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FPM
Bulletin
Australian and New Zealand
College of Anaesthetists
& Faculty of Pain Medicine
WINTER 2024
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Farewell Professor
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GLP-1/GIP advice
A new guide
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ON THE COVER

Dr Jane Leadbeater in action during the ASM veterinary anaesthesia workshop in Brisbane.

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 and FPM comprise about 8900 fellows and 1950 trainees. mainly in Australia and New Zealand. It serves the community by upholding the highest standards of patient safety.

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Editor: Clea Hincks
Production editor: Liane Reynolds
Feature writer: Carolyn Jones
Advertising manager: Vivienne Forbes
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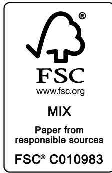
Contact us
ANZCA, 630 St Kilda Road, Melbourne
Victoria 3004, Australia
+61 3 9510 6299
communications@anzca.edu.au
www.anzca.edu.au

Faculty of Pain Medicine
+61 3 8517 5337
fpm@anzca.edu.au



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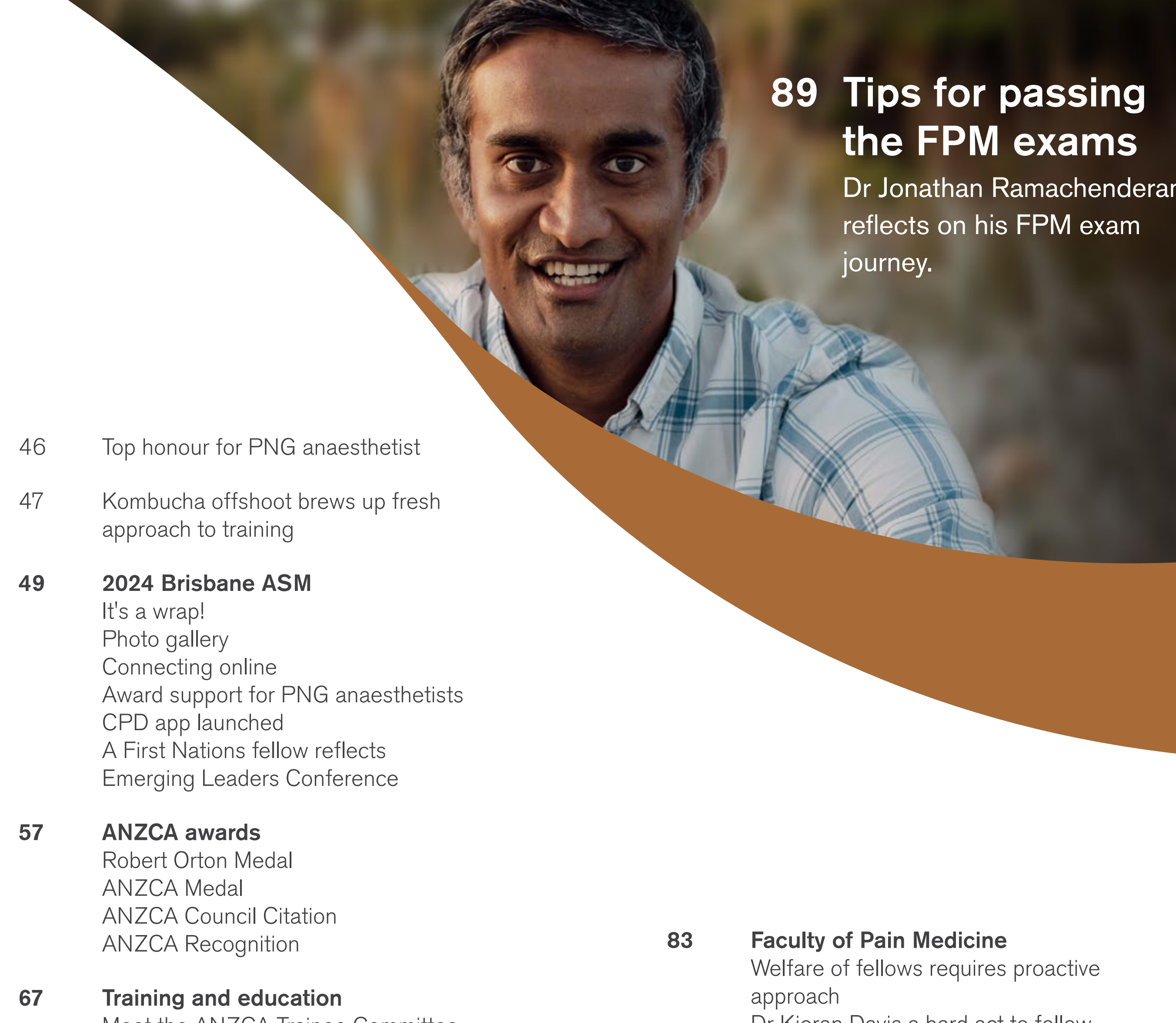

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Catch up on the changes to ANZCA Council, the FPM Board and key college committees.

Civil debate a must in this complicated world

Like many before me, I start my two-year term as ANZCA president feeling a combination of excitement, trepidation, and a bit of imposter syndrome. ANZCA is a specialist medical college that by national and international standards is outstanding. First, I'd like to thank Chris Cokis who is now immediate past president and please read a longer thank you to Chris on page18 in this *Bulletin*.

Briefly, who am I? My day jobs are 1) part-time staff specialist anaesthetist at Austin Health in Melbourne with an interest in high-risk adults including liver transplantation, and 2) professor of anaesthesia and head of the Department of Critical Care at the University of Melbourne. Our university department covers anaesthesia, intensive care, and emergency medicine. As a teaching and research academic I am involved in curriculum for medical students and a research program centred on perioperative medicine and patient outcomes.

I am mindful of the role of ANZCA president to act as the chair, and council as the board, of a not-for-profit, for purpose trans-Tasman company. Our stated purpose is: "*to serve our communities by leading high quality care in anaesthesia, perioperative and pain medicine, optimising health and reducing the burden of pain*". ANZCA Council leads the ANZCA strategic plan which follows from the purpose and will be renewed over the next 18 months.

Much has changed since the last strategic plan, developed in the depths of the COVID pandemic. There are four interacting priorities (dare I say Venn diagrams) for ANZCA fellows, trainees and specialist international medical graduates (SIMGs), to have a vibrant, effective, and efficient future in Australia and New Zealand, and beyond. Importantly underpinning these priorities are diversity, equity and inclusion with special focus on First Nations peoples; and both financial and environmental sustainability.

The four priorities are:
1) education
2) patient safety and quality of care
3) workforce and workforce wellbeing
4) data, cybersecurity, and artificial intelligence.

Education

Education, both training and continuing professional development is across the ANZCA BIG THREE: anaesthesia, pain medicine, and perioperative medicine.

Education is our primary function and focus. Training and continuing professional development (CPD) should provide and sustain the skills, knowledge, and good judgement to enhance individual patient journeys, public health, value, and workforce wellbeing.

Patient safety and quality of care

ANZCA will continue to lead in patient safety and quality of care through our authoritative and widely used professional documents, and ongoing analysis and outreach by our vital Safety and Quality Committee. Professional documents will continue to evolve and will include elements of perioperative medicine.

The highly effective ANZCA research grant program continues to provide new knowledge supporting high quality patient care, education, and workforce wellbeing.

Recently funded research covers a wide spectrum from lab bench work on propofol reversal agents to sustainability to education to First Nations perioperative medicine. Our Clinical Trials Network and Professional Practice Research Network are platforms supporting leading research across an increasingly broad range of research questions.

Workforce and workforce wellbeing

A major challenge for workforce and workforce wellbeing is governments worldwide looking to increase medical workforce. However, in our two countries a more important problem is lack of medical practitioners including anaesthetists in regional and rural centres. Anaesthesia is high on the priority list for Australian federal, state and territory health ministers. However, the data supporting an absolute lack of anaesthetists is unclear.

There is a strong government push to increase the intake of SIMGs to deal with the perceived problem. ANZCA is concerned that governments are focusing on a short-term solution rather than expanding anaesthesia training posts in ANZCA accredited hospitals.

Of note, we continue to increase the number of accredited hospitals. We are concerned that government focus is on numbers rather than quality of patient care and workforce wellbeing. Further, ANZCA cannot support government imposed trans-Tasman poaching of anaesthetists or pain medicine specialists.

Data, cybersecurity and artificial intelligence

The biggest changes since the 2022 strategic plan are in data and data privacy, cybersecurity, and artificial intelligence. It is an understatement to say that these are fast moving areas with the trifecta of the good, the bad, and the ugly.

Operationally, ANZCA now has a chief information officer, and an Information, Communication Technology and Governance Committee that includes fellows, staff and external experts. Artificial intelligence is particularly hard to adequately address due to its potential and risks which both seem to rapidly change.

Civility

I am concerned that the ANZCA fellowship is being infected with the aggression seen in politics, the media, and in public that is aggravated by the unfiltered, and at times unhinged, social media cauldron.

Further, we live and work immersed in uncertainty and rigid and often subjective right versus wrong thinking is destructive. Irrespective of professional position, seniority, qualifications, personal attributes, or lived experience, no one is necessarily correct and everyone can be challenged on views and opinions.

Vigorous debate is vital for the purpose of ANZCA but must be conducted with civility, knowledge, and empathy. That is: be polite, know what you are talking about, and try to walk in the shoes of others. We must all do better.

Onward and upward

I hope that along with ANZCA Council we can support our college with sound strategic leadership, particularly for the many fellows, trainees, and SIMGs who volunteer time for ANZCA and FPM. Constructive collaboration with the Australian and New Zealand societies of anaesthetists is essential.

Finally, I want to acknowledge our wonderful ANZCA staff without whom all would come to an untidy halt. To help guide strategy ANZCA will repeat the 2021 fellowship survey looking at fellows' attitudes to a list of priorities. It is a chance for fellows to have their say.

It is vital that we have a college that fellows want to belong to.

Professor Dave Story
ANZCA President

King's Birthday Honours

Four of our fellows have been recognised in the 2024 honours list.

Please join us in congratulating the following:

MEMBER (AM) IN THE GENERAL DIVISION

Dr Amanda Baric, AM, FANZCA, Vic.
For significant service to anaesthesiology, to pain medicine, and to tertiary education.

Dr Brendan Moore, AM, FANZCA, FFPMANZCA, Qld.
For significant service to anaesthesiology, and to pain medicine.

Professor Vernon Van Heerden, FANZCA, FCICM, WA.
For significant service to intensive care medicine, to professional associations, and to tertiary education.

Clinical Professor Daryl Williams, FANZCA, Vic.
For significant service to anaesthesiology and pain medicine.

Anaesthesia workforce pressure continues

Workforce continues to be an area of focus and pressure for governments, medical colleges and the wider health sector. This is mainly due to legacy impacts of the COVID-19 pandemic, Australia's growing and ageing population, the increasing impetus for cost efficiencies and shifting ways of working post the pandemic.

As a result, the profile, capacity and needs of the health workforce, including anaesthetists and specialist pain medicine physicians continue to come under the spotlight and governments are driving reforms.

Supply of anaesthesia services and workforce numbers

The *Independent Review of Overseas Health Practitioner Regulatory Settings* ("the Kruk report") notes an undersupply of anaesthesia services in four of Australia's largest states – NSW, Victoria, Queensland and South Australia.

The supply of services, both under and/or over, is contentious. Training numbers for specialist anaesthetists in Australia are limited by state and territory health service allocations of registrar positions within anaesthesia training departments, with these processes varying in each jurisdiction. The college has no direct influence over trainee numbers.

Medical Workforce Advisory Collaboration

Recognising the priority focus of workforce, the Commonwealth Department of Health and Aged Care is currently establishing the Medical Workforce Advisory Collaboration (MWAC) to advise federal, state and territory health ministers, through the Health Workforce Taskforce, on medical workforce.

Membership includes the Commonwealth, states and territories, 18 peak bodies and representative organisations (including the Council of Presidents of Medical Colleges), and five positions for specialist medical colleges (selected via a detailed nomination process).

ANZCA is pleased to announce following an assessment of all nominations received, ANZCA's nomination was assessed as highly suitable for MWAC membership as one of the specialist medical college positions.

The first meeting of this group will be in Canberra in August 2024.

Expedited pathway for SIMGs

One of the recommendations in the Kruk report is the establishment and implementation of an expedited registration pathway through the Medical Board of Australia (MBA) for specialist international medical graduates (SIMGs) to address workforce shortages, particularly in rural areas. This pathway bypasses existing medical college assessment processes (for agreed qualifications). The following four specialities have been identified as priorities for implementation by the end of 2024: general practice is first, followed by anaesthesia, obstetrics and gynaecology and psychiatry.

ANZCA acknowledges that internationally qualified health practitioners play a vital role in our health system and are needed to supplement and fill critical vacancies in the short term. We also recognise there has been a level of reliance on recruiting SIMGs to address workforce shortages, particularly in regional and rural settings. Travel restrictions related to the pandemic and immigration laws have demonstrated there is significant risk with this reliance.

ANZCA is working closely with the Australian government to modify and/or establish processes to ensure an appropriate SIMG pathway is in place, noting that our SIMG assessment process conforms to the Medical Board of Australia's good practice guidelines and is regularly reviewed for consistency with regulatory changes.

This approach to working collaboratively with government is to ultimately ensure that ANZCA's proven experience relating to SIMG assessment is harnessed and the high standards of safety and quality of anaesthesia care continue in the community.

We consider that initiatives such as increasing SIMG numbers is an option in the short-term, however, we would like to work with governments to increase local trainee numbers as a longer-term or large-scale strategy for specialist staffing recruitment.

Junior medical officer recruitment project

ANZCA has nominated Dr Kara Allen to represent ANZCA on this project – opportunities for co-ordination and streamlining of junior medical officer recruitment.

The project is being led by the Health Workforce Taskforce who will report to the Federal Government about junior doctor recruitment, appointment and training with a particular focus on employment and attrition.

The project will address a wide-ranging number of issues including selection processes, the role of independent trainees, interrupted training, engagement with Aboriginal and Torres Strait Islander trainees and pathways for First Nations trainees, regional training, progression and trainee welfare.

NZ health reform

Cost saving and a hiring freeze by Health New Zealand/Te Whatu Ora, alongside ongoing workforce shortages have been a significant concern.

Anaesthesia medicine national committee deputy chair Dr Sarah Nicolson and pain medicine national committee chair Dr Chris Rumball, met with the incoming New Zealand Health Minister, Dr Shane Reti in April. Workforce issues (including anaesthetic technicians) was a key topic of discussion.

NSW Special Commission of inquiry into healthcare funding

Following ANZCA's submission to the inquiry in late 2023, the college met with inquiry representatives in late May to discuss the topics in our submission. Four representatives from our NSW Regional Committee and ANZCA staff provided the commissioners with a better understanding of evidence sought for the June hearings.

ANZCA also compiled and provided a notable list of documents, policies and procedures as part of a "summons to produce documents" official request.

The inquiry report is due to be delivered to the NSW government by late March 2025.

Scopes of practice

The potential expansion of scopes of practice for all health professionals continues to be monitored by ANZCA in a precautionary sense.

This has been particularly pertinent where nurses are administering sedation that traditionally would be given by anaesthetists. ANZCA's release of *PG09(G): Guideline on procedural sedation 2023* speaks to this and is aimed at optimising patient care in the management of procedural sedation by all duly qualified health practitioners in Australia and New Zealand. It is a collaborative document that recognises the many different models of sedation that exist. ANZCA is committed to ensuring safety is the focus of any model of patient care that involves sedation and anaesthesia.

National Health Practitioner Ombudsman (NHPO) Working Group

Blue Miller Group has been contracted to oversee/manage the National Health Practitioner Ombudsman (NHPO) AMC/ Medical Colleges Working Group to support implementation of recommendations from the specialist medical training site accreditation process review.

- The first meeting in April addressed the following draft cross-college accreditation standards and templates. Future meetings will occur monthly.
- Draft model procedure for the development of accreditation standards (Recommendation 1).
- Review of college accreditation reports and Example Accreditation Report (Recommendation 4).
- Comparative data collection of accreditation of specialist medical training sites (Recommendation 5).

ANZCA remains very active and engaged across the multiple working groups, consultations and reviews associated with these workforce issues. We are taking a very proactive role, advocating for fellows, trainees and SIMGs, seeking to influence and inform decision makers of the risks and potential solutions to maintain a sustainable medical workforce, and ultimately ensure the high standards of safety and quality of anaesthesia care continue in the community.

Nigel Fidgeon
CEO

ANZCA staff awards

We recently held the annual staff awards at ANZCA House in Melbourne. ANZCA's then Vice President Professor David Story presented the awards along with service certificates to staff who achieved service milestones in 2023.

Congratulations to the 2024 staff excellence recipients:

Staff Excellence Award for Customer Service – Kym Buckley

Staff Excellence Award for Innovation or Process Improvement – Melanie Roberts & Colin Lynas

Staff Excellence Team Award – Rural Generalist Anaesthesia Team (Stephenie Cook, Harjot Kaur, Nicole Pulitano, Anthony Wall, Dr Vaughan Laurenson, Moira Besterwitch, Tracy Le, Associate Professor Robert O'Brien)

Letters to the editor

WHY ANZCA SHOULD ADVOCATE FOR CLIMATE ACTION

As fellows debate the merits of ANZCA's role in advocating on issues outside clinical anaesthesia, I contend that climate change is inextricably linked to the health of humanity and is therefore an issue that is fair game for our college.

While discussions around climate change often focus on the environmental and economic impacts of the climate crisis, the human health impacts of climate change are of enormous significance.

The most sobering prediction regarding these health implications comes from the World Health Organization which says that from 2030 there will be an additional 250,000 deaths each year due to the impacts of climate change.[1]

The unrelenting heat of 40 degree plus days with high humidity will cause illness such as dehydration with renal failure and heat stroke. Heat stroke occurs when body temperature rises to 40 degrees and physiological dysfunction ensues resulting in a systemic inflammatory response syndrome and DIC.[2] Seizures and loss of consciousness will occur if the patient is not given appropriate emergency medical care. It is babies, older people and those with co-morbidities who are most at risk of these heat related medical sequelae.[3]The 2019-2020 bush fires blanketed Sydney with smoke pollution which can lead to an increase in pulmonary and cardiovascular illness[4,5], and has been shown to increase the risk of death in older people.[6]

ANZCA has a responsibility to speak up, and to speak up loudly, for climate action now.

Dr Stephen Lightfoot, FANZCA MEM
Consultant Anaesthetist and Director, Australian Conservation Foundation (ACF) Board

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ANAESTHESIA FOR PATIENTS TAKING MONOAMINE OXIDISE INHIBITORS

We wish to alert anaesthetists to our expert review advising on the safe administration of anaesthesia and perioperative care in patients taking the classic irreversible antidepressant drugs called monoamine oxidise inhibitors (MAOIs).[1]

This is particularly because they are now being used more frequently and because there remains much deficient and incorrect information in standard texts. My international MAOI expert group has also published the first-ever comprehensive guideline about their general therapeutic use.[2]

Misinformation may cause surgeons and anaesthetists to give advice that puts patients at risk of relapse, and even suicide, by unnecessarily instructing preoperative cessation of MAOIs. Our expert review focuses on anaesthetic considerations to avoid such errors.

Most drugs used in routine modern anaesthesia are perfectly safe. The opioid analgesics are a group that can cause uncertainty because one or two of them do have weak serotonin reuptake inhibitor properties, which can make them problematic (particularly meperidine and tramadol).

There is much confused discussion in the literature, especially concerning fentanyl (which is perfectly safe) and our review clarifies this issue with appropriate detailed tables and pharmacological data explaining interactions, and the difference between serotonin-mediated side-effects and the much more serious issue of the potential for serious serotonin toxicity, which has caused fatalities.

We also highlight the importance of recognising the potent MAOI effect of methylene blue, demonstrated some years ago[3] – but which is still missing from current reviews and guidelines – and the advisability of having a timeout procedure before its administration in any critical care or peri-operative setting. We also explain why the warnings issued about one or two other groups of drugs, particularly the anti-emetic "Setron" drugs, are incorrect and misguided.

We trust it will bring practice up-to-date and enable confident and appropriate management of patients who are being treated with MAOI drugs.

Dr Ken Gillman, MRCPsych, MRCS
Presiding Council Chairman,
International MAOI Expert Group

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CONCERNS OVER TRENDS IN ANAESTHESIA PRACTICE

Having trained in the late 1980s I have seen many changes in anaesthetic practice. Pulse oximetry was a significant addition to our monitoring capability during my training and current registrars wonder how we provided anaesthesia without one.

However, some recent trends in anaesthetic practice are, I believe, a cause for concern.

During my training and in my current practice the use of vasopressor agents is infrequent and mostly limited to preventing hypotension secondary to neuraxial blockade. I have noticed an increasing use of metaraminol to the extent that it is second only to sugammadex as the highest cost agent in our theatres. This will change now that sugammadex has come off patent.

What has changed to make us so reliant on vasopressors? My belief is that use of total intravenous anaesthesia and sevoflurane have necessitated the increased use of vasopressor agents. The effect site concentrations of these agents required to suppress response to surgical stimulus can in many patients, especially the elderly and comorbid, also significantly drop blood pressure.

I find it difficult to understand that we accept techniques that we know are going to produce hypotension and expect that we will have to treat the side effects of our drug administration as if it is of no consequence. Those who know me would suggest that I say this only because I am a strong supporter of desflurane but the truth is I rarely have to treat hypotension when using this agent.

Another major concern is the now common practice of deep extubation in children especially following ear, nose and throat surgery. I can only assume that the practice of deep extubation has become routine to avoid emergence delirium in young patients. The time therefore when laryngeal spasm occurs becomes delayed until the patients are in someone else's care and occasionally after the anaesthetist has commenced the next case. Even if the incidence of this is low I think any instance of avoidable airway complications should in fact be avoided and not accepted as a potential natural consequence of an increasingly common technique.

There are other changes that I could highlight including epidurals in the sitting position, not using a guedels airway when hand ventilating and the increasing use of oxycodone but I could and almost certainly will be accused of being old fashioned and resistant to change.

The truth is I embrace change as long as I believe it's beneficial and an improvement in practice.

Dr Louis George, FANZCA
VMO Anaesthetist
Deputy Director Gosford Hospital Department of Anaesthesia and Pain Management

CONTEMPORARY USE OF NITROUS OXIDE

I read with interest Dr Lightfoot's letter in the Autumn 2024 *ANZCA Bulletin,* noting that he has stopped using the agent and it hasn't impacted on his practice.

I work at Royal Perth Hospital, our state's trauma hospital with a catchment of a million square miles. The case-mix and acuity of our patients may differ from his. I am fortunate to have learned how to use N_2O as well as ether, cyclopropane, trilene, halothane, enflurane and isoflurane. We reduced and rejected N_2O from the 1990s for a variety of reasons (except in my paediatric practice). But over the last 10 years, I have resumed its use in particular scenarios, such as tolerant polysubstance abusing patients, or with the elderly and frail. It can be a useful adjunct to reduce anaesthesia requirements and promote cardio-stability. If we had Xenon available, I'd use that.

Learning the wave signatures of more modern cerebral function monitoring helps guide depth and minimise agent use. Ensuring low flows and preventing manifold leakage are all important factors to minimise waste.

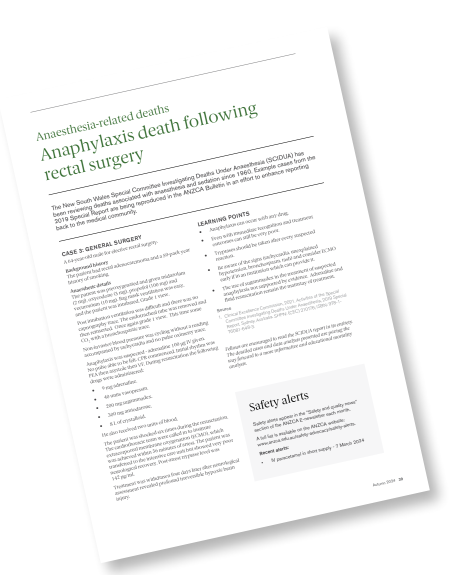
My decision to use is a clinical one. I am concerned that my ability to make informed clinical choices is affected by bureaucratic therapeutics boards that have been unduly influenced by well-meaning, enthusiastic junior consultants with limited clinical experience.

We must be wary of giving up agents further limiting our therapeutic options. We also need to ensure we have junior anaesthetists who have been trained and are competent in a variety of anaesthetic techniques.

It's strategically important in an era of supply issues of "just in time economics". I expect the problems with the manufacture and supply of agents such as propofol to be just as precarious in the future as they have in the past. Anaesthetists need to be able to adapt and not just be a "one trick pony" with total intravenous anaesthesia.

Dr Lightfoot notes the relatively low contribution of medically generated N_2O, compared to agriculture. As anaesthetists we can also influence the impact on climate from the health system in a variety of ways, including reducing the reliance on single use items for the majority of theatre items.

Dr John Akers, FANZCA, FFPMANZCA
Department of Anaesthesia and Pain Medicine
Royal Perth Hospital


Anaesthesia-related deaths

Anaphylaxis death following rectal surgery

The New South Wales Special Committee Investigating Deaths Under Anaesthesia (SCIDUA) has been reviewing deaths associated with anaesthesia and sedation since 1960. Example cases from the 2019 Special Report are being reproduced in the ANZCA Bulletin in an effort to enhance reporting back to the medical community.

CASE 3: GENERAL SURGERY

A 64-year-old male for elective rectal surgery.

Background history

The patient had rectal adenocarcinoma and a 50-pack year history of smoking.

Anaesthetic details

The patient was preoxygenated and given midazolam (2 mg), oxycodone (3 mg), propofol (100 mg) and vecuronium (10 mg). Bag mask ventilation was easy and the patient was intubated. Grade 1 view.

Post intubation ventilation was difficult and there was no capnography trace. The endotracheal tube was removed and then reinserted. Once again grade 1 view. This time some CO_2 with a bronchospastic trace.

LEARNING POINTS

- Anaphylaxis can occur with any drug.
- Even with immediate recognition and treatment outcomes can still be very poor.
- Tryptases should be taken after every suspected reaction.
- Be aware of the signs (tachycardia, unexplained hypotension, bronchospasm, rash) and consider ECMO early if in an institution which can provide it.
- The use of sugammadex in the treatment of suspected anaphylaxis not supported by evidence. Adrenaline and fluid resuscitation remain the mainstay of treatment.

Source

1. Clinical Excellence Commission, 2021. Activities of the Special Committee Investigating Deaths Under Anaesthesia, 2019 Special Report. Sydney, Australia. SHPN: (CEC) 210176; ISBN: 978-1-76081-648-3.

Safety alerts

ANAPHYLAXIS DEATH FOLLOWING SURGERY

I would like to comment on the case detailed by the NSW Special Committee Investigating Deaths Under Anaesthesia (SCIDUA) in the Autumn edition of the *ANZCA Bulletin* concerning the anaphylaxis death following surgery – an awful outcome for all involved.

I believe that in the learning points listed more emphasis needed to be put on the importance of the early use of larger boluses of adrenaline, until an adrenaline infusion can be established. A 100-microgram bolus in a patient with no cardiac output is really homeopathic.

Adrenaline is the only drug of any use in the very first instance, along with vigorous fluid infusion, and in extremely severe cases such as the one mentioned, needs to be given immediately in repeated 1mg boluses to maintain any sort of cardiac output – allowing time for the adrenaline infusion to be started and providing a palpable pulse for an arterial line to be placed – crucial for monitoring the progress of resuscitation.

I am certainly no expert in anaphylaxis, but over my 40-year career had the misfortune to have three extreme cases of anaphylaxis to Mivacurium, Cephazolin and Rocuronium.

All three cases required over 10 x1mg boluses of adrenaline – the latter two cases right from the start, having learnt from my initial case.

I was very fortunate that all three survived helped by lots of skilled assistance, early arterial line insertion (one into the internal Iliac artery as the abdomen had already been opened), great aftercare in the intensive care unit and, of course, luck.

However, I do believe early 1mg boluses of adrenaline also helped and should be used in severe cases with no, or very little, cardiac output.

Dr Peter Pryor, FANZCA
Christchurch, NZ

ANAESTHETISTS AND BILLING

In recent weeks, there has been extensive media coverage of alleged fraudulent, excessive and/or incorrect billing by anaesthetists. Our college has responded by saying that "the overwhelming majority of anaesthetists and specialist pain medicine physicians operate with integrity and make every effort to comply with increasingly complex billing requirements".

We are disappointed by this response, as we do not believe any data exist to support it. In fact, our own anecdotal experience suggests that we are not facing a minor problem, as is often claimed, of just "a few bad apples".

We are, however, pleased that the college has chosen to involve itself in this matter.

ANZCA's statement of purpose gives primacy to the "promotion (of) professional standards". It is the only organisation to which we all belong. It is the face of the anaesthetic profession, for both governments and the public. ANZCA's recently revised "Supporting Anaesthetists' Professionalism and Performance" document refers to our important role in "recognising wider health needs of the community in a system with resource limitations".

We urge ANZCA to now take a leading advocacy role with the Australian government in driving a radical review of the Australian Medical Benefits Schedule for anaesthetists to create a simplified, unambiguous self-enforcing schedule of fees.

The benefit of this to both patients and healthcare funders is self-evident. For ourselves, a simplified system would help us to act with integrity, and to be seen to do so. The only losers would be those who wilfully game or defraud the system.

(We acknowledge that this important matter in Australia does not concern fellows based elsewhere)

Dr Richard Barnes, FANZCA, Victoria

Dr Craig Noonan, FANZCA, Victoria

Dr Noel Roberts, FANZCA, Victoria

The views expressed by letter writers do not necessarily reflect those of ANZCA.

What we're talking about

Facebook

COLLEGE CEREMONY FOR 300 NEW FELLOWS

A wrap up of the College Ceremony at the Annual Scientific Meeting (ASM) on Saturday 4 May was our most popular post on Facebook.

While the ceremony at the Brisbane Convention Centre was live streamed our later post featuring photos from the night, including the presentation of the college's highest honour, the Robert Orton Medal, to Dr Lindy Roberts, Professor David A Scott and Dr Peter Roessler, reached more than 4000 people and had more than 1300 post engagements (likes, shares, comments). Fourteen fellows were recognised for their contributions to ANZCA on the night.

Instagram

ASM CICO WORKSHOP

Brisbane anaesthetist Dr Linda Beckmann's video post from the popular ASM CICO (Can't Intubate Can't Oxygenate) workshop sessions on 3 May was popular on Instagram, attracting nearly 3000 views and reaching more than 1300 accounts. Dr Beckmann is chair of the Airway Management special interest group and her clinical interest is in head and neck anaesthesia and the management of difficult airways. The CICO workshop emergency response activities led by Dr Beckmann attracted nearly 400 delegates and 68 instructors throughout the day. Dr Beckmann noted that the sessions would help grow a "network of facilitators" who would take their CICO skills back to their hospitals.

Media

ANAESTHESIA UNPLUGGED ON ABC RADIO

ANZCA Vice-President Tanya Selak (@GongGasGirl) was interviewed about general anaesthesia and the specialty on the ABC Radio Weekend Evenings program with Sirine Demachkie on Friday 24 May.

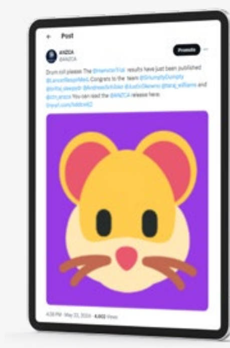
The 25-minute segment not only explored the science behind anaesthesia and its effect on the brain but the history of the specialty dating back to 1846 when ether anaesthesia was first demonstrated publicly. At the end of the segment Dr Selak nominated *Sweet Dreams* by the Eurythmics as her top song about sleep.

The broadcast reached nearly 40,000 people.

X (formerly Twitter)

HAMSTER TRIAL RESULTS RELEASED

The results of the Hamster (High-flow oxygen for children's airway surgery) ANZCA Clinical Trials Network study were released on 22 May and published in *The Lancet Respiratory Medicine*. The ANZCA X post announcing the findings received nearly 4000 impressions and 300 engagements. The post included a link to the ANZCA media release "Children to benefit from faster oxygen delivery during surgery" which quoted Chief Investigator Associate Professor Susan Humphreys, a paediatric anaesthetist at Queensland Children's Hospital: "The results show that the new technique is as safe as the standard method and offers a second option to the anaesthetist in deciding how best to deliver oxygen to these children during the anaesthesia."



ANZCA & government

We work with national, state and territory governments and their agencies to ensure we're appropriately consulted on decisions affecting our members; the health systems they work within; and their ability to provide every patient with safe, high-quality, and culturally competent care.

Workforce reform tops agenda

MEETING WITH THE MINISTER OF HEALTH WORKFORCE ADVISOR

In April the president, vice-president and CEO met with Australian Health Minister Mark Butler's primary care and workforce advisor. The meeting was in response to a request from ANZCA to discuss how we can work together to facilitate changes across the health sector to create a sustainable workforce, in particular the specialist anaesthetist and pain medicine workforce.

Several issues integral to our workforce were covered, such as strategies to increase domestic trainee numbers (together with states and territories) as a long-term approach and the potential benefits of perioperative medicine as a standard operating approach. A follow-up letter will be provided to the Commonwealth Department of Health and Aged Care's Health Workforce First Assistant Secretary to continue the discussions.

We understand workforce will continue to be an area of focus for the minister throughout 2024 and in the lead up to the Commonwealth government's mid-year budget review process.

MEDICAL WORKFORCE ADVISORY COLLABORATION

Recognising the priority focus of workforce, the Commonwealth Department of Health and Aged Care is currently establishing the Medical Workforce Advisory Collaboration (MWAC) to advise federal, state and territory health ministers, through the Health Workforce Taskforce, on medical workforce.

The MWAC will also oversee ongoing implementation and evaluation of the National Medical Workforce Strategy. MWAC's ongoing role will seek to match medical workforce planning to community needs by contributing to decisions about:

- The size and structure of the medical workforce.
- The number and distribution of university places in medicine.
- Specialty training numbers.
- Migration policy settings.
- Distribution levers.

Membership includes the Commonwealth, states and territories, 18 peak bodies and representative organisations – including the Council of Presidents of Medical Colleges (CPMC) – and five positions for specialist medical colleges.

The five successful colleges will need to represent the medical workforce ecosystem, not just issues facing their specific college. Raising issues with MWAC can be facilitated through the CPMC in addition to college member representatives.

In April, ANZCA submitted a detailed nomination form for one of the five medical positions. We are pleased to announce following an assessment of all nominations received, ANZCA's nomination was assessed as highly suitable for MWAC membership as one of the five specialist medical college positions. MWAC is anticipated to be established by mid-2024 and hold its inaugural meeting in Canberra in August 2024.

POTENTIAL EXPEDITED REGISTRATION PATHWAY FOR SPECIALIST INTERNATIONAL MEDICAL GRADUATES (SIMGS)

One of the recommendations identified in the 'Independent Review of Australia's Regulatory Settings Relating to Overseas Health Practitioners' report (in late 2023) was the potential establishment and implementation of an expedited registration pathway for SIMGs to address workforce shortages, particularly in rural areas.

The college has received correspondence and attended meetings in March and April identifying that the Australian Health Practitioner Regulation Agency (Ahpra) and the Medical Board of Australia have been commissioned to develop this pathway, prioritising the following four specialties: general practice, anaesthesia, obstetrics and gynaecology and psychiatry.

ANZCA recently wrote to Ahpra to reiterate that we do not believe an expedited pathway is required in anaesthesia or pain medicine due to the college's satisfactory performance against all agreed timeframes and metrics within our control. In our experience, delays in SIMG registration as a specialist in anaesthesia or pain medicine are associated with visa processing and receiving an offer of employment.

We will continue to work with Ahpra, the Medical Board of Australia and government to ensure the complexities, specifications and impacts of these processes are appropriately understood and the safety and quality of service provision is not adversely impacted as a result. It is important that medical specialist colleges expertise and knowledge of the requirements for a specialist to practise safely and competently in Australia is harnessed, with ANZCA's effective and successful SIMG assessment process.

NSW SPECIAL COMMISSION OF INQUIRY INTO HEALTHCARE FUNDING

Following ANZCA's submission to the inquiry in late 2023, the college is continuing to work with heads of anaesthesia departments across NSW, committees, key anaesthetists and other sector stakeholders to provide feedback and advice on how the issues are impacting them and key aspects to continue prosecuting for action to the inquiry.

ANZCA has been invited to meet with the inquiry in late May, prior to the June public hearings, to discuss the topics in our submission. Four representatives from our NSW Regional Committee will attend this meeting to provide the commissioners with a better understanding of evidence sought for the hearings.

The inquiry report is due to be delivered to the NSW government by late March 2025.

NATIONAL HEALTH AND CLIMATE CHANGE STRATEGY

The chair of the Environmental Sustainability Network, Dr Archana Shrivathsa, fellows and college staff attended a Climate Change and Health Multi-College Advisory Committee meeting in April. The meeting included attendees from 12 medical colleges and the Commonwealth Department of Health and Aged Care and covered:

- A roundtable with state and territory governments to occur in May 2024 to agree a phase-out date for desflurane.
- Implementation of the National Health and Climate Strategy, with the Department of Health and Aged Care seeking to arrange a roundtable in June 2024 to develop and approve a five-year framework for action.

ANZCA also provided written feedback in April to a range of questions requested by the department to understand the clinical perspectives and challenges in relation to the use of both desflurane and nitrous oxide.

FEDERAL BUDGET 2024-25 HEALTH PORTFOLIO

Following the 2024–25 budget being handed down by the Australian treasurer on Tuesday 14 May, ANZCA attended a briefing webinar hosted by the Department of Health and Aged Care.

The webinar included the department's portfolio ministers – Mark Butler, Anika Wells, Ged Kearney, Emma McBride and Senator Malarndirri McCarthy. The portfolio ministers participated in a question and answer session with the Secretary of the Department of Health and Aged Care, Blair Comley.

Some of the budget initiatives related to ANZCA and our anaesthesia and pain medicine environment include:

- A new medical school in Northern Territory from 2026.
- Funding to grow and support the First Nations health workforce with more First Nations non-GP medical specialists.
- A new *National Health and Medical Research Strategy* that will help Australia build a sustainable research pipeline covering all levels of government, industry, philanthropy, academia and consumers.
- Extending the Medicare Benefits Schedule (MBS) Continuous Review program.
- Increased funding for state and territory public hospitals of at least an additional $A13 billion over the next 10 years.
- Two years of funding from 2024–25 to continue support for preventive health and chronic disease research in support of the *National Preventive Health Strategy 2021–2030*.

MEETING WITH THE NEW ZEALAND MINISTER OF HEALTH

Following a briefing from the college on anaesthesia and pain medicine provided to the incoming New Zealand Health Minister, Dr Shane Reti, New Zealand National Committee deputy chair Dr Sarah Nicolson and pain medicine national committee chair Dr Chris Rumball met with Dr Reti on 16 April. Key topics of discussion included pain services and the *Mamaenga roa model of care*, perioperative medicine, workforce issues (including anaesthetic technicians), and the potential for a nationally compatible, anaesthesia-specific, electronic patient record.

NEW ZEALAND HEALTH SYSTEM NEWS

Cost saving and a hiring freeze by Health New Zealand/ Te Whatu Ora, alongside ongoing workforce shortages and growing winter pressures are causing concern. Health funding was relatively protected in the budget, though inflation means that some major infrastructure projects are paused, while the health ministry has six per cent job cuts, including to public health. Hiring freezes continue in many hospitals, and industrial unrest continues by resident doctors over unmet wage claims.

SUBMISSIONS

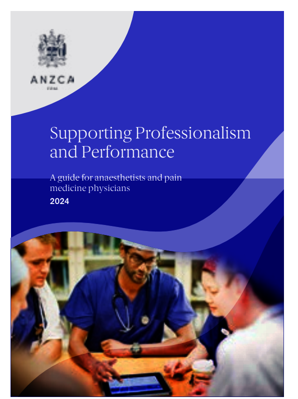
The college prepares submissions and makes representations to government and other stakeholders on a range of policy initiatives and inquiries. Our submissions to public inquiries are available on the college website following the closing date. Note that some inquiries and requests for college input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

Australia

- Australian Medical Council: Delegation of accreditation decision making to Accreditation Standing Committees.
- Australian Resuscitation Council: Draft ANZCOR guidance statement: legal and ethical issues related to responding to emergency situations and resuscitation – consent.
- Australian Resuscitation Council: Draft guidelines for acute coronary syndrome.
- Australian Resuscitation Council: Resource document - Introduction to and principles of in-hospital resuscitation.
- Department of Health and Aged Care: National Health and Climate Change Strategy - anaesthetic gases consultation.
- Neurosurgical Society of Australasia: Surgical Education and Training (SET) program in neurosurgery curriculum.
- Therapeutic Goods Administration: Medicine shortages in Australia.
- Therapeutic Goods Administration: Reporting medication/device concerns and finding TGA information.

New Zealand

- Medical Council of New Zealand/Te Kaunihera Rata o Aotearoa: Treating yourself and those close to you.
- New Zealand Psychologists Board/ Te Poari Kaimātai Hinengaro o Aotearoa: Proposed framework for scopes of practice.



Professionalism guide revised

Our revised and updated professionalism guide "Supporting Professionalism and Performance: A guide for anaesthetists and pain medicine physicians" was launched at the May ANZCA Annual Scientific Meeting in Brisbane.

Developed following broad consultation, the guide has a number of updates to reflect current practice, changes to roles in practice and to include specialist pain medicine physicians. It is a valuable tool in reflective practice and integrating CPD activities.

The guide builds on the previous edition and reinforces our college's commitment to meeting standards for the provision of quality care as well as the importance of respectful interaction and communication with our patients and each other.

The guide provides a framework for understanding professionalism and performance as it applies to anaesthesia and pain medicine. This mirrors the ANZCA and FPM roles in practice and builds from the curriculum frameworks of the anaesthesia and pain medicine training programs under each of these roles.

The "roles in practice" were extensively reviewed and updated, maintaining the format of "good" and "poor" behavioural markers which serve as guidelines for evaluating and promoting safe practice and respectful interactions with colleagues and patients.

The primary objectives of the framework are:

- Define and promote the highest standards of professionalism in practice.
- Set clear performance expectations for anaesthetists and pain medicine physicians.
- Facilitate continuous professional development and improvement, including:
  - Critical self-reflection.
  - Gathering multisource feedback.
- Enhance patient safety and quality of care.

"Supporting Professionalism and Performance: A guide for anaesthetists and pain medicine physicians" is relevant to clinicians at all stages of their careers – junior doctors, trainees, specialist international medical graduates (SIMGs) and those not involved in direct patient care.

The guide is divided into the seven roles in practice and explores a set of positive and negative behaviours for each role.

Cultural competency and cultural safety are incorporated under many of the roles in practice within the guide and we expect this area to evolve in line with our Reconciliation Action Plan, Te Tiriti o Waitangi strategy and any college curricula review.

The guide is enhanced with additional resources that are included in the appendix 2.

The working group, led by Professional Affairs Executive Committee Chair, Dr Scott Ma, consulted with a number of internal organisations including the ANZCA Professional Affairs Executive Committee (governance), ANZCA Council, FPM Board, FPM Professional Affairs Executive Committee, ANZCA Education Executive Management Committee, ANZCA Education Development and Evaluation Committee, ANZCA Trainee Committee, FPM Training and Assessment Executive Committee, ANZCA and FPM CPD Committee, ANZCA regional and national committees, FPM regional and national committees, ANZCA Safety and Quality Committee, Indigenous Health Committee, SIMG Committee, and the Leadership Special Interest Group.

External groups consulted include The Royal Australasian College of Physicians, the Royal Australasian College of Surgeons, Royal Australian College of GPs, the Australian College for Rural and Remote Medicine, the Australian Society of Anaesthetists, the New Zealand Society of Anaesthetists, the College of Intensive Care Medicine and the Australian College of Perioperative Nurses and the Australasian College of PeriAnaesthesia Nurses.

PROFESSIONALISM WORKING GROUP

Dr Scott Ma, Councillor, PAEC Chair (SA)

Dr Lindy Roberts, ANZCA DPA Education (WA)

A/Prof Michael Vagg, FPM DPA Professional Affairs (Vic)

Dr Benn Lancman, PAEC member (Vic)

Dr David Kibblewhite, PAEC member (NZ)

Dr Peter Roessler, ANZCA DPA Professional Documents (Vic)

Dr Debra Devonshire, Councillor, ANZCA and FPM CPD Committee Chair (Vic)

Dr Leona Wilson, ANZCA Executive DPA (NZ)

Dr Alec Beresford, ANZCA Trainee Committee Co-chair (NZ)

Dr Anthony Notaras, ANZCA Trainee Committee Co-chair (NSW)

Dr Michelle Mulligan, ANZCA DPA Policy (NSW)

Prof David A Scott, ANZCA DPA Policy (Vic)

Ms Jan Sharrock, Executive Director Fellowship Affairs (Vic)

Ms Alecia Savale, Membership Services Manager (Vic)

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Council changes

ANZCA Council governs the college with the support of the FPM Board and various committees. Significant changes to council generally happen every two years when a new president takes over.

Thank you to our post-pandemic president

As president from May 2022 to May 2024 Dr Chris Cokis led ANZCA out of the pandemic and into a brave new world dominated by politics both within Australia and New Zealand and internationally.

It has been my privilege to serve as Chris's vice president during that time. My primary image is of Chris with a calm yet determined approach to working with council to guide ANZCA strategy and governance as required of the chair of a board of a not-for-profit, for-purpose, company under the laws of the two trans-Tasman countries.

Despite what some may think, ANZCA Council is not an exercise in group-think and Chris was able to keep discussions civil despite at times differing strong opinions and a tendency of councillors (including me) to deep dive into operational rather than strategic matters.

Chris is from Western Australia and had the challenge of the Perth to Auckland time zones which meant some early mornings and long flights. He continued his mixed public and private anaesthesia practice in Perth, including cardiac anaesthesia. As with all councillors, clinical practice helped Chris focus on what really matters: patient care.

As a past examiner and chair of the ANZCA final exam, Chris was, and is, very aware of the demands on trainees, examiners, and ANZCA staff with these exams vital to ensuring that FANZCAs are highly knowledgeable clinicians.

The political challenges have been many. In 2023 ANZCA Council decided to support a "Yes" vote in the Voice to Parliament referendum in Australia. This was primarily because of the strong message from Australian experts from within and outside First Nations communities that the Voice could help close the gap in First Nations health.

Chris was passionate about supporting the Voice in the face of limited but strongly worded criticism from fellows who felt this stance was "too political". Conversely, ANZCA Council declined to comment on conflicts well beyond the shores of our two countries where some thought we should be more political.

The major challenges, however, have come from governments, particularly Australian federal and state governments with multiple inquiries and working groups examining ways to increase the number of practising doctors in our countries but with with some ambivalence from government towards the specialist medical colleges, including ANZCA. Chris has been an important member of the Committee of the Presidents of Medical Colleges, trying to work with government and advocate for patient care and workforce wellbeing.

Important innovations during Chris's presidency include moving council meetings beyond ANZCA House in Melbourne to the Wellington office and to the new Hobart office. The Wellington meetings provided an opportunity for Australian councillors to better understand Māori culture including visiting a Marae (Māori meeting ground).

Now that he has more time for himself and his family, and less time with Qantas, Chris will now have a new role working on engaging external bodies with ANZCA's world leading perioperative medicine program. Chris also introduced a podcast series, "Conversations with Chris", showcasing the diverse journeys of senior members of ANZCA which I hope will continue. For the next two years Chris will have the role of immediate past president, supporting me as president and Dr Tanya Selak as vice president.

Tanya and I and the broader ANZCA Council will rely on his wise and calm counsel, undoubtedly prefaced with a polite "Can I just say…".

Professor Dave Story
ANZCA President

ANZCA Council appointments

Following is a list of individual appointments and chairs of committees reporting to ANZCA Council.

For a full list of committees visit anzca.edu.au/about-us/our-people-and-structure

President	Professor Dave Story
Vice president	Dr Tanya Selak
Honorary treasurer	Associate Professor Deb Wilson
Chair of examinations	Dr Michael Jones
Councillor on FPM Board	Dr Scott Ma
Medical editor	Dr Kate McCrossin
Honorary curator	Dr Christine Ball
Honorary historian	Professor Barry Baker
Safety and Quality Committee chair	Associate Professor Joanna Sutherland
Professional Affairs Executive Committee chair	Dr Scott Ma
Perioperative Medicine Steering Committee chair	Dr Sean McManus and Dr Vanessa Beavis
Education Executive Management Committee chair	Professor Leonie Watterson
Training Accreditation Committee chair	Dr Mark Young
ANZCA Research Committee chair	Professor Britta Regli-Von Ungern-Sternberg
ANZCA Foundation Committee chair	Dr Rod Mitchell
Finance, Audit and Risk Management Committee chair	Mr Richard Garvey
Information and Communications Technology (ICT) Governance Committee chair	Associate Professor Stuart Marshall
Awards Advisory Panel chair	Dr Maryann Turner

Australian regional and New Zealand committees

Elected national and regional committees act as a conduit between fellows and trainees in the regions and the ANZCA Council to which they report. The committees assist with:

- Implementing college policy in their regions.
- Advising ANZCA Council on issues of interest to the college and its fellows and trainees in the regions.
- Representing the college and promoting the specialty in the regions.
- Developing and maintaining relationships with key regional stakeholders.
- Training, continuing medical education, and other professional activities at a regional level.

New Zealand National Committee chair	Dr Graham Roper
ACT Regional Committee chair	Dr Jennifer Hartley
NSW Regional Committee chair	Dr Frances Page and Dr Sharon Tivey
Queensland Regional Committee chair	Dr Sarah Bowman
SA and NT Regional Committee chair	Dr Nagesh Nanjappa
Tasmania Regional Committee chair	Dr Bruce Newman
Victoria Regional Committee chair	Dr Dean Dimovski
WA Regional Committee chair	Dr Bridget Hogan

Introducing our new councillors

There are four new members of ANZCA Council following an election earlier this year

DR SARAH NICOLSON

Dr Nicolson has been actively involved with ANZCA for many years, and has extensive experience in training, regulation and advocacy. Her experience in accreditation has given her an extensive knowledge of the standards required by the Australian Medical Council and the Medical Council of New Zealand and highlights why governance by the profession is so important in achieving high quality care for patients.

Responsibility in roles in Australia and New Zealand has provided her with a broad insight into specialty medical colleges and medical training.

Dr Nicolson supports the development of a robust workforce and making continuing professional development straightforward and relevant.

ASSOCIATE PROFESSOR DAVID STURGESS

Associate Professor Sturgess recently led the establishment of the anaesthesia department of a new greenfield hospital, the Surgical, Treatment and Rehabilitation Service (STARS) in Brisbane. Dr Sturgess's role involved workforce planning, recruitment, and retention of talented anaesthetists and highlighted for him the importance of defending the rigour of the ANZCA training program, development of safe but efficient work environments, and sustainability of the workforce and workplace.

Associate Professor Sturgess is a dual qualified specialist anaesthetist and intensive care physician, with complementary qualifications and experience in general practice, medical administration, clinical ultrasound, and research. His roles include deputy director at the Princess Alexandra Hopsital in Brisbane and in private practice at hospitals across the city. His clinical interests focus on higher risk procedures (vascular and oncologic surgery) and co-morbidity.

He has made significant contributions to ANZCA in recent years including as scientific convenor for the 2017 annual scientific meeting and Primary Exam Sub-Committee member.

DR ADAM LEVIN (NEW FELLOW COUNCILLOR)

Dr Levin is an anaesthetist at University Hospital Geelong in Victoria and recently completed his training through the Monash Anaesthetics Training Scheme. He has a longstanding commitment to representation through involvement in ANZCA and non-anaesthesia committees.

As new fellow councillor he will be advocating for equity in opportunity for ANZCA trainees, fellows and specialist international medical graduates, upholding the college's high standards in education and quality assurance and improving environmental sustainability in anaesthesia practice.

DR DILIP KAPUR (FPM DEAN)

Dr Kapur joined the FPM Board in 2022 and was elected to the role of FPM vice-dean. Dr Kapur chairs the FPM Executive Committee and is a former chair of the FPM Training and Assessment Executive Committee.

Based in South Australia, Dr Kapur was previously an elected member of the board serving from 2013 – 2015. During this time he held the roles of FPM Assessor and FPM Deputy Assessor, SIMG.

He has extensive experience in pain medicine through a long career in the discipline. He supports a proactive approach to maintaining the wellbeing and motivation of FPM fellows, recognising the stressors that specialist pain medicine physicians can face in their practice.

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.

DR VANESSA BEAVIS

After joining ANZCA Council in 2012 Dr Beavis was elected ANZCA president in 2020, the first year of the COVID-19 pandemic, and completed her term in May 2022. As ANZCA's "pandemic president" she faced an extraordinary period in the history of the college and the global medical community.

She was determined to ensure that ANZCA's trainees experience minimal pandemic disruption during her leadership and this was achieved following many long days and nights of virtual meetings involving examiners, trainees and educational staff.

In a significant milestone for ANZCA in 2021, Dr Beavis led the council in its decision to formally adopt a Māori name for the college, Te Whare Tohu o Te Hau Whakaora.

That same year she also became the inaugural chair of the International Academy of Colleges of Anaesthesiologists (IACA) an international collaboration of five specialist anaesthesia colleges with ANZCA as a founding member.

Dr Beavis's medical career began in South Africa before she moved to New Zealand in 1993 as a specialist anaesthetist with an interest in liver transplantation.

She has played a key role in introducing ANZCA's perioperative medicine qualification and recently took on the role of a Director of Professional Affairs Assessor.

Dr Beavis has spent more than 25 years contributing to college activities including chairing the Continuing Professional Development (CPD) Committee, the Training and Accreditation Committee and the New Zealand National Committee.

She has been a final examiner, led the development of several professional documents, established the Leadership and Management Special Interest Group (SIG) and the Perioperative Medicine SIG.

Dr Beavis was for 16 years (under various titles) the director of Perioperative Services at Auckland City Hospital, before taking on the position of president of ANZCA.

DR MICHAEL JONES

Dr Jones served on council for nine years and during his tenure worked on several key ANZCA projects and committees. As chair of examinations he was thrust into the challenging role of leading ANZCA's "pivot" to pandemic examinations processes from 2020, successfully minimising disruption to trainees as they prepared and sat for their exams, often under stressful and challenging circumstances.

His other most recent roles include deputy chair of the ASM and Events Planning Committee and deputy chair of the Education Executive Management Committee.

He has been a member of the Specialist International Medical Graduates Committee since 2017 and continues as Chair of Examinations, a role he has held since 2016.

Through his years on council and committees he has seen firsthand the commitment, dedication and enthusiasm of fellows, trainees and SIMGs in Australia and New Zealand.

DR BRIDGET EFFENEY (CO-OPTED)

Dr Effeney is a specialist anaesