associated inflammation due to crosstalk between hemostasis and innate immune responses modulated by platelets. it is associated with many diseases such as Covid-19; sickle cell anaemia; and thrombophlebitis.

Translational science, biomedical

The field of investigation which seeks to understand the scientific and operational principles underlying each step of the translational process to increase the efficiency and effectiveness of translational research in all therapeutic areas.

Predatory journals as topic

Works about medical journals that publish articles online with little or no peer review, low academic standards, and little credibility.

Respiratory aerosols and droplets

Physiological aerosols and droplets expelled during coughing, sneezing, speaking and exhalation. Depending on the size, aerodynamic distribution or concentration they may play a role in transmission of infectious respiratory diseases.

Research Consultation Service now permanent

The new Research Consultation Service, piloted in 2021, will be ongoing for 2022 and beyond. The service has aims to develop and deliver research services to fellows, trainees, college staff and other key college stakeholders.

The Research Librarian is involved in:

- Conducting literature searches (and producing evidence summaries), as well as advising on the literature review process.
- Responding directly to queries related to the conduct of research, as well as helping to guide emerging investigators through the research lifecycle and full utilisation of the Research Support Toolkit.
- Teaching academic literacy skills through activities like online webinars and participation in key workshops.
- Collaborating with the Policy and Communications unit in the creation and review of professional documents.

For more information, including contact details, see the Research Consultation Service webpage: anzca.edu.au/library/research-consultation-service.

KEEPING UP-TO-DATE: USE LIBKEY NOMAD TO ACCESS FULL-TEXT IN PUBMED

Did you know that it's possible to use the LibKey Nomad extension in your Chrome browser to quickly access ANZCA library full-text while searching PubMed?

LibKey Nomad automatically provides instant links to articles from ANZCA library subscribed journals – and open-access sources – connecting you to literature discovered on the web. LibKey Nomad works with ANZCA Library to determine the fastest path to content across thousands of publishers and millions of articles. LibKey Nomad also adds in-line enhancements to popular sites like PubMed, Wikipedia, Scopus, Web of Science and more.

Simply enable the LibKey Nomad browser extension and you will be able to instantly link to the ANZCA full-text using the Article Link or Download PDF button.

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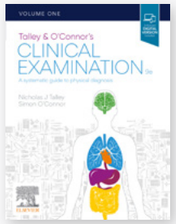
New books

NEW EXAM BOOKS

A number of new primary and exam prep titles are now available online:

https://libguides.anzca.edu.au/training-hub



Talley and O'Connor's clinical examination: a systematic guide to physical diagnosis (vols 1 & 2), 9e

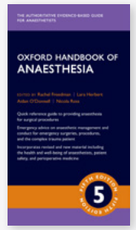
Talley NJ, O'Connor S. Amsterdam: Elsevier, 2022.

Basic Anesthesiology Examination Review

Williams GW, Williams ES [eds]. [New York]: Oxford University Press, 2016

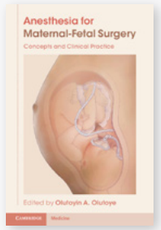
Access the complete list of newly added titles on our website: **libguides.anzca.edu.au/latest.**

NEW EBOOKS



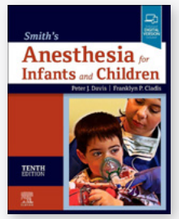
Oxford Handbook of Anaesthesia, 5e

Freedman R, Herbert L, O'Donnell A, Ross N [eds]. Oxford, United Kingdom: Oxford University Press, 2022.



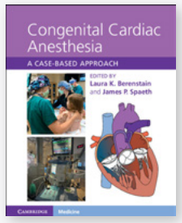
Anesthesia for maternal-fetal surgery: concepts and clinical practice

Olutoye OA [ed.]. New York: Cambridge University Press, 2021.



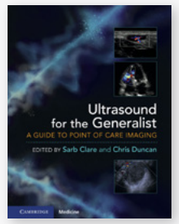
Smith's anesthesia for infants and children, 10e

Davis PJ, Cladis FP [eds]. Philadelphia, PA: Elsevier, 2021.



Congenital cardiac anesthesia: a case-based approach

Berenstain LK, Spaeth JP [eds]. Cambridge, UK: Cambridge University Press, 2021.



Ultrasound for the generalist: a guide to point of care imaging

Clare S, Duncan C [eds]. Cambridge, UK: Cambridge University Press, 2022.

Crucial conversations: tools for talking when the stakes are high, 3e

Grenny J, Patterson K, McMillan R, Switzler A, Gregory E. New York: McGraw-Hill Education, 2021.

Training and education

Ray Hader Award 2021

NSW FELLOW Dr Sally Wharton (right) is the recipient of the 2021 Ray Hader Award for Pastoral Care.

Dr Sally Wharton, a specialist anaesthetist at The Children's Hospital at Westmead (CHW) in Sydney, is an exceptional educator and supervisor of training. The Ray Hader Award recognises her many years supporting the welfare and education of anaesthetists throughout Australia.

Dr Wharton counsels and mentors ANZCA final exam (Part 2) examiners and supervisors of training, and NSW anaesthesia trainees who undertake paediatric terms at CHW. Her support has been crucial for many trainees and consultants over the last two years as they have had to deal with the additional stresses of COVID-19 on the frontline.

Dr Wharton has been ANZCA's NSW Education Officer since 2017 supporting and guiding trainees before and after their final examinations. She is an active member of the ANZCA NSW Regional Committee and ANZCA/ASA NSW ACE Committee, a former ANZCA Part 2 examiner (2005-2017). and a former member of the education committee for the Society for Paediatric Anaesthesia in New Zealand and Australia (SPANZA) promoting paediatric anaesthesia to trainees (2011-2018).

According to NSW anaesthesia trainee Dr Melissa Chin and Canberra fellow Dr Adam Eslick who nominated Dr Wharton for the award, "the trainees, nursing and anaesthesia colleagues are honoured to have been taught by Sally and blessed by all that she does for them."

