ANZCA
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Bulletin

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

WINTER 2020

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Fellows around the world share their COVID-19 experiences on page 24

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

Medical editor: Dr Nigel Robertson
Editor: Clea Hincks
Production editor: Liane Reynolds
Features writer: Carolyn Jones
Designer: Frances Rowsell
Advertising manager: Vivienne Forbes

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Contact us
ANZCA
630 St Kilda Road, Melbourne
Victoria 3004, Australia
+61 3 9510 6299
communications@anzca.edu.au
www.anzca.edu.au
Faculty of Pain Medicine
+61 3 8517 5337
fpm@anzca.edu.au
www.fpm.anzca.edu.au

Cover: ANZCA President Dr Vanessa Beavis in personal protective equipment.

Rare privilege of medicine a responsibility for us all

TĒNĀ KOUTOU, E HOA MĀ. Greetings from Auckland, on the eastern edge of ANZCA's large geographic footprint.

As this is my first ANZCA *Bulletin* as president, I should introduce myself. I'm a specialist international medical graduate, originally from South Africa. I moved to New Zealand 27 years ago, and was so impressed with the quality of my colleagues' practice that I wanted to contribute to the college responsible for their education, training and skills. Wonderful opportunities, friendships and deep satisfaction have come from my increasing involvement in ANZCA.

I thank my predecessor, Dr Rod Mitchell, for his wise and warm leadership of ANZCA. My two-year apprenticeship for this role has been under Rod's guidance. It could not have been better – but more about Rod later (see page 8).

"The rare privilege of medicine" (Dr Tess Brophy's expression) comes with a responsibility to look constantly for ways to improve our patients' quality of life. With this in mind, here is where I see ANZCA going in the next two years:

The further development of perioperative medicine

Anaesthetists are the natural leaders and co-ordinators to develop comprehensive multidisciplinary perioperative care.

Other disciplines have much to contribute to this. I see perioperative medicine developing as a multi-specialist field of practice, in the same way as pain medicine has evolved, and continues to do so. We can do things which will enable patients to live longer, and to feel well for longer.

I want ANZCA to develop a diploma in perioperative clinical care, harnessing the strengths of anaesthetists as the logical leaders.

"The ANZCA fellowship embraces huge intellectual horsepower."

Equity

Equity is at the heart of good patient outcomes. The health statistics of both Australia and Aotearoa/New Zealand tell us of the disparity between the health of our Indigenous people and that of the general population.

Rod Mitchell has highlighted this problem. We need to seek to understand it, and to build trust and confidence between cultures. We need to find ways to give wholehearted respect and support to the diverse nations of Aboriginal people and Torres Strait islanders. Their diversity of languages makes this a complex project, but we shouldn't shy away from it.

Even small steps carry a high symbolic value. One such step would be to add a Māori name for our college, to symbolise that our Māori fellows and Māori patients in Aotearoa/New Zealand feel welcome and well cared for.

ANZCA, the public thinker

The ANZCA fellowship embraces huge intellectual horsepower. It is a respected professional organisation whose opinion matters. Our advocacy in both countries has brought about many changes for the better. We must continue this, while guarding carefully ANZCA's political neutrality.

During the pandemic, ANZCA has shown that it can move quickly and decisively in producing clinical guidelines and quality improvement measures. Amidst conflicting political views, varying information about the availability of personal protection equipment, and rapidly evolving new clinical knowledge, ANZCA fellows displayed agility, scientific expertise and common sense, in producing sound, practical and well-regarded clinical standards.

Fellows of ANZCA have also earned an excellent international reputation for research. I would like to see this expertise extended into audit and quality improvement.

The environment

Education, training, professional affairs, and advocacy are core business. Climate and environmental issues need continued focus if we are to reduce our impact on the vulnerable environment. I look to those passionate and knowledgeable about this to continue to advise us on best practice.

The pandemic

Eventually, the COVID-19 pandemic will end. For now, life is challenging and uncertain, personally and financially for many. Eventually it will return to some normality, when we can reconnect properly with friends and colleagues. In the meantime, look after your own health and wellbeing, and that of your families, so that you are fit to care for them, to care for your patients, to improve medical practice and to advance scientific knowledge.

"For now, life is challenging and uncertain, personally and financially for many."

My heartfelt sympathy and thanks go to the organising committees, the volunteers and the ANZCA events team, who put so much work into the ANZCA Annual Scientific Meeting that was to be held in Perth. The pandemic deprived us of this year's event. Planning for 2021 in Melbourne is well advanced. In 2022, the ASM will go back to Perth.

I particularly thank fellows in rural and remote areas. Without the backup available in bigger centres, they often have to provide care outside their comfort zone. They have shown strong commitment to the health of the communities that rely heavily their skills, expertise and ingenuity.

Finally, I thank our CEO, Nigel Fidgeon and all the ANZCA staff who have worked extraordinarily hard to keep the college functioning as normally as possible during this period.

Tēnā tātou katoa.

Dr Vanessa Beavis
ANZCA President

Our 'virtual' college rises to pandemic challenge

COVID-19 HAS CREATED numerous well-known challenges for our fellows and trainees. Your dedication and commitment in these stressful times is recognised and admired by ANZCA staff who have continued focusing on supporting you all in these stressful times.

I am very proud of the way staff have adapted to this strange and not pleasant new world. Since 17 March we have been working from home, many juggling available space in kitchens and lounge rooms with partners, and some also overseeing their children's schooling.

For many this is against a background of fear and the added uncertainty caused by spousal lay-offs and caring for elderly and/or high-risk family members. Some live alone and miss their daily interactions with colleagues.

The pandemic has meant staff workloads have shifted across the college. Some areas have been overwhelmed with additional work while others have had less to do, so where we can, we have been reallocating work. In some cases, staff have been asked to work reduced hours and all have been asked to reduce their leave balances and have been understanding and willing to do this.

Like most organisations, the college is carefully monitoring its financial position. Income is down due to a number of reasons such as cancelled events – not least being the ANZCA Annual Scientific Meeting and the associated Emerging Leaders Conference, FPM Symposium and Perioperative Medicine Special Interest Group (SIG) meeting in Perth. Numerous other SIG and continuing medical education meetings (CMEs) and courses have also had to be cancelled or postponed.

Our investments have also taken a hit due to the tumultuous global financial markets and we have more outstanding subscriptions than usual at this time.

But expenditure is also down – in fact, almost matching the downturn in revenue. Staff have worked hard with venues and suppliers to roll over events into 2021 rather than lose deposits. A great example of working with suppliers to minimise costs is that that 2022 ASM will now be held in Perth following the 2020 postponement. This is also true of most events including SIGs and CME with postponements to 2021 and the rollover of payments already made.

Also down are significant travel and accommodation costs associated with being a bi-national college with a large committee structure. Research funding allocations for 2021 have also been put on hold.

We have also successfully applied for Jobkeeper funding in Australia and with the NZ Covid Employer Payment scheme.

Our very capable finance team is in regular discussion with our financial advisers, who are providing updates on our investment portfolios and are in close discussions with our Honorary Treasurer and Vice President, Dr Chris Cokis, who is overseeing our financial activities. The college's finance committee is meeting fortnightly during this time.

The college normally does a mid-year financial outlook in July each year but due to the operational changes resulting from COVID-19, this was brought forward to May, taking into account rescheduled activities, reduced travel and reprioritised projects.

There will be numerous learnings resulting from the pandemic as we have all become more innovative.

One is the proliferation of Zoom as a very successful – and less expensive – alternative to face-to-face meetings and I expect we will see this as a means of communication extending beyond the days of this pandemic, especially now that we have been assured of its security by external experts in this field given the business enterprise system that ANZCA has implemented.

Another is the versatility of ANZCA staff. These include the IT team who had all staff set up with a secure Zoom system within weeks including secure access to our VPN network in order to access all college systems remotely. The events and regional staff have also worked hard to ensure we don't lose deposits on scheduled courses and events and started planning for use of virtual options into the future for some events and CME activities.

> "I am very proud of the way staff have adapted to this strange and not pleasant new world."

The exams team has been sorting through the difficulties of holding exams during a pandemic and are developing a comprehensive plan to make sure what we do is successful allowing these to proceed in 2020.

The safety and quality team have been supporting the team developing our clinical guidance to fellows and trainees, including our comprehensive and much-vaunted personal protection equipment statement.

Our communications team has coped well with getting important information to all and dealing with an increase in media queries related to the pandemic.

The library staff have supported fellows who have curated the plethora of information out there on COVID-19 so that we have accurate, evidence-based COVID-19 information for our fellows and trainees, all the while keeping business-as-usual library activities running for our trainees and others.

The corporate office staff ensured our first online annual general meeting and presidential handover went without a hitch, and the facilities and people and culture staff have ensured our workplaces are safe. It is a long list.

The pandemic has also made us focus more on online education and learning, an area that will no doubt grow beyond the days of the pandemic.

The pandemic is also making us rethink how we approach National Anaesthesia Day on 16 October. We want to build on the profile the pandemic has given anaesthetists but without impacting on the workloads of fellows and trainees whose workplaces have already been significantly disrupted.

We are slowly starting the process of returning to our workplaces as guided by the different requirements of the various jurisdictions in Australia and New Zealand – something many of us are looking forward to.

So while we slowly get back to "normal" operations I think it's fair to say things will be different, but in many ways for the better, following the COVID-19 pandemic.

Nigel Fidgeon
ANZCA Chief Executive Officer

Queen's Birthday Honours

ANZCA and FPM fellows have been recognised in the 2020 Queen's Birthday Honours.

- **Professor Lorimer Moseley, AO**, an honorary FFPMANZCA from SA was recognised for distinguished service to medical research and science communication, to education, to the study of pain and its management, and to physiotherapy.
- **Dr Richard Walsh, AM**, from NSW was recognised for significant service to medicine, to anaesthesia and perfusion, and to professional societies.
- **Dr David Fahey, AM**, from NSW was recognised for significant service to emergency response organisations, and to medicine in the field of anaesthesia.
- **Dr Richard Morris, AM**, from NSW was recognised for significant service to medicine, and to emergency and disaster medical response.

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Letters to the editor

ANZCA and pharmaceutical industry sponsorship: time to break the link?

In this extract of a longer article, ANZCA fellows Dr Barbara Rodriguez and Dr Richard Barnes explain why they believe ANZCA should exclude pharmaceutical industry sponsorship. To read the full version of the article and references in Networks go to https://networks.anzca.edu.au/d2l/le/content/7632/viewContent/85930/View.

In September 2017, ANZCA released its first partnerships and sponsorship policy. This document guides decisions around sponsorship of conferences and other continuing medical education (CME) activities, research grants, and other resources which support the operation of the college and the Faculty of Pain Medicine. We believe that it is time to revise the policy, to specifically exclude pharmaceutical industry sponsorship of all college activities.

To view pharmaceutical sponsorship as unrestricted philanthropic donations is to fail to recognise the vested interest the industry has in being associated with, and by implication approved by, ANZCA and similar peak medical bodies. Pharmaceutical companies spend twice as much on drug promotion as they do on research and development. The majority of this expenditure promotes drugs which are new, expensive, less tested, and often of minimal marginal value.

Despite our belief to the contrary, research shows that, as doctors, we consistently underestimate our susceptibility to pharmaceutical marketing. As professionals, we should make our therapeutic decisions based on scientific evidence and are exhorted to do so by our college's professional guidelines.

Advocates of industry-sponsored CME assert that it provides a valuable resource. While the importance of CME is undeniable, the case for its provision to be sponsored by pharmaceutical companies is weak. We are well-remunerated professionals who can afford unsubsidised CME activities.

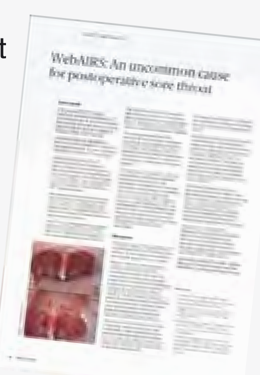
To what extent does ANZCA currently rely on these partnerships for its activities? If the amount is small, we argue that accepting pharmaceutical industry sponsorship for professional activities is an unnecessary compromise which we can easily forego. Conversely, if we are significantly dependent on these sponsorships, this raises questions about power imbalance and vested interests and makes the need for severing these compromising ties even greater. It would be interesting to know what increase in fellows' annual fees would be necessary to cover the loss of all pharmaceutical financial support.

In 2019, the *British Medical Journal* launched a major global campaign to separate healthcare from commercial interests, particularly the influence of pharmaceutical companies. One of the authors' key messages is that "widespread financial dependence on industry brings commercial bias in research evidence, medical education and clinical practice". ANZCA has a proud history of leadership in healthcare, in measures affecting patient safety and patient advocacy. By severing sponsorship ties with pharmaceutical companies, our college would continue that leadership role.

Dr Barbara Rodriguez, FANZCA
Dr Richard Barnes, FANZCA
Staff anaesthetists
Monash Medical Centre, Melbourne

In early 2020 ANZCA established a Healthcare Industry Sponsorship and Partnership Working Group to review the college partnership and sponsorship policy and develop procedures to guide and evaluate the college's relationship and engagement with the healthcare industry. Dr Richard Barnes is a member of the working group.

Postoperative sore throat


WebAIRS: An uncommon cause for postoperative sore throat

In the Autumn 2020 college *Bulletin* there is an article "WebAIRS: An uncommon cause for postoperative sore throat." It describes uvular necrosis as a "rare complication of oropharyngeal devices" and aggressive oropharyngeal suction is at the end of the list of causes.

Many years ago an ENT surgeon I worked with commented that several patients had complained about a sore throat postoperatively. He examined their pharynxes and saw the tip of the uvula torn as described in this article.

Some research found an article not referenced in the *Bulletin*: Das PK, Thomas WJW. Complication of pharyngeal suction. Anaesth Intens Care 1980;8:375-376, which reads: "At the end of an anaesthetic before tracheal extubation it is usual to clear the mouth and pharynx of mucus, saliva or blood by the use of a catheter, or more rigid Yankauer's suction apparatus. This is normally carried out under direct vision at laryngoscopy. However, slothfulness on the part of the anaesthetist, increased masseteric tone, or other patient factors which may make it impossible to visualise the pharynx lead to the blind technique of suction. We wish to report two cases of damage to the throat as a result of the latter technique."

In both cases disposable plastic Yankauer suckers had been used with high suction, and it seemed likely that the trauma was caused by the uvula being drawn into the holes of the sucker. This is very easy to do, even under vision. The holes in the plastic sucker tips are large and square with sharp edges, and readily lacerate the soft uvula after it is sucked in, and then forcibly separated. The few, large holes have high airflow through them which tends to entrain the soft uvula by the Bernoulli effect.

When we changed to using the surgical metal Yankauer sucker heads, which have small round holes, to clear the pharynx at the end of cases, and only sucking under clear vision, cases of lacerated uvula ceased.

We contacted the manufacturer of the plastic sucker tips and pointed out the design flaw, suggesting the tips be made more like the metal ones, but they replied that the suckers were within their specifications and they weren't interested in changing.

Forty years after Das and Thomas's paper in the Australian literature sore throat remains the commonest postoperative complication. Redesign of the disposable Yankauer sucker heads and education about the risks of blind pharyngeal suction could greatly increase patient satisfaction with anaesthesia, as laceration of the uvula is probably greatly under-diagnosed and under-reported.

Dr Ian Woodforth MB,BS. FANZCA
Mosman, NSW

Passing the baton: In praise of Dr Rod Mitchell, leader, advocate, communicator

There are many pathways to leadership of ANZCA. Some have been academics, others have come up through big metropolitan hospitals, while the backgrounds of others have been more eclectic.

MY PREDECESSOR, Dr Rod Mitchell, arrived at anaesthesia via rural/remote general practice, pausing to gain diplomas in anaesthesia (with the Royal College of Surgeons in the UK) and obstetrics (with RANZCOG) along the way. He became a fellow of the Royal Australian College of General Practitioners in 1995, and a fellow of the Australian and New Zealand College of Anaesthetists in 2004.

His most formative experiences, though, came from spending the best part of a decade in central Australia, mainly with the Royal Flying Doctor Service, in Indigenous primary health care and retrieval medicine, and later as the director of anaesthesia at Alice Springs Hospital.

This imbued him with a lasting affection and respect for Australia's Indigenous people, and a commitment to promoting equity of access to healthcare. Reflections on these experiences were published in *Anesthesia and Analgesia* last year[1]. In a practical expression of that commitment, Rod became the founding chair of ANZCA's Indigenous Health Committee from 2010 to 2015 and remains a member of it to this day.

He has led ANZCA in examining the disparity between, on the one hand, the health of Indigenous people and other marginalised communities and, on the other, that of the general populations of Australia and New Zealand. His voice of experience comes through in his four practical measures to address this inequity, outlined in his first president's message. They are worth re-reading[2].

Adelaide became home for Rod and Sue and their four children in 2007. He has divided his day jobs between the Department of Anaesthesia at The Queen Elizabeth Hospital, the Intensive Care Unit at Lyell McEwin Hospital, critical care at the Memorial Hospital, North Adelaide, and private practice.

The development of perioperative medicine as a multidisciplinary specialisation has always been high in Rod's priorities. It is closer to reality as a result of his advocacy, notable for his skill at avoiding unnecessary pitfalls.

He has offered a vision in which we are all perioperative practitioners, but some will be perioperative specialists, in a discipline "led (but not owned by) anaesthetists,

Dr Rod Mitchell

because we are best placed to provide the necessary co-ordination, logistical support, vision and energy for this collaboration"[3].

In short, Rod has shone as a leader, advocate and communicator. ANZCA has had the benefits of his skills of analysis, warmth, humanity, wisdom and patience, supported by an underlying steely determination to lead our organisation with a clearly considered and defined purpose.

On a lighter note, the COVID-19 pandemic has seen the separation of Rod from his trademark beard, in order to achieve an airtight seal around his mask when treating diagnosed or suspected COVID-19 patients.

While the beard has added to his distinguished appearance, the loss of it has made him the first president of ANZCA to look younger at the end of his term than he did at the start.

Dr Vanessa Beavis
ANZCA President

References

1. Enright A, Mitchell R. *Go to the People. Live Among Them, Reflections on Anaesthetic and Surgical Care in Rural and Remote Regions.* Published in Anesthesia and Analgesia 2019, 129 (1): 13-15.
2. *ANZCA Bulletin*, June 2018, p4.
3. ibid.

Departing councillors

ANZCA fellows look to their council for guidance, knowledge and advice on key issues and practices in anaesthesia. Here, we farewell five councillors and acknowledge their significant contribution.

PROFESSOR DAVID A SCOTT

David Scott was elected to the ANZCA Council in 2008, was honorary treasurer from May 2014 to May 2016, and held office as ANZCA president from May 2016 to May 2018. He is a clinical professor with the University of Melbourne and director of the Department of Anaesthesia and Acute Pain Medicine at St Vincent's Hospital in Melbourne.

David has been chair of the Safety and Quality Committee and previously chair of Examinations. He is currently chair of the Research Committee. He has also served as chair of the Cardiothoracic, Vascular and Perfusion Special Interest Group. He is a past member of the Australian Drug Evaluation Committee of the Therapeutic Goods Administration and the Victorian Consultative Council for Anaesthetic Morbidity and Mortality. David worked as a final examiner for the college for 12 years and was chair of the Final Examination Committee for two years.

In 2017, during David's term as president, research funding to support fellows reached a record $A1.74 million, and an Emerging Investigators Sub-Committee was established to support the next generation of researchers.

Other initiatives that were either introduced or enhanced during his presidency include the development of a first-ever Joint Position Paper on Day Surgery in Australia with the Royal Australasian College of Surgeons and the Australian Society of Plastic Surgeons, further progressing the evolution of perioperative medicine, strengthening international relations with our sister colleges and societies overseas, and developing the college's five-year strategic plan including strategies for overseas aid work and Indigenous health.

David also strongly supported council's advocacy for marriage equality, and led the ANZCA review which preceded the development of the strategic framework to address bullying, discrimination and sexual harassment, and the college's Doctors' Support Program.

His clinical interests include regional anaesthesia, acute pain management, vascular and cardiac anaesthesia. He has researched and published extensively in these areas, especially with respect to acute pain management techniques, regional anaesthesia, patient blood management and cognitive outcomes and anaesthesia. David completed a PhD in the area of neuropathic pain in 2004 and has been a co-editor of the upcoming and last three editions of *Acute Pain Management: Scientific Evidence*.

He was awarded his FFARACS in 1986 (and then FANZCA in 1992). He was elected to fellowship of the Faculty of Pain Medicine, ANZCA in 2005. His current research interests are safety and perioperative complications, and particularly cognitive outcomes and delirium following anaesthesia and surgery and their relationship to biomarkers of neuronal injury.

David is recognised nationally and internationally for his clinical and academic excellence.

ASSOCIATE PROFESSOR MEREDITH CRAIGIE

As FPM dean from May 2018 to May 2020 Meredith was a member of the ANZCA Council. She joined the FPM Board in 2012 and as dean and vice-dean sat on the FPM Board Executive Committee.

She led the faculty's Curriculum Redesign Project and chaired the Training and Assessment Executive Committee from 2016-18. She represents the faculty on the Pain in Childhood Special Interest Group of the Australian Pain Society. She was an FPM examiner from 2002-2017, chairing the Examinations Committee in 2011-2012 and again in 2017.

She trained in medicine followed by anaesthesia and intensive care in Adelaide, further specialising in paediatric anaesthesia in the United Kingdom. She later completed a Masters of Pain Medicine at Sydney University.

Meredith works at the CALHN Pain Management Unit at the Queen Elizabeth Hospital in Adelaide and is a Clinical Associate Professor at the University of Adelaide.

Her interests include medical education, pain in childhood and adolescence, persistent pelvic pain and transition from acute to chronic pain. Meredith was a foundation board member of the Pelvic Pain Foundation of Australia and has participated in overseas aid programs with Flinders Overseas Health Group. She was the recipient of the inaugural Steuart Henderson Award in 2017.

Introducing our new councillors

DR ROWAN THOMAS

Rowan Thomas joined ANZCA Council in 2014. At that time he was deputy director of Anaesthesia at St Vincent's Hospital, Melbourne. Since then he has continued as a staff specialist anaesthetist in Melbourne and worked for a two-year period as the group chief medical information officer at St Vincent's Health Australia.

On council he helped establish and now chairs the Information and Communications Technology Governance Committee, promoting information security improvements and establishing an ICT strategy as well as oversight of major projects.

He is a former medical editor of the *ANZCA Bulletin*, contributed to the audit modules for continuing professional development, evaluated and edited training materials on Networks and developed materials to assist in the "Promotion of good practice and management of poor performance in anaesthesia and pain medicine".

He contributed to the Professional Affairs Executive Committee, the Education Executive Management Committee and the Education Development and Evaluation Committee and has played an active role in hospital accreditation, staff excellence awards, trainee performance review and appeals committees.

DR CHRISTINE VIEN (New Fellow Councillor)

Dr Vien underwent anaesthesia training in Victoria, and now holds a full-time public position at St Vincent's Hospital in Melbourne.

She was new fellow councillor from 2018-20 and was the first sitting ANZCA councillor to have a baby during her term (her daughter Ella even made a brief appearance on Zoom before the start of the college's first virtual annual general meeting in May this year).

Dr Vien has particular interests in regional and paediatric anaesthesia, having completed sub-specialty fellowships in regional anaesthesia at St Vincent's Hospital and paediatric anaesthesia at the Royal Children's Hospital in Melbourne.

Aside from clinical roles, her experiences extend to medical management – having membered and chaired a number of committees at Monash Health and ANZCA during her specialist training, focusing on the welfare and training of junior doctors.

DR SIMON JENKINS

Simon Jenkins joined ANZCA Council in 2014 and stepped down as councillor in late 2019. He was a deputy chair of the Professional Affairs Executive Committee, was a member of the Education Executive Management Committee and Diving and Hyperbaric Medicine Workgroup and continues as a member of the Safety and Quality Committee. He chairs the college's Mortality Sub-Committee that produces *Safety of Anaesthesia: A review of anaesthesia-related mortality reporting in Australia and New Zealand*.

Simon is a clinical anaesthetist and former director of the Department of Anaesthesia and Divisional Director of Critical Care at the Lyell McEwin Hospital in Adelaide, South Australia.

His interests include emergency anaesthesia, difficult airway management, healthcare reform, human factors and sailing.

DR DEBRA DEVONSHIRE

Dr Debra Devonshire was awarded her FANZCA in 1998 and was elected to ANZCA Council in May 2020. She's a visiting medical officer at Monash Health, Cabrini and Peninsula private hospitals.

She's eager to continue developing ANZCA as an innovative leader while respecting the traditions of all those who've contributed time and effort before. As a member of multiple college committees, she has the skills to collaborate with all levels of stakeholders.

Debra is involved in both public and private practice giving her breadth across multiple anaesthesia view points. Education is a current focus for her, and she's the chair of our CPD committee.

DR STU MARSHALL

After completing his anaesthesia training across the UK, NZ and Australia, Stu has held a number of diverse roles in education, research, professional affairs, in academic, public and private anaesthesia.

In addition to clinical work, his research has centred around safety, education and innovation. Stu holds an National Health and Medical Research Council (NHMRC) ECR fellowship examining clinical human factors and applies this work at the Australian Centre for Health Innovation in Melbourne.

Stu founded an Australian registered charity for clinical education in low-income countries, which has given him valuable board experience.

He is now a consultant anaesthetist at Peninsula Health, an EMAC supervisor at Monash University/Epworth and a senior research fellow in anaesthesia at Monash University.

He was the founding president of the International Clinical Skills Foundation and is on the editorial board (International Advisory Panel) of the *Anaesthesia* journal and assistant editor for the SESAM official journal *Advances in Simulation*.

PROFESSOR DAVID STORY

Professor David Story is foundation chair of Anaesthesia and Deputy Director of the Centre for Integrated Critical Care at the University of Melbourne. He is a part-time staff anaesthetist at the Austin Hospital in Melbourne where his clinical work is predominantly perioperative care for sicker adults including for liver transplantation.

His research includes perioperative outcomes and models of care; applied physiology including acid-base disorders; environmental aspects of anaesthesia; and surveys. He is also a consumer investigator in diabetes care. He studied medicine at Monash University and also graduated with a bachelor of medical sciences on exercise at high altitude. David received his FANZCA in 1997. His doctorate from the University of Melbourne (2004) is on simplifying the Stewart approach to acid-base disorders.

David chairs the ANZCA Safety and Quality Committee and is deputy chair of the ANZCA Research Committee. He has been a member of the ANZCA Clinical Trials Network since its inception in 2003 and is a member of the ASM and Events Planning Committee. He was an examiner in the ANZCA primary exam for 12 years. His government roles have included being on the council of the National Health and Medical Research Committee (NHMRC) and the Victorian Perioperative Consultative Council.

David was elected to ANZCA Council in May 2020.

DR TANYA SELAK

Tanya Selak joined the ANZCA Council in May 2020. Tanya is a specialist anaesthetist working in public and private practice in Wollongong, NSW.

She commenced anaesthesia training in Auckland, moved to London to continue her training before immigrating to Australia. Tanya was the joint head of department at Wollongong and Shellharbour hospitals for five years, is a member of the International Advisory Panel of the Anaesthesia journal and completed a masters of health administration. Her main area of clinical interest is head and neck anaesthesia.

Tanya has a large social media presence where she explores novel communication strategies to promote fellows, trainees, anaesthesia and interdisciplinary and international collaboration. She can be found on Twitter as @GongGasGirl.

DR MARYANN TURNER (New Fellow Councillor)

Dr Maryann Turner is a paediatric anaesthetist with fellowship experience at London's Great Ormond Street Hospital, Auckland's Starship Hospital, and Queensland Children's Hospital.

Her longstanding interest in advocacy, wellbeing, research and education led to co-chairing the 2017 ANZCA Trainee Committee, co-establishing Australia's first anaesthesia trainee-led research network and engagement with multiple ANZCA committees, working groups and special interest group executives.

Before becoming an anaesthetist, Maryann was admitted as a lawyer of the NSW Supreme Court; completed a masters in medical law; and worked in corporate and criminal law, providing insight into governance issues.

ASSOCIATE PROFESSOR MICK VAGG (FPM Dean)

Associate Professor Michael Vagg is a specialist pain medicine physician and a rehabilitation physician. He graduated from Monash University in 1994 and spent several years as a uniformed medical officer in the Royal Australian Air Force before undertaking vocational training.

He is a director of Pain Matrix, a private comprehensive pain service in Geelong, clinical director of rehabilitation and pain services at Epworth Geelong and a clinical senior lecturer at Deakin University Medical School.

He writes regularly for The Conversation as a health and medicine columnist. His areas of clinical interest include soft tissue pain, postamputation pain and interventional pain treatments.

CHAIRS OF COMMITTEES THAT REPORT TO ANZCA COUNCIL	
ANZCA Executive Committee	Dr Vanessa Beavis
ANZCA Information and Communications Technology (ICT) Governance Committee	Dr Rowan Thomas
ANZCA Research Foundation Committee	Dr Rod Mitchell
Education Executive Management Committee	Associate Professor Leonie Watterson
Finance, Audit and Risk Management Committee	Mr Richard Garvey
International Liaison Committee	Dr Michael Jones
Perioperative Medicine Steering Committee	Dr Vanessa Beavis
Professional Affairs Executive Committee	Dr Nigel Robertson
Research Committee	Professor David A Scott
Safety and Quality Committee	Professor David Story
Training Accreditation Committee	Dr Mark Young

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Robert Orton Medal

Professor Milton Cohen AM

The Robert Orton Medal is awarded at the discretion of ANZCA Council, the sole criterion being distinguished service to anaesthesia, preoperative medicine and/or pain medicine. The award was established by the Faculty of Anaesthetists, Royal Australasian College of Surgeons, in 1967.

Professor Milton Cohen AM graduated in medicine and surgery with first class honours from the University of Sydney in 1972, achieved fellowship of the Royal Australasian College of Physicians in 1978, specialising in rheumatology and Doctor of Medicine (Sydney) in 1985. His realisation that pain was the most daunting challenge for his patients and himself as a physician led him to join the St Vincent's Hospital (Sydney) pain clinic in 1988.

Milton has made significant and lasting contributions to the Faculty of Pain Medicine and ANZCA, and the discipline of pain medicine in Australia and internationally as a leader, clinician, teacher, researcher and mentor. He made major contributions to the recognition of pain medicine as a medical specialty in Australia in 2005 and as a scope of practice in New Zealand in 2012. Milton was appointed as a Member of the Order of Australia in the 2019 Australia Day Honours.

Milton was a foundation board member and third dean of the Faculty of Pain Medicine from 2004-06. He has served the faculty in many roles including as the chair of the Education Committee that developed the foundation curriculum in 1998 establishing the faculty as a world leader in pain medicine. Milton has been the Director of Professional Affairs since 2010 and chair of the faculty's Learning and Development Committee. He remains active in many other organisations including the International Association for the Study of Pain, and as an adviser to federal and state governments. Milton has taught extensively, published more than 100 articles in peer reviewed journals and more than 30 book chapters and is a senior editor for the journal *Pain Medicine*. He is recognised for his incisive analysis and wise counsel.

Professor Milton Cohen is a worthy recipient of the Robert Orton Medal in recognition of his significant and lasting contributions to the Faculty of Pain Medicine, the college and pain medicine internationally.

Dr Meredith Craigie
Immediate Past Dean,
Faculty of Pain Medicine

Steuart Henderson Award

Dr Damian Castanelli

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

Have you ever wondered why the ANZCA training program uses workplace-based assessments (WBAs) to inform decisions about competence and progression?

In the not-so distant past, trainees progressed through ANZCA training without any robust assessments of their competence, and their performance in the examinations was the primary measure of progress. That all changed with the introduction of the 2013 curriculum and greater emphasis on performance in the workplace, its assessment through WBAs, and a clearly articulated curriculum through learning outcomes. One of driving forces and leaders behind these developments has been, and continues to be, Dr Damian Castanelli.

Damian's achievements in medical education, training and influence are both exceptional and numerous. He has mentored and guided hundreds of Victorian trainees as a supervisor of training and as the education officer. He was a final examiner for 11 years, and a member of the Final Examination Sub-Committee. Damian was chair of the Education Development and Evaluation Committee until 2019, and continues to be a member of that committee and the Education Executive and Management Committee. He has contributed to many college educational offerings including the curriculum and the diploma in hyperbaric medicine.

Damian has been an inspirational mentor and provided support and guidance for new researchers and committee members. Perhaps most importantly, Damian's research, as well as his collaborations with other educational leaders, has informed and significantly influenced the development of the ANZCA training program and demonstrated that it is a world-class, robust program. He has been the recipient of multiple ANZCA research grants exploring aspects of the ANZCA training program. The findings from these projects have provided evidence in support of ANZCA training as well as shaping the development of new resources and the future directions of the program.

Damian welcomes diversity of ideas and innovative approaches, encourages participation, and recognises and promotes the skills and expertise of others. Damian's achievements make him a very worthy recipient of the 2020 Steuart Henderson Award.

Dr Jennifer Woods, FANZCA
Chair, Education Development and Evaluation Committee

These awards were due to be presented at the 2020 Annual Scientific Meeting (ASM) in Perth this year. Plans are under way for them to be presented at the 2021 ASM in Melbourne next May.

ANZCA and FPM in the news

COVID-19: fit testing and elective surgery key topics for media

COVID-19 HAS DOMINATED ANZCA and FPM media coverage since the last *ANZCA Bulletin* with President Dr Vanessa Beavis and Immediate Past President Dr Rod Mitchell being interviewed on issues including fit testing and elective surgery for broadcast, print and online media articles and stories in Australia and New Zealand.

In her first media interview since taking office in May Dr Beavis appeared live on Radio New Zealand's *Saturday Morning* program with Kim Hill on 9 May in which she discussed the build-up to the COVID-19 response in New Zealand. For 35 minutes Dr Beavis talked about the enormous work that went into preparing hospitals for the possible "tsunami" of COVID patients and the consequent move to working on the backlog of elective surgery. The interview was also compiled into an article on stuff.co.nz and this attracted an audience of 270,000 readers.

Dr Beavis also featured in the popular online New Zealand news site The Spinoff on 22 May. The article "Doctors without orders: How the new ANZCA president is handling surgery during Covid-19" examined the challenges she faced when taking charge of one of Australasia's largest medical colleges in the middle of a pandemic. This reached an audience of 40,000 people.

The issue of elective surgery and COVID-19 continued to attract media interest. Dr Beavis was interviewed by *The Sydney Morning Herald* about elective surgery waiting lists on 17 June and proposals to expand operating hours in NSW to clear the backlog. Dr Beavis stressed that patient safety needed to be considered and a long-term sustainable plan needed. The article also ran in *The Age*, *WA Today* and *Brisbane Times* online reaching an audience of 700,000 people.

Dr Mitchell also featured in several broadcast and print articles about elective surgery, the supply of personal protective equipment (PPE) and fit testing issues following the release of the college's joint statement with the Royal Australasian College of Surgeons welcoming the Australian government's resumption of elective surgery.

He was interviewed for the ABC's national AM program on 20 April on elective surgery and why its resumption needs to be carefully controlled and monitored. This reached an audience of 450,000 people. He was also interviewed by ABC Radio Melbourne's morning host Virginia Trioli on 21 April in a five-minute interview which reached an audience of 140,000 people.

ANZCA was also referenced in several online print and online articles in News Limited publications on 21 April about our support of controlled elective surgery. This included a *Herald Sun* page one article.

News bulletins on radio stations 3AW in Melbourne, 6PR in Perth and 4BC in Brisbane and regional stations also broadcast audio grabs of Dr Mitchell in their news bulletins on 21 April. He was also interviewed for Channel Seven Melbourne on 19 April via zoom for a news report on elective surgery.

Other media coverage of Dr Mitchell included an article in the *Weekend Australian Financial Review* on 18 April following our joint elective surgery statement with RACS. This attracted 45,000 readers. Dr Mitchell also featured in an online *Guardian Australia* article on fit testing and why it's important.

Dr Mitchell was interviewed by ABC Radio Sydney on April 10 for radio news bulletins about the supply of PPE in Australia and whether it had improved. ABC Radio Sydney and ABC regional radio stations ran audio segments on April 11.

ANZCA fellows working on hospital COVID-19 frontlines around Australia have been profiled in several print, online and broadcast stories. Sydney Royal North Shore Hospital specialist anaesthetist and former ANZCA councillor Dr Michelle Mulligan was profiled in a 2000-word article in the *Australian Financial Review* on 9 April. Dr Mulligan oversaw the set-up of a new high dependency unit at the hospital in preparation for an influx of COVID-19 cases.

FANZCA and FFPMANZCA Dr Jennifer Stevens was interviewed for a feature article for *Marie Claire* magazine on 11 May on how healthcare workers and specialists are dealing with the coronavirus in their hospitals. Westmead Hospital anaesthetist Dr Kanan Shah, a past co-chair of the ANZCA Trainee Committee, was profiled in a *Vogue Australia* feature article that highlighted the role of essential workers during the COVID-19 pandemic.

Professor David Story, ANZCA councillor and chair of the Safety and Quality Committee, and fellow Dr David Wright were featured in an ABC Four Corners program *Flattening the Curve* on 4 May. The anaesthetists were two of several specialists and healthcare workers across Australia who kept video diaries for five weeks so they could record their thoughts and reactions as the pandemic unfolded around them.

Professor Story was also interviewed for a *Sydney Morning Herald* article on 26 May that examined counterfeit masks in Australia. Professor Story said he was concerned about fake N95 masks "putting lives at risk." The article was also syndicated to *The Age*, *Brisbane Times* and *WA Today* and reached an audience of 750,000 people. The issue was followed up by Australia's *A Current Affair* television program which ran a four-minute segment on 20 June featuring an interview with Professor Story. The segment attracted an audience of 850,000 people.

A *Guardian Australia* podcast and online article on the mechanics of intubation and how ventilators work on March 31 also featured Professor Story. He was also interviewed for Ten News Melbourne and Channel Seven news reports on April 10 about how the Centre for Integrated Critical Care is working with engineering company Grey Innovation to manufacture 2000 ventilators in two months.

Newly elected ANZCA councillor, Wollongong anaesthetist Dr Tanya Selak, was profiled in a 950-word article in the *Illawarra Mercury* on 15 April. The article included a page one photograph of Dr Selak and was syndicated to more than 100 Australian Community Media online titles with an audience of over one million people including *The Bendigo Advertiser*, *The Canberra Times* and *The Border Mail*.

Fellow and anaesthesia researcher Professor Paul Myles and ANZCA's Clinical Trials Network was the focus of an article in *The Age* and *Sydney Morning Herald* "Thousands of elective surgery patients to be screened for COVID-19" on 13 June which highlighted a new research project across 14 Australian public and private hospital testing sites initiated by a national elective surgery taskforce. The article, which also ran online in *WA Today* and *the Brisbane Times* websites reached an audience of 900,000 people.

Melbourne FANZCA, Associate Professor Forbes McGain, featured in a page one article "Hood of hope for COVID-19 patients" and photo in the *Herald Sun* on 9 April for his work with engineers developing a protective hood for COVID-19 patients in just 12 days. The 350-word article reached an audience of over 300,000 people.

The Age and *Sydney Morning Herald* on 15 May reported on a study by Melbourne doctors that examined the effectiveness of aerosol boxes. FANZCA Dr Jonathan Begley was the lead author in the study reported in *Anaesthesia*, that examined the effectiveness of aerosol boxes. The study found that instead of shielding medical staff from infectious droplets the devices could actually put them in more danger and threaten the lives of their critically ill patients. The article attracted 400,000 readers.

FPM Dean Associate Professor Mick Vagg was interviewed by *The Medical Republic* for an article on 15 June about the faculty's $A1.2 million grant from the Therapeutic Goods Administration to expand the Better Pain Management e-learning opioid modules for GPs and other health practitioners. He also featured in an ABC multi-platform package of stories highlighting an opioids educational video produced by the faculty with NPS MedicineWise. Articles were also included in *Australian Doctor* and an interview with the dean was broadcast on the National Radio News network of Australian community radio stations. These reports reached an audience of more than three million people.

Associate Professor Vagg was also interviewed by Australian Associated Press about the latest Australian Institute of Health and Welfare report on chronic pain. The story was syndicated to 100 online media outlets on 7 May, reaching a combined audience of over one million people. Associate Professor Vagg also featured in *The Conversation* with an opinion piece that tied in with the release of the report.

Paediatric anaesthetist Associate Professor Justin Skowno was interviewed for a 60 Minutes segment on the Nine Network on 7 June that examined the gas pipeline tragedy at Bankstown-Lidcombe Hospital in 2016. Nitrous oxide was attached to the oxygen outlet, with doctors and nurses having no idea of the mistake. Associate Professor Skowno said oxygen deprivation could result in irreversible brain damage in newborns. The program reached an audience of 1.2 million people.

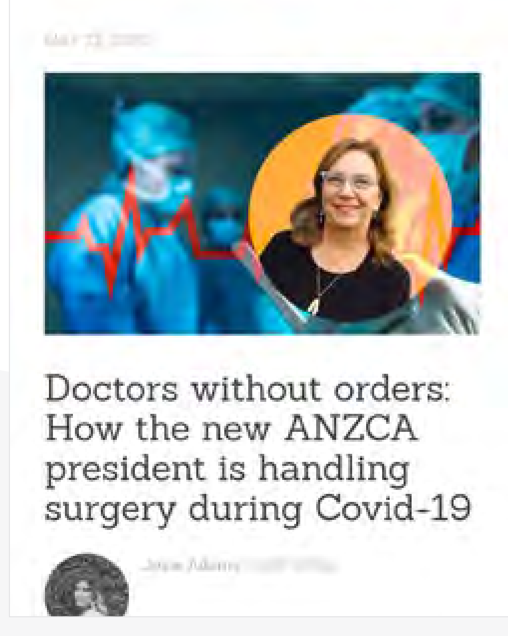
ANZCA's immediate past New Zealand National Committee chair Dr Jennifer Woods was quoted in a stuff.co.nz article on 22 June "Calls to review Pharmac model after more drug shortages" about the role of Pharmac in ensuring adequate drug supplies.

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

- 12 print reports.
- 150 radio reports.
- 252 online reports.
- 6 TV reports.

Since the Autumn *Bulletin* the communications team has distributed two media releases which can be found at anzca.edu.au/communications/media/media-releases-2020.

Right: Professor David Story on *A Current Affair* and ANZCA President Dr Vanessa Beavis features in The Spinoff.


THE SPINOFF

Doctors without orders: How the new ANZCA president is handling surgery during Covid-19

This advertisement is for medical professionals only and has been removed for this edition.

ANZCA and government

Aboriginal and Torres Strait Islander medical specialists report

Australia

Indigenous report released

The COVID-19 pandemic continues to dominate our advocacy and government relations work on issues such as personal protective equipment (PPE), telehealth, workforce, scopes of practice and drug shortages. Nevertheless, other work continues in the background and May saw the release of a landmark report that represents more than two years of work between specialist medical colleges, the Australian Indigenous Doctors' Association (AIDA) and the Department of Health. This important project will serve to focus college activities to improve health outcomes for Australia's First Nations people in the coming years.

Addressing the health and wellbeing of Aboriginal and Torres Strait Islander people is an urgent priority due to significantly poorer health outcomes compared to non-Indigenous Australians. As one of Australia's largest specialist medical colleges, ANZCA is a trusted and respected organisation in society and has a responsibility to improve equity in healthcare for all Australians and New Zealanders. In 2018 the college launched an Indigenous Health Strategy accompanied by an action plan that identifies a number of initiatives to tackle health inequities across a broad range of college activities.

As a training college, the specialist medical workforce represents a core pillar of ANZCA's strategy to addressing inequities in Indigenous health. Evidence has shown that medical workforces that are more representative of Indigenous communities are more likely to understand and be responsive to the needs of these communities and to deliver culturally appropriate care. Workforce development involves increasing recruitment, retention and support of Indigenous health practitioners. It also involves ensuring that non-Indigenous health practitioners are equipped to practice in a culturally safe and responsive manner to improve the ability of mainstream care to meet the needs of Indigenous people.

Despite improvements over the past decade, Aboriginal and Torres Strait Islander health practitioners remain significantly under-represented in the workforce. While 3.3 per cent of the Australian population identify as Aboriginal and Torres Strait Islander, less than 1 per cent of medical practitioners, registered nurses and dental practitioners are represented by First Nations people. Medical Board of Australia data reveals that of Australia's approximately 71,700 medical specialists around 110 (or 0.15 per cent) identify as Aboriginal and Torres Strait Islander. At ANZCA, Aboriginal and Torres Strait Islander people represent 0.1 per cent of fellows and 0.6 per cent of trainees.

There are a number of barriers to entering the health workforce, including financial hardship, reduced access to secondary and tertiary education, lack of access to information about higher education, and policies that focus on enrolment rather than graduation quotas. Doctors who are Aboriginal or Torres Strait Islander often face extra challenges in the workplace, such as discrimination.

In 2017 the Australian Department of Health funded AIDA to work with specialist medical colleges to devise practical and achievable ways to increase the recruitment and retention of Aboriginal and Torres Strait Islander doctors into medical specialties. The first stage of the project involved colleges providing AIDA with information on what activities they were already undertaking to address the under-representation of Aboriginal and Torres Strait Islander peoples in their membership. Using this as a baseline, an AIDA-led group of college representatives and organisations in the field of medical education, training and regulation, worked for two years in close collaboration to develop a set of nine minimum standards and six best practice standards.

College presidents endorsed the proposed 15 standards at a meeting of the Council of Presidents of Medical Colleges in late 2019 and agreed to publicly report their progress towards implementing the standards every two years. The first biennial report was released in May and is available on the websites of AIDA, the Council of Presidents of Medical Colleges and the Medical Workforce Reform Advisory Committee. The report lists the activities undertaken by 14 of the 15 specialist medical colleges to progress the implementation of each of the minimum and best practice standards. It represents a baseline against which our progress can be measured in the coming years. It is intended that implementation of the standards will:

- Build the capacity of colleges and their members to provide culturally safe care to Aboriginal and Torres Strait Islander patients.
- Foster a more culturally safe work and learning environment for Aboriginal and Torres Strait Islander doctors.
- Provide improved support to Aboriginal and Torres Strait Islander doctors throughout their training and into successful fellowship.
- Embed the standards into policies and structures, thereby enhancing longevity and mitigating the risks of a decrease in prioritisation or dismantling already achieved successes.

ANZCA already meets many of the standards and will continue to work towards meeting, and exceeding, all 15 as we implement our Indigenous Health Strategy over the coming years. Since the launch of the strategy, ANZCA has commenced dozens of initiatives across every area of the college including:

- The establishment of a project group to review Indigenous culture and health learning outcomes in the anaesthesia and pain medicine training program curricula.
- A new career and professional advice service for Indigenous medical students and prevocational doctors.
- Developing a guide for staff and fellows to provide appropriate acknowledgment to the Aboriginal and Torres Strait Islander people of Australia and Māori of Aotearoa New Zealand at events and meetings.
- Relocating cultural competency under the continuing professional development program to the practice evaluation category.
- New scholarships to provide financial assistance to Aboriginal, Torres Strait Islander and Māori trainees to attend regional trainee exam preparation courses.
- Introducing events at ANZCA House to mark National Reconciliation Week.
- Building closer relationships with key stakeholders including the Australian Indigenous Doctors' Association, Leaders in Indigenous Medical Education, the National Aboriginal Community Controlled Health Organisation and Te Ohu Rata o Aotearoa (Māori Medical Practitioners).

The 15 practice standards to attract, recruit and retain Aboriginal and Torres Strait Islander specialist trainees.

MINIMUM STANDARDS

1. Develop or update and implement a Reconciliation Action Plan.
2. Collect, update and report data on the number of applicants, trainees, and fellows, identifying as Aboriginal and Torres Strait Islander, including data on retention and graduation.
3. Establish and sufficiently fund an Aboriginal and Torres Strait Islander health committee.
4. Aboriginal and Torres Strait Islander histories, cultures and health must be a mandatory and assessed learning objective and part of the curriculum for all specialist college trainees.
5. All specialist medical colleges and their training curricula actively support practical experience in Aboriginal and Torres Strait Islander health.
6. High visibility of Aboriginal and Torres Strait Islander health, peoples, and workforce at the college and college website.
7. Use the definition of cultural safety developed and endorsed for the National Registration and Accreditation Scheme throughout all college materials.
8. Engagement with AIDA.
9. Engagement with AIDA's annual conference.

BEST PRACTICE STANDARDS

1. Specialist medical colleges provide scholarships, bursaries, awards and resources for Aboriginal and Torres Strait Islander medical students and doctors to support their pathway into practice and specialisation.
2. Specialist medical colleges develop and apply targeted selection strategies for Aboriginal and Torres Strait Islander applicants meeting college selection standards.
3. Specialist medical colleges are responsible for ensuring access to mentoring and support for Aboriginal and Torres Strait Islander trainees.
4. All members of specialist medical colleges undergo ongoing and accredited cultural safety training as part of professional development activities. Specialist medical colleges provide cultural safety training for their staff.
5. Specialist medical colleges develop an Aboriginal and Torres Strait Islander health strategy.
6. As part of their advocacy role, specialist medical colleges have a responsibility to take a public stance by developing and publicising position statements on issues relevant to Aboriginal and Torres Strait Islander health and workforce.

ANZCA Indigenous Health Strategy framework

Governance
ANZCA will ensure Aboriginal, Torres Strait Islander and Māori voices are represented at high levels across its governance structure.

Partnerships
ANZCA will develop relationships and work together with Indigenous community groups, consumers, academic groups, service providers, and health organisations.

Workforce
ANZCA will develop initiatives to support recruitment and retention of Indigenous doctors, undertake education through its training, curriculum and CPD programs, and strengthen cultural safety training for all trainees, fellows and ANZCA staff.

Advocacy
ANZCA will advocate for health equity issues to be addressed across a wide range of spheres, including research, education, policy and service provision.

New Zealand

COVID-19 recovery is eclipsed by overhaul review of the health system

While the pandemic still dominates policy work in the New Zealand office with ongoing issues around PPE, telehealth, resuming elective surgery and other issues, the mid-June release of the long-awaited Health and Disability System Review has shifted attention for all health organisations. The review was due to be released in March but the government put that on hold as the country dealt with the pandemic.

Across the board, medical bodies welcomed the recommendations on the future of what has been described as an underfunded and fractured health service at both primary and secondary level. The big take home is the recommendation that the existing 20 district health boards be reduced to between eight to 12 bodies over the next five years. The report has also proposed that a new Crown entity called Health NZ be set up. This would have accountability over DHBs, and would in turn be accountable to the health minister. There would also be a Māori Health Authority established, "to include specific provisions for commissioning Māori health services".

The Māori Health Authority proposal has been welcomed with some reservation that it doesn't go far enough. "An independent, empowered and empowering Māori Health Authority must have the teeth to implement the bold transformation required to improve health outcomes for Māori," said Helen Leahy, pouārahi of Te Pūtahitanga o Te Waipounamu, the Whānau Ora Commissioning Agency (South Island).

The review stresses the importance of a population health approach and notes that "improving population health must become the driver of all planning within the system".

"COVID-19 brought into sharp relief the critical role and importance of population health measures," president of the College of Public Health Medicine, Dr Felicity Dumble said.

Health workers and specialists' unions have welcomed a shake-up of the "fractured" system while one health academic commented that the focus on community and better responsiveness is heartening. Dr Anna Matheson, senior lecturer in health policy, School of Health at Victoria University of Wellington said, "In 2008 the World Health Organization's Commission on the Social Determinants of Health reviewed the global evidence of what causes health and illness. It concluded that most of health and equity is created in the places we are born, live, work and play – our communities. It is pleasing that there is recognition of this evidence."

However as the country moves towards the 19 September general election, it is likely that these recommendations will be put aside as the lobbying and electioneering that were hold during lockdown, begin in earnest.

Submissions – Australia

- Department of Health: Consultation on Medicare Benefits Schedule specialist services for possible expansion to phone and telehealth.
- New South Wales Parliament: Inquiry into the current and future provision of health services in the south-west Sydney growth region.
- Therapeutic Goods Administration: Review on the safety of low dose cannabidiol.

Submissions – New Zealand

- Ministry of Health: Review of the Burial and Cremation Act 1964 and Related Legislation.
- Medicines Classification Committee, MEDSAFE: Reclassification of Pholcodine to a restricted medicine.
- Ministry of Health: Draft terms of references for performance reviews of regulatory authorities
- Medical Council of New Zealand: Revised statement on Unprofessional behaviour: How it impacts patient safety and team based care.
- Accident Compensation Corporation: Request for data on ANZCA's NZ based membership.

College meets the COVID-19 challenge

In just months since the world first heard of COVID-19, our fellows, trainees and the college have confronted and managed the many challenges of a pandemic of a new and dangerous virus.

IN MARCH ANZCA created the COVID-19 Clinical Expert Advisory Group (CEAG) to provide urgent guidance on how to manage patients while not contaminating ourselves or other members of the team. The result was the ANZCA statement on personal protective equipment and its accompanying flowchart – excellent documents released in April and regularly updated. Credit is due to CEAG for the enormous volume of work that they did, and in particular to Associate Professor Leonie Watterson.

CEAG also curates the resources on COVID-19 for the ANZCA Library Guide.

The college has also responded quickly to concerns about supply chains and drug shortages. It has amended the *PS51 Guidelines for the Safe Management and Use of Medications in Anaesthesia*, to allow for safe ampoule splitting in certain circumstances. The new version is in the pilot phase.

The ANZCA and FPM CPD Committee also moved quickly to develop and approve a COVID-19 airway management emergency response standard.

Meanwhile, the college is planning to ensure that our trainees are disrupted as little as possible by the impact of the pandemic on training. Sound educational principles have guided our decision-making on education and training. They provide the framework for the college's position when an individual's training is disrupted by COVID-19.

After the May vivas were postponed, ANZCA sought the views of trainees on whether to run the exams this year. As a result, ANZCA Council decided at an extraordinary meeting on 12 May 2020 that the anaesthesia primary and final exams will go ahead in the second half of 2020 if at all possible.

The situation may change and the college is working on a comprehensive plan, with contingencies, including holding viva examinations in New Zealand if travel restrictions are still in place. The Faculty of Pain Medicine exams would also go ahead as planned.

Meanwhile, other college business continues. We are working on ways to hold scientific meetings and other courses and events differently, with more webinars and online learning on the horizon.

A world dominated by COVID-19 is far from over, but a lot of good work by the college from the early stages of the pandemic means we are well positioned to manage whatever comes our way in the coming months, and to make use of the opportunities that it brings.

Dr Vanessa Beavis
ANZCA President

Anaesthesia post-COVID-19: What needs to change?

It has been called a reset. There is no going back to business as usual. The COVID-19 pandemic has changed how we do things. In health and in the practice of anaesthesia, this especially rings true.

"I BELIEVE WE will look back on this time with a certain degree of horror. Horror about how we actually managed to get through it...I think what this period has thrown up for me is the fragility of the system," said Dr Nigel Robertson as he addressed a packed webinar on COVID-19 and anaesthesia held in early May.

The webinar was held just six weeks after New Zealand and parts of Australia had been put into lockdown and it appeared that community transmission of COVID-19 was being brought under control in both countries. Dr Robertson and others had a chance to reflect on where the pandemic had left the specialty and how it would have to change.

"So we have time to look to the future," said Dr Robertson, the former chair of the Safety and Quality Committee who also chaired the Clinician Expert Advisory Group that was set up by ANZCA as the pandemic swept the globe. He wanted to talk about the "new normal" and what it might look like for anaesthesia.

"It won't look anything like it did in January or February, or 2019, or before. I really think we have to reset our thinking around how we manage patients with transmissible diseases through the operating room and in our anaesthesia practice."

Dr Robertson and others see this as big strategic piece of work, both nationally and internationally.

That "fragility" that he talked about in the webinar was apparent throughout our health system where decisions had to be made in haste.

"We went from a standing start to where we are now in a matter of weeks."

That has raised some serious issues around pandemic preparedness and the operational aspects of planning at the frontline of healthcare. For instance, it was clear that even the existing guidelines on processes such as personal protective equipment (PPE) training and use had not been universally adopted.

However, the entire world was working on a novel and rapidly evolving crisis; the evidence on transmission and management of SARS-CoV-2 infection was sketchy, incomplete and often no better than expert opinion. This led to equally rapid development of guidelines and decision-making that was done with the best evidence available but which was confusing and conflicted at times.

The clear message is that countries and healthcare systems must learn from this and build a better and more resilient systematic response to deal with future threats.

"The clear message is that countries and healthcare systems must learn from this and build a better and more resilient systematic response to deal with future threats."

However the fragility wasn't only in patient management pathways but also in how at-risk staff were assessed and protected.

"COVID-19 has thrown up some questions about how we manage our workforce. We had staff who were deemed at high risk from SARS-CoV-2 infection and it took some time for clear guidance about work-place risk stratification to be issued," Dr Robertson said. "Some of our staff were unable to work for several weeks, even when they were well. That again shows a fragility in the system."

Understandably, the anxiety that staff were feeling watching COVID-19 overwhelm health systems overseas created yet another problem during the height of the pandemic and that had to be sensitively managed. This has highlighted the importance of wellbeing networks and support systems for all staff working in anaesthesia and the operating rooms

So how do we get that resilience in the health system for our specialty and what needs to change?

That, as Dr Robertson says, will take a great deal of reflection, research and analysis.

Adele Broadbent
Communications Manager, NZ

Planning for a pandemic

Here are some of the issues from the COVID-19 pandemic that we will all be looking at over the coming weeks, months and years.

- Adoption of public health measures to limit the impact of transmissible disease.
- Revised guidelines on the use and implementation of PPE for all staff managing hazardous patients.
- PPE fit-testing as part of employee on-boarding, and regular re-checks.
- Investment in remote patient consults/telehealth in pre-assessment clinics.
- Re-prioritisation of planned surgery in a constrained economic model.
- Less tolerance of "presenteeism" – in other words "stay home if you're sick"!
- Fewer face-to-face meetings and better use of IT for communication and education.
- More robust supply chains for essential equipment.
- Use of simulation to train for disaster scenarios.
- Improved craft-group collaboration (anaesthesia/intensive care unit/ emergency department).
- Re-design of hospital intensive care and operation room facilities to accommodate hazardous patients in isolation.
- Enhanced wellbeing and mentor networks that are interdisciplinary.

FROM THE GLOBAL ANAESTHESIA FRONTLINE

Anaesthetists have been at the forefront of COVID-19 response teams around the world. Here, ANZCA fellows, US anaesthesiologists and a Canadian emergency medicine doctor reveal how they have been coping.

Dr Kasia Tanguy, FANZCA

Anaesthetist

Polyclinique Saint George
Nice, France

SINCE 2009, I'VE been living and working in a large private hospital in sunny Nice on the Côte d'Azur, France, where we have prepared for a disaster that many believe will never reach us.

To date we have had "only" 860 deaths, which pales into insignificance alongside the chaos that befell Paris and the northeast.

My curiosity was initially piqued in late February when COVID-19 began to saturate the Italian health system. I followed our numbers closely, which appeared to be lagging by about 10 days. At the same time, the French media was reassuring us that it was nothing more than a bad flu season.

My ANZCA training pushed me towards "preparation", instituting protocols and running drills. But officially there was no formally recognised problem, and waiting for official guidance precluded us from initiating any individual protocols. I had trouble accepting this perceived inertia and was frustrated that my suggestions and input were rejected seemingly on the basis that I was overseas trained.

As our elective workload stopped and I had nothing better to do – I studied – even harder than for the primary exam. An old adage from my days as a trainee was "prepare for the worst and hope for the best" – and I did. My senses were heightened, the adrenaline was running, sleep was difficult and I occasionally felt overwhelmed.

By late March we still had no protocols in place. Other French regions were inundated by catastrophic numbers of patients. We had emails from them making us feel like the apocalypse was inevitable. I felt panicked and lacked confidence. We had very few masks due to theft and

delivery issues – the same for hydro alcoholic solutions. Our local response appeared lacking. So, I reached out to ANZCA and the next day I had a call that changed my perceptions.

It was reassuring to talk out my fears with an ANZCA colleague – not only for my physical health or that of my husband's, but for my ability to rise to the occasion. It was most disconcerting to be at odds with some of my colleagues. I missed the camaraderie. I missed having my husband in a good mood. I missed being in control of my life and destiny.

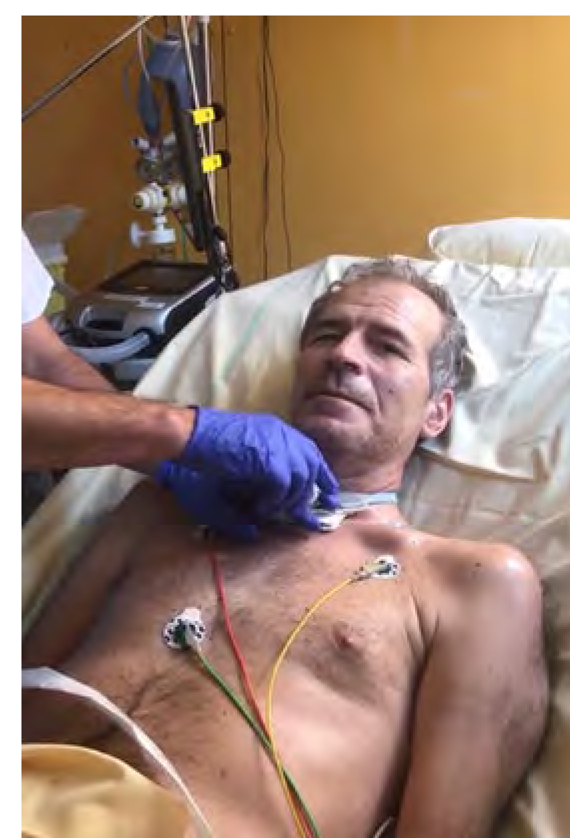
Our plastic surgery unit was converted into a COVID ward and intensive care unit (ICU), though the latter was never used. By comparison, for a period of 36 hours, Paris had only 10 ICU beds remaining for a catchment area of 12 million people. Our COVID ward was filled up by a revolving patient load – several of whom were triaged as not potential ICU candidates – a hard choice for French doctors where do not resuscitate orders or advanced health directives do not exist as we normally resuscitate everyone.

Very little general work was done. A 14-year-old lost his testicle due to late presentation of a torsion and another patient came in with a haemoglobin of 5g/dl due to a bleeding ulcer. The myocardial infarct waited for 15 days with chest pains before presenting and getting his stent. The on-calls were eerily quiet.

In the meantime, my brother in law Jean Michel was being transferred all over Paris, like a jumping Lima bean. Aged 57 and previously fit and well, he tested positive for SARS CoV-2 only in the last of his four tests. Communicating with his doctors was difficult as they were often too busy to speak. At first he simply had the classic symptoms of fever and fatigue. A week later he was transferred to hospital in the middle of the night and after five days he had an emergency intubation and the search was on for a ventilator. Then came the tracheostomy. One night we didn't even know where he was, following yet another transfer. Thankfully he is now recovering, and is very slowly on the mend.

Ready access to personal protective equipment has been problematic and it was hard to justify asking for the precious P2 mask – if the anaesthetist wanted one, then everyone else wanted one. And so for the most part we did without – it seems that in my hospital we got away with it. No healthcare workers (HCWs) are known to have become COVID positive.

The community has come together. Artists have 3D printed face shields for us to use as protection. At 8pm every night there is music and clapping in support of HCWs and I run errands in my spare time for the elderly couple two floors down. The green grocer puts a punnet of raspberries aside for me. Somewhere in the last eight weeks of confinement we've gotten used to the fear, and have learned to live with it. Every day new jokes arise and for everything that's lost, something new is found. For me it's been a rekindling of old friendships and becoming more independent.



Dr Tanguy's brother-in-law, Jean Michel Vialaneix, was a COVID-19 patient.

Left: Dr Tanguy in the Nice hospital where she works.

Below: Dr Tanguy (second from left) takes a break with colleagues.

It appears increasingly likely that COVID is a reality that's not going to magically disappear and that we will need to learn to function with it. At the same time, patients are scared of hospitals and thus are staying away. Diseases have not stopped, so it's time to go back to the general business of doctoring. The economy is a shambles.

Compared to February, I'm a much more relaxed individual – I am wary and respectful of COVID but it no longer scares the living daylights out of me. I am also ready for practice guidelines to change again. Being flexible appears to be part and parcel of new life post COVID.

My husband teases me that COVID will become my new sub-specialty. Our marriage has pretty much survived lockdown – some others didn't – domestic violence and mental health issues have been real problems. I've given up trying to predict what might happen. I accept we are heading into unchartered territories – some of it is frightening but it's invigorating as well.

I don't believe it has ever been as interesting to be an anaesthetist. As for the long term – I hope to come back to Australia – dealing with disaster preparation as a foreigner has made me long for the order and the sense of belonging to my Australian home.

Dr Henry Davidson, FANZCA

Attending (consultant) anesthesiologist
University of California

San Francisco, US

I AM AN Australian anaesthetist living in San Francisco, California. For the past 10 months I have been working clinically in the University of California, San Francisco (UCSF) hospital system. I initially came over as a fellow and have stayed on to work as an attending (consultant) anesthesiologist since obtaining my FANZCA. When the COVID-19 pandemic hit in March, my wife and children returned to Australia to self-isolate with family, and I am soon planning to return to Melbourne to join them.

Thankfully California, and particularly the Bay Area including San Francisco, has done remarkably well with controlling the viral spread. This is thought to be due to a number of factors, although the reasons are still not fully understood. We now know from post-mortem data that California's first death from COVID-19 was in January. Serological studies have revealed a higher prevalence of antibodies among the population than testing has, albeit with large confidence intervals and some inherent inaccuracies of the testing process. This has prompted some speculation that there was COVID-19 circulation in the community ahead of the known breakout time.

Dr Henry Davidson

I believe most credit goes to the fact that California was the first state to initiate a state-wide shelter-in-place order and closure of non-essential businesses. For this, we're grateful to San Francisco Mayor London Breed and the Governor of California, Gavin Newsom. However, even before this in early-March the tech companies including Facebook, Apple and Google all asked their employees to work from home. This significantly reduced all San Francisco city-based activities and created a noticeable void of people who would normally commute to the city.

Numerous measures have been taken to assist the disadvantaged and homeless populations with social distancing. These include makeshift tent camps in vacant parking lots and the use of hotel rooms to avoid crowded shelter environments. I have always felt very insulated here from any federal government policy (or lack thereof) as actions and decisions are really being made exclusively at the state and local government level. In general, San Francisco's population is an affluent, educated, and progressive cohort who have been very compliant and patient with restrictions that are still largely intact.

Throughout this crisis, I give huge credit to UCSF and its handling of the pandemic as an institution, especially the anesthesia department. From the get-go, we have had regular (at least weekly) briefings on the situation as it has unfolded. Personal protective equipment (PPE) has been readily available thanks to early stockpiling, and a policy that permits re-use of unsoiled N95 masks. We had early and thorough fit-testing for N95s and powered air purifying respirators (PAPRs). We have regularly simulated COVID intubations, auditing and revising policies. I have been involved in the care of four COVID-19 patients and intubated two. There have been no known cases of transmission from patient to healthcare worker. Every inpatient is now tested, with in-house testing capable of a result within hours. Also every individual in the hospital is mandated to wear a facemask.

For approximately six weeks, from the end of March the hospital ran a low census, cancelling anything other than category one and two urgent surgery. This resulted in a workflow reduction for most anaesthesia staff, however there was still a large amount of emergency and cancer surgery proceeding, wherever possible as day surgery to maintain bed capacity.

As the initial wave of the pandemic did not overwhelm the UCSF hospital system, we resumed almost all elective surgery in May. At the same time, appropriate concern regarding a potential second wave has resulted in much forward planning, including refurbishment of old intensive care units in peripheral centres in order to stay prepared.

Dr Lloyd Kwanten, FANZCA

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

London, England, UK

I HAVE BEEN working in the UK National Health System (NHS) for almost five years. Initially I came over to the UK for my fellowship year and I stayed to further my career in cardiothoracic anaesthesia. As in Australia and New Zealand, working in a country that provides universal healthcare is incredibly rewarding and this becomes even more demonstrable in times of crisis. The onset and permeation of SARS-CoV-2 into our hospitals and society has been staggering.

Within just a couple of weeks the NHS changed completely, and hospitals had different mechanisms of coping with the influx of patients. COVID-19 positive bed spaces in our hospitals became bays, then wards, and then whole floors. Our intensive care units quickly expanded to over four-fold capacity and the layout in and around the hospital needed to be redesigned and controlled.

Dr Lloyd Kwanten

Here, in London, I went from being a cardiothoracic anaesthetist to an intensivist, managing a team of junior medical staff (most were not intensive care trained), looking after a unit of COVID-positive patients.

A Pan London Emergency Cardiac Surgery (PLECS) service was developed to facilitate the ongoing care of urgent cardiology and cardiothoracic surgical cases during the pandemic. Patients are treated across two sites, one being St Bartholomew's Hospital where I'm based, already a dedicated cardiothoracic centre in the centre of London.

It became essential to screen patients preoperatively for proven or suspected COVID infection in a stepwise approach. This involves a screening questionnaire for symptoms and contacts, then (if asymptomatic) a combination of blood tests (LDH, lymphocyte count and ferritin), a COVID PCR from a combined nose and throat swab, and then a CT scan of the chest. Multidisciplinary team discussions about the risk/benefit ratio of proceeding with surgery are held for patients who test positive.

All emergency cases (for example, aortic dissections and airway emergencies) are treated as COVID-positive, requiring full personal protective equipment (PPE) for the duration of the case.

The increase in the number of critically ill patients being admitted required everyone to adapt to a new way of working. Medical, nursing, catering, cleaners, security, IT and communications all had to be led by a responsive senior management team.

With non-urgent elective surgeries postponed, rosters and job plans were quickly rewritten to provide cover for ICU and allow for extra surgical, anaesthetic, and perfusion runners for theatre cases. Staff needed to be trained-up in the safe use of PPE and intubating and proning hypoxic patients became a regular ritual. The cross-skilling of non-ICU trained nurses and doctors had to be efficient and quick to safely continue proving 24/7 care for a growing number of patients needing intensive care. This required dedicated staff members to step forward, sometimes beyond their level of comfort or capability, to help out.

The patients admitted into hospital are sick, their length of ICU stay is prolonged, and many will not fully recover. Of those patients that get admitted to critical care in the UK mortality is over 45 per cent (27 per cent are still continuing to receive care). This is a death rate on par with Ebola (ref: www.medrxiv.org/content/10.1101/2020.04.23.20076042v1.full.pdf).

Patients' families are not allowed in the hospital, relying on a dedicated communication team to keep them up to date, with phone calls from the intensivist when we can. It is difficult for those dealing with their loved one being away and isolated from other means of support at home.

In terms of PPE availability, which is always highlighted in media reports, it does seem like we are skating on thin ice. Daily deliveries have kept the supplies up and the staff protected. We are cautious with how much we use, generally using two to four sets of PPE per 13 hour shift, knowing in the back of our minds there is a potential supply issue. Other hospitals and trusts have found procurement even harder.

There is nothing specific in our anaesthetic training that prepared us for this pandemic.

However, our training gives us such a breadth of skills and knowledge that we have an invaluable malleability in such a crisis. As the airway and ventilation experts with a range of critical care and procedural skills, anaesthetists around the world have taken on expanded roles and have been well placed to be able to support other colleagues in these challenging times. In the future, this should change the way we interact with trainees, colleagues and patients. Consultants, researchers and educators have seen the postponement of most medical conferences around the globe this year, with other professional development, research, collaboration and funding opportunities curtailed.

Our anaesthesia trainees have had to deal with changes in their training requirements, examinations and rotations on top of working in a constantly changing and stressful environment. The normal teaching sessions and training opportunities have been scrapped, and core anaesthesia time may have been reduced. They are confronted with experiences and skills that cannot just be ticked off in a workplace-based assessment checklist.

Australia and New Zealand have been relatively successful in curbing the tide of COVID-19 transmission and deaths, with both countries carrying out more widespread tests than the UK or the US.

As at the end of the first week in May, of those who tested positive for coronavirus in the UK, over 43,000 have died.

There are some obvious lessons to learn about the importance of early physical distancing measures, border control, and having aggressive testing, tracing and isolating procedures.

I'm hoping the numbers continue to plateau and decline as the lock-down restrictions generally ease. The lessons we all take going forward, including in public health, will make us all better anaesthetists and doctors.

> "There are some obvious lessons to learn about the importance of early physical distancing measures, border control, and having aggressive testing, tracing and isolating procedures."

Dr Albert Chan, FANZCA, FHKCA, FHKAM (Anaesthesiology)

Associate Consultant, Department of Anaesthesia and Intensive Care, Prince of Wales Hospital

Clinical Assistant Professor (Honorary), Chinese University of Hong Kong

Hong Kong

Dr Albert Chan

WE WERE FORTUNATE that we did not do a great load of cases, but we did admit a few confirmed cases in the intensive care unit at the Prince of Wales Hospital.

At the same time, elective surgeries were reduced to preserve personal protective equipment (PPE) which was in short supply. This meant that some of us were deployed to help out in the intensive care unit as we belong to the same department.

At the onset of the COVID-19 pandemic towards the end of 2019 and the beginning of 2020, there was a lot of unease in the hospital due to the uncertainties surrounding the disease and our proximity to China with lots of travel between the mainland and Hong Kong.

However, when the nature of the disease became clearer, and our training and protocols were in place, we were all better equipped to manage the situation. That being said, our hospital wasn't overwhelmed by COVID-19 cases, and many of those that were admitted did not require intensive care management, nor operative management.

As early as 4 January, the Hospital Authority (a statutory body which manages all government hospitals and institutes in Hong Kong) activated a response level due to frequent traffic (flight and high-speed rail) between Wuhan and Hong Kong. The response was further elevated towards the end of January and full PPE was recommended for all aerosol generating procedures.

It was an evolving situation at the time, because the epidemiological data and reporting criteria were still under constant review. Guidelines and protocols for management of suspected/confirmed cases were promptly developed in our department, along with interprofessional simulation training targeted at infection control. Elective operations were also cut, apart from cancer surgeries.

During February and March when it was clear that COVID-19 was spreading quickly around the world our department became increasingly concerned about PPE supply. We were fortunate to have adequate drug supplies for anaesthesia and intensive care.

As a result of the coronavirus we have certainly become more vigilant in infection control procedures and protocols, especially for aerosol generating procedures. Airway teams are able to plan and communicate better before and during airway management. There is also a tendency to use more rapid sequence induction at our institution, along with more video laryngoscopes. We have also learned that simulation based medical education plays a crucial role in staff preparedness for COVID-19.

We have done reasonably well in controlling the disease in a timely manner with social distancing, quarantine measures, public education, universal masking, infection control protocols and training for healthcare workers — although a resurgence of locally transmitted cases is a bit concerning.

Dr Kane O Pryor, MD and Dr Hugh C Hemmings, Jr

Vice Chair and Chair for Academic Affairs
Department of Anesthesiology, Weill Cornell Medicine
NewYork-Presbyterian Hospital/Weill Cornell Medical Center

New York

ARGUABLY NO LOCATION in the western world is more structurally susceptible to the spread of COVID-19 than New York City. Over eight million people live in the city proper, at a population density 25 times that of Sydney.

Nearly 25 million people live in the extended metropolitan area. But perhaps of greater epidemiological significance, New York is distinguished by its extremely high rate of mass transportation use: Two thirds of all rail commuters in the US live in the city or its suburbs, and nearly six million people ride the densely-packed subway system daily. Therefore, when the first community transmission case of COVID-19 was confirmed in a suburban commuter on 3 March, executive leadership at the major city hospitals understood that an accelerated exponential surge in cases was a distinct possibility.

Weill Cornell Medical Center is one of two major academic centers (the other being Columbia University Irving Medical Center) at the core of NewYork-Presbyterian Hospital, the largest hospital system in the US. The campus is located on the Upper East Side of Manhattan, but draws a wide and diverse natural catchment, and receives transfers from a network of acute-care and community hospitals throughout the city and region.

The Department of Anesthesiology comprises approximately 100 faculty, 95 resident and fellow trainees, 80 nurse anaesthetists, 50 researchers, and 50 administrative and support staff.

"The ferocious rapidity of COVID-19 transmission throughout New York City forced enormous strain on operational structures, communications, and psychological preparedness."

The ferocious rapidity of COVID-19 transmission throughout New York City forced enormous strain on operational structures, communications, and psychological preparedness. NewYork-Presbyterian cancelled all elective surgery system-wide on 13 March, only 10 days after identification of the first community-acquired case.

The priorities of the Department of Anesthesiology during this short pre-surge phase focused on: logistics of an unprecedented massive structural expansion in ICU capacity; synchronous development of novel staffing models to broaden the reach of critical care and airway management clinical expertise; acquisition and preservation of personal protective equipment (PPE); and, rapid establishment of communications and psychological support resources to address the escalating concerns and fears of the department staff and their families.

Informed by the high infection rates reported in healthcare providers during the preceding surges in Wuhan and northern Italy, one of the earliest interventions was to dedicate our simulation education facility to continuous and repeated training in donning and doffing of PPE. This was shortly followed by the deployment of a 24-hour anaesthesia airway management team, who assumed sole responsibility for the intubation of COVID-19 patients throughout the hospital. As the most experienced practitioner, a senior attending performed all tracheal intubations, and a trainee assistant supervised donning and doffing and watched for breaches of PPE.

As the immense scale and speed of the surge took form as an impending tsunami, the need for dramatic improvisation became extremely urgent. The most striking action was the near-overnight conversion of the main operating room complex into a 45-bed COVID-ICU. All operating rooms were converted to negative pressure, and accommodated two or three ICU beds with anaesthesia machines serving as ventilators. Additional capacity was created in recovery room areas through the rapid construction of sealed walls. Staffing challenges were enormous, as the number of COVID-ICU patients in the hospital tripled the maximum capacity of specialised critical care beds requiring staffing by physicians, nurses and respiratory therapists. Key to the response was the promotion of non-intensivist anaesthesiologists with relevant critical care skills to the role of leading COVID-ICU teams managing eight to 15 patients, with specialised intensivists serving as higher level consultants to multiple teams.

Dr Hugh Hemmings (left) and Dr Kane O Pryor

Critical care fellows, who had completed nine of 12 months specialty training, were provided emergency exemption status by regulatory authorities and the hospital to serve as intensivists, while senior anaesthesia residents were promoted to the role of fellow. Junior anaesthesia residents and selected residents from surgical subspecialties covered patients at 4:1. Special credentialing was provided to the many physicians from around the country who voluntarily came to New York to assist, despite the personal risks involved. Perioperative and recovery nurses and nurse anaesthetists filled most of the critical care nursing roles, while nurse anaesthetists focused on ventilator management. A critical adjunct to this unprecedented staffing model was daily teleconferencing conducted by the intensivists to provide clinical education and emerging evidence for the many physicians who were functioning well outside their normal sphere of practice.

The early days of the COVID-ICU were a medical version of trench warfare, touched by both fear and remarkable camaraderie. Then, after two months, it was gone almost as quickly as it arrived. The arresting sight of field hospitals in the Javits convention center and Central Park disappeared, and the latter was replaced by traumatised New Yorkers slowly venturing to isolated patches of green lawn. Physicians who had separated themselves from their families saw their children again, and colleagues compared battle stories and antibody status. The psychological recovery has only just begun, but as summer arrives small glimpses of our previous lives are recaptured. But the walls in the recovery rooms are still there, ready, because nobody knows what is coming as we emerge from social and business lockdown.

"As the immense scale and speed of the surge took form as an impending tsunami, the need for dramatic improvisation became extremely urgent."

Dr James Stempien

Provincial Head Emergency Medicine
Saskatchewan Health Authority

Saskatchewan, Canada

Dr James Stempien

Not many people visit Saskatchewan, it's a flat province in the middle of the country with eight months of winter interrupted by four months of heavy insect traffic.

Saskatchewan has a relatively low population for its size – one million people, half of whom live in smaller towns or rural areas.

Due to our relative isolation COVID-19 took its time getting here. So far, we've had about 570 positive patients in the province with six deaths.

Medical care is overseen by one provincial health authority which centralised the pandemic response.

Before we saw any cases, a myriad of committees were formed: aerosol-generating medical procedures (AGMP), personal protection equipment (PPE), code blue, prehospital, physician compensation, to name a few.

Due to the remote nature of much of the population a provincial patient flow committee was formed. Certain centres would be trained for intubation and to become COVID receiving hospitals while some of the more remote or rural centres would be bypassed. We have rotary and fixed wing aeromedical transport teams and they were trained in and prepared for receiving and transporting patients.

One plan was for intubation teams to be stationed at the fixed wing hanger so they could leave immediately to support any small rural centre if intubation was required. So far, we haven't needed this service and the anaesthesia intubation teams are now based at the hospital.

Regional and tertiary care centres that will be receiving COVID-19 patients have done extensive simulation training on intubation, donning and doffing and code blue response. This has proven to be incredibly useful for the centres that have received COVID-19 patients, both in developing the necessary skill set and creating confidence in the staff.

We have a large Indigenous population in the province, especially in the north. One of the worst fears of the province became real when returning COVID positive workers from Alberta, our neighbour, spread the virus into some vulnerable communities.

These communities are at particular risk due to increased family numbers in homes and the lack of access to advanced medical facilities. There has been an excellent provincial and local response with healthcare workers being sent up north and the local community supporting the lock down measures.

The initial advice of early intubation is being questioned. One of the regional centres had a 130 kilogram man with COVID pneumonia with low O_2 saturations, but still mentating well. Intubation was considered as saturations dropped but they optioned for CPAP and positioning. The most affected lung was positioned down for up to 18 hours a day, this keeping the oxygen saturation up and the patient stable. After 48 hours he was weaned back to optiflow and eventually oxygen by nasal prongs.

A few weeks ago the decision would have been for early intubation and transfer to the tertiary care centre. We all feel we are learning new things daily.

My administrative role has confined me to WebEx purgatory, attending seemingly constant meetings. My shifts in Saskatoon, the major referral centre for the north, were initially quiet as people were staying away from the emergency room (ER), probably due to fear of the virus, anecdotal stories of patients staying home with chest pain prompted the government to put out messages that it is safe to come to the ER.

At present the curve of new viral cases is flat. Modelling experts say we'll probably get a peak in July. The north is closed to visitors so many cabins will remained closed this year, but we seem to be doing ok.

Dr James Stempien

Dr Michael Cooper and Dr Yasmin Endlich

Chair and Deputy Chair, ANZCA Overseas Aid Committee

Papua New Guinea

ON 11 MARCH the World Health Organization declared the novel coronavirus (COVID-19) outbreak a pandemic. Around the world, healthcare professionals have spent the past months preparing themselves, and their hospitals, to deal with the rapidly spreading novel coronavirus. This has included ensuring adequate supplies of essential pharmaceuticals, personal protective equipment, consumables and ventilators, increasing the number of intensive care unit (ICU) beds, reassessing staffing levels, fast-tracking the return to work of recently retired practitioners, and re-prioritising surgeries.

Australia and New Zealand have done an admirable job in both preparing their health systems and containing the spread of the virus, however, imagine the challenges of making these arrangements in an environment where resources are severely limited.

Papua New Guinea, Australia's nearest neighbour, has a culturally and linguistically diverse population of more than eight million people. More than 80 per cent of the population live in rural settings with around 830 spoken languages (which represents 12 per cent of all the spoken languages in the world). Across the diverse and widely dispersed population, there are around 100 surgeons and less than 35 physician anaesthesia providers (including trainees). This compares with more than 6000 anaesthesia fellows and trainees in Australia. There is a very limited number of ICU beds and only a handful of ventilators in the country. COVID-19 testing was available in Goroka and now samples are sent to Brisbane. Reagent availability to undertake analyses in-country is challenging. To date there have been only a handful of confirmed cases in several provinces of PNG but the future is uncertain and concerning in a resource poor health system.

Dr Arvin Karu

What Papua New Guinea does have is a healthcare workforce that is dedicated, hard-working and absolutely committed to obtaining the best outcomes for their patients. The Society of Anaesthetists of PNG has already established clinical guidelines for anaesthesia and intensive care at Port Moresby General Hospital and disseminated these around the country.

ANZCA's Overseas Aid Committee has close ties to Papua New Guinea and the country continues to be a core focus for our international activities. Strong bonds between healthcare professionals have been established over decades and so as the scale of the COVID-19 pandemic became apparent the Overseas Aid Committee engaged with our Papua New Guinean colleagues to see how we could assist.

While many activities such as our scholarships and vocational training visits have been put on hold due to travel restrictions, the committee has been actively working with other colleges, societies and government departments to provide practical support such as online forums, developing educational resources and donating equipment and consumables. Through Lifebox Australia and New Zealand the committee was involved in a rapid needs assessment for pulse oximeters in the region, which has resulted in the purchase of more than 150 oximeters for distribution in Papua New Guinea (50), Timor-Leste, Laos, Fiji, Tonga, Samoa, the Solomon Islands and Micronesia.

In early May the college participated in a COVID-19 online support forum for anaesthetists and anaesthesia providers in Papua New Guinea, along with the Royal Australasian College of Surgeons and the Australian Society of Anaesthetists. Chaired by Dr Arvin Karu (President, Society of Anaesthetists of Papua New Guinea), a panel comprising ourselves and Dr Mark Nicholls (Intensivist, St Vincent's Hospital, Sydney) answered questions from clinicians around the country. Further COVID-19 support forums are being planned for both Papua New Guinea and Timor Leste.

Since May, five anaesthesia senior medical officers have been joining the weekly continuing medical education meetings via Zoom at the paediatric anaesthesia department of Adelaide's Women's and Children's Hospital. This latest initiative adds a new level of educational support to the Papua New Guinean anaesthesia training. Learnt topics and presentations are shared further within the Papua New Guinean anaesthesia community by the five attendees.

Associate Professor Adam Montagu from Adelaide Health Simulation and Port Moresby anaesthetist Dr Pauline Wake have set up regular Zoom teaching sessions for the students at the Medical School of Papua New Guinea. Dr Wake was recently the recipient of the ANZCA International Scholarship, which allowed her to spend time in Adelaide and to build these valuable relationships between anaesthesia departments and medical organisations.

The Overseas Aid Committee has also been involved in the development of an oxygen therapy flow chart in the treatment of COVID-19 severe acute respiratory infections specifically designed for low resource settings where the availability of ventilators is non-existent or severely limited. Over the coming months the committee will continue to work closely with our colleagues in Australia and New Zealand's nearest neighbours to provide whatever assistance we can to support them to manage this global health challenge.

Safe airway management poster goes global

HONG KONG ANAESTHETIST and FANZCA Dr Albert Chan had not yet started his anaesthesia career when the severe acute respiratory syndrome (SARS) outbreak emerged in 2003 but many of his colleagues at Hong Kong's Prince of Wales Hospital where he now works as an associate consultant still have vivid memories of the impact the epidemic had on their work.

When the first coronavirus cases were discovered in Wuhan, China in January Dr Chan and his colleagues were mindful of the need to apply some of the lessons learned from SARS in Hong Kong and the Prince of Wales Hospital to the new unfolding health emergency. Dr Chan's experience in simulation education at the Chinese University of Hong Kong where he is an honorary clinical assistant professor meant he was well placed to help prepare anaesthetists and other specialists at the hospital for COVID-19.

In just a few months Dr Chan, who tweets as @gaseousXchange, has achieved international recognition as the creator of a simple, colourful infographic on safe airway management in patients with confirmed or suspected coronavirus. The resource, which he first tweeted in February, has gone global, helping clinicians to build better infection control processes and keep themselves safe. The infographic is available for free download on the university's COVID-19 website at www.aic.cuhk.edu.hk/covid19/.

He developed the Principles of Airway Management in COVID-19 resource with the help of a commercial artist in Hong Kong thinking at first that it might be a useful resource for the Hong Kong anaesthesia community. The infographic provides a checklist for infection control procedures to reduce the transmission of COVID-19. It covers before, during and after guidelines for staff protection, preparation, team dynamics and technical aspects when treating patients suspected of having COVID-19.

It was only after he posted the graphic on Twitter and through WeChat in China that he quickly realised that it had struck a chord with the international anaesthesia and intensivist community who embraced its simplicity and information.

Dr Chan told the *ANZCA Bulletin* via Zoom from Hong Kong that the information was based on the Prince of Wales Hospital's extensive experience managing SARS patients and a subsequent research and literature review. His experience with systems testing through simulation testing also helped guide his thinking on what should be included.

In collaboration with various centres around the world, the infographic has since been translated into simplified Chinese, traditional Chinese, French, Spanish, Italian, Portuguese, Japanese, German, Dutch, Polish, Serbian, Farsi, Turkish, Vietnamese and Thai.

Dozens of hospitals and organisations globally including ANZCA, the Australian Society of Anaesthetists, the World Federation of Societies of Anaesthesiologists, the UK ICM Anaesthesia Covid-19 Collaboration, Brazilian Anaesthesiology Society and the French Society of Anaesthesia and Intensive Care Medicine are now using the infographic as a resource on their websites and COVID-19 communication platforms.

Hospital departments of anaesthesia and emergency departments in Australia, the US, Switzerland, Singapore, Japan, Germany, China, Spain, France, Brazil, Austria, Italy, Poland, Vietnam, Thailand and Canada are also using the infographic as posters and or flyers.

Anaesthetists and intensivists in different countries modified the information to suit their own local requirements. For example, double gloving was a technique that the Italian community requested, and the infographic was modified to accommodate this for the Italian translation.

Dr Chan admitted he was surprised by the response to the infographic that has been praised by anaesthetists and anaesthesia departments worldwide. He has since written a paper in the journal *Anaesthesia* on its reach, noting: "This redistribution of the material through additional, highly accessed and trusted dissemination platforms markedly increases the value of the infographic, and reduces the need for other individuals and units to waste needed resources reproducing similar material. The rapid uptake and sharing across networks, driven by healthcare workers' needs, demonstrates 'just-in-time' health professional information sharing."

Since the infographic was published on Twitter on 19 February there have been more than 74,900 impressions on Twitter and more than 25,000 page views on the departmental website.

"Free and rapid access to high-quality information from verifiable sources is valuable to optimise the global medical response to crises such as the current COVID-19 pandemic," Dr Chan explained.

"In the beginning, in January, because of our proximity to China there were a lot of uncertainties. The public health measures in Hong Kong had just started and we were still trying to grapple with understanding the virus, its mode of transmission and what this meant for airway management and high risk procedures."

"So we started to think about whether we should be designing a protocol for workflow for use in theatre and how to train up staff before the pandemic hit us hard. Anticipating potential shortages of available personal protective equipment (PPE) given the international nature of the pandemic, there was a debate here about whether to stop elective surgeries to conserve the limited stocks of PPE.

"Some of my colleagues here had experienced the SARS epidemic and had been through it and they recall that staff morale was quite affected at the time. We knew that in designing the information that it had to be easy to understand and able to be accessed not just in operating theatres but also in emergency departments, intensive care units and even hospital offices."

Dr Chan had had some experience with infographics as part of his research and work in simulation and quality and safety in the operating theatre, but when he decided to start working on the resources he sounded out other anaesthetists and intensivists on their thoughts.

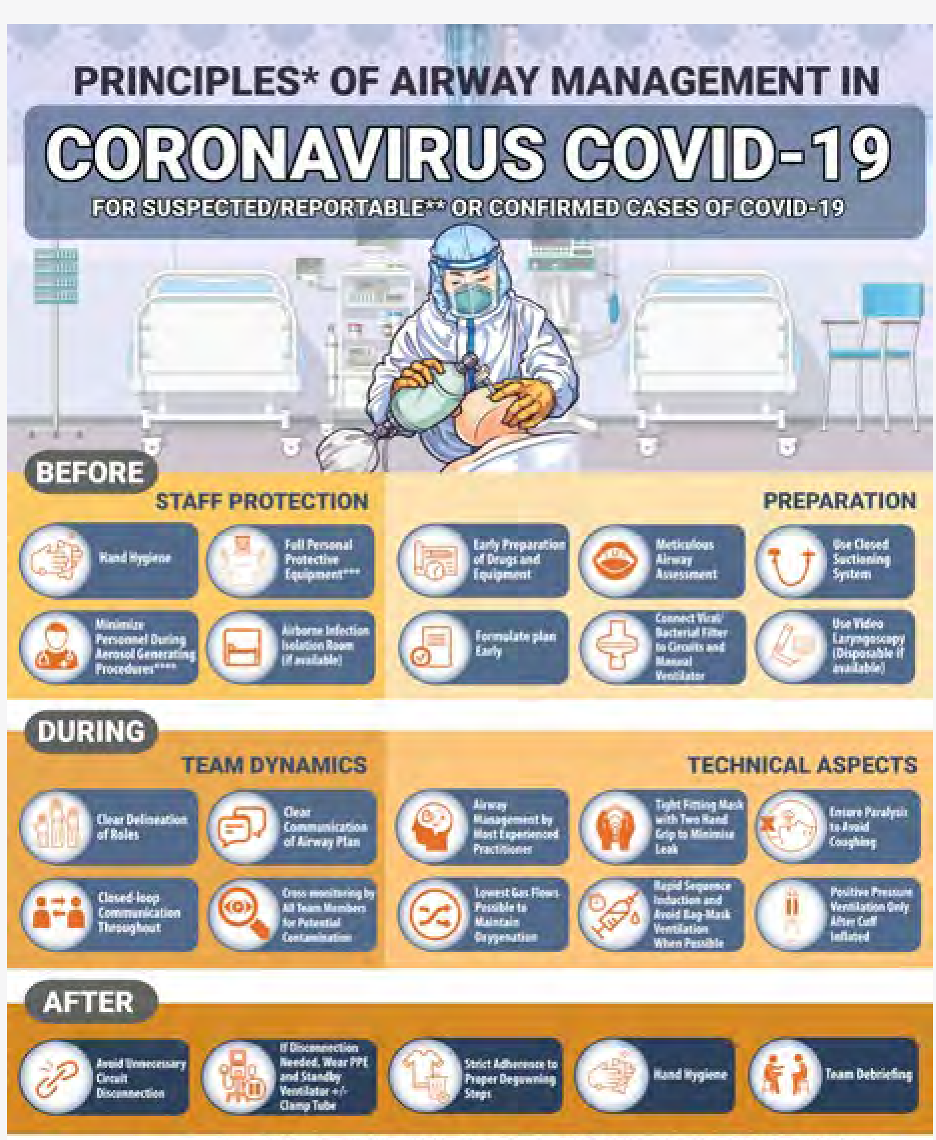
"Most of the time we were thinking of anaesthesia but it was also important to get the perspective of other specialists," he said.

"When we had all the information I then drew out all the steps and then passed it over to a commercial illustrator to pull it together. It's now being used in hospital emergency departments, intensive care units, operating theatres, offices and I've also seen it attached to COVID airway trolleys. I guess we were fortunate to be among the first to think of doing something like this as the pandemic hit. Now there are tons of infographics out there and I am still amazed at how ours has taken off."

Carolyn Jones
Media Manager, ANZCA

Reference

Anaesthesia first published: 30 March 2020
https://doi.org/10.1111/anae.15057



Dr Chan's "Principles of Airway Management in Coronavirus COVID-19" is being used by anaesthetists around the world.

Webairs: Disruption to anaesthesia services

THE COVID-19 CRISIS has sent heightened anxiety and increased levels of fatigue throughout the frontline staff working in anaesthesia in our healthcare organisations within Australia and New Zealand. In the past few months, webAIRS has received reports with concerns for protective personal equipment availability, guidelines for use, staff unfamiliarity with procedures and equipment, staff and equipment shortages, and suggested changes to routine practice, that are all related to COVID-19 precautionary measures. There is a chance that a second wave of COVID-19 positive cases will appear in Australia and New Zealand and we will continue to monitor the webAIRS incidents that are reported in relation to the COVID-19 pandemic and add these as an ANA-Alert to the webAIRS website.

WebAIRS has received a number of incident reports where COVID-19 or personal protective equipment (PPE) related issues have been a contributing factor in the environment surrounding the incident.

PPE

- PPE was not available or inadequate. This could lead to procedure cancellation where aerosolisation might occur such as ear, nose and throat (ENT), maxillofacial and endoscopy procedures.
- The type of PPE was unfamiliar with a risk of not wearing it correctly.
- Fogging of the protective goggles led to difficult visualisation during intubation.
- Interpretation of the guidelines for use of PPE were reported as inconsistent.

Equipment

- Lack of the anaesthesia trolley present in the room led to delays with emergency drug availability.
- Equipment was unfamiliar to anaesthesia staff who do not usually work in the emergency department. This is turn led to difficulties with patient management.
- Bag mask ventilation (BMV) equipment for COVID-19 cases was unfamiliar to anaesthetists and assistants.
- An endotracheal tube (ETT) failed on two occasions during a planned fibreoptic nasal intubation.
  A patient with no known risk factors for COVID-19 presented with pain and limited mouth opening for incision and drainage of an abscess. After assessment and consent, an awake fibreoptic nasal intubation was planned. The intubation was successful but associated with a large leak and inability to inflate the ETT cuff. A tube exchange was performed with an airway catheter but there was still a large leak from the ETT. Ear, nose and throat (ENT) surgical assistance was requested and a decision made to proceed to surgical tracheostomy. However, the ENT team was concerned about aerosolisation and insisted that a powered air-purifying respirator (PAPR) be worn by each of their team. There was a delay as a result, but fortunately there was no desaturation despite the large leak from the ETT. This case illustrates the heightened awareness of the possibility of undiagnosed COVID-19 cases in the community and how this impacts on current surgical practice. The patient had the procedure and recovered well after the procedure, without any harm as a result of these events. There was however a prolonged period where the patient airway was not completely secured as a result of COVID-19 concerns, which in turn means that the patient was exposed to an additional hazard.

Staff/facilities shortages

- Lack of personnel present in the room led to a delay in obtaining a replacement piece of equipment that was requested when the original ETT encountered a leak.
- A patient suffered anaphylaxis and after successful management the procedure was postponed. It was planned that the patient would have skin testing and after the results were available the patient was to be rebooked. However, COVID-19 preparation had resulted in the closure of elective allergy testing facilities. The procedure was not urgent but was required within a time frame of weeks. At the time of reporting it was not clear whether the clinic would reopen in time, or the procedure would be required in the absence of formal testing of the agents previously used.
- ICU bed delays and shortages occurred due to COVID-19 preparations.
- Operating room entrances were not clearly marked that PPE precautions were in place.

Unexpected events

- Drugs were left unattended following an intubation in a negative pressure room.
  The patient was transferred to intensive care accompanied by the anaesthetist and the anaesthetic assistant. When the anaesthetist and the assistant returned to the negative pressure room it had been cleaned and there were no staff present. The anaesthetic drugs were left on a tray outside the room and were left unattended due to a lack of a clear plan for drug disposal. This raises two issues; firstly, the drugs and tray were potentially infected, and also controlled drugs were left unsupervised and unlocked which contravened the state regulations.
- Difficulty ventilating a patient occurred during an emergency gastroscopy.
  After a difficult visualisation of the larynx, it was determined that a bougie was required and there was a longer than usual delay before it was produced. During the delay it was difficult to ventilate the patient. The anaesthetist reporting suggested that if COVID-19 precautions are in place, it would be a good idea to routinely preload a bougie into the ETT during intubation.
- A patient suffered what appeared to be a severe bronchospasm, following an intubation with COVID-19 precautions in place. The patient had a history of TB and it transpired that there was a tension pneumothorax present, either prior to intubation, or as a result of the high ventilation pressures required. It was difficult to diagnose a pneumothorax, perform initial chest decompression, and insert a chest drain in these circumstances as the usual equipment required was not in the room.

Heightened tension and anxiety

- Difficulty managing patients with difficult airway anatomy, which is difficult even in normal circumstances, but is much more difficult where there is potential for the spread of a COVID-19 viral infection.
- Difficulty deciding whether an emergency case merits full COVID-19 precautions especially with ENT, maxillofacial, endoscopy and any other procedures where aerosolisation might occur.

We encourage anaesthetists to report any incidents with COVID-19 patient management and will provide regular notifications of issues via the ANA-Alerts.

Please login or register at the webAIRS website – www.anztadc.net – and select the ANA-Alerts menu option. Reporting an incident also qualifies for CPD points.

ANZTADC Case Report Writing Group

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Free ANZCA Doctors' Support Program

How to make an appointment:

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

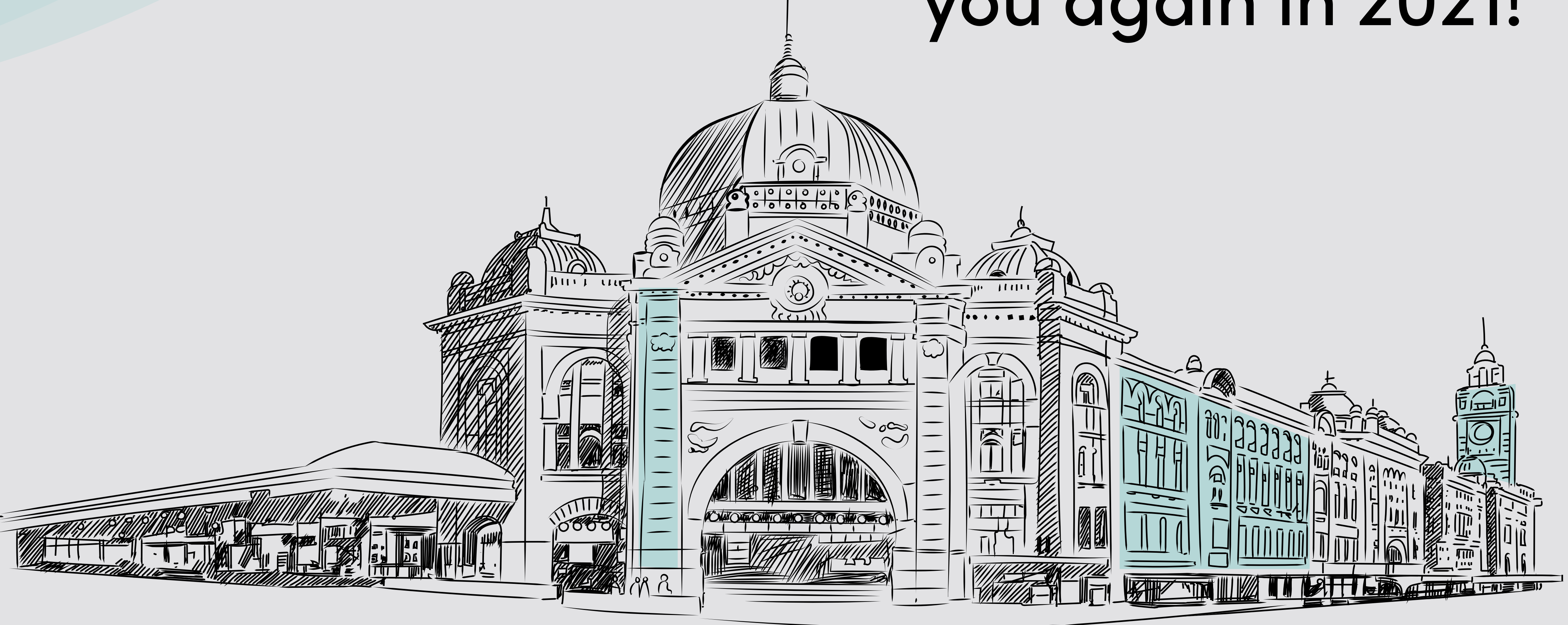
- Telephone 1300 687 327 in Australia or 0800 666 367 in New Zealand.
- Email eap@convergeintl.com.au.
- Identify yourself as an ANZCA fellow, trainee or SIMG (or a family member).
- Appointments are available from 8am to 6pm Monday-Friday (excluding public holiday).
- 24/7 emergency telephone counselling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

HELP IS ALSO AVAILABLE VIA THE

Doctors' Health Advisory Service:

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

Can't wait to see you again in 2021!



Making hospitals safer

In November 2012 Matthew Gunter had a routine operation to remove his appendix. During his recovery, signs of fluid on his lungs were not acted upon. This led to Matt's death. He was 15 years old.

IN 2019 DR Vanessa Beavis, then ANZCA vice president, heard a presentation by district nurse, adverse events campaigner and community representative, Heather Gunter. She was telling the story behind her son Matt's death at a presentation at the Auckland Symposium on Perioperative Medicine. Dr Beavis followed up, approaching Ms Gunter to join the ANZCA Perioperative Medicine (PoM) Steering Committee as the community representative. It had complete symmetry for Ms Gunter. Her reaction to the offer? "Definitely! Whatever I can do to help make healthcare and hospitals safer."

Over the past 12 months, the Accident Compensation Corporation (ACC) in New Zealand has been supporting Ms Gunter to visit district health boards around the country – more than 60 hospitals to date – to talk about what can be learnt from Matt's operation and subsequent death as part of the ACC's prevention program. Ms Gunter points out that this is not about "naming, blaming or shaming" but sharing "Matt's story" in the hope that people can learn from his death in order to prevent it from happening to someone else.

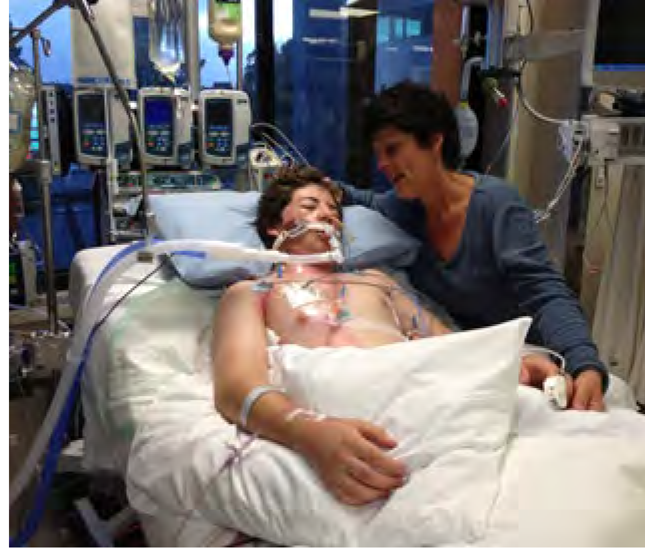
ACC promotes the talks saying "Matt's story is a powerful reminder of the importance of a strong safety culture in health care and reminds us that behind every event there is a person and their whānau/family."

For Ms Gunter, her son's death meant a seismic shift in her life and a new calling.

"Matt's death changed me. You look at [life] completely differently," she told the Bulletin.

"So there was a lot of indicators there. But nobody was putting two and two together. And Matt paid for that with his life."

Opening transcript to the Health Safety and Quality Commission video *Patient story: Matthew Gunter.*
https://www.hqsc.govt.nz/our-programmes/partners-in-care/publications-and-resources/publication/3445/



Heather Gunter sits by her son, Matt in Christchurch Hospital.

She explains, as a health professional, when you have to stand on the other side of that health equation as a patient or family of the patient, the optics are different: "It's not the same as standing there in your uniform."

"Six months after [Matt's death] I got some real fight in me. It was like no." (There's a deep inhale and a very long pause at the other end of the line.) "No. They've taken my son, they are not going to take my licence and who I am. I know there were mistakes made but that's not me and that's not how I practice. It's not a blame game. That's not going to help. It's not going to change anything at all."

She says the reason she has been on this extended roadshow with Matt's story is because she wants people to realise these adverse events can and do happen, but we all have the ability to stop it from happening.

"Nobody goes to work to cause harm, but it still happens and when it does we need to take accountability and learn from it. Ours should not be a punitive justice system but rather one that understands the human factors involved in each situation and how we can learn and grow from it to create a safer and better patient journey. That's why I tell Matt's story. Yes, it is really hard to watch [video] but people get it and they understand I am not there to growl at them, or name anybody. I'm just there to remind them. We need to speak up and we need to communicate more. We just don't communicate enough across our silos."

Being a health professional helps when talking about preventable harm.

"Because I understand where they are all coming from," Ms Gunter explained.

"I understand how busy it can get and I talk about that. But I also point out that should never take away from the reason that they are there, for the patient. They should be the centre of all [health professionals'] care."

She says joining the ANZCA PoM Steering Committee makes perfect sense as she has been impacted by what she calls the "disconnect".

"I have worked in this system for 30 years in many areas of healthcare. I believe it can just run more smoothly. It can be a better journey for the patient and most certainly a hell of a lot smoother if we have better structures in place."

She's talking about people working in their specialties and not seeing the big picture. "It's thinking, so I've done my job so the next person can do their job. Then they walk away without really establishing good flow for the patient through the whole process. Maybe it is just not having a good understanding of what happens next."

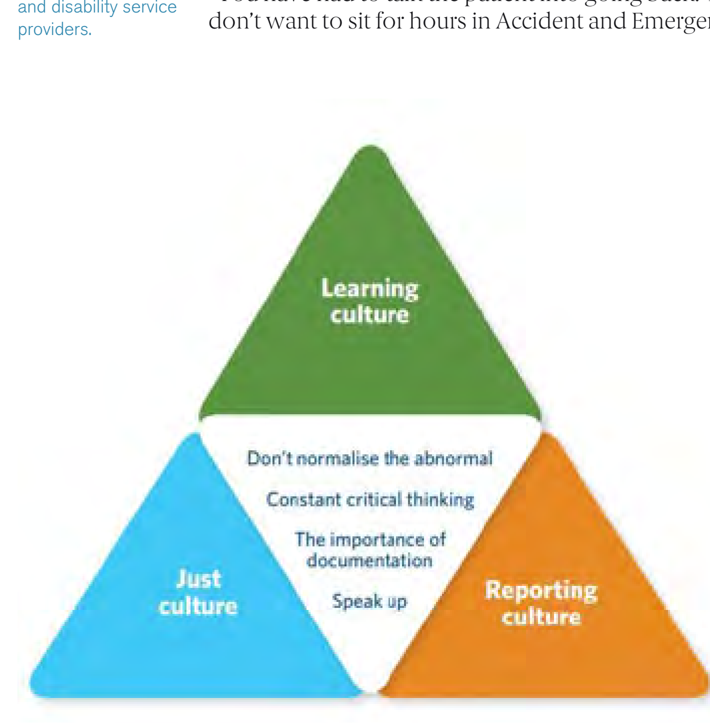
This is where Ms Gunter's role as a district nurse comes in. She has seen the lack of continuity between primary and secondary care and it scares her.

"When you are in hospital, you have all the staff around you so you have a greater chance of living if anything goes wrong. It's all hands on deck. Once you leave the hospital, you don't have the same support. There's a huge disconnect in the community."

She speaks about how people often don't have the same GP at each visit. More than likely the new doctor doesn't have the discharge information (digital records don't translate across platforms) and the patient can't always fill in the gaps.

Getting patients back into hospital can also be difficult. "You have had to talk the patient into going back. They don't want to sit for hours in Accident and Emergency

Below: Adverse events triangle from Learning from adverse events: Te ako i ngā pāpono kōaro – a report prepared by the Health Quality & Safety Commission based on information and data provided by district health boards and other health and disability service providers.



"...these adverse events can and do happen, but we all have the ability to stop it from happening."

to be seen by yet another doctor who doesn't know them – a different surgeon and anaesthetist. We are missing important indicators of a patient's condition that means things go wrong and people die."

Ms Gunter recognises resource and capacity constraints but she says doctors often don't use the one free resource sitting in front of them – the patient and their family.

"One of the biggest complaints I hear from patients is they weren't listened to. As busy health professionals I understand that our time is limited and we are often in and out of rooms. But no one knows that person in the bed better than the patient themselves or their family. So I ask you all – please listen when they are speaking. They are the ones who notice the small changes that we may not see because we simply don't know them as well. We need to empower the patient and the family to "speak up" to prevent deteriorating patients from dying. We need to "normalise" this and encourage it. I spoke up and I questioned symptoms when Matt was in the recovery room. Unfortunately I was ignored. I am a nurse as well as a mum so I am very aware of how hard it would be for someone without any medical knowledge to question. I cannot stress enough the importance of listening. We are missing things because we don't have a good way of getting sick people back into hospital when there are problems, and we are missing deteriorating patients when they are the in hospital as well."

So can she imagine a future with more of a connected patient flow and more integrated patient care with a more holistic view of the patient?

"Absolutely. That is why I joined the [ANZCA] perioperative team."

Ms Gunter says in discussions so far, the committee has been looking at the perioperative timeline, which she believes needed to be extended to 90 days post-operation. "By doing that, patients should still be under the umbrella of the perioperative team so they should have better access to hospital readmission and flow of care."

The creation of a liaison to the perioperative specialist could also assist in this flow. She says the pluses are obvious – "we save lives, we are more effective, the system is more efficient and we save money." She refers to the anaesthetist-led, ground-breaking Fit for Surgery, Fit for Life pilot in Whanganui.

"Let's get these people well enough before we even put them in surgery. The before and after – we can do better!"

Adele Broadbent
Communications Manager NZ, ANZCA

Safety and quality

National COVID-19 Clinical Evidence Taskforce

IN LATE MARCH, a diverse coalition of peak health bodies united to focus on clinical care across the country. A first of its kind, the National COVID-19 Clinical Evidence Taskforce was formed to provide a clear and consistent voice of cross-disciplinary consensus on the clinical care of Australians with COVID-19.

Encompassing the brightest minds from across 29 leading health organisations covering primary, acute and critical care settings, the taskforce now works around the clock to analyse global research findings, debate the evidence and update Australia's COVID-19 Clinical Guidelines accordingly. While conventional clinical guidelines are updated every three to five years, the taskforce delivers "living" guidelines that are updated every week by nine expert panels made up of Australia's leading researchers and clinicians.

ANZCA President Dr Vanessa Beavis is representing the college on the National Steering Committee of the taskforce. Professor Paul Myles, Associate Professor Nolan McDonnell and Dr Simon Hendel are contributing to the panels of clinical experts that are reviewing the evidence and making recommendations. Using this innovative, collaborative and rapid-response model, the taskforce is arming Australian clinicians with the up-to-date evidence and trusted advice they will need and depend on throughout this global health crisis. For more information, visit covid19evidence.net.au.

Supply of critical medicines

THE THERAPEUTIC GOODS Administration (TGA), through its Medicine Shortages Working Party (MSWP), has undertaken modelling to assess the feasibility of return to elective surgery considering critical medicine supplies. A statement published on the TGA website states that the modelling "demonstrates that current and anticipated supply of critical medicines for ventilating patients is sufficient to support both a return to elective surgery and a rise in COVID-19 cases."

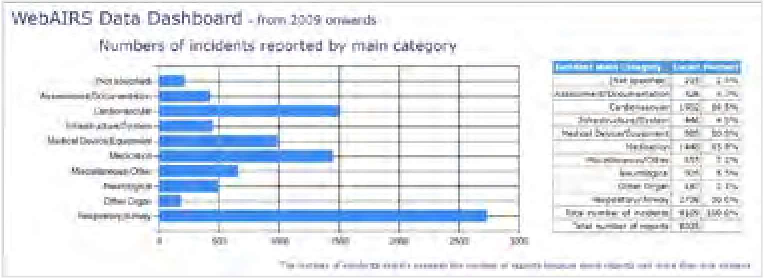
The supply of critical medicines has been in sharp focus for the college, with a number of fellows raising the issue. The college has been in contact with the TGA to confirm that medicines of concern, such as propofol and fentanyl, are in sufficient supply to support the return to elective surgery and in the event of a "second-wave" of COVID-19 infections. PHARMAC in New Zealand has also been in contact with the college to raise the issue of critical medicine supplies and the college continues to work collaboratively with PHARMAC to monitor the issue in New Zealand.

The college continues to proactively assess and consider how we can assist fellows in navigating the issue of medicine shortages in Australia and New Zealand. As a matter of urgency, the ANZCA Council resolved to review, and release for pilot, a revised *PS51 Guideline for the safe management and use of medications in anaesthesia* which provides clarity as to when ampoule-splitting may be deemed necessary.

WebAIRS milestone

TOWARDS THE END of May, webAIRS reached an important milestone of more than 8000 reports, making it one of the largest collections of anaesthesia incident data in the world.

A summary of the main categories of event are shown in the figure below.



There were 9109 subcategories among the 8035 reports, as it is possible to record more than one event subcategory per report, for instance, airway obstruction leading to desaturation. One of the advantages of webAIRS is that the main categories and subcategories of the incident, as well as many other data points, are coded by the reporter. These are checked by a data analyst within 30 days of data entry and will assist analysers in the preparation of articles for publication.

WebAIRS has also started to publish alerts that have been submitted in a new feature called advisory notices to anaesthetists (ANA). This is modelled on a similar system used in the airline industry called notices to airmen (NOTAMs). To see some of the case reports login to webAIRS and select "ANA – Alerts" from the main menu.

There are other features under development such as an online bowtie diagram that will enable all users to drill down and see the codified data presented as tables for each subcategory of the incidents in the database.

During the recent COVID-19 crisis, webAIRS received a number of COVID-19 related issues which are published in an article titled "Disruption to anaesthesia services due to COVID-19", in the COVID -19 section of the *Bulletin* on page 38.

We encourage anaesthetists to report any incidents and will provide regular notifications of issues via the ANA – Alerts. Reporting an incident also qualifies for CPD points. Please login or register at the webAIRS website – www.anztadc.net.

ANZTADC Case Report Writing Group

Online data tools can help anaesthetists

Digital software programs and the rollout of My Health Record in Australia may help to transform patient record keeping and other medical information.

HAVING RECENTLY JOINED as an associate at a private practice in Adelaide, specialist anaesthetist Dr Preeti Krishnan is all too aware of the need to have quick and easy access at her fingertips to her patients' history and other medical information.

Anaesthetists in private practices are increasingly seeing patients for pre-consultations in their rooms two to three weeks before surgery. When the *Bulletin* visited Dr Krishnan at Adelaide Anaesthetic Services (AAS) earlier this year she was preparing to meet with a patient who had been booked for a hip revision. The patient's detailed history had been uploaded into a digital anaesthesia software program so she could see at a glance his past medical and surgical history, and other relevant information.

Later that afternoon we met up with her again at Adelaide's Calvary Hospital where she was about to start an eye list. Using a software program called VaperTrail she was able to quickly source patient information on her mobile phone without having to consult bulky paper documents and files.

Dr Krishnan supports the concept of digital health as a practical and paperless way of managing and accessing patient history and medical information. The anaesthesia software she's now using also enables her to keep track of her lists and her billings.

"All my patients' information including investigations, results and GP summaries – is in one place and only a click away. I can easily see upcoming patient lists which allows me to plan accordingly – to determine which patients need pre-op consults or further medical information. This functionality of the software gives me great peace of mind.

A study of contrasts in record keeping. At the Wakefield Anaesthetic Group the mobile phone has replaced reams of monthly list books, streamlining office record keeping.

"I might do 10-12 sessions a week and I could be working at four different hospitals in a day so being able to have everything on a screen that I can access with a logon on either my phone, a hospital PC or a laptop is a big advantage for me. There is a huge amount of information that you can access as you go. All the information is there for each patient."

Dr Krishnan believes the "one stop shop" digital concept benefits patient safety.

"This is really so important. Just recently I had to cancel a patient's eye surgery because there were some issues and complexities that the surgeon hadn't told me about so having the patient's history and other information immediately available in a digital format in one place is vital especially when you're dealing with high risk patients."

Anaesthetists and anaesthesia practice managers interviewed by the *Bulletin* all agreed that the concept of a digital health record was a positive move for both patients and practitioners. Some though are still wary about the privacy protocols and stress that the ultimate success of digital health systems depends on the applications being user friendly for patients and practitioners.

Others also noted that in Australia, the logistics of rolling out the national My Health Record (MHR) so that it "talks" to state and territory health networks and hospital systems is also challenging.

According to Dr Rowan Thomas, Chair of ANZCA's Information and Communications Technology (ICT) Governance Committee and, until recently, the Group Chief Medical Information Officer at St Vincent's Health Australia, the greatest advantage of the digital health concept and Australia's My Health Record is "being able to see previous visits, hospital admissions, discharge summaries and test results in a digital format that is easy to access before, during and after a pre-operative visit."

A former ANZCA councillor, Dr Thomas's role with the college's ICT committee means he receives regular updates from the Australian Digital Health Agency (ADHA) on the rollout of MHR.

Adelaide anaesthetists Dr Preeti Krishnan and Dr Bob Singh check patient information on their mobile phones. Photos: Carolyn Jones

> "When you've only got 15 minutes to see a patient for a pre-op assessment and it takes you five minutes to find the patient's details online that's way too long."

"One of their main concerns at the moment is getting hospitals to upload data to MHR. They want to ensure that data from patients who have been through the hospital system has been uploaded properly," Dr Thomas said.

"Some hospitals do have the ability to open MHR through their own electronic medical records but for the hospitals without that connection they have to use an online viewer that is provided by the Australian Digital Health Agency. At St Vincent's for instance we upload our data regularly but if we want to look at that data through MHR we have to use the Digital Health Agency's viewer."

Dr Thomas has had a long interest in digital health. In 2005 he and medical director for the Australia and New Zealand Tripartite Anaesthesia Data Committee (ANZTADC), Dr Martin Culwick, were appointed as clinical leads for the introduction of Australia's first personally controlled electronic health record (PCEHR), which was later renamed My Health Record.

Dr Thomas says while he's not aware of anaesthetists in the public system using MHR on a regular basis, he understands how anaesthetists in private practice might find it a useful addition to their pre-op consults.

"In the public hospital system we tend to rely on previous (patient) visits to the hospital for information already being available on our own internal hospital records management system. There are great advantages that MHR can and will deliver. It's really the first step of quite a long road map where the user experience will be much better and the amount of information that will be available will be better but I expect this will be over decades. The downside is that people are still concerned about issues to do with privacy, confidentiality and security of information."

Dr Thomas told the *Bulletin* that the ADHA had been very "conscientious and careful in the way they have deployed very effective security around the system."

"They really have thought carefully about the choices that people may make about what sort of data can be viewed and by whom," he said.

"They have also been working with hospitals to better inform chief medical officers about the system and its benefits through various online videos and webinars. It is very ambitious what they're trying to do. They're trying to ensure that as many hospitals are uploading information as much as they can.

The VaperTrail program enables quick, digital access to information on a mobile phone.

"About six years ago no one had been successful at rolling out a national digital health record system but New Zealand is now having some success and also some Scandinavian countries. Here there are a lot of complexities based around all the differences between our states and the different funding models and stakeholders," he explained.

"If you continually look into a record and don't see anything there people will slowly lose interest. But one of the comments I heard recently in a radio interview asked how can doctors work if they only have incomplete information but in actual fact that's how we are taught how to work -- we get a little (information) from a patient, from a test, from a colleague, from past history, and fill in the gaps if there are any so it's a process we are used to using."

In Western Australia, anaesthetist Dr Sean Oberholzer, a visiting medical officer at Bunbury and Busselton Hospitals, works in both the private and public system and, like Dr Krishnan in Adelaide supports the concept of a digital health record as a "one stop shop" that would help anaesthetists to quickly access patients' health records.

Some WA health system hospitals, particularly those in the south-west, use an electronic health record system called BOSSnet. This links with My Health Record but for now, specialists working outside of the public system such as Dr Oberholzer can't access MHR in private rooms. A separate login is required for Dr Oberholzer to see a patient's blood tests or X-ray results through the BOSSnet system. He says this is time consuming and interrupts efficient workflow.

"The hospitals hold paper files on patients while in hospital and these are only scanned when a patient is discharged. As far as I'm aware there's no integration with private practices. Working as an anaesthetist in the private system there is no software, we still rely on paper forms and use a cloud-based filing system," he explained.

"Ideally there would be a security or PIN coded My Health app where we could type in a patient's name and then see their summary. When you've only got 15 minutes to see a patient for a pre-op assessment and it takes you five minutes to find the patient's details online that's way too long. Any little obstacle or hold up causes delays and it means you can't use the system.

"When you can have anything between four to 12 patients a day on a list it would be so beneficial for us to see the patient's summary, blood tests, X-rays and current medications because we don't get referral letters from surgeons. And at the moment there's also no scope for anaesthetists to upload information on a patient so we can't share our anaesthetic records if patients have multiple surgeries or have anaesthetic alerts, such as difficult airways or sensitivities to drugs."

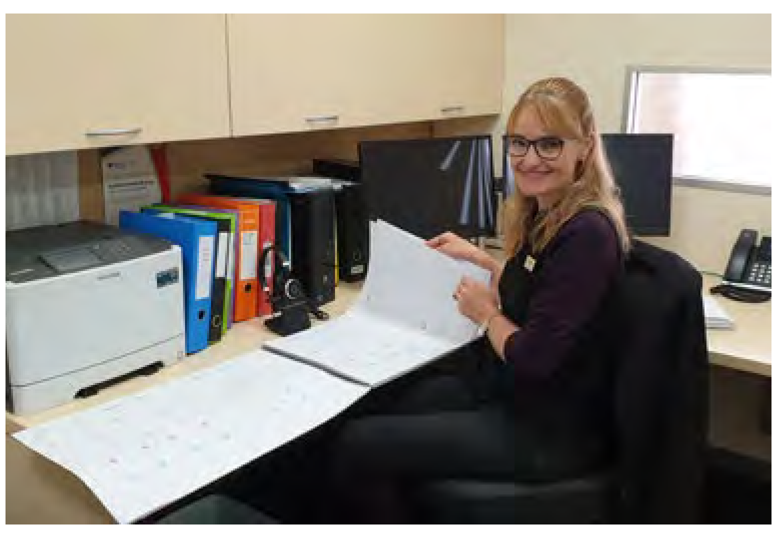
Back in Adelaide, one of Dr Krishnan's colleagues is Dr Bob Singh, the creator of the VaperTrail anaesthetic practice software program. Dr Singh came up with the idea of the system back in 2011 when he was recovering from a serious spinal injury. It was while he was spending months in rehab that he started to fine tune the concept. While he and other anaesthetists at Adelaide Anaesthetics had been using a medical digital management and billing system it wasn't a bespoke anaesthesia program.

Now, nearly a decade later, three South Australian practices, and one in NSW are using the VaperTrail program.

The program enables anaesthetists to view their diary, lists and patient notes in real time on any device.

With 56 anaesthetists who perform about 80,000 cases each year, and 11 full time equivalent staff, Adelaide Anaesthetics is the largest anaesthesia practice in Adelaide.

"Without the digital platform we would still be using a range of different communication methods such as SMS, paper folders, cards and emails."



Wakefield Anaesthetic Group practice manager Tracey Wurfel with a 2016 monthly list book. The books have now been replaced by the VaperTrail digital program.

"I see quite a high number of pre-op consults here in our rooms and we often do big neurosurgical or vascular cases. I don't want to turn up to one of these cases and find out the patient has other complications," Dr Singh explained.

"On average I would perform anaesthesia on about 40 patients a week, sometimes 60, so the ability to quickly access relevant and current information about the patient is crucial."

The administration team at the practice input all patient information into the VaperTrail program so the practice's anaesthetists can see "live" information at a glance.

"All the interactions with the patients are documented so this also gives the patients a more personalised approach. It means we can 'flag' every patient with clinical notes, information on scheduling, and billing. It means the patients get a seamless and very professional experience with the practice."

Dr Singh estimates that before the practice went digital its administration team received 4000 faxed sheets a week from surgeons with patient information and anaesthetic lists.

"Without the digital platform we would still be using a range of different communication methods such as SMS, paper folders, cards and emails."

As a paperless practitioner Dr Singh understands the benefits of how a customised system can liberate specialists and staff from laborious manual paper files, invoices and list books. He supports the principle behind the My Health Record concept and is keen to work with the Digital Health Agency to explore how anaesthetists can best access and participate in a national digital record system.

"I don't think we should have to go through multiple log ins and authorisations to find out a patient's history. For example, I don't need to see how many rehab sessions they've had in the last year but I do need to see their latest blood tests and scans. Anaesthetists often have to go looking for patient information. It's unusual for an anaesthetist to be the primary referrer so the ideal system would be one where we can find out patient information quickly and easily without having to open multiple applications or pages."

At another Adelaide practice, Wakefield Anaesthetic Group, practice manager Tracey Wurfel unearthed two 2016 monthly list books and placed them alongside a mobile phone to show how moving to a digital software platform had streamlined their office management.

"We really weren't in the 21st century until a couple of years ago. We worked off paper diaries and lists. Our billing was electronic but anaesthetists couldn't access their patient information in theatre if they needed to.

"This has made a huge difference to how we manage the practice," she explained.

Carolyn Jones
Media Manager, ANZCA

***Editor's note:** The *ANZCA Bulletin* did not intend for the above article to be read as an endorsement of a particular digital application over another. We apologise if the article has been misconstrued in this way.

ANZCA's prof docs

What would you do?

Dr Peter Roessler explains ANZCA's professional documents using practical examples.

STANDARDS IN ANAESTHESIA

The director of nursing attracted my attention in the corridor and invited me to their office to discuss concerns regarding my performance. As incredulous as this seemed at the time, given my own perceived commitment to safety and quality of patient care, it evoked a range of emotional reactions, which were possibly a reflection of my own insecurity!

On entering the office, I was informed that my performance may not be to ANZCA standards. If this had been you, what would you have done? How would you have responded?

Clearly, we are all keen to learn, and we thrive on feedback, yet we may be disappointed to discover that our performance is being questioned. This prompts our curiosity to ponder the possible nature of the concerns and the basis for the allegation.

Accusations of failing to meet expected standards trigger questions as to how such a conclusion was drawn, and the criteria used. Indeed, what standards had not been met?

Can consulting ANZCA professional documents (prof docs) provide some answers?

In considering standards some fundamental questions arise, not least of which is "What is a standard?".

The college sets standards of professional practice that are reflected in the college's prof docs, which encompass all the ANZCA roles. The purpose of this article is to clarify the intent of ANZCA prof docs, address apparent confusion, and provide insight into the applicability of prof docs.

In this context, there are a number of terms, such as standards, policies, guidelines, and (position) statements, which are not infrequently confused and used interchangeably. Needless to say, such confusion raises concerns with regard to the implications of college documents and their standing.

Clearly, there is a need for clarity and consistency, which demands a glossary of terms that can be applied to all college documents.

The challenges faced in developing a glossary is that dictionary definitions tend to be numerous, variable, and not infrequently circular. Consequently, they are often unhelpful in the clinical context and have revealed the need to define terms in a way that clarifies their intent and ensure that they are fit for purpose. This is critical when it comes to defining criteria, as actions are determined by decisions, supported by well-defined and clear criteria that facilitate the decision-making process.

While few things are black and white (unless you happen to be a Collingwood supporter), the fewer the shades of grey (no further comment here) the simpler the choice. Averting the need for interpretation reduces uncertainty and doubt and simplifies the process to a binary one, the pathway to a decision-making nirvana. An example of this can be seen with traffic lights.

Most countries, but not all, have a three-light system. Red = stop, green = go, amber = caution. The first two are clear and signify either stop or go leaving no room for interpretation. However, the third is open to choice as to whether to stop, or to accelerate and hope to get through before one's image is captured if the run is misjudged.

So, returning to prof docs and standards against which performance may be assessed, it would be fair to say that prof docs embody the standards set by the college. Standards are authoritative statements regarding levels of performance that serve as benchmarks and against which performance can be measured or gauged. They may identify minimum levels of acceptable performance, in which case they are minimum standards and therefore, mandated; or at the other end of the spectrum they may identify levels of excellence, in which case they are aspirational; or they may identify a range of acceptable performance.

Applicable standards can be inferred from either the introduction, purpose, or scope sections of ANZCA prof docs.

By way of example, *PS03 Guideline for the Management of Major Regional Analgesia*, provides guidance to anaesthetists and pain medicine specialists for managing patients to whom major regional analgesia is being administered. One of the implied standards in this document is that patients should expect that administration of a regional block will be effective at the surgical site. Any wrong site (wrong side) block fails to meet this expected (minimum) standard of care. However, a patchy block, which will not meet the excellence level, may fall within the range of acceptable performance, depending on how it is managed.

When it comes to evaluation of performance, standards need to be identified against which performance can be gauged. Clearly, ANZCA prof docs are not titled as standards, but rather as policy, (position) statement, or guideline. They are categorised in this way for two reasons, the first being to distinguish that policies are mandatory whereas statements and guidelines are advisory; and second being that there is a hierarchy with policy at the top, guideline at the bottom, and statement in between. This is not an indication of their importance but rather the "strength" of the document.

Within the library of professional documents there are only two ANZCA policies – *A01 Policy for the Development and Review of Professional Documents*, and *A02 Policy on Endorsement of Externally Developed Guidelines*, and one FPM policy – *AP01 Policy for the development and review of professional documents – 2018*. The remainder of the library consists of guidance documents being either position statements or guidelines. Development of advisory documents involves identification of standards and making recommendations to which discretion is permitted to accommodate individual cases as determined by need and uniqueness of circumstances.

The recommendations are based on best available evidence, or consensus where evidence may be lacking, with a view to facilitating achievement of applicable standards.

Given that these documents list multiple recommendations the question could be asked as to whether all recommendations need to be followed, or just some, in order to meet the standard. Clearly this is controversial and subject to debate, although it would be reasonable to expect that adherence to all recommendations deemed to be essential would be required in the case of any minimum standard. Careful crafting to deliver the desired outcome, but avoid unintended consequences, is essential where documents are based on minimum standards. But what of those recommendations promoting levels of excellence, or acceptable range? Setting an arbitrary percentage of compliance with, or prioritising/weighting recommendations all have their drawbacks.

So, in the introductory scenario above, a reasonable response might include a request for specific information regarding the alleged poor performance and the standards against which this was assessed. Consulting prof docs should be considered as part of the enquiry, but in the context that an understanding of what a standard is and how it is reflected in prof docs is essential.

An offshoot of this is that it is likely to assist in targeting any area(s) on which to focus when it comes to remediation, if indeed that is required.

When faced with a seemingly adverse situation a civilised approach goes a long way towards resolution. In the words of Mahatma Gandhi, when asked what he thought of Western civilisation, he replied that he thought it would be a good idea.

Professional documents – update

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

Recent updates

- Document development group (DDG) membership has been established for the review of *PS09 Guideline on sedation and/or analgesia for diagnostic and interventional medical, dental or surgical procedures*. This is to become a co-badged document involving a true multidisciplinary collaboration between 25 colleges/societies.
- The formation of DDG membership for *PS49 Guideline on the Health of Specialists, Specialist International Medical Graduates and Trainees* is in progress. The DDG will include representatives bringing with them a diverse range of perspectives.
- DDG membership has been established for the development of *PS67 Professional document on end-of-life care for patients scheduled for surgery*. The DDG is constituted from multidisciplinary groups including anaesthetists, pain medicine physicians, ethicists, surgeons and physicians.
- The release of *PS55 Position Statement on minimum facilities for safe administration of anaesthesia in operating suites and other anaesthetising locations for consultation with stakeholders* has been temporarily delayed.
- The release of *PS56 Guideline on equipment to manage a difficult airway during anaesthesia* for consultation with stakeholders has been temporarily delayed.

In pilot

- *PS06 Guideline on the anaesthesia record* (until August 2020).
- *PS26 Guideline on consent for anaesthesia or sedation* (until October 2020).
- *PS29 Guideline for the provision of anaesthesia care to children* (until August 2020).
- *PS43 Guideline on fatigue risk management in anaesthesia practice* (until August 2020).
- *PS51 Guideline for the safe management and use of medications in anaesthesia* (until November 2020).
- *PS66 Guideline on the role of the anaesthetist in commissioning medical gas pipelines* (until October 2020).

Recent release

- *PS04 Statement on the post-anaesthesia care unit.*

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

ADVERTISEMENT

Novel VET technology directly measures elasticity not amplitude for greater clinical accuracy

True POC device for bleeding management when time is critical, with results within 15 minutes

The Quantra® System is a new point-of care (POC) device for managing bleeding in the critical setting. Its novel viscoelasticity technology pioneers the use of ultrasound and directly measures elasticity not clot amplitude – with results in 15 minutes or less.

Unlike classic VET systems, there are no moving parts to come into contact with blood or the need for pipetting. Dials display the results numerically, with no complex curves to decipher. It takes less than a minute to use with minimal training.

In acute perioperative situations, urgent decisions must be made on how to treat critically bleeding patients, while avoiding the unnecessary use of blood products. Quantra reduces the time between diagnostics and haemostatic intervention and minimises the complications linked to bleeding or transfusions.

"Quantra's advantage is that it utilises a fully enclosed cartridge with no moving parts in contact with blood. A unique benefit reducing the risk of infections among medical staff"

Dr. Florian Raimann, Anesthesiologist, University Hospital Frankfurt, Germany

Accuracy of platelet contribution to clot stiffness

The Quantra system, available from Stago ANZ, provides parameters relating to clot time and clot stiffness – the first whole blood viscoelastic testing (VET) system to provide direct quantification of the 'platelet contribution to clot stiffness', or PCS.

Easy-to-interpret, intuitive dials display

The PCS is derived from direct measurement of the clot's elastic properties and accounts for both platelet count and the platelets' ability to aggregate, contract and contribute to clot strengthening. Further, it measures the evolving clot stiffness without any manipulation or disruption to the clot, thanks to its unique SEER technology. Current evidence indicates that calculating the platelet component to clot stiffness is more accurate if based on measuring elasticity rather than the clot amplitude used by current thromboelastography or thromboelastometry devices.

Unique ultrasound technology

Blood is automatically drawn up from the collection tube into four separate channels and into a chamber. Here the Quantra's unique ultrasound technology, Sonic Estimation of Elasticity via Resonance (SEER) sends a pulse into the sample to generate a shear wave and estimate sample motion. The shear modulus of the sample is calculated at a specific time point by analysing sample motion patterns.

Ultrasound enables the patient's blood to be analysed without it having contact with any moving parts. This reduces the potential interference seen with classic VET methods. The result is increased sensitivity to early clot formation - and also to soft clots, often linked to clinical bleeding. As the cartridge is fully enclosed there is no risk of blood spillage when disposing. This is a unique, safety benefit that minimises the risk of blood exposure among critical care staff.

The Quantra offers a unique and intuitive dials display. Instead of complex curves, it provides actionable and easy-to-interpret information with minimal staff training required.

"The only device we can operate safely without needing specialised rooms and a biohazard cabinet for COVID-19 patients"

Ekaterina Baryshnikova PhD, IRCCS Policlinico San Donato, Milan, Italy

Quantra is the first whole blood viscoelastic testing (VET) system to provide direct quantification of the 'platelet contribution to clot stiffness'

Two Quantra cartridges

The Quantra® QPlus® cartridge offers the following parameters: clot time (CT), clot stiffness (CS), clot time with heparinase (CTH) and fibrinogen contribution to clot stiffness (FCS). From these, two additional parameters are automatically calculated: clot time ratio (CTR), and platelet contribution to clot stiffness (PCS). Studies demonstrate good correlation with standard laboratory parameters and good concordance with the clinical presentation.

The Quantra® QStat® cartridge is for other critical bleeding settings such as trauma and liver transplants, because of its additional ability to measure fibrinolysis.

Information provided by the Quantra system can be integrated into an effective and comprehensive algorithm for the management of perioperative bleeding.

email: info@au.stago.com
if you would like a demonstration

Further information including references, email: **info@au.stago.com**. Diagnostica Stago Pty Ltd, 351 Burwood Highway, Forest Hill, 3131 VIC, Australia

Clean Up Theatre Day – "Reduce Bluey Use"

Inspired by Clean Up Days throughout Australia, a group of trainees hosted the first Clean Up Theatre Day in seven hospitals across Australia on 4 March.

THIS WAS THE first initiative for the trainee group called TRA2SH (Trainee-led research and audit in anaesthesia for sustainable healthcare) and its theme was "Reduce Bluey Use". Knowing that Australian hospitals create 3.3 kilograms of waste per patient per day (of which 25 per cent are attributable to operating theatres), trainees have collaborated to generate environmentally-focused projects to engage their departments in reducing, reusing and recycling in theatre (*PS64 Statement on Environmental Sustainability in Anaesthesia and Pain Medicine Practice*).

Trainees hosting Clean Up Theatre Day had an opportunity to execute a scholarly role by conducting a local audit of bluey use over 12 months, giving a presentation to the department and raising awareness of sustainable healthcare by liaising with the wider theatre community. TRA2SH is founded on the goal of collaborative trainee audit and research in sustainable anaesthetic practice. Collating data, sharing ideas and experiences to promote collective learning across Australia and New Zealand were key components to the project's success.

Professor Kate Leslie tweeted her repurposed theatre packaging being put to good use as a trolley "tablecloth" alongside an otherwise unused kidney dish.

Using the principles of reduce, reuse and recycle, the "Reduce Bluey Use" theme was chosen as bluey underpads are a high-use and non-degradable theatre item (even when marketed as "biodegradable") that can be neither reused nor recycled.

An audit of the total number of blueys used in a 12-month period was used by trainees to encourage their colleagues to reflect on practices where alternatives to a bluey could be found – without compromising infection control. In order to promote local solutions that suit each department's needs, TRA2SH trainees were free to "host" the project in a manner that fitted their department's needs, which also helped to generate new and creative solutions to reduce theatre waste. The number of blueys used ranged from 15,600 to 96,000 per annum, relative to the number of operating theatres (range 4-16).

Reducing (rather than reusing or recycling) one's use of any given item, is the most effective way of making a positive impact on the environment because it not only reduces landfill but also reduces the environmental impact of manufacturing, sourcing, transporting and processing raw materials.

One trainee traced the steps of a "locally" manufactured bluey and found that 14 countries were involved in the sourcing, processing and manufacturing of items.

Solutions included avoiding bluey use (for example as a "tablecloth" on the trolley), reusing other items such as towels for spills or wrist positioning, scrub towels and surgical packaging in place of a bluey. The enthusiasm spread – one hospital launched a "Reduce Bluey Use" campaign on the wards, some consultants reported a spillover effect in their private practice and others went beyond blueys to find creative solutions for reducing other theatre waste items. These included avoiding plastic drug trays and repurposing or recycling packaging.

Interested trainees from New Zealand and nearly all states and territories in Australia contacted TRA2SH via email, social media or word of mouth to plan their project. Of those, seven trainees hosted Clean Up Theatres Day on 4 March. TRA2SH provided information to help them carry out the project within their department and standard posters which could be customised to each location. Trainees were surveyed to find out how the day went, what barriers and supports existed and what could be improved next time.

Dr Jess Davies with her TRA2SH Poster and some alternatives to using a bluey.

Dr Niketh Kuruvilla and his nurse colleague Eilidh Ratcliffe pose next to TRA2SH posters and demonstrating a unique use for reusable absorbent pads.

Many thanks to the trainees who participated – Dr Tejas Chikkerur at Westmead Hospital (NSW), Dr Jess Davies at Royal Darwin Hospital (NT), Dr Jack Dixon at Caboolture (Qld), Dr Sophia Grobler at Royal Children's Hospital (Vic), Dr Niketh Kuruvilla at Mercy Hospital for Women (Vic), Dr Nicole Muir at St Vincent's Hospital (Vic), Dr Jinesh Patel at Royal Melbourne Hospital (Vic) and Dr Genna Verbeek at Alfred Health (Vic). The project would not have been possible without the support of the nurses and theatre staff.

TRA2SH's core goals are to remain trainee-led, collaborative and non-judgmental and always welcomes interested trainees to join and work towards new sustainability projects. Follow @tra2sh1 on Twitter and email tra2shgroup@gmail.com for information, and please – reduce, reuse and recycle at home and at work!

> "One trainee traced the steps of a "locally" manufactured bluey and found that 14 countries were involved in the sourcing, processing and manufacturing of items."

Dr Sophia Grobler and Dr Jess Davies
Anaesthesia trainees

Environmental Sustainability Audit Tool

THE ANZCA ENVIRONMENTAL Sustainability Working Group (ESWG) was established to assist the college in promoting environmental sustainability within the organisation and the profession. One of its projects was to design a tool that clinicians and departments could use to improve their performance in sustainability. This was launched on World Environmental Day, Friday 5 June.

The ESWG understands that the issue of sustainability can be overwhelming. The audit tool provides a framework of activities and it's designed to help identify interventions that could reasonably be considered at an individual, departmental or organisational level. The tool can be found on the ANZCA website.

I thank the members of the ESWG for their work on this project and I welcome feedback from fellows and trainees via enviro-sustainability@anzca.edu.au.

Dr Scott Ma FANZCA
Chair, Environmental Sustainability Working Group

Dr Ray Hader Award for Pastoral Care

Applications are now open for the Dr Ray Hader Award for Pastoral Care. This award acknowledges the significant contribution by an ANZCA fellow or trainee to the welfare of one or more ANZCA trainees. The nature of such a contribution may be direct, in the form of support and encouragement, or indirect through educational initiatives or other strategies.

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.

The winner of the award receives $A2000 to be used for training or educational purposes. Any ANZCA fellow and/or trainee can be nominated for this award. Individuals must be nominated and seconded by an accredited ANZCA trainee or fellow and supply the details of two additional referees (other than the nominator and seconder). The nomination must consist of a cover letter written by one or both of the nominators explaining the rationale and justification for the nomination and be accompanied by the nominee's curriculum vitae. The cover letter and CV should include how the candidate has made a significant contribution to the pastoral care of trainees.

Application forms can be found at www.anzca.edu.au/about-anzca/our-awards/dr-ray-hader-trainee-award-for-compassion. All applications must be emailed to training@anzca.edu.au by Friday 25 September 2020.

This advertisement is for medical professionals only and has been removed for this edition.

The ANZCA Library

What's new in the library?

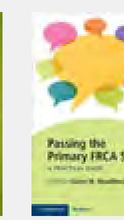
Exam resources update

The library has created a new Training & Examinations Hub that aims to bring together all the resources designed to support the education and training programs at ANZCA and FPM for both trainees and educators.

Many guides have been updated, highlighting a number of new resources.

In addition, the library has finally been able to add e-book access for a large of number of exam-related titles that were previously only available in print.

Newly added exam e-book titles include: Foundations of Anesthesia: Basic sciences for clinical practice; Graphic Anaesthesia: Essential diagrams, equations and tables for anaesthesia; and The Final FRCA Structured Oral Examination: A complete guide.



Access the hub here: https://libguides.anzca.edu.au/training-hub.

New library resources hubs

In addition to the Training & Examinations Hub, the library has also created several new resources hubs to better support the activities of ANZCA fellows and trainees.

A new Professional Development Hub that aims to bring together all the resources designed to support professional development and maintenance. Again, many guides have been freshly updated, highlighting a number of new resources, and – where possible – indicating their CPD credit value.
http://libguides.anzca.edu.au/cpd-hub

The Safety & Advocacy Hub brings together all the library guides/resources in the Safety, quality and advocacy arena. The hub includes the safety and quality and anaesthetic allergy library guides plus the Coronavirus/COVID-19 library guide – the focal point for all COVID-19 clinical resources.
http://libguides.anzca.edu.au/safetyadv

The Special Interests Group Hub brings together resources related to the ACE Special Interest Groups, including those resources available through the ANZCA Library.
https://libguides.anzca.edu.au/sig-hub

IAC Review on obesity anaesthesia

The latest issue of *International Anesthesiology Clinics* contains an obesity update.

Articles include:

- Alternate airway strategies for the patient with morbid obesity.
- Challenges of paediatric obesity in perioperative care.
- ERAS protocols in bariatric surgery: A systematic review.
- Procedural sedation in the morbidly obese: implications, complications, and management.
- The trauma patient with obesity: anaesthetic challenges.

The full-text can be accessed via BrowZine or the Library Journals page.

https://tinyurl.com/IACobese

Recent anaesthesia and pain-medicine COVID-19-related articles

The "Other resources" tab of the COVID-19 resources guide includes a dedicated "Recent articles" section. The list of articles is updated weekly and includes many newly published articles. Recent articles include:

- Bowdle A, Munoz-Price LS. Preventing Infection of Patients and Healthcare Workers Should Be the New Normal in the Era of Novel Coronavirus Epidemics. Anesthesiology. 2020;132(6):1292-1295.
- Deer T, Sayed D, Pope J, et al. Emergence from the COVID-19 Pandemic and the Care of Chronic Pain: Guidance for the Interventionalist [epub ahead of print, 2020 May 21]. Anesth Analg. 2020;10.1213/ANE.0000000000005000.
- A complete list can be accessed via the COVID-19 guide –http://libguides.anzca.edu.au/covid-19/

Calling all ANZCA and FPM researchers – promote your research and publications!

Want to expose your articles and research to a wider audience?

Add your publications to ANZCA's new institutional repository (AIRR), and it will also be discoverable on both Google and Trove.

airr.anzca.edu.au

Recent contributions to AIRR:

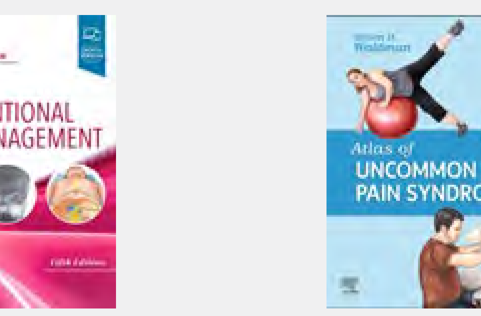
- *Acute Pain Management: Scientific Evidence* – the second, third and fourth editions have recently been added to AIRR, with links to the PDF full-text.
- Huang L, Dharmawardana N, Badenoch A, Ooi EH. *A review of the use of transnasal humidified rapid insufflation ventilatory exchange for patients undergoing surgery in the shared airway setting.* J Anesth. 2020;34(1):134-143. doi:10.1007/s00540-019-02697-3.
- Boden I, Skinner EH, Browning L, et al. *Preoperative physiotherapy for the prevention of respiratory complications after upper abdominal surgery: pragmatic, double blinded, multicentre randomised controlled trial.* BMJ. 2018;360:j5916. Published 2018 Jan 24. doi:10.1136/bmj.j5916

To learn more about the ANZCA and FPM institutional repository and how you can contribute, check out the dedicated AIRR Library guide: libguides.anzca.edu.au/research/airr

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

New titles in the library

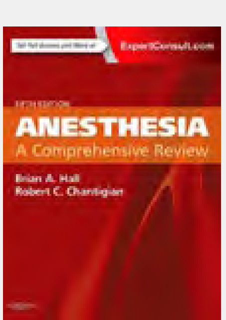
Anesthesiologist's manual of surgical procedures, 6e
Jaffe RA, Schmiesing CA, Golianu B. Philadelphia, PA: Wolters Kluwer, [2020].



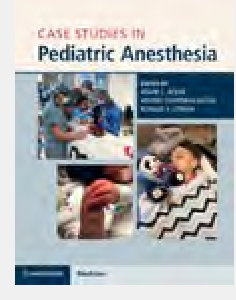
Atlas of interventional pain management, 5e
Waldman SD. Philadelphia, PA: Elsevier/Saunders, [2021].

Atlas of uncommon pain syndromes, 4e
Waldman SD. Philadelphia, PA: Elsevier/Saunders, 2020.

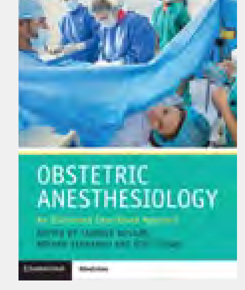
Gregory's pediatric anesthesia, 6e
Andropoulos DB, Gregory GA [eds]. Hoboken, NJ: Wiley-Blackwell, 2020.

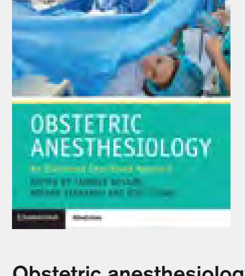


Anesthesia: a comprehensive review, 5e
Hall BA, Chantigia RC. Philadelphia, PA: Elsevier, 2014.

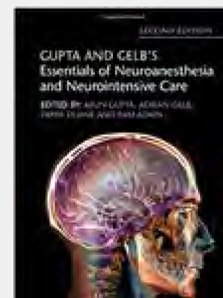


Case studies in pediatric anesthesia
Adler AC, Chandrakantan A, Litman RS [eds]. Cambridge: Cambridge University Press, 2019.

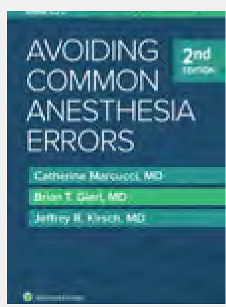




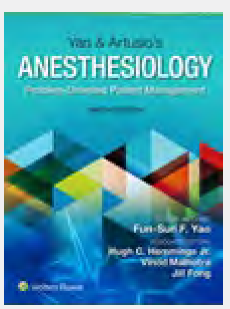
Obstetric anesthesiology: an illustrated case-based approach
Husain T, Fernando R, Segal S [eds]. Cambridge: Cambridge University Press, 2019.



Gupta and Gelb's essentials of neuroanesthesia and neurointensive care, 2e
Gupta AK, Adapa R, Gelb AW, Duane D. Cambridge: Cambridge University Press, 2018.



Avoiding common anesthesia errors, 2e
Marcucci C, Gierl BT, Kirsch JR. Philadelphia, PA: Lippincott Williams & Wilkins, 2020.



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Research

Clinical research in a COVID-19 world

THE COVID-19 PANDEMIC has required the ANZCA Clinical Trials Network (CTN) to adapt to a rapidly transforming clinical trials landscape in just a short few months.

With elective surgery cancelled by many governments to free up hospital beds and to ensure an adequate supply of personal protective equipment, many sites could no longer recruit to, or substantially slowed down, recruitment to CTN trials.

This has produced grave concerns for the already vulnerable network of anaesthesia research co-ordinators that mostly rely on funding from per patient payments for their salary. Research co-ordinators across many sites have reported re-deployment, taking unplanned leave, being stood down or reduced hours to preserve departmental research funds.

While some research co-ordinators had the opportunity to work from home, this has brought a new set of challenges, particularly lack of remote access to clinical and research files which are core requirements for research activity.

From left: Professor Kate Leslie AO, Vi Ha and Wendey Purcell at the Royal Melbourne Hospital.

Through these trying times, the CTN has responded with flexibility, creativity and innovation in the way we conduct trials. For many departments, anaesthesia and perioperative research prior to the pandemic often involved a number of face-to-face visits with clinical trial participants and a research co-ordinator workforce almost exclusively based onsite at clinical facilities.

The COVID-19 pandemic has accelerated a huge leap forward in many areas we once imagined were too challenging. In particular, it has highlighted opportunities for expansion into the area of telemedicine, which in turn has improved accessibility of healthcare and research into remote locations. The removal of anaesthesia pre-admission clinics has forced us to streamline processes and better utilise phone contact with patients. Working from home has led to an increased utilisation of e-signatures on clinical trial documents, an area traditionally slow within the start-up of new clinical trials, and the running of virtual team meetings.

All these changes not only save time but importantly reduces unnecessary risk of COVID-19 exposure to patients and staff. While vital, these changes also come with a raft of technical, data safety and confidentiality issues to tackle.

The CTN has also had to temporarily shift away from our core business to run COVID-19 research and seize funding opportunities to support the network. We've also launched several virtual workshops in lieu of our annual face-to-face strategic research workshop to continue the vital learning, education and mentoring of research co-ordinators and emerging researchers. When we look back in time, the pandemic may in fact be the key pivot point on which we fundamentally change the way we do things. In a post-COVID-19 world returning to the "status quo" may be too risky for the CTN. Instead, we must continue to establish new processes to lead the way in efficient and innovative clinical trial conduct.

Allison Kearney
ARCN Sub-Committee Chair

Karen Goulding
CTN Manager

ANZCA Research Foundation update

Foundation Committee Chair

On behalf of the foundation team and members of the foundation committee, we extend our sincere thanks to Dr Genevieve Goulding who has stepped down after four years of service as chair of the ANZCA Research Foundation Committee. The foundation acknowledges and thanks Dr Goulding for her guidance and support over this time.

At the 9 May ANZCA Council meeting, Dr Rod Mitchell was appointed as the new chair. The foundation looks forward to working with Dr Mitchell in continuing to build support for research, education, Indigenous health and overseas aid. It is a mark of the importance placed by the college on the role of these important areas which are clearly identified in its vision and strategic priorities that several successive presidents have served as chairs of the foundation following their presidential terms.

Dr Nerida Dilworth Bequest

The foundation was humbled to be notified that it had been named as a significant beneficiary in the estate of the late Dr Nerida Dilworth AM.

Nerida devoted her career to establishing outstanding paediatric anaesthesia in Western Australia. She was director of the anaesthesia department at Princess Margaret Hospital (PMH) for Children from 1960-90, and the longest serving director of an anaesthesia department in Australia. She was also chair of the Division of Surgery for several years and inaugurated intensive care at the PMH.

Nerida was a tireless contributor to the college and was duly acknowledged for her significant contribution to anaesthesia by receiving many awards including a member of the order of Australia and the inaugural Australian Society of Anaesthetists Medal.

Her generosity will help build the foundation's future capacity to provide supportive grants for important work led by fellows and trainees.

Any fellow interested in creating a special endowment, or including a foundation bequest in their will, should contact the foundation to discuss options and how we can help.

Dr Nerida Dilworth

Professor David Story

Medibank Better Health Foundation COVID-19 screening grant

A significant new grant of $A50,000 has been negotiated with the Medibank Better Health Foundation for a study of the outcomes of COVID-19 screening in two major Melbourne hospitals, the Austin and St Vincent's, and will be very important in building confidence for the recommencement of elective surgery. The study is led by Professor David Story, Foundation Chair of Anaesthesia at Melbourne Medical School, in collaboration with fellows at St Vincent's and Austin Hospitals, and will assess outcomes of COVID-19 screening, particularly the incidence or otherwise of false negatives, and the implications for risk identification prior to elective surgery.

Member Advantage

The ANZCA Member Advantage program provides fellows, trainees, specialist international medical graduates and their family members access to exclusive discounts on a great range of attractive lifestyle, leisure and financial services benefits, including dining, accommodation, airline lounge memberships and many more. Members wishing to join the Member Advantage program should contact Anna Smeele at foundation@anzca.edu.au to opt in. Anna will add your name to our monthly upload of new members to the service provider, Member Advantage. Members receive a regular benefits newsletter with access to exclusive offers.

Through the foundation, the program supports fellow and trainee-led research, overseas aid and Indigenous health projects.

Supporting advancement through the foundation

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

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Continuing professional development

COVID-19 and CPD update

The ANZCA and FPM Continuing Professional Development (CPD) Committee and team continue to monitor and discuss all communications from fellows and regulatory authorities in response to the COVID-19 pandemic.

We recognise the difficulties specialists may have accessing their usual channels and methods to undertake learning and development to meet CPD requirements.

The possibilities of restructuring the CPD program's duration/requirements have been considered, but at this stage no decision to implement changes has been made. The pandemic's impact will weigh heavily on any potential changes as our unique triennial structure, whereby there are three active trienniums, requires a considered response to ensure all CPD participants are treated fairly. While, at this time no confirmed changes have been made to annual or triennial CPD requirements, the CPD committee and team will monitor this space closely.

In the meantime, our focus has been on providing clarification for CPD activities completed during the COVID-19 pandemic and mapping over to the current CPD framework. Our new COVID-19 and CPD webpage – anzca.edu.au/fellows/continuing-professional-development – is your go-to for all CPD specific questions relating to pandemic specifically the frequently asked questions and listed resources.

More than 1800 participants have recorded the COVID-19 ER activity

Since its release in April the COVID-19 Airway management emergency response (ER) activity has being claimed by more than 1800 CPD participants in their CPD portfolio. This activity/standard relates to airway management and essential use of personal protective equipment (PPE) in response to the COVID-19 pandemic. No recognition of suitability application process is required, and the recognition code ER-20-COVAIR-123 is to be used when recording participation in your CPD portfolio.

End of 2017-2019 triennium and 2019 verification results

The 2017-2019 triennium, with more than 3000 participants, resulted in 99.9 per cent successful completion. This is an amazing achievement and highlights the dedication fellows have to their professional development.

Furthermore, our annual (2019) verification of CPD activities with 450 participants (7 per cent of fellows) also resulted in a high success rate of 99.5 per cent. Our thanks to all who participated in these core college functions.

Auto-population from TPS to CPD portfolio

The training portfolio system (TPS) and continuing professional development (CPD) portfolio auto-population function provides synergy between the two systems to reduce data duplication. That is, if assessments are completed on trainees and logged in the TPS, credits will be automatically be entered into the CPD participant's portfolio for later confirmation or editing. Also, provisional fellowship trainees (PFT) can also select activities submitted.

It was recently identified that certain scholar role activities (SRA) weren't auto-populating to the CPD portfolio. This technical error has been resolved and retrospective activities for active CPD trienniums have now been synced. The table below has been provided for clarity on current activities that populate between the systems.

Alternatively, activities will be required to be entered manually. This is usually down to being unable to map a particular activity from the training framework to the CPD program. Further review of the auto-population process is to be investigated in 2020.

TPS	CPD
Activities completed by assessors	
Workplace-based assessments (WBA) (awaiting trainee response and completed)	WBA of trainees
Specialist study unit reviews (completed)	Other assessment of trainees
Clinical placement review (completed)	Other assessment of trainees
Core unit and PFT review (completed)	Other assessment of trainees
Scholar role activities (SRA) (completed)	Other assessment of trainees
Activities complete by provisional fellowship trainees	
Multi-source Feedback (MsF) (completed)	MsF
SRA	
Attend regional or greater conferences/meetings.	Learning sessions
Complete an audit and provide a written report.	Clinical audit
Critically appraise a paper published in a peer-reviewed indexed journal for internal assessment.	Reviewer/editor of journal
Critically appraise a topic for internal evaluation and present it to the department.	Presenting

Ethical considerations for clinical audit and quality improvement activities

Clinical audit and quality improvement (QI) activities are increasingly a part of our "business-as-usual" activities in our healthcare organisations. It is one of our ethical obligations to ensure that the gap between evidence-based practices and the actual patient care delivered is minimal to ensure safe quality care.

Alongside the perioperative movement and the need to fulfil continuing professional development (CPD) and scholar role audit requirements, there has been more focused and disciplined efforts to undertake QI projects such as introducing new patient pathways and protocols, and to use clinical audits as a measurement tool.

In any situation where patients and their personal data are involved, there is a potential risk of not only psychological but physical harm. For example, the burden of time for a survey, the compromise of patient autonomy in collecting patient data, or choosing certain patient groups into untested patient pathways which may differentially treat one group over another. The cost of time and effort to an organisation may be wasted or unjustified if not properly conducted or results disseminated and acted upon.

Although clinical audit and QI projects have a different intent and focus, we should be no less stringent about our ethical considerations and oversight for audit as we do for research as the distinction between the two can sometimes be unclear. Departments and individuals should be aware of their local guidelines, policies and ethical obligations.

Therefore, the ANZCA and FPM CPD Committee has reviewed this and added a statement to reflect the importance of ethical considerations for quality improvement and clinical audit within the *CPD handbook appendix 10 clinical audit guidelines*. This will align with what is expected of trainees for their scholar role activity audit to ensure that everyone respects the rights of patients and their data in such activities.

Dr Veronica Gin
Specialist Anaesthetist
Christchurch Hospital

This advertisement is for medical professionals only and has been removed for this edition.

Unlocking the controlled drug book data

FANZCA Dr Sarah Bowman supervised an audit project by registrars Dr Louis Yin and Dr Pi Songsiritat of 3000 patients at a Queensland hospital to examine the practice of splitting opioid ampoules.

THE FIRST AUDIT showed that about 40 per cent of 500mcg vials of fentanyl were being used for more than one patient, far higher than expected and clearly against ANZCA guidelines at that time. However, a follow-up audit showed improvement.

The opioid crisis has made headlines over recent years, especially in the US where an estimated two million people have opioid use disorder.

Australia has also seen significant growth in opioid prescribing and with it, an increasing number of casualties (about 1600 people died from opioid overdoses in 2017) related to their use. Opioid use in the perioperative setting plays an important role in the opioid crisis and has become a topical issue in the field of anaesthesia.

As perioperative physicians, anaesthetists have explored their role in minimising opioid exposure and decreasing misuse among surgical patients. This has included multi-modal anaesthesia, with the use of adjuvant analgesics and regional anaesthesia becoming increasingly popular. Anaesthetists have also tried to minimise the inappropriate prescription of opioids in the postoperative setting, with the 2018 ANZCA *Position statement on the use of slow-release opioid preparations in the treatment of acute pain* advising against the use of slow-release opioids for acute pain, citing an increased risk of long-term opioid use.

With the increase in opioid governance and stewardship, consideration into how and why they are used in our practice has commenced. In our department (at a metropolitan hospital in Queensland) it had been noticed that multidosing or "ampoule splitting" (administering medication from one ampoule to multiple patients) of opioids may be prevalent.

ANZCA had clear guidelines advising against this practice - Medication Safety (*PS51 Guidelines for the Safe Management and Use of Medications in Anaesthesia* 2018) and Infection Control (*PS28 Guidelines on Infection Control in Anaesthesia* 2015). PS51 has recently been amended to allow ampoule splitting in certain circumstances.

The practice of ampoule splitting can also lead to poor documentation by creating discrepancy between medication dispensed and administered for a designated patient, and potentially increase the risk of misappropriation by susceptible individuals. We conducted an audit into this practice for 500 mcg vials of fentanyl to assess its prevalence. The data was presented to the department and then followed up with another audit to assess change.

Data on over 3000 patients across 749 theatre lists was collected for the two audits in 2018 and 2019.

The data was analysed using a computer program written in Python to detect where "ampoule splitting" likely occurred. This program identified theatre lists where fentanyl 500mcg was dispensed, but not all used (administered, returned, or discarded) for the designated patient, followed by another patient on the same list receiving more fentanyl than was dispensed.

The initial audit found 41.4% of theatre lists were positive for "ampoule splitting" of opioids. In the second audit in 2019, ampoule splitting was still commonly practiced but had decreased to a rate of 23% of theatre lists.

Whilst the practice of ampoule splitting was still commonplace, the improvement demonstrated the benefit of increased awareness through auditing and departmental education.

The audit also found the incidence of documenting medication discards to be very low. For 500mcg fentanyl ampoules dispensed, there was a 38% discrepancy between the amount dispensed to the amount administered or discarded for the designated patient. This discrepancy was likely due to ampoule splitting or medication discarded without documentation, but we should not be creating an environment where such a large portion of fentanyl unaccounted for is open to guesswork.

While there has been an increase in opioid governance awareness in recent years, the administration of opioids in the perioperative setting by anaesthetists has received little attention.

Anaesthetists are often in the unique role of being solely responsible for opioid prescription, dispensing, preparation and administration. Our audit demonstrates only one aspect where inadherence to guidelines in this process may be common practice. Anaesthetists play a central role in addressing the opioid crisis and perhaps it is time we put a microscope on how opioids are being used in our daily practice.

Dr Louis Yin, Intensive Care Unit Registrar
Dunedin Public Hospital, New Zealand

Dr Pi Songsiritat, Emergency Department Principle House Officer, Ipswich Hospital, Qld

(Dr Yin and Dr Songsiritat were both resident medical officers at the Brisbane hospital when the audit was performed)

Dr Sarah Bowman, FANZCA, Staff Specialist QEII Hospital, Senior Lecturer Anaesthetics, University of Queensland

Training and education

Initial assessment of anaesthetic competence

THE INITIAL ASSESSMENT of anaesthetic competence (IAAC) is a summative assessment completed towards the end of introductory training (IT), typically six to 12 months after commencing as an ANZCA trainee. The purpose of the IAAC is to verify that the trainee has attained key competencies to safely undertake basic anaesthetic practice in a more independent capacity.

Currently the IAAC comprises two components:

- Workplace-based assessments.
- Initial assessment of anaesthetic competence questions (IAACQ) based on the learning outcomes from the introductory core study unit of the curriculum.

There is limited guidance on how to conduct the IAACQ, resulting in a wide variation in implementation of the assessment between different anaesthetic departments. The 2018 *Trainee Wellbeing Working Group Report* identified this variation as a source of stress for trainees. Differing assessment practices between training sites was also noted as being potentially unfair. We surveyed supervisors of training and IT tutors from a range of hospitals across the training regions to ascertain how the IAAC is currently undertaken.

All hospitals use locally drafted tests for assessment of knowledge, although there are varying degrees of formality, length, structure and difficulty. The formats used include:

- **Face-to-face discussions**
  At one end of the spectrum this involves a viva under primary exam-like conditions (with multiple examiners, structured marking schemes mapped to IT learning outcomes and little feedback) and at the other extreme a "Socratic dialogue" with supervisors.
- **Written exams**
  Both SAQ and MCQ exams are used, often completed under primary exam-like conditions, however, some centres describe using a take-home written paper (open book and completed over several months).
- OSCEs
- **Logbooks**
  Documentation of learning outcomes studied and discussed, verified by list supervisors.

Nine mandatory WBAs are required for assessment of workplace performance, but are perceived by many of the supervisors surveyed as unreliable and incomplete for making decisions about clinical competence and progression. This is in contrast to the evidence that WBAs (particularly case-based discussions and multi-source feedback) are reliable in performance assessment and correlate well with the final exam result[1].

Additional workplace performance assessments widely used to support decisions include:

- **Discretionary WBAs** usually focused on running a list or doing an after-hours case.
- **Direct observation by SOTs** followed by a discussion of the case.
- **Formal discussions** about trainees at senior staff meetings.
- **Informal "corridor" discussions** about trainees.
- **Local written feedback systems** often using electronic survey forms.

Assessment of crisis management and emergency responses are considered essential in most hospitals, perhaps reflecting the need to assess trainees for transition to more independent practice

Assessments used include:

- **Viva.**
- **DOPS** following a training session.
- **Simulation** training and assessments.

Most SOTs surveyed thought their interpretation of how to conduct the IAAC worked well for their situation. It is apparent, however, that there is wide variation in practice.

With the awareness of this variability, the challenge for ANZCA is to produce an IAAC that satisfies the following:

- Incorporates assessment of knowledge, performance and crisis management.
- Is standardised enough to be perceived as fair by all trainees.
- Allows local flexibility.
- Is feasible for all training sites to use.
- Demonstrates reliability between different training sites.

Options that could be considered include assessment of knowledge by multiple-choice questions (possibly administered electronically, from a central repository); single best answer type questions; vivas based on templates; short answer questions. WBAs have shown reliability and validity as a marker of workplace performance but the number and type of these for use in the IAAC needs to be determined. Other systems, such as daily reports on trainee performance, are commonly used in other jurisdictions. Emergency responses and crisis management could be assessed through vivas, on-line modules (similar in style to the anaphylaxis module developed for the ANZCA CPD program) or simulation.

Wide consultation with trainees and supervisors is planned. Please contact StrategyQuality@anzca.edu.au if you would like to be included in this.

Dr Neroli Chadderton (NZ)
Dr Chris Wilde (Tas)
Dr Sancha Robinson (NSW)
Dr Tim Hodgson (Qld)
Teri Snowdon (Operations Manager, Strategy and Quality, ANZCA)

Reference

1. Castanelli DJ, Moonen-van Loon, JMW, Jolly B, Weller JM. The reliability of a portfolio of workplace-based assessments in anesthesia training. Can J Anesth 2019; 66: 193-200

Provisional fellowship survey

The provisional fellowship (PF) year is designed to provide opportunities for trainees to consolidate the clinical skills and experience they have accumulated and transition from being a trainee undertaking supervised practice to specialist undertaking independent practice and supervising more junior colleagues.

In 2015, the Provisional Fellowship Program Sub-Committee performed a survey to seek feedback from provisional fellows nearing the end of their training about their experience in the different study plans approved by the subcommittee. These study plans included predefined positions, individualised and overseas study plans.

This survey has been conducted every year since 2015 and despite a low response rate has provided the sub-committee an understanding of what experiences PF trainees have in key areas of their preapproved study plans. The survey also helps the sub-committee understand whether a preapproved study plan at a particular training site has allowed the trainees to meet their goals of the PF year.

Key findings:

- General feedback was positive and provided reassurance on the effectiveness of the process of approval of the provisional fellowship study plans.
- There were a few concerns raised about some of the study plans and the sub-committee noted that these belonged predominantly to the training sites which have had some training issues in the past.
- The issues stated were mainly related to clinical support time and adequate exposure to subspecialty area being compromised to reallocate PF trainees to manage staff shortages at individual hospital sites.

What's next?

We hope to continue conducting the survey on a regular basis, and work towards an improved response rate so we can use the feedback to work on the following areas:

- Identify study plans/training sites which are preapproved and don't provide enough opportunity to meet the goals of the PF year especially around clinical support time and subspecialty exposure.
- Provide this information to the Training Accreditation Committee (TAC) in order to feedback to the respective training site and help address these issues.
- Allow the sub-committee at the time of review and approval of study plans to focus on the areas of concerns identified through the survey including seeking more information from the training sites directly.

We thank Shilpa Walia, Nicole Pulitano and Tracy Le for their work on the provisional fellowship program survey.

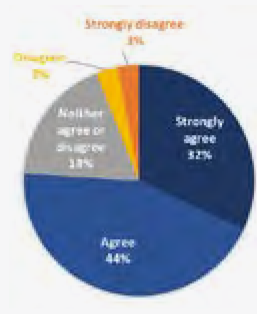
Dr Scott Ma FANZCA
Chair, Provisional Fellowship Program Sub-Committee

Dr Nadia Koehler Vargas FANZCA
Member, Provisional Fellowship Program Sub-Committee

2019 results overview

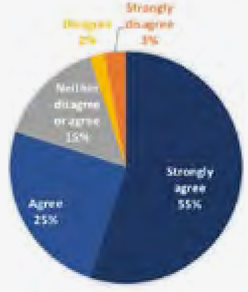
Overall experience

Q: This provisional fellowship position facilitated your transition to independent practice as a specialist anaesthetist.



Supervision

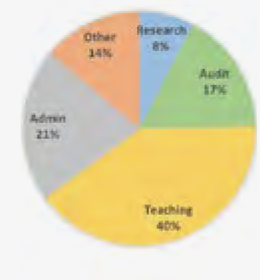
Q: This provisional fellowship position gave me adequate opportunity to run lists independently.



Clinical support activities

Q: Of your clinical support time, what percentage was spent in the each of the following areas?

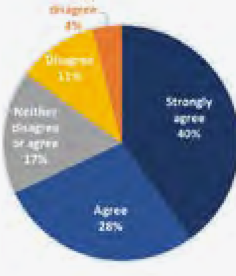
- 90 per cent of all PFs who responded to the survey in 2019 indicated up to 20 per cent of their time was allocated to clinical support activities.
- 92 per cent either agreed or strongly agreed that exposure to clinical support activities was a valuable part of their transition to specialist anaesthetist.



Subspecialty experience

Q: This provisional fellowship position provided me with adequate clinical exposure to the sub-specialty area.

- 96 per cent of all PFs who responded to the survey agreed or strongly agreed that they were confident to manage simple/routine cases in their sub-speciality area.
- 63 per cent agreed or strongly agreed that they were confident to manage complex cases in their sub-speciality area.



Designing a provisional fellowship study plan: Tips for success

STARTING PROVISIONAL FELLOWSHIP training is an exciting time – for many it signals the promise of greater independence and newfound autonomy. It can also be a chance to seek out those opportunities, clinical and non-clinical, which are most inspiring and previously most elusive. Notwithstanding the excitement, creating the perfect fellowship study plan can be a daunting task. So where to begin? Here are a few tips from the Provisional Fellowship Program Sub-Committee to get you started on the right track to finding or creating the ideal provisional fellowship for you.

If you're keen to stay local, there is a list of both general and subspecialty fellowships across Australia and New Zealand, which have been pre-approved. A list of these study plans is available on the ANZCA website.

If you want to create an individualised study plan (which also includes going overseas), you'll need to submit an application with supporting documentation including a position description and a copy of your employment contract. Your application is submitted to the Provisional Fellowship Program Sub-Committee which reviews and approves applications every week. It's worth keeping this process in mind and leave enough time before your contract starts so that all of your provisional fellowship time can be prospectively approved; and training time can only be recorded once the study plan is approved!

When creating your individualised study plan, make sure you talk to your prospective supervisor to nut out some important details. Read through the application form before you chat to them so you can gain some key insights.

Some questions you might like to ask include:

- What clinical opportunities will I be exposed to which will help me transition to consultant practice?
- What is the size and capacity of the institution? What subspecialties are available and how many cases are being done each year?
- What activities will I be completing that will be different to my experience as a trainee?
- With respect to a subspecialised provisional fellowship year, how much time will I spend doing my subspecialty compared to general or "service" lists?

Take the time to plan out a weekly timetable with your supervisor, including anticipated lists, clinics and protected clinical support time. This is a good opportunity to ask about your on-call and overtime requirements. You'll need to submit a sample session planner as part of your application.

Make sure you confirm that your clinical support time constitutes a minimum of 10 per cent of your roster. This is a great time to discuss with your supervisor what non-clinical opportunities there are in the department and to negotiate your own specific research, teaching or auditing goals.

If your dream fellowship is made up of less than 20 per cent clinical anaesthesia time, your application will be reviewed by the Director of Professional Affairs, Assessor. Similarly, part-time applications are also acceptable and requires prospective approval by the assessor.

If you have any questions, speak to your supervisor of training or provisional fellowship supervisor. You can also contact the provisional fellowship officer at ANZCA.

Good luck and happy applications!

Dr Lizi Edmonds FANZCA
Deputy Chair, Provisional Fellowship Program Sub-Committee

Dr Rebecca McNamara FANZCA
Member, Provisional Fellowship Program Sub-Committee

This advertisement is for medical professionals only and has been removed for this edition.

This advertisement is for medical professionals only and has been removed for this edition.

Faculty of Pain Medicine

Boost for pain medicine initiatives

THIS IS A fascinating time to be taking over stewardship of the faculty. We have achieved a number of milestones towards the aims of our strategic plan, yet there remains so much to do.

New circumstances arise and must be dealt with, such as the effect of the COVID-19 pandemic on planning for exams, trainee experiences and advocacy efforts. Some older, persistent problems continue to hamper our efforts to bring high-quality pain care to the people of Australia and New Zealand, such as the difficulties in staffing and maintaining public units during times of financial austerity and the efforts of well-intentioned (and sometimes frankly opportunistic) individuals and organisations to influence the pain management endeavor for commercial ends.

In particular, as an avid conference-goer myself, the loss of the ANZCA Annual Scientific Meeting and FPM Symposium, Spring Meeting, Australian Pain Society, New Zealand Pain Society and the International Association for the Study of Pain World Congress meetings was keenly felt. These are the times for reconnecting with colleagues and communing with "our" people, and are impossible opportunities to replace.

Against these headwinds we have had some successes. The efforts of the faculty to position itself as a trusted source of expertise in the sector has resulted in the award of two significant Australian federal government grants, worth a potential total of $A1.75 million over the next two years. One is for us to develop for the federal government a detailed strategy for pain management education for all health professionals. The other is a Therapeutic Goods Administration (TGA) grant to provide free licenses to six of the Better Pain Management modules for up to 10,000 users over the next two years. Both of these grants provide a source of extra revenue as well as positioning us as a reliable and authoritative source of advice for regulators and government.

We convened and hosted a national workshop day for organisations engaged with delivery of the National Strategic Action Plan for Pain Management, and the report from that workshop will be handed to the federal minister in upcoming weeks. It was the largest gathering of pain sector organisations since the National Pain Summit a decade ago. The Procedures in Pain Medicine Project continues to hit its targets, with the final details of the pilot phase well advanced in development. We expect to see the pilot sites commencing during the 2021 training year.

At the time of writing, we intend to deliver an exam process this year which will ensure that our standards for admission to fellowship are maintained, despite the uncertainty of the last few months. Such a process must reflect not only the high standard of professionalism required for fellowship, but also be flexible and innovative enough to cope with the restrictions of the present time, and not unduly burden or disadvantage our trainees.

In Australia, the TGA reforms regarding opioids will require our close involvement. The availability of smaller pack sizes for immediate release formulations will help to reduce the number of people who persist with opioid use after acute admissions. The requirements for authority prescription for all sustained release formulations may have significant unintended consequences for our chronic pain patients, and this situation will require close monitoring. The newly revised *PS01(PM): Statement regarding the use of opioid analgesics in patients with chronic non-cancer pain* – 2020 is part of a body of work including proposals to update the highly successful opioid calculator app, the Better Pain Management modules, and a new opioid consent video produced in conjunction with NPS Medicinewise to complement the less visible advocacy work we do to ensure that more Australian prescribers use these medications in a way that provides their patients with high-value care.

All of these achievements are a credit to our staff and our fellows. The poet Robert Frost famously "could see no way out but through". So must we, for there is no other. We have a dedicated staff, a talented and diverse fellowship, and we are part of a well-run organisation. Whatever form "business as usual" takes over the next few months, it will continue to deliver on our strategic goals and support our fellows and trainees.

Associate Professor Michael Vagg
Dean, Faculty of Pain Medicine

Recognising Associate Professor Meredith Craigie

IT IS BOTH my duty and my pleasure to recognise the achievements of the outgoing dean of the faculty, Associate Professor Meredith Craigie.

Meredith crowned a stellar career in pain medicine when she became dean in 2018. A year earlier, she was honored by the college with the Steuart Henderson Award for her contributions as a scholar, educator and mentor, having been a paediatric anaesthetist and ANZCA fellow since 1992 and a pioneer advocate for paediatric and adolescent pain services since the turn of the century.

That same year she also received the Distinguished Member Award from the Australian Pain Society. She has served the faculty as an examiner (including as chair of the Examination Committee), supervisor of training, educator, mentor and administrator. To get a clear picture of the scope and diversity of Meredith's achievements prior to becoming dean, I recommend a brief perusal of her citation for either award.

Meredith was elected to the board of the faculty in 2012, at the same time as me. I well recall the daunting feeling of attending a daylong strategic workshop as my first duty as a board member, and my relief at finding a companion "newbie" who shared my sense of trepidation. That didn't last long for Meredith however. Within a year she was heavily involved in the development of the 2015 curriculum which was an enormous amount of work that led to a world-leading achievement.

Dr Meredith Craigie was awarded the inaugural ANZCA Steuart Henderson Award. She was presented the award by then-president Professor David A Scott.

The curriculum has since been adopted as the basis for the European diploma of pain medicine. More recently, her extraordinary work ethic and attention to detail has resulted in the adaptation of the Better Pain Management (BPM) modules firstly for the international format of the QxMD platform, and then at short notice for the Australian Therapeutic Goods Administration (TGA) contract. These enhanced modules have increased the potential reach of the BPM program to more than a million potential users in North America and Europe as well as Australia and New Zealand.

The US politician Michael Enzo observed "If you're not at the table, you're on the menu", and Meredith has left no stone unturned to tirelessly promote the faculty's strategic interests. Her personal advocacy with the TGA and state and federal health ministers has led directly to the two major grants we have been awarded for strategic projects, and positioned the faculty as a key player in political and bureaucratic decision-making.

In her term as dean, Meredith's emotional intelligence and strategic thinking skills have created a quiet revolution in many of the faculty's key relationships. We continue to have a solid partnership with pain societies in Australia and New Zealand, and have benefited from improving relationships with the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, the Royal Australasian College of Surgeons and Painaustralia

Meredith's emotional intelligence and strategic thinking skills have created a quiet revolution in many of the faculty's key relationships

thanks to Meredith's personal touch.

She formed a formidable team with ANZCA's immediate past president Dr Rod Mitchell, and the progress that has been made on her watch to the internal workings of the board and its relationship with ANZCA Council during the faculty's "difficult adolescent" late teenage phase has set the scene for a new era in synergy and collaboration.

Meredith has been a highly visible leader to the fellowship and trainees, by continuing her long-term attendance at the Basic Clinical Skills course, Emerging Leaders' Conference and road tour of regional committee meetings (including the New Zealand National Committee).

One of Meredith's most frequently used words is "collegial". I think this encapsulates her drive to collaborate and bring others along on her quest to improve life for pain patients. She has been a pioneer of paediatric and adolescent pain medicine and pelvic pain care, and a mentor to a generation of younger fellows.

Her term as dean can be summarised as one of skilled, inclusive leadership and relationship building. She hands over a faculty that is well positioned to weather the deep uncertainty of the current times and emerge ready to thrive.

On behalf of the fellowship and staff of the faculty, I thank her unreservedly and salute her enormous legacy built on dedication, professionalism of the highest order and, dare I say one more time, collegiality.

Associate Professor Michael Vagg
Dean, Faculty of Pain Medicine

FPM Board restructure – towards improving fellowship voice

FPM Board, photographed earlier this year.

FROM ITS INCEPTION in 1998 until the 2020 annual general meeting, the FPM Board maintained its original structure. Revolutionary for its time, the board was multidisciplinary, comprising representatives pro rata from the five foundation colleges, with one elected new fellow and two elected positions open to any fellow.

As the faculty has matured, the number of accepted primary specialties has doubled and the fellowship is more evenly drawn from across these disciplines. Moreover, as the roles of a specialist pain medicine physician have been delineated, and the curriculum improved, there is a new breed of fellow emerging that identifies foremost as specialist pain medicine physician. To honour and empower their voices, rather than the traditional institutions from whence they sprang, the board undertook to restructure.

The first step was a critical "self"-reflection upon the board's historical purpose, its strengths, and the changing identities, needs and opinions of fellows and the communities we serve. At the risk of oversimplifying deep, iterative deliberations, the board concluded that:

- The multidisciplinary and binational composition of the board is a valued and inalienable asset of the faculty.
- FPM Board should function as a diverse collective of energetic individuals working toward shared objectives, rather than as representatives communicating the interests of foundation institutions.
- A diverse board, with a culture of respectful listening and exchange of diverse views, is the ideal vehicle for good governance.
- The fellowship has the maturity to nominate and elect board members that are wide ranging in experience and diversity.
- In order to empower marginalised voices, the FPM Board needs a mechanism to co-opt members in order to round out diversity and experience mix following elections.

Consequently, in the 2020 board restructure, the quotas of protected board positions elected from the five foundation specialties were removed. The number of positions elected by and from the general fellowship increased from two to seven. The new fellow position remains unchanged. The two ex-officio board positions (ANZCA president and ANZCA Council representative) continue because, as the board of directors of the company, ANZCA Council maintains responsibility for FPM business under company law.

In addition to these eight elected and two ex-officio positions, the new by-law has provision for board to co-opt up to three additional members to redress diversity and skill mix gaps on board. In voting to co-opt a nominee, board members will consider how they might contribute to: specialised knowledge and skills, diversity of culture and ethnicity, the importance of Indigenous voice, gender equity, a mix of primary specialities, and regional/bi-national participation.

The success of the faculty depends on leadership by a board with sufficient diversity in its membership to provide the appropriate skill mix for optimal board function, and to broadly reflect the concerns of the faculty membership and communities we serve. Fellows curious about committee and board roles are encouraged to express their interest. Talking with a mentor can help build confidence and skills to take on future leadership roles.

Dr Susie Lord
Board member and Chair,
Professional Affairs Executive Committee (FPM)

New fellows

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

- Dr Sarah Donovan, FANZCA, FFPMANZCA (Vic).
- Dr Vyhunthan Ganeshanathan, FRCA, FANZCA, FFPMANZCA (WA).
- Dr Desmond Ho, FANZCA, FFPMANZCA (Singapore).
- Dr Abhilasha Sharma, FRACP, FFPMANZCA (NSW).
- Dr Akhilesh Tiwari, FANZCA, DNB Anaesthesia, FFPMANZCA (Qld).
- Mahboubeh Adinehzadeh, FRACGP, FFPMANZCA (Qld).

Professional document update

PM01: Recommendations regarding the use of Opioid Analgesics in patients with chronic Non-Cancer Pain has recently been superseded by *PS01(PM)(2020): Statement regarding the use of opioid analgesics in patients with chronic non-cancer pain*. This is due to recent changes to the regulations regarding opioid analgesics in Australia. PM01's title included the word "recommendations" which was inappropriate in the changed regulatory environment and also comprised of a category that has since been removed from the ANZCA document taxonomy.

The document's new title, where the PS01 stands for "Professional Statement" allows the document to be the faculty's statement for use of opioid analgesics instead of a recommendation.

Farewell to FPM Board members

PROFESSOR STEPHAN SCHUG, WA

Professor Schug was elected to the FPM Board in 2014 and held a number of positions during his tenure.

Professor Schug is the editor for the fourth and fifth editions of *Acute Pain Management: Scientific Evidence*. He has been involved in a number of committees and working groups including the faculty's Education Committee, Research and Innovation Committee, Western Australian Regional Committee, Perioperative Medicine Steering Committee, ANZCA Research Committee and Clinical Trials Network and chaired the Acute Pain Special Interest Group to name a few.

He was the Scientific Convenor for the 2004 Annual Scientific Meeting (ASM) held in Western Australia and has since provided great mentorship to new convenors informally and through his membership on the ANZCA and FPM CPD Committee.

He is a regular speaker at ISAP World Congresses and other major international pain meetings. His deep knowledge of drug development and pain pharmacology has ensured that the faculty board has always had excellent insight in developments with analgesic medications. He has contributed to educational content including presentations at many scientific conferences and also co-wrote modules 5, 6 and 7 of the faculty's Better Pain Management program.

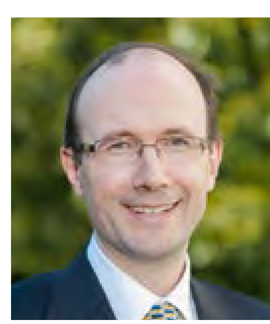
ASSOCIATE PROFESSOR ANDREW ZACEST, SA

Associate Professor Zacest was elected to the FPM Board in 2014. During his time on the board, Associate Professor Zacest was a member of the Procedures Steering Group and Procedures Training Group.

Since 2012, he has been an examiner for the faculty. He also co-wrote Modules 9 and 10 of the Better Pain Management program.

He is also one of the joint authors for one of the faculty's Choosing Wisely recommendations regarding spinal fusion which has helped to shape health policy in Australia. He will continue to be an examiner for the faculty.

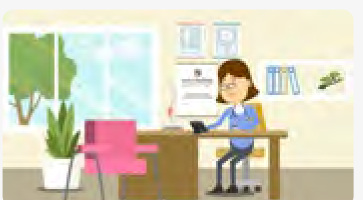
Professor Stephan Schug



Associate Professor Andrew Zacest

Patient information video

A new animated video, "Managing chronic pain", will be launched with the new ANZCA website.



Introducing our new FPM board members

DR MURRAY TAVERNER, VIC

Dr Murray Taverner obtained FANZCA in 1992 and his FFPMANZCA in 2007. He is the director and founder of Frankston Pain Management, which is a private collaborative multi-disciplinary pain clinic. Dr Taverner is also an adjunct senior lecturer at Monash University and a founding member the Neuromodulation Society of Australia and New Zealand.

His areas of clinical interest include musculoskeletal pain, post-surgical pain and interventional pain treatments. He is also a tireless patient advocate for a comprehensive holistic pain management and the application of evidence-based therapy in public and private sectors.

DR RENATA BAZINA, NSW

Dr Bazina has been a fellow of the faculty since 2011. She is the head of unit for Liverpool Hospital, and a supervisor of training in neurosurgery. She is also chair of the faculty's NSW Regional Committee.

Dr Bazina's areas of clinical interest include persistent post-surgical pain, complex regional pain syndrome (CRPS) and facial pain.

FPM OFFICE BEARERS AS ELECTED AT THE NEW BOARD MEETING ON SUNDAY 3 MAY	
Dean	Associate Professor Michael Vagg
Vice Dean	Dr Kieran Davis
Assessor	Dr Melissa Viney
Deputy Assessors	Dr Kieran Davis and Dr Dilip Kapur
Chair, FPM Executive Committee	Associate Professor Michael Vagg
Chair, Training and Assessment Executive Committee	Dr Kieran Davis
Chair, Examination Committee	Dr Kieran Davis
Chair, Learning and Development Committee	Professor Milton Cohen
Chair, Training Unit Accreditation Committee	Professor Michael Veltman
Chair, Professional Affairs Executive Committee	Dr Susan Lord
Chair, Professional Standards Committee	Dr Diarmuid McCoy
Chair, Scientific Meetings Committee	Dr Jennifer Stevens
Chair, Research and Innovation Committee	Dr Chris Hayes
Senior Editor, Pain Medicine Journal	Professor Milton Cohen
Co-opted Council Member (appointed by Council)	Dr Chris Cokis

THE FPM EXECUTIVE COMMITTEE COMPRISES:

Dr Michael Vagg
Dean

Dr Kieran Davis
Vice-Dean, Chair of Training and Assessment Executive Committee

Dr Susie Lord
Chair, Professional Affairs Executive Committee

Ms Juliette Whittington
FPM Acting General Manager

New Zealand

COVID-19 plus review signal big changes to the NZ health system

Dr Ashley Bloomfield

THE LONG-AWAITED Health and Disability System Review was made public in the middle of June recommending the biggest shake up of the beleaguered New Zealand public health system for many decades.

One veteran political journalist labelled it one of the most "sensible, potentially politically sustainable, rigorously argued reports that he's seen come out of any government enquiry". While another health commentator says the review was "botched" by "failing to grasp the basic point that if you radically restructure when trying to improve the quality and effectiveness of a health system, disruption, destabilisation, and non-achievement of the sought improvements eventuate".

All decisions on the recommendations such as reducing the number of district health boards, are likely to be put on hold as the country prepares for the 19 September general election. However the pandemic had already signalled changes to how our health system may function in the future.

In late May, the Director General of the Ministry of Health Dr Ashley Bloomfield addressed the first meeting of the Council of Medical Colleges (CMC) since the country's lockdown began. He wanted to talk "recovery" as New Zealand had effectively reached zero new cases (at that time) and zero people in hospital with the virus. Dr Bloomfield wanted to discuss the recovery. "What do you need and what can we do from the centre?" He pointed out that we were in a different environment from the one in which "inertia is caused by large systems".

Equity was another big talking point of the health response to the pandemic. Dr Bloomfield said previous pandemics such as 1918 had proved that it was poorer communities that are disadvantaged. He explained that the formal ways of getting input were not there with the speed with which the response was ramped up. "We had many people lean in and offer their support and advice from iwi and Māori leaders. We appreciated their leadership." Te Rōpū Whakakaupapa Urutā, the National Māori Pandemic Group, was acknowledged for its support and advice.

On the big issue of personal protective equipment (PPE) security of supply, Dr Bloomfield explained that the ministry didn't hold the supply or quantities of PPE. These were the responsibility of each district health board. However that looks set to change. "We need to un-devolve the system and keep some areas as a national function."

PPE was the subject of a critical report from the Auditor General released in mid-June. The report stated the Ministry of Health had no idea how much PPE it had, how much it needed, what had expired and how it should be distributed. The Ministry of Health: Management of personal protective equipment report in response to COVID-19 report also criticised Dr Bloomfield's "mixed messages" during a press conference that led to a panic response increasing demand. "For a national reserve system to operate well, you need to know how much stock might be needed, what is held in supplies, whether the stock is usable, how stock can most effectively be distributed, and how you can quickly source more stock if you need to," the report said.

Dr Bloomfield opened the way for more communication and advice from colleges. "This is about relationships not hierarchy. The public has new faith in its Ministry of Health and health practitioners. Let's not let them down."

Following the meeting, CMC wrote to the prime minister and put out a media release backing the government's COVID-19 response.

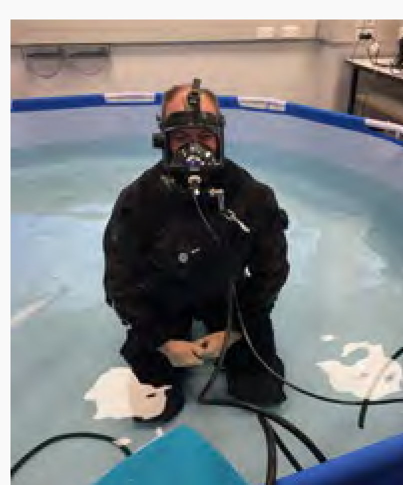
"CMC, which is the collective voice of more than 7000 doctors in 37 specialities, has formally thanked the prime minister and public health sector led by Dr Ashley Bloomfield for their tireless work and sound decision-making in managing New Zealand's response to COVID-19. With only one active COVID-19 case in the country, it is clear the right public health measures were taken to prevent what would have been catastrophic for the health sector and the New Zealand public," says the spokesperson, Dr John Bonning.

As the *Bulletin* goes to print, Dr Jennifer Woods and Dr Sally Ure from the New Zealand National Committee are due to meet with Dr Bloomfield to talk about issues affecting ANZCA and FPM.

The Thailand cave rescue and its implications for underwater airway management

AT ONE POINT during the Thai cave rescue that gripped the world media for two weeks in July 2018, 7000 people were on the northern Thai mountain from medics, engineers, army and navy personnel, to those feeding the rescuers, all contributing to the remarkable success of the mission. But a previously unheralded contributor to this success was a diving mask.

Most of us know of the integral role ANZCA fellow, Dr Richard Harris played in anaesthetising the 12 young soccer players and their coach before their perilous dive out of the cave. However the role of the full-face mask – the Interspiro Divator is less widely explored in the multiple articles and documentaries. In fact the underwater rescue guidelines caution against relying on any mask to protect the airway in unconscious divers underwater. Dr Harris and the team had no time to do evidence-based tests and none had been done. It was a leap – or swim – of faith. And, as we know now, it worked. Now retrospectively, the mask that was used has undergone rigorous testing and a journal article has just been published with the findings.



Right: Xavier Vrijdag wearing one of the Divator masks just prior to prone immersion in one of the experiments. Below: Dr Nick Gant standing next to the paddling pool we set up in his lab in order to bring very sensitive pressure measuring equipment close to the water's edge.

The *Diving and Hyperbaric Medicine Journal* is the combined journal of the South Pacific Underwater Medicine Society and the European Underwater and Baromedical Society. Editor, Professor Simon Mitchell (ANZCA fellow) from the Department of Anaesthesiology at the School of Medicine, University of Auckland along with colleagues including Dr Harris and Dr Hanna van Waart undertook the testing and are among the co-authors of the subsequent article[1].

The Divator mask was chosen by rescuers for several reasons including a function designed to maintain a degree of internal positive pressure throughout the respiratory cycle; effectively a form of constant positive airway pressure (CPAP). The aim in employing this feature was to stop water entering the mask and to help keep the airway of the young Thai team members open while they were unconscious.

The journal article gives the first detailed published account of the anaesthetic used on the children. The use of ketamine in this setting exemplifies, in the most extraordinary way, all the unique properties of this drug that are taught to ANZCA trainees. It then discusses the history of guidelines applied to underwater rescues, the results of the testing of the mask in Auckland (which showed that the CPAP function works) and discusses the implications of these results and events in Thailand for the future of those guidelines.

The article reads "The most striking aspect of the Thai cave rescue narrative is that 12 unconscious non-diver children and one adult were rescued through 1.1 km of flooded, tortuous cave passage in near zero visibility, and none drowned. These were not the 'ideal conditions' in which 'a period' of underwater airway management might be achievable according to current rescue guidelines. Indeed the Thai cave scenario represented the antithesis of 'ideal conditions' and seen through that lens, the success of the operation was remarkable. One obvious question arising is 'what are the implications of this event for recommendations about attempting airway management in an unconscious diver underwater'? In particular, should related guidelines be less discouraging of managing an unconscious diver underwater when lessons learned from the Thailand cave rescue are applied and where there are the compelling reasons to attempt it?"

In addressing these questions, the article points out that there are aspects of the Thai cave rescue that complicate its generalisation to other scenarios and states "we do not believe the positive outcomes in Thailand challenge the fundamental principle that the safest place for an unconscious diver is on the surface". Nevertheless, in relation to scenarios where rescuers are left with little choice, it concludes by stating: "it seems justified to conclude that if faced in future with a similar situation to the Thailand cave rescue (such as rescue of an injured unconscious caver through a sump [flooded tunnel]), the methods employed by the Thailand rescue team could be utilised again with a reasonable expectation of success. Such a conclusion would have seemed very implausible before the Thailand event".

The paper will be available for download from 30 June on the journal website – www.dhmjournal.com/index.php/full-journals-embargoed/immediate-release-articles – and will appear on PubMed Central soon after.

Reference

1. van Waart H, Harris RJ, Gant N, Vrijdag XCE, Challen CJ, Lawthaweesawat C, Mitchell SJ. Deep anaesthesia: the Thailand cave rescue and its implications for management of the unconscious diver underwater. Diving Hyperb Med. 2020;50(2):121-9. doi: 10.28920/dhm50.2.121-129.

Keeping connected

UNFORTUNATELY DUE TO the cancellation/postponing of many of our events and courses across the country we do not have individual entries from each of the regions for this bulletin edition, with the exception of one event for South Australia and the Northern Territory (see below) that managed to take place before the COVID 19 face-to-face meeting restrictions came into force.

We do however want to highlight that each of the regions are keeping connected and video conference calls via Zoom have become a new way of life for all of us during this time.

There have been many Zoom meetings with the ANZCA staff in each of the regions, along with ones held for each of our state's regional and training committee meetings, and various supervisors of training, heads of department and rotational training scheme meetings. We are all working hard to address any issues and concerns, minimising any effects where we can, discussing important issues and moving forward with our future event planning.

We look forward to seeing you at our meetings in 2021, and any we are able to hold later this year when things have settled (possibly some via Zoom too). We are sure it will be nice for everyone to escape the same walls (of homes and workplaces) and be able to venture out in the world again. In the meantime we can always pretend on Zoom with virtual backgrounds that we are elsewhere; as we have done in a few of our regional calls.

From all of us in the regions, we would like to thank all of our fellows and trainees, and a special mention to our committee chairs, committee members, education officers, and course and event convenors for everything that you have done and continue to do during this challenging time. We look forward to this global pandemic to settle and for all our frontline clinicians to have rested and recovered.

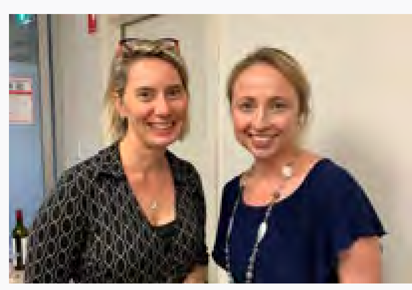
Please take care and stay safe.

Kym Buckley (ACT)
Warren O'Harae (General Manager, Regional Operations),
Annette Strauss, Tina Lyroid, Deb Callaway, Gabrielle Beverakis (NSW)
Camille Smith, Julie Donovan, Karan Shah, Iesha Iselin (Qld)
Teresa Camerelli, Michelle Gully, Alison Cook (SA and NT)
Janette Papps (Tas)
Cathy O'Brien (Vic)
Melanie Roberts, Joyce Roberts (WA)

South Australia and Northern Territory

FPM MEETING

The SA FPM continuing medical education meeting "Headaches and facial pain" was held on 17 February. Consultant neurologist Dr Jessica Hafner presented on "Migraine: A clinical approach and recent advances in treatment" and consultant neurosurgeon Associate Professor Andrew Zacest presented on "Surgical treatment of trigeminal neuralgia". The evening saw the highest attendance at a South Australian FPM meeting with attendees also enjoying the social pre-meeting drinks with their peers.



From top: Dr Irina Hollington and Dr Alette Roux; Dr Jessica Hafner and Associate Professor Andrew Zacest.

We are excited to announce these 2020 events

Haumi ē-! Hui ē-! Tāiki ē-!
To draw together as one, progress our common purpose

NOVEMBER 18-20, 2020

Hosted by the New Zealand National Committee this Hui will canvass themes of leadership, and cultural safety, equity and cultural competence and Te Tiriti o Waitangi |The Treaty of Waitangi in health.

Waitangi Treaty Grounds, Bay of Islands, New Zealand

For further information please email events@anzca.edu.au

Ngātokimatawhaorua (ceremonial war canoe), Waitangi Treaty Grounds

These events have been postponed to 2021

Would you like to join a special interest group (SIG)?

Ever thought about becoming a member of a SIG? Joining a SIG is the perfect way to meet like-minded people, exchange ideas, and shape the future of your sub-speciality or area of interest.

Anaesthesia Continuing Education (ACE) is a partnership between ANZCA, the Australian Society of Anaesthetists and the New Zealand Society of Anaesthetists.

ACE was established to promote and co-ordinate combined continuing medical education activities in anaesthesia and related disciplines.

It manages 17 SIGs that allow anaesthetists and others to study, report and develop educational events in specific areas of anaesthesia in which they have an interest or skills.

Membership of a SIG is available to specialists from all medical disciplines and is representative of the collegiate and collaborative nature of medicine and the multidisciplinary work of many SIGs.

Associate membership is open to non-medical specialists who are not eligible for general SIG membership. This may include associate members of the ASA and NZSA and/or allied health professionals. Associate membership requires endorsement from the SIG executive committee.

If you are interested in joining a SIG please download and return a completed SIG membership application form available from www.anzca.edu.au/fellows/special-interest-groups or contact events@anzca.edu.au and we'll email you the form.

Charles McKinnon (Mack) Holmes

1935-2020

"Mack Holmes will be remembered by his colleagues as a talented dedicated anaesthetist who took a strong interest in teaching registrars and mentoring them for their future role."

Dr Mack Holmes

Mack Holmes died peacefully in Dunedin hospital in New Zealand on 26 March after a brief illness though he had been suffering from renal failure and had been on peritoneal dialysis for 18 months.

He was born in Dunedin on 11 June 1935 and educated in England, in part at Harrow, when his father was an agricultural advisor for the British government. Later, the family returned to Dunedin where his father was appointed superintendent of Invermay Agriculture Research Station. Mack completed his education at Otago Boys High School before entering Otago Medical School, graduating MB ChB in 1958, following which he spent two years in resident positions in Dunedin Hospital.

He commenced his anaesthetic training in 1961 as an anaesthetic registrar in the department in Dunedin, and was awarded a prestigious Nuffield Clinical Assistantship to continue postgraduate studies in the Nuffield Department of Anaesthetics in Oxford. Mack was the second such registrar from the Dunedin department to be awarded this position in Oxford, following Jim Clayton who preceded him in 1960.

Early in 1962 he travelled to Oxford with his wife Janet and a new baby to take up the scholarship. At the time, the Nuffield Department in Oxford, under the guidance of Dr James Parkhouse had been undertaking ongoing studies on postoperative pain with which Mack became involved resulting in a number of publications. However before he left Dunedin, Mack had recently rediscovered the so-called Bier's block, and while in Oxford, with the newer safer local analgesic agents then available was able to investigate the technique and repopularised it as a very simple method of providing anaesthesia for hand and arm procedures.

The technique of intravenous regional analgesia immediately caught on and led to a number of publications and speaking engagements, in particular a landmark paper in *The Lancet* which gave worldwide publicity to the technique, which soon became generally used by non-anaesthetists as well and made his name in anaesthetics internationally. While in Oxford in 1962 to 1964, Mack completed his English fellowship in 1963, before returning to Dunedin in 1965 to a position as specialist anaesthetist at Dunedin Hospital and lecturer in anaesthesia at the Otago Medical School.

It soon became apparent that Mack was not one to sit on his hands. His analytical mind and innovative approach resulted in a change from traditional techniques to the eventual avoidance of nitrous oxide and various vapour supplements to very low flow systems and wholly intravenous narcotic techniques, about which he published widely. Simultaneously he championed the undesirability of pollution in the operating theatre and contributed to establishing a passive scavenging system in the Dunedin operating theatres in early 1973-74.

In 1972 with the proposed introduction of a cardiac surgery unit for the South Island, he was responsible along with Dr Trevor Dobbinson and Professor Pat Molloy for setting up the cardiac theatre and postoperative cardiac care unit. In 1969 he was elected fellow of the Faculty of Anaesthetists of the Royal Australasian College of Surgeons (FFARACS) and in 1970 promoted to senior lecturer.

Mack's regular attendance at New Zealand and overseas anaesthetic meetings and his popularity as a speaker soon led to an appreciation of his innovative and discerning mind. His audience could always guarantee to be educated and entertained. His repertoire of humorous anecdotes was legend. He was the author or co-author of more than 30 papers, as well as an excellent monograph on the story of Sir Robert Macintosh, *A Famous New Zealander*[1], who occupied the foundation Chair of Anaesthesia in the Nuffield Department of Anaesthesia, University of Oxford, the first such chair in the UK. Interestingly Sir Robert was a second cousin once removed – Mack's great-grandmother was a sister of Sir Robert's grandfather.

Mack was elected to the New Zealand regional committee of the Faculty of Anaesthesia in the 1970s, becoming chairman in 1978. In 1982 he was elected to the Board of Faculty and appointed honorary librarian there from 1982 to 1990, chairman of the education committee in 1985, and until 1987 both a primary examiner for 12 years and occasional final examiner, retiring from the Board of Faculty in 1990. The New Zealand Society of Anaesthetists honoured him with life membership in 2009. Mack had an encyclopaedic mind eminently suited to crosswords – when travelling to college activities from Dunedin he used to do *The Daily Telegraph* puzzle during the 45-minute flight to Christchurch and *The Times* one in the three-hour flight to Melbourne! He also had a love for languages and was fluent in conversational French with a good working knowledge and understanding of Russian, Italian, German and Mandarin, which gave him access to a number of eminent European anaesthetists.

Outside of medicine his life was more than full with a growing family of four sons and their demands. However that didn't stop him from becoming a competent sailor and crewing a Cavalier class 32 yacht, belonging to a friend and colleague, Dr Peter Renshaw, on which he was able to entertain the department members from time to time. Likewise he qualified with a private pilot licence and also became a medical officer for the examination and certification of pilots, and a life member of the Otago Aero Club. He was also part of the syndicate that owned a Piper Cherokee plane and he frequently entertained and unnerved some of his fellow anaesthetists and friends when flying with him. Mack's first wife had died suddenly in 1978 and he married Lyn in 1981. He was a keen tramper, enjoying the outdoor life and exploring much of Otago's scenery, and even at the age of 80 went tramping with the family. Mack had also become a qualified scuba-diver and managed some diving at Port Douglas and Tahiti on his travels.

He retired from his Dunedin Hospital position in 1992 to enter full-time private practice at the Mercy Hospital though he had been in part-time private practice since the mid 1970s. Following retirement from anaesthetic practice in 2007, he continued for a time working as a medical officer doing locums in some of the provincial hospitals. In his complete retirement there was plenty to keep him occupied. He became a volunteer and active member of the Dunedin gasworks museum and a volunteer on the Taieri Gorge railway. During the years before and after retirement he had travelled with Lyn extensively throughout Europe and Asia, sailing with colleagues in the Mediterranean and Greek islands and several sailing visits to Tahiti.

Mack Holmes will be remembered by his colleagues as a talented dedicated anaesthetist who took a strong interest in teaching registrars and mentoring them for their future roles. He will be sadly missed by friends, colleagues, and family alike. He is survived by his wife Lyn, four sons, a stepdaughter and six grandchildren.

Dr Jim Clayton, FANZCA,
Dunedin

Emeritus Professor AB Baker, FANZCA
Sydney

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Dr David Lindsay

1954-2020

Dr David Lindsay

DAVID LINDSAY WAS born on 13 April 1954 in England. The family emigrated to Australia in 1966 and his secondary education was at Scotch College in Melbourne where he matriculated in 1969. Being too young to go to university, he did a second year 12 in 1970 as was the fashion then, thus becoming one of those rare folk to have passed both "Matric" and the HSC. Captain of rugby at Scotch, he continued to play A grade rugby throughout his medical training at Melbourne University, graduating in medicine in 1977 including an elective year in Oxford.

Dave met his wife Sally in 1978. The two of them had an incredible time travelling to exotic and faraway places, they even met the Dalai Lama in Tibet, before settling down to happily married life in 1983 back in Melbourne, where they had four children and three grandchildren.

Anaesthesia was his metier, and Dave trained both in Melbourne and England to qualify for his fellowship in 1984 at the Austin Hospital. A highly talented anaesthetist renowned for his genial manner and obvious leadership qualities (not entirely hidden by his humility), he was rarely ruffled and ran his lists with a calm, efficient resolve. As his reputation grew he was snapped up by the Melbourne Anaesthetic Group in 1987 where he went on to establish himself as one of the finest, most admired, and most skilful anaesthetists in Melbourne.

I had the pleasure of meeting him at that time and we developed a close association, both personal and professional. We had many friendly, yet competitive, games of tennis over the years and collaborated closely resulting in the formation of a journal club, and the publication of a paper on axillary brachial plexus blocks at a time when regional anaesthesia was regarded in some quarters as unnecessarily long before the use of ultrasound became available.

As our journal club expanded, Dave would sometimes enlighten us – especially the younger members – with some of the more colourful episodes in his training while still a registrar in the UK. One such occasion was being directed to perform unsupervised anaesthesia for quinsy on a foreign dignitary with two armed security guards hovering beside him!

Dave went on to become chairman of the Melbourne Anaesthetic Group and successfully masterminded some significant reforms over that time, to the enormous and lasting benefit of all members. Dave's penchant for meticulous project management was particularly evident during his senior years in the group. His determination to achieve the right outcome was true in both his professional and personal life.

His other passions included competitive yachting both at Sorrento in "couta" boats and at Hamilton island in racing yachts, skiing at Falls Creek where he and Sally owned an idyllic lodge, and following the fortunes of the Melbourne Rebels rugby union team.

Tragically, David was diagnosed with motor neurone disease in July last year. This insidious, relentless illness rapidly coursed through his nervous system rendering him a shadow of the larger-than-life character he had been but thankfully his mischievous wit and the twinkle in his eye remained to the end. He died, peacefully, at home on 20 March.

One of our very best has been lost to us, but as a leader, a role model to his peers, and a proud family man and grandfather, David Lindsay will never be forgotten. It was a privilege to be his friend.

Dr Hugh Pearce, FANZCA
Melbourne

Dr Robert Eyres

1944-2020

Dr Robert Eyres

ROB (BOB) EYRES will be remembered as a perspicacious, inspirational and charismatic larger than life extrovert, a bon vivant, a brilliant anaesthetist with enormous intellect, a gastronome, an oenophile with a razor-sharp palate, and for his penchant for motor sports.

He was a world renowned major contributor to paediatric anaesthesia, intensive care and pain management as a clinician, researcher, teacher, mentor and administrator, and helped forge the now-thriving global paediatric anaesthesia community.

Rob was born in Deniliquin, NSW where he attended the local primary school before moving to Melbourne where he boarded at Caulfield Grammar School and rowed for the firsts. He finished matriculation in 1961 with top marks. He commenced studying medicine at Melbourne University in 1962 and started anaesthesia training at Whipps Cross Hospital in London in 1970.

In January 1974 Rob was awarded the Fellowship Prize by the Faculty of Anaesthetists of the Royal College of Surgeons of England after completing the Final Fellowship Examination – the third person to receive the award.

Dr Kester Brown got wind of a bright young Australian anaesthetist and paid Rob a visit at his home to interview him when he was visiting London. Kester offered him a registrar job at the Royal Children's Hospital (RCH) in Melbourne. In 1975, Rob and his family returned to Australia aboard the TSS Fairstar, he as the ship's doctor.

In his book Catalyst, Kester wrote, "Rob proved to be an outstanding, although somewhat unconventional registrar". In October 1976, Rob was admitted to Fellowship of the Faculty of Anaesthetists, Royal Australasian College of Surgeons (FFARACS) by examination. The following year Rob was appointed to a consultant post at RCH.

Rob soon took charge of cardiac anaesthesia. He had a brilliant mind and could get to the nub of a problem quickly, expressing his view clearly and concisely. He helped develop improvements in cardiac anaesthesia and perfusion, and used his unique skill set to provide services in the Paediatric Intensive Care Unit, covering Thursday night and weekend shifts for 20 years. His special anaesthesia interests were cardiac surgery and catheterisation, and urology. The latter led to seminal research into the pharmacokinetics of local anaesthetics, especially for epidural anaesthesia that he helped establish at RCH. This in turn led to international research collaborations and involvement in Phase II trials of levobupivacaine.

Rob's broad clinical experience and people skills led to his increasing involvement in senior executive roles at RCH, including as Divisional Director of Specialist Services and Co-deputy Director, Anaesthesia and Pain Management. From 2000-04, Rob served as director. Thereafter he continued providing high quality clinical care and played an impornt mentor role until 2011.

Rob was active outside the RCH Anaesthesia and Pain Management Department. He was a member of the FARACS Anaesthesia Research Group. He served a full 12-year term (1985-1998) as an examiner for the ANZCA Primary Examination and later taught at the primary examination course. He was elected to the Executive Committee of the Society for Paediatric Anaesthesia in New Zealand and Australia (SPANZA) when it was formed in 1998, and served as treasurer until 2004. He was on the editorial advisory board for the journal, *Paediatric Anaesthesia*.

Rob gravitated to those who really cared about improving and developing the surgical and anaesthesia professions. His sage advice was widely sought by both. He taught, influenced and mentored many, supporting their quest for higher achievement. His sharp clinical acumen, technical skills and knowledge commanded the respect of surgeons, intensivists, paediatricians, nursing staff, anaesthesia technologists, perfusionists and anaesthetists. He had a unique ability to engage people from diverse backgrounds, to disarm them, make them feel important and heard, and to make them laugh.

His contribution to anaesthesia was recognised by being awarded honorary membership of the Association of Paediatric Anaesthetists in Great Britain and Ireland (APAGBI) in 2006, and in 2008 the SPANZA medal that conferred honorary life membership of the society. In 2017, Rob was honoured with an RCH Grand Round presentation, On the Shoulders of Giants, (https://blogs.rch.org.au/grandrounds/2017/07/26/on-the-shoulders-of-giants/). RCH staff presented key ongoing research and developments that were grounded in the contributions Rob had made. A packed Ella Latham Auditorium concluded the presentation with a standing ovation – a fitting tribute to an extraordinary contribution.

Rob inspired a fierce loyalty. Many will fondly recall his bonhomie, signature RM Williams boots with the Cuban heel, his passion for MotoGP, Formula 1, Bathurst, Ducati motorbikes, and his extraordinary palate for, and knowledge of wine.

Rob is survived by his loving wife Olivia, his daughters Sophie and Cassie, and his sister, Margaret.

Associate Professor George Chalkiadis, FANZCA
Royal Children's Hospital, Melbourne

Dr David Griffin Woods

1943-2020

Dr David Griffin Woods

DAVID WAS THE son of two medical practitioners in Adelaide. He was educated at St Peter's College and graduated MBBS (Adel) in 1968.

He obtained the FFARACS in 1972 post fellowship he worked at the Hammersmith Hospital in London followed by locums in Sweden and Holland. Returning to Australia he went into Private Practice Anaesthesia and then to Adelaide Anaesthetic Services in 1978.

David was an accomplished anaesthetist in the various sub-specialties especially in ophthalmic anaesthesia where he was one of the few anaesthetists to do retrobulbar blocks before peribulbar blocks became widely used by anaesthetists.

David's other interests outside of anaesthesia were in farming and wine making in the Robe area, south-east of South Australia. In 1975 he established the Griffin Pastoral Company and then Karatta Wines some 25 years later.

David was treasurer of the ASA in the 1980s for many years. As for sport interests he enjoyed tennis and golf and was an accomplished downhill snow skier.

David is survived by his wife Peg, four children and 12 grandchildren.

Dr Stephen J Scammell, FANZCA
Senior Anaesthetist (Retired)
Associate founder of Adelaide Anaesthetic Services

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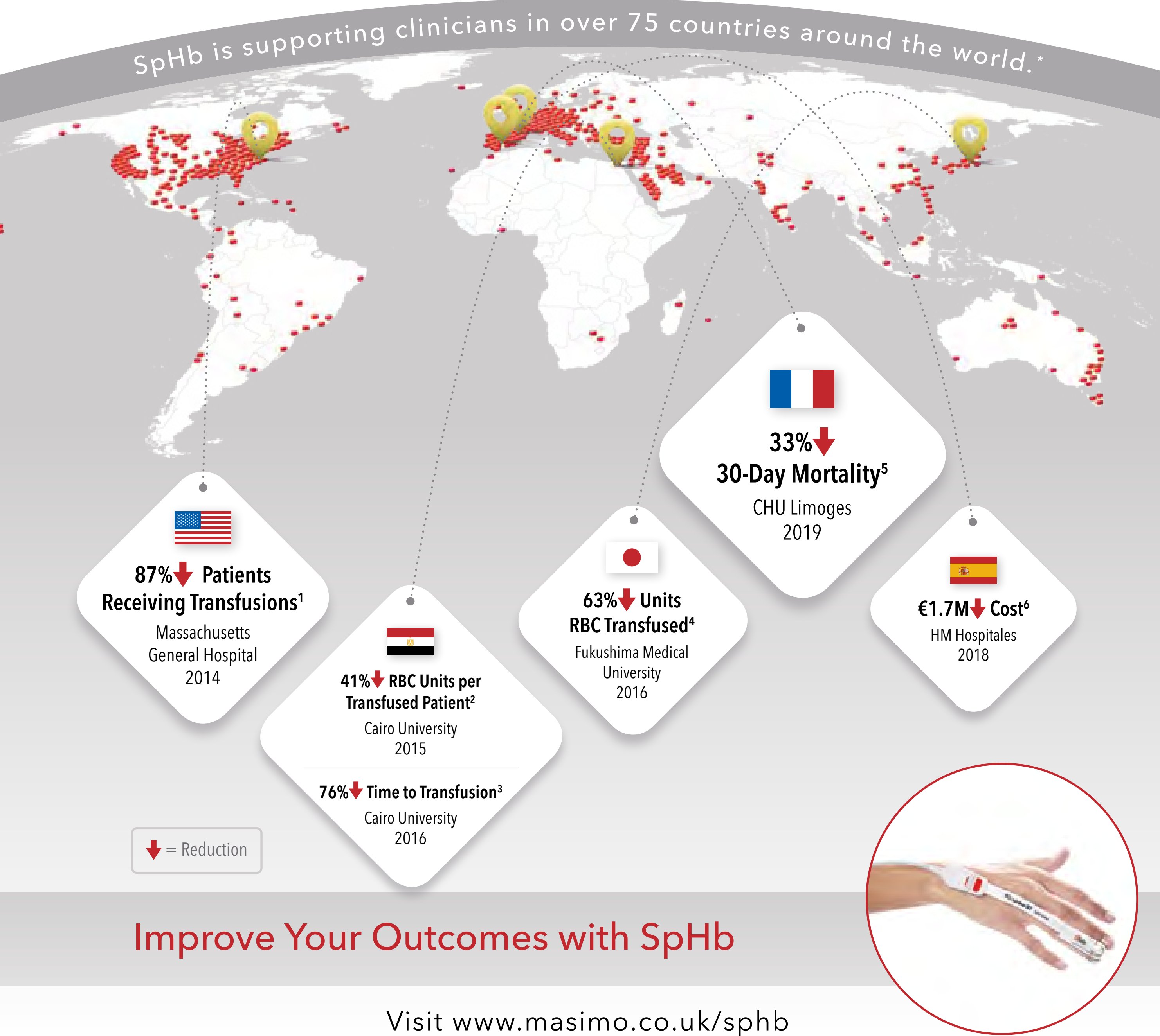

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