They highlighted her "enduring influence, mentorship, support and leadership" that has "contributed to the journey of generations of anaesthetists".

Fellow Dr Anne Jaumees, an anaesthetist at Westmead Hospital, said Dr Wharton had influenced her to be a "better anaesthetist and teacher".

"Sally has always been immensely encouraging and supportive to all those within her immediate sphere at the Children's Hospital at Westmead. She also continues to support those who pass through the hospital on rotational terms and fellowships long after they are gone. I'm not sure how she does it, but she seems to remember everyone who has ever come through the Children's Hospital and always greets them with enthusiasm wherever and whenever she meets them," Dr Jaumees explained.

"Sally's warm approach to everything means that she is often a sounding board for all things anaesthetic but also all things in life. This is always helped by her baking of treats and her warm approach during what can be some of the most stressful times in people lives (exams and training). This approach improves people's welfare directly, but also indirectly as it helps people deal with their working and studying life but also helps gain perspective and balance in their non-work life. These are some lessons that really stay with people."

*The Dr Ray Hader Award for Pastoral Care is awarded to an ANZCA fellow or trainee who is recognised to have made a significant contribution to the welfare of one or more ANZCA trainees in the area of pastoral care. This may have been in the form of mentoring and influence, encouragement in education directly or indirectly, or in terms of overall welfare and leadership.

The award is named after Dr Ray Hader, a Victorian ANZCA trainee who died of an accidental drug overdose in 1998 after a long struggle with addiction. Established in memory of Dr Hader by his friend Dr Brandon Carp, this award promotes compassion and a focus on the welfare of anaesthetists, other colleagues, patients and the community. In 2012 Dr Carp agreed to continue sponsorship of the award and to expand the criteria to recognise the pastoral care element of trainee supervision.

Recipients receive $A2000 to be used for training or educational purposes and a certificate.

For more information about the Ray Hader Award visit https://bit.ly/3LSoqHI

Communication skills for anaesthetists

OVER THE PAST 20 years anaesthetists have become increasingly aware of non-technical skills and the vital role they play in providing safe, high quality care. The communicator role (one of the ANZCA seven roles in practice) underpins not only all non-technical skills but also technical skills. Communication is core to working in teams – this includes techniques such as closed loop communication and graded assertiveness which have been translated from the aviation industry as strategies to improve safety. Anaesthetists may be less aware of the large body of scientific evidence from psychology and neurolinguistics which is helping us unravel how humans process language and has enabled a deeper understanding of how communication works. This is of relevance not only for how we work with colleagues and in teams but also in our interactions with patients, their carers, and families.

The ability to communicate expertly is fundamental to the practice of anaesthesia. Whether we are consenting a woman in labour, explaining gaseous induction to a parent, resolving conflict with a surgical colleague or reassuring an awake patient undergoing fiberoptic intubation, we are using communication as the foundation of our clinical practice. The ability to rapidly establish rapport and trust, to be able to "speak the patient's language" and to use our words to optimise patient's understanding and cooperation is what makes an anaesthetist a doctor rather than a technician. Anaesthetists as clinicians embody through communication Osler's principles that have been the foundation of modern medicine for over a century – emancipation from priestcraft; practicing our art based on science; professionalism; and primum non-nocere.

Interestingly, the explicit teaching of communication skills has not figured prominently in either undergraduate or postgraduate training programs. Perhaps this has been due to assumptions that communication skills are "innate" or that these skills cannot be taught and can simply be acquired passively. Most anaesthetists consider themselves good communicators but all of us have encountered challenging communication situations such as the angry patient on the APS round or an open disclosure scenario. Whatever the situation, there are some fundamental processes underlying good communication. The LAURS framework describes five key processes to support good communication and enhance our interactions:

"The ability to rapidly establish rapport and trust, to be able to "speak the patient's language" and to use our words to optimise patient's understanding and cooperation is what makes an anaesthetist a doctor rather than a technician."

1. **Listening** – this is an active process involving listening for content, emotional aspects and language structures such as metaphors and similes used by the speaker as well as recognising body language. Listening for meaning and "checking in" with patients or colleagues in a way that ensures they know they have been heard and understood.
2. **Acceptance** – this is the process of having a non-judgmental acceptance of the other person's situation, beliefs, wishes and choices at that point in time. Acceptance allows us to engage with people irrespective of age, gender, religion, ethnicity or sexual orientation. In particular, it helps us build rapport and develop an understanding of people who may have radically different beliefs to ourselves. It does not imply endorsement of that person's beliefs but does convey respect and more importantly creates the opportunity to engage. Failure to accept or recognise another person's reality is a frequent cause of conflict and miscommunication.
3. **Utilisation** – involves using the information provided by the other person in order to build connection and rapport and ultimately bring about the goal of the interaction for example conflict resolution or obtaining consent.
4. **Reframing** – this process is primarily used when there is a need to shift someone's perspective or belief. It involves opening up a different viewpoint to help the other person see more options or possibilities than they currently are aware of. It is a great value when working with patients or colleagues who are stuck with a narrow construct of what has happened or will be happening. For example, patients are often told when injecting local anaesthetic that "this may sting" or "Sting coming". The reframe may be "This will numb the skin and allow us to finish the procedure as comfortable and safely as possible" if the patient has a concern about pain after surgery, this can be accepted, utilised and reframed by "Knowing you are concerned about pain has now allowed us to address all the different ways we can optimise your comfort and safety while healing and recovery occurs after the operation".
5. **Suggestion** – is a verbal or non-verbal communication which brings about a subconscious (non-volitional) change in perception, mood or behaviour. In contrast to a spoken command "Pass me the laryngoscope", suggestions cover a huge spectrum of our communications previously unrecognised in our communication (for example, nocebo). Suggestions can include non-verbal cues, for example, beckoning a patient into a waiting room or handing a patient a vomit bag when there is no indication of PONV. Suggestion is essentially how we bring about change such as supporting an extremely anxious patient or communicating with a needle-phobic patient prior to and during cannulation. An understanding of how to use suggestion to bring about positive therapeutic outcomes is a powerful tool with implications for every anaesthetic interaction. In particular, an understanding of "nocebo" or "negative suggestion" is important when communicating with patients. There is evidence to support the concept that we may inadvertently produce negative effects in our everyday communications that are inadvertently incorporating negative suggestion. For example, warning patients that the epidural needle "only hurts for a short time" are intended to provide information and reassure the patient. In fact, there is clear evidence of such communications function as suggestions that may increase patients' anxiety and perception of pain. Nocebo type communications are very common in healthcare practice and an understanding of these concepts when honing our communication skills will help improve patients' experiences.

While most people recognise when communication is failing, it is much harder to identify what makes a good communicator and then distill those attributes and behaviours into something that can be taught and even assessed. The LAURS framework goes some way towards describing the basis of effective therapeutic communication.

There is a plethora of resources to support the teaching of traditional anaesthetic technical skills (for example, medical expert) but both supervisors of training (SOTs) and trainees feel that more resources are required to assist the teaching of the other ANZCA roles in practice – communicator, collaborator, scholar, health advocate, manager and professional. To this end ANZCA has established the "Communicator Role in Practice" project to review and develop resources to support the teaching of communication and help trainees meet the communication learning objectives laid out in the curriculum. The working group comprised a selection of fellows with interest and expertise in communication and medical education as well as a trainee representative and ANZCA administrative support. The resources developed by the group are available on the ANZCA website and include scientific papers, texts, courses and a selection of communication videos demonstrating common anaesthesia communication scenarios. It is hoped these resources will form the basis of a clearer understanding of communication skills and help both trainees and fellows develop their capacity to communicate effectively.

Dr Suyin Tan, FANZCA, FFPMANZCA

Communicator Role Project Group member

Communications SIG member

Director, Department of Anaesthesia and Pain Management, Nepean Hospital, Penrith, NSW

Foundation news

Pandemic challenges in 2021 did not prevent a strong year for the foundation, thanks to generous donor support, with many new donors joining the ranks in supporting ANZCA fellows' and trainees' significant academic and philanthropic work.

NAME CHANGE

As our supporters know, the foundation exists to support fellows and trainees leading important research in anaesthesia, pain, and perioperative medicine, but also philanthropic education and training programs improving access to urgently needed anaesthesia and pain medicine services in Aboriginal, Torres Strait Islander and Māori communities as well as developing countries. To reflect these important community contributions, ANZCA Council approved a name change, from the ANZCA Research Foundation to the simple and inclusive ANZCA Foundation.

RESEARCH GRANTS

The research committee met on 10 September and awarded just over $A1.55 million in new research grants, for 28 new projects to start in 2022. Please see the summer editon of the *ANZCA Bulletin* for more information.

The 2023 research grants round opened on 1 December. The new ANZCA Environment and Sustainability Research Grant and ANZCA Patrons Emerging Investigator Research Award to commence from 2023 were both included, as was the Skantha Vallipuram ANZCA Scholarship introduced in 2022 and available in 2023. Applications for ANZCA grants closed at 5pm on 1 April 2022.

PROFESSIONAL PRACTICE RESEARCH

On 11 November, the new Professional Practice Research Network (PPRN) Executive met and confirmed its two first key initiatives: Planning a new proposal workshop session for later in 2022, and sourcing high-quality educational resources for qualitative and mixed-method professional practice researchers, for a new online PPR Guide. The new guide is expected to be launched by the ANZCA Library, PPRN Executive and the foundation in April 2022.

DONOR FUNDING

Last year again saw generous giving with subscriptions payments, and some large gifts from committed supporters. Dr Peter Lowe gave $A30,000 for the 2022 ANZCA Melbourne Emerging Researcher Scholarship and ANZCA Melbourne Emerging Anaesthesia Researcher Award, Mrs Asoka Vallipuram gave $A15,000 for the first Skantha Vallipuram ANZCA Research Scholarship, and Dr Brenton Sanderson and Dr Amardeep Singh gave leading gifts for the Environment and Sustainability Research Grant. Mrs Ann Cole gave $A70,000 for the annual Russell Cole Memorial ANZCA Research Award for pain medicine, which has supported several pain medicine studies. New Zealand colleagues again donated for the Darcy Price ANZCA Regional Research Award.

Thanks to these and other generous foundation patrons and donors, and an inspirational large bequest from the late and highly-respected WA anaesthetist Dr Nerida Dilworth, and despite the loss of some large corporate grants due to COVID-19, the foundation achieved a fundraising total of more than $A550,000.

GLOBAL DEVELOPMENT AND INDIGENOUS HEALTH

Health Equity grant applications for 2022 closed on 31 July. Four grants went to global development projects, and the first application for an Indigenous health project was received and approved. Seven Māori students and junior doctors were sponsored to attend the New Zealand Annual Scientific Meeting in October.

The college's first Reconciliation Action Plan was submitted to Reconciliation Australia in November, while the final Pacific Online Learning and Education webinar for 2021 on 16 October saw 80 healthcare professionals from over eight Asia Pacific countries participating.

Two Global Safer Surgery Fund grant reports were received from Associate Professor Bruce Biccard, University of Cape Town. The grants, generously supported by Dr Genevieve Goulding, supported the African Surgical Outcomes Study obstetrics arm, and a paediatric infections study in Africa, crucial benchmarking studies which will support improving outcomes in regions of great need.

FOUNDATION/CTN BENEFIT DINNER AT 2022 PERTH ASM

The foundation's second planned attempt to launch its inaugural Foundation and CTN Benefit Dinner on Sunday 1 May at the 2022 ASM in Perth, WA, has again been put on hold after it became necessary for the college to make the ASM fully virtual.

The dinner was to feature keynote speaker Professor John Newnham (acclaimed obstetrician researcher and Senior Australian of the Year 2020), and ANZCA speakers Professor Kate Leslie, AO and Professor Andrew Davidson (Chair, ANZCA CTN).

Apologies and thank you to our speakers and all those generous supporters who committed to sponsoring tables at the dinner. The foundation hopes to renew plans to launch the dinner at next year's ASM in Sydney. Individual tickets can be refunded through the ANZCA Events Team.

FIRST FOUNDATION FRIENDS WEBINAR

The first ANZCA Foundation Friends webinar was held on 18 November. Almost 70 people registered to hear presentations from two talented emerging researchers and PhD candidates, ANZCA grant recipients Dr Jennifer Reilly and Dr Courtney Thomas. Dr Reilly, introduced by past ANZCA president Professor Kate Leslie AO FAHMS, gave a fascinating talk on the COMPASS study which is developing a new perioperative risk prediction tool. Dr Thomas, introduced by past ANZCA dean of education Professor Barry Baker AM, spoke on her ground-breaking mixed-methods study on Māori engagement with perioperative medicine.

Please watch for and attend our future Foundation Friends webinars on themes of interest to current and considering foundation supporters. We hope these will provide easy access to news of exciting work supported by the foundation, regardless of location.

FOUNDATION TEAM

The foundation is delighted to welcome our new fundraising administration coordinator, Ms Leah Wolf, who joined us in November 2021. Leah was previously with ACEM Membership Services, and is already providing enthusiastic support to the foundation and our valued donors.

CONTACT US

To donate search "GiftOptions – ANZCA" in your browser.
For queries, contact:

- **Rob Packer**
  General Manager, ANZCA Foundation,
  +61 3 (0)409 481 295, rpacker@anzca.edu.au
- **Leah Wolf**
  Fundraising Administration Officer,
  lwolf@anzca.edu.au

Research grants program:

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

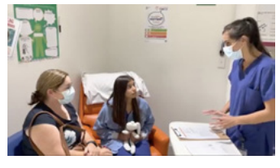
CTN workshop takes the cake again

IN AN ANZCA CTN first, the CTN Executive together with the Anaesthesia Research Co-ordinators Network (ARCN) Sub-committee ran a workshop in March. This workshop was in addition to the annual CTN workshop which takes place in August and formed part one of the annual CTN workshop.

The workshop included a new proposals session coupled with a session that would normally be held as part of the annual ARCN workshop. The core aims of these sessions were to provide further opportunities to refine new research proposals ahead of other major funding deadlines, such as the ANZCA Research Grant program and the Medical Research Future Fund. It also provided opportunities for research co-ordinators who often don't have the funds to travel to the annual CTN workshop in August to contribute to the new research proposals sessions.

The part one workshop was held virtually on 4 March with 125 delegates in attendance. Session one was moderated by Ms Margie McKellow, Dr Aine Sommerfield and Professor Philip Peyton and included a keynote presentation by Dr Ira van der Steenstraten on mindfulness and strategies to help deal with challenging situations. This was followed by thoroughly entertaining and thought-provoking video scenarios starring members of research teams on the dos and don'ts for co-enrolling participants to trials, ethical considerations for consenting children to trials, and dealing with challenging situations to gain support from colleagues to facilitate trials.

Delegates then had the opportunity to network with other attendees online during the networking break and in-person if watching in a group setting. The second session was chaired by Professor Andrew Davidson and featured a presentation from Professor David Story on the importance of pilot work to assess feasibility of the main study. Our keynote statistician, Dr Anurika De Silva, together with our delegates provided valuable feedback to four investigators presenting new research proposals.



Clockwise from top: Professor Philip Peyton moderating the first session; Dr Tom Painter and Dr Shona Osborn from Royal Adelaide Hospital; Dr Aine Sommerfield, Ms Simone Gonsalves and Ms Michaela Ragarathnan from Perth Children's Hospital.

BAKE OFF CHALLENGE WINNER

We are now running the CTN bake off challenge annually following the success of the inaugural CTN trial cake bake off in 2021. Congratulations to Ms Pauline Coutts on winning the 2022 CTN bake off challenge with her LOLIPOP breast cancer awareness cake. Thank you to all our participants and judges.

RESEARCH SCENARIO VIDEO AWARDS

After extensive consultation, we're pleased to announce the following awards:

- Best actors: Tom Painter as himself and Shona Osborn as "Dr Vial" in "Lavender Water".
- Best child actor: Michaela Ragarathnan in "Sommerfield's daughter".
- Best screenplay: Tom Painter and Louise de Prinse for "Lavender Water".
- Best iPhone photography: Robyn Seale, Peter Mulcahy and Michael Baker for "An intubation in Hobart".
- Best Director: Sophie Wallace for "Co-enrolment" and "Co-enrolment 2: Three is not a crowd".
- Best accent: Jaseen Hayer as "Mrs Jones" in "Lavender Water".

THANK YOU

Thank you to all our delegators, presenters, video actors and moderators for their involvement. A special thank you to the ARCN Sub-committee, Gillian Ormond, Paige Druce, Allison Kearney, Karen Goulding, Majella Coco, Elodie Garcia, the ANZCA Events and Communications teams, and our AV partner, Wallfly. We welcome any feedback from delegates and look forward to seeing you in Brisbane on 4-7 August for the Part 2 workshop.

Professor Philip Peyton
Immediate past chair, CTN Executive

Ms Karen Goulding
CTN Manager

Ms Majella Coco
ANZCA Events Officer

Hybrid pays off for the Annual Registrars' Meeting

Dr Peter Xiang with his award.

ANNUAL REGISTRARS MEETING

The New Zealand Annual Registrars' Meeting (ARM) went virtual for the first time in 17 years on 3 December after Auckland limped out of four months of lockdown. The online event attracted more than double the normal attendance and organisers Dr Nicola Broadbent and Dr Carolyn Deng believe it will probably be the way of the future.

There was a push to hold the popular ARM despite the challenges of Auckland's extended lockdown as there has been so much disruption for trainees over the past couple of years.

Dr Nicola says with Auckland moving to "red" just the day before the meeting, the audience was limited to just 55 people at the Auckland City Hospital hub. "We ran in a hybrid format with a virtual Zoom webinar and small socially-distanced audience at the hub for Auckland presenters. We had more than 100 attendees to the virtual webinar as well as local trainees present as a physical audience to watch the 11 presentations from across the country."

"A positive side-effect of offering a virtual webinar is a more inclusive event with presenters and attendees being able to join from their home base rather than having to travel to Auckland. This was reflected by five presentations from non-Auckland region district health boards – Hutt Valley, Nelson-Marlborough, Northland and Waikato." Dr Broadbent says organisers will continue with the hybrid model to promote a more accessible event for all of New Zealand.

The judges for the event were Dr Robyn Billing, Dr David Sidebotham and Dr Michael Webb who were able to be at the hub. They were impressed with the overall quality and explained that in making their decisions they gave significant weighting to a clear outline of methodology in the scientific presentation delivered.

Dr Peter Xiang received the ANZCA award for best scientific presentation. Dr Xiang presented the results of the INPOD-NZ study (Incidence of Postoperative Delirium in NZ) using big data to look at the incidence of postoperative delirium in surgical patients in New Zealand. The paper will be coming to a journal near you shortly.

Dr Sebastian Ang received the New Zealand Society of Anaesthetist's (NZSA) award for best quality assurance presentation. Dr Ang looked at door-to-surgery times for patients with fractured neck of femur in Whangarei Hospital and reasons for surgical delay. He also had some great ideas on how things could be improved.

Dr Tom Scott received the Caduceus award for excellence in anaesthesiology research. Dr Scott pulled off a logistical nightmare and worked out how to take ABGs from a free diver at surface and at 60m depth underwater to look at changes in PaO_2 and $PaCO_2$ during deep free dives. The Journal of Applied Physiology published the paper in May 2021.

To read more about Dr Tom Scott's research see the feature on page 42-43 of this edition of the Bulletin.

"A positive side-effect of offering a virtual webinar is a more inclusive event with presenters and attendees being able to join from their home base rather than having to travel to Auckland."

Western Australia

INTRODUCTION TO ANAESTHESIA COURSE

This year, WA invited 16 new trainees to the course which was held at the ANZCA WA office. 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. We'd 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.

INFORMATION EVENING

Dr Anna Hayward co-ordinated the anaesthesia trainee information evening, which was held on the 16 March via Zoom, with thirty-three attendees. Due to increased demand, it will be repeated on the 19 April. Medical students and junior doctors are invited to learn more about the training program and what it is like to be an anaesthesia trainee.

EXAMS

The primary and final written examinations were conducted on the 8 and 25 March respectively in the ANZCA WA office. We wish the candidates well with their results.

If you're 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.

CONFERENCE

The ACE WA Country Conference will be held from the 28-30 October 2022 at the Pullman Resort in Bunker Bay. The theme is "What's new in '22?" and is convened by St John of God Midland Public and Private Hospitals with the WA ACE CME Committee.

New South Wales

COURSES

Introduction to Anaesthesia

The NSW Trainee Committee and NSW ANZCA team successfully delivered our first ever virtual Introduction to Anaesthesia Training Program on Saturday 13 November 2021 via Zoom.

We had more than 60 attendees and 16 presenters involved. We would like to thank our presenters for taking the time to come along and participate on the day. Thank you Dr Mark Priestley, Dr Rebecca Wood, Dr Michael Stone, Dr Jessica Lim, Dr Sally Wharton, Dr Michelle Moyle, Dr Tim Marshall, Dr Rebecca McNamara, Dr Lucy Kelly, Dr Cameron Dunn, Dr Kieran Easter, Dr Katherine Gough, Dr Michelle Moyle, Dr Mark Chemali, Dr Ken Harrison and Dr Dushyant Iyer.

ANZCA NSW would like make a special thank you to our course convenor for the success of the day, Dr Rebecca Lewis, and the support of Dr Benjamin Wan and Dr Natalie Kent.

Primary Exam Refresher Course 2021.2

The NSW Primary Exam Refresher Course was held from Monday 29 November to Friday 3 December 2021 via Zoom with 56 candidates, five presenters and eight examiners.

The NSW ANZCA team and trainees would like to thank our Course Convenor Dr David Fahey for orchestrating this course. A special thank you to presenters Dr Mincho-Marroquin-Harris, Professor Ross MacPherson, Dr Frank Sun and Dr Marianne Sidhom for your dedication to supporting our trainees and their exam preparation.

We would also like to thank our examiners who've dedicated their time in our practice viva day on day five of the course. Thank you Professor Ross MacPherson, Dr Kar-Soon Lim, Dr Angela Walker, Dr Katherine Gough, Dr Karthik Nagarajan, Dr Rebecca MacNamara, Dr Luke Barnett and Dr Jo Chapman.

Final Exam Refresher Course 2021.2

The NSW Final Exam Refresher Course was held from Monday 6 December to Friday 10 December 2021 at Northside Conference Centre.

We successfully supported 39 in-person and 61 online trainees.

The NSW ANZCA team and trainees would like to thank our Course Convenor Dr Sally Wharton, Co-Convenors Dr Veronica Payne and Dr Shanel Cameron.

A special thank you to all 30 presenters for their amazing efforts and dedication to coming along and supporting our trainees.

UPCOMING EVENTS

- NSW ACE Winter Meeting Sydney – Saturday 18 June 2022
- NSW ACE Spring Meeting Terrigal – Saturday 12 and Sunday 13 November 2022
- NSW ACE Anatomy Workshop Sydney – Saturday 26 November 2022

Australian Capital Territory

After the unfortunate postponement of this year's event, we are excited to announce that the Scan and Ski workshop will take place in Thredbo from Thursday 11 August to Saturday 13 August 2022. The workshop will feature world-renowned ultrasound specialists including Dr Ross Peake, Dr Alwin Chuan, Dr Peter Hebbard, Dr Andrew Lansdown, Dr Katrina Webster, Dr Monika Konig and Dr Harmeet Aneja. Hands-on ultrasound scanning and instruction will be held during the morning and evening sessions, leaving the middle of each day free for skiing or sightseeing in the beautiful NSW Snowy Mountains. The workshop will cover upper-limb blocks, lower-limb blocks, trunk, and spinal blocks, among other topics. We are also pleased to announce the inclusion of a CICO (Can't Intubate Can't Oxygenate) workshop into the 2022 program, to be run by Dr Freya Aaskov. Head to our website for all the details and online registration.

2022 ART OF ANAESTHESIA CME – SAVE THE DATE

Save the date for the 2022 Art of Anaesthesia CME – 8-9 October at the Hotel Realm, Barton, ACT. The working title of next year's meeting is "The occasional anaesthetist" and the focus for much of the lectures will be refreshers in the main anaesthetic disciplines. Pop the date in your diary now and we look forward to seeing you in Canberra in Spring. Registrations will open shortly!

ACT TRAINEE COMMITTEE

This year we welcome a new trainee committee and look forward to getting to know them over the next year. The committee members are: Dr Fabio Longordo, Dr Dharan Sukumar (chair), Dr Shruti Krishnan (deputy chair), Dr Cristy Rowe and Dr Laura Staples. We look forward to working closely with the committee during 2022.

Victoria

RECENT COURSES AND EVENTS

In the first few months of 2022, Victoria held two exam preparation courses, the Final Exam Refresher (14-18 February) and the Final Anatomy (21 February), along with our Introduction to Anaesthesia Course (25 February), engaging more than 200 registered trainees online around Australia and New Zealand.

At our Introduction to Anaesthesia Course, trainees were welcomed by co-convenors Dr Adriana Bibbo and Dr Genna Verbeek. Some of the presentations covered the anaesthesia training program, the primary exam, welfare of anaesthetists, research opportunities and parenting during training, and updates on college resources. A significant part of the course was run by trainees for trainees. There was also an interactive Q&A session with supervisors of training and the day finished with an airway, point of care ultrasound, and environmental sustainability talk. 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 Genna Verbeek for their help to bring this meeting together.

For our exam preparation courses, trainees heard from a diverse group of researchers, clinicians and leaders in healthcare sharing their expertise on 29 topics, including: anaesthesia for burns, biochemistry, interpretation of ECGs, perioperative management, spinal anaesthesia, law and ethics, exam techniques, tips and tricks, and upper and lower limb anatomy.

In her "Anaesthesia for Burns" session, Dr Annabel Orr gave trainees an insight into the pathophysiology of burn injury, treatment approaches, perioperative issues and assessment, as well as reviewing case studies, as part of the Final Exam Refresher Course. Dr Orr also explored current research efforts, opinions and perspectives when considering colloids and crystalloids for fluid replacement treatment in burn patients. Dr Orr is a staff anaesthetist at The Alfred hospital.

We appreciate and acknowledge the amazing contribution that clinical educators make as they volunteer their time in instructing, guiding and inspiring trainees. We extend a special thank you to Dr Irene Ng (anaesthesia for neuro surgery), Dr Paul Davies (cardiac physiology), and Dr Matt Richardson (law and ethics), who have relayed their teaching baton to other educators, over the last couple of months.

2022 MELBOURNE WINTER ANAESTHETIC MEETING – SAVE THE DATE

Save the date – 30-31 July 2022 – for our Melbourne Winter Anaesthetic Meeting, bringing together a meeting program of lectures, workshops and small group discussions. More information coming soon.

UPCOMING EXAM PREPARATION COURSES

- **Primary Refresher Course**
  Monday 16 May – Friday 27 May
- **Final Refresher Course**
  Monday 18 July – Friday 22 July
- **Final Anatomy Course**
  Monday 25 July 2022
- **Primary and final viva practice nights**
  Four-to-six sessions are scheduled and held on various nights (usually Monday to Thursday) during the weeks leading up to each of the viva exams. Places are limited for individual sessions and Victorian trainees sitting the next exam will be contacted and offered allocations.

Please email vic@anzca.edu.au for further information on our events and courses.

Tasmania

SAVE THE DATE – TASMANIAN WINTER MEETING

The 2022 Tasmanian Winter Meeting will be held on Saturday August 20 at the picturesque Josef Chromy Vineyard in Relbia, just outside of Launceston.

The theme for this year's meeting is "Keeping the glass half full". Delegates are invited to bring a sense of optimism to the meeting and explore a range of topics including the changing landscape that is education in anaesthesia and medicine, social media, regional anaesthesia and pain medicine. The meeting will be bookended by a breakfast emergency response workshop and a guest speaker winemaker to lead into drinks and dinner at the award-winning restaurant on site.

Dr Ryan Hughes,
Convenor, 2022 Tasmanian Winter Meeting

CPD IN A DAY

You are invited to save the date – 5 November 2022 – for CPD in a Day to be held at the Medical Science Precinct in Hobart. More details soon as workshops are still being finalised.

The meeting convenors Dr Nat Jackson and Dr Harry Laughlin are excited for the day and feel that the workshop day is a much-needed meeting in Tasmania.

TASMANIAN ASM 2022 IS NOW TASMANIAN ASM 2023

Thank you to all the registrants for the Tasmanian ACE ASM 2022. We are thrilled with the interest in our conference and would like to convey our deep disappointment in not being able to proceed with a face-to-face meeting this year.

We were keen to preserve the integrity of the fantastic meeting we had planned, so have decided to postpone the meeting until 2023. This means our attendees and speakers will get to enjoy a face-to-face meeting, and all the perks of Tasmanian travel. Our primary concerns, driving the decision to postpone our meeting, were the current community spread of COVID-19, the safety and wellbeing of our attendees and the potential impact on our respective health services.

We are grateful that our speakers for 2022 will be returning to the 2023 line up, demonstrating their fantastic commitment to the meeting.

Looking forward to seeing you all on 25 and 26 February 2023!

Dr Stephanie Cruice and Dr Jana Vitesnikova
Co-convenors of the Tasmanian ASM 2023

INTRODUCTION TO ANAESTHESIA TRAINING

The Introduction to Anaesthesia Training event (formerly known as the "Part Zero Course") was successfully held on 12 February. With COVID restrictions in place, the event was entirely online for the first time in Tasmania.

Nine attendees (first year anaesthesia trainees, as well as others interested in a future career in anaesthesia) logged on to a program encompassing a top-to-bottom overview of training in Tasmania, as well as tips on interviews, selection, exams and achieving success in the career.

Given the uncertainty around COVID's future impacts on social proximity, an online event appeared a suitable alternative until face-to-face meetings can resume.

Thank you to all those involved in the meeting's success

Dr Greg Bulman
Convenor of Introduction to Anaesthetic Training, Tasmania

TRAINEE DAY

Friday 25 February 2022 saw another first for Tasmania with the transition of the annual Tasmanian Trainee Day from face-to-face to a fully virtual day with local speakers and the presidents of ANZCA and ASA supporting the day with their live presentations.

Co-convenors Dr Bing Chang and Dr Dheeraj Sharma were pleased with how the day went and appreciated the quality of the presentations and contribution of all speakers.

Altogether 31 attended the day which finished in a lively panel discussion where key fellows shared their experiences and knowledge with all the trainees present.

The planning committee are hoping for a face-to-face meeting in 2023.

South Australia and Northern Territory

ROTATIONAL SUPERVISORS

After more than 12 years of expertly managing the South Australian and Northern Territory Rotational Anaesthesia Training Scheme, rotational supervisors Dr Sam Willis and Dr Ken Chin have handed over the reigns to incoming ROTs Dr Amanda Brewster and Dr Chelsea Hicks. As the record holders for the longest serving ANZCA ROTs, Sam and Ken have survived countless changes of government, hospital restructures, external auditors and a monumental move to a brand new hospital. They have adapted to the changes with steadfast equity, fairness, patience and a sense of humour, retaining trainee education and welfare as a priority.

Testament to SANTRATS excellent reputation is the large number of interstate trainees applying twice a year and good exam outcomes/results.

The anaesthesia community extends its thanks to Sam and Ken for the integral part they contributed to shaping the calibre of anaesthetists that serve the dual regions. We wish them well in their future endeavours both personally and professionally.

Right: Dr Sam Willis, Dr Ken Chin, Dr Christine Hildyard (SA/NT Education Officer) and Dr Richard Church (SA/NT Regional Committee Chair).

REGIONAL COMMITTEE CHRISTMAS DINNER

The festive season kicked off in late November for the SA/NT Regional Committee and staff who enjoyed their end of year dinner at Golden Boy restaurant.

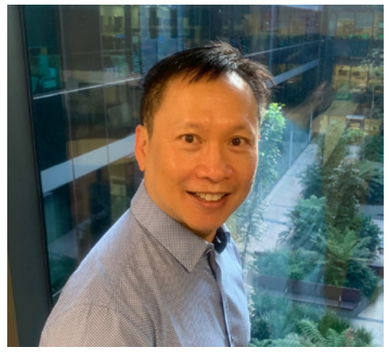
Left: Dr Amanda Brewster, Dr Chelsea Hicks, Dr Brigid Brown, Dr Tim Donaldson, Dr Div Kumar, Dr Sam Lumb, Dr Sam Willis, Dr Rowan Ousley and Dr Rachelle Augustes.

PRIMARY EXAM REFRESHER COURSE

The SA primary course ran via Zoom from 31 January to 4 February. This course would not be possible without the tireless effort of the course convenor, Dr Gary Tham, whose passion and enthusiasm for trainees to pass the primary exam is outstanding.

INTRODUCTION TO ANAESTHESIA COURSE

The SA/NT Introduction to Anaesthesia Course ran via Zoom on Saturday 22 January. Twelve presenters attended an information-packed session, along with 12 new SANTRATS and three independent trainees. A social gathering will be held later in the year (COVID-permitting) so that the new trainees can meet each other face to face.



Right: Dr Gary Tham.

Queensland

TRAINEE COMMITTEE

We welcome the Queensland Trainee Committee members for 2022: Dr Rosalyn Boyd, Dr Benjamin Cahill, Dr Martha Ghaly, Dr Gabriela Kelly, Dr Siobhan Lane, Dr Jane Leadbeater, Dr Shelly Lee, Dr Paul Lim, Dr Louise Rafter, Dr Sophie Turner, Dr Jing Yuan Jessica Wu and Dr Cecilia Xu. Congratulations to the new co-chairs of the committee Dr Cecilia Xu and Dr Siobhan Lane. We look forward to working with the committee during 2022.

COURSES

The Queensland Introduction to Anaesthesia Training Program for introductory and basic trainees (formerly known as the Part Zero Course) was held virtually on Saturday 12 February, with 42 introductory trainees attending and 19 presenters. Thank you to co-convenors Dr Cecilia Xu and Dr Martha Ghaly. The course was very well received.

The Primary Lecture Program is once again on offer and will run across five Saturdays from February through to June, with the first session held on February 19. There is still availability for the second semester, held across five Saturdays from July to November. Contact qldcourses@anzca.edu.au now to secure your spot! Please visit the ANZCA website for the full list of course dates for 2022.

Once again we would like to offer our sincere thanks to all the convenors and presenters for their time and commitment to our academic activities.

Above from left: Dr Cecilia Xu and Dr Martha Ghaly, 2022 Queensland Introduction to Anaesthesia Training Program co-convenors; Dr Christopher Stonell, Queensland Regional Committee Chair, welcoming attendees to the course.

THE SUNSHINE STATE WELLBEING OF ANAESTHETISTS NETWORK

We talk a lot about supporting our colleagues especially with respect to wellbeing advocates and supervisors of training with trainees. A lot of this puts emphasis on public departments of anaesthesia while private anaesthetists are often left out. Also, who supports those who provide support to their colleagues?

In Queensland we have set up the Sunshine State Wellbeing of Anaesthetists Network (SSWAN) which is a peer support network for wellbeing advocates, supervisors of training and anyone interested in looking after their colleagues. The network is in no way therapeutic but through online meetings we support each other by confidentially discussing difficult situations, comparing ideas and sharing knowledge about support services which are available to us and our colleagues.

ANZCA have helped by hosting our Zoom meetings and we hope to have a face-to-face meeting at the Combined SIG meeting in September. If anyone in Queensland, in either private or public practice, has an interest in wellbeing and would like to meet with like-minded anaesthetists to exchange ideas and support, please contact Mairead Jacques mjacques@anzca.edu.au (ANZCA Operations Manager, Fellowship Affairs), Dr Usha Gurunathan usha.gurunathan@health.qld.gov.au (ANZCA Queensland Regional Committee – Wellbeing Lead) or Dr Anna Hallett anna.hallett@health.qld.gov.au (Wellbeing SIG Queensland representative).

Did you know that there are wellbeing networks for fellows in New Zealand and in the Australian states and territories? If you are interested in learning more, contact membership@anzca.edu.au.

Dr Nicholas Mark Thackray

1955-2022

EVERYONE WHO KNEW Mark was shocked and saddened to hear of his death earlier this year. He had been unwell on and off for many years, but this was unexpected, even by those closest to him. He had so much talent, and had so much to offer, that this was a tragedy.

Nicholas Mark Thackray was born in England on February 1, 1955. He signed his name as NM Thackray, but was always known as Mark. To his many friends he was known as "Thackers". He emigrated to Australia in 1974, when his father took up a position as senior lecturer and later head of music at The University of Western Australia. Mark was initially enrolled in first year science, but achieved the rare feat of switching mid-course to medicine.

I first met Mark when we were second year medical students in 1975. At that time he had shoulder length dark blond hair, and often wore a green velvet jacket. He smoked a lot. He had an old open-topped sports car. He was very cool. He was successful academically throughout medical school, graduating MBBS (1980).

Mark completed his internship at Royal Perth Hospital, and was initially interested in emergency medicine, but switched to anaesthesia training, which he completed in 1992 (FANZCA). Outside of work he was interested in wine, fast cars, music, and windsurfing. In 1993 with his wife Jo, he spent a fellowship year at Sunnybrook Medical Centre in Toronto. When he returned in 1994 he joined the Department of Anaesthesia at Sir Charles Gairdner Hospital, a position he occupied for the next 22 years.

At this stage I have to go back a little, because Mark's life was heavily affected by his mother's long illness and early death, and also his father's death in 1987. Mark had an older sister living in England, but they were rarely in contact. Mark and Jo had three children, Kate, Nicholas, and Georgia, all of whom he was immensely proud. He also had a close group of friends, many from his medical school days, none closer than Digby Cullen, with whom he shared a February birthday. Mark was part of a group who spent a summer rebuilding "Gallows", the Cullen family holiday home in Wilyabrup, after it was destroyed in a fire.

At Sir Charles Gairdner Hospital, Mark was acknowledged as a superb anaesthetist. He had an interest in both neuroanaesthesia and cardiothoracic anaesthesia and published many scientific papers in both areas. He was also interested in trauma, and was an instructor and keen supporter of the Early Management of Severe Trauma course nationwide. He had a knack for managing complex cases, and came up with innovative approaches. Mark co-ordinated the department's mortality reporting, keeping detailed notes, and developing an outstanding database. He had a reputation for being forthright, but this was a façade, because he always enjoyed teaching and helping others in their work. Regrettably, by 2014 he needed to take periods off work, and by 2016 he stopped working as an anaesthetist altogether.

Mark and Jo eventually separated in 2006. Jo and Georgia moved to Canberra to continue Georgia's education. The older children followed soon after. They remained in regular contact over the years but this became increasingly difficult in recent times with Covid travel restrictions.

In the late 2000s he met Karin, who would become his partner for the rest of his life. He and Karin travelled widely, and developed many interests together. Mark was amazingly supportive of Karin through her extended illness, researching novel therapies, and following up possibilities. Similarly, Karin was a wonderful support to Mark throughout. They had a holiday house on the inlet in Dawesville, where Mark chose to spend more and more of his time, pursuing other interests such as woodwork, bird watching, photography, and rock climbing. Karin continued to provide love, care, and encouragement, and they had spent time together only a few days before his death.

It is trite to refer to Mark as being "unwell", but much of what he was going through was private and against a complex background exacerbated by tragic inter current events. While he was supported over the years by Jo and his children, his many friends, and many work colleagues, more recently he relied almost exclusively on Karin. For those who knew him, many of us are regretting missed opportunities to reach out to him. We all wished for a return of the "charming, generous, clever, funny, witty side" of Mark. We now remember all these attributes fondly, along with his expansive knowledge, keen insights, incredible ability, and great company, which we will always miss.

Dr Neville Gibbs, FANZCA
Sir Charles Gairdner Hospital, Perth

RELEVANT CONTACTS

- Lifeline 13 11 14 www.lifeline.org.au/
- Australasian Doctors' Health Network New Zealand 0800 471 2654
- Dr4Drs 24/7 Crisis Support 1300 374 377 www.drs4drs.com.au/
- ANZCA Doctors' Support Program 1300 687 327 (Australia) or 0800 666 367 (New Zealand). www.anzca.edu.au/about-us/doctors-health-and-wellbeing/doctors-support-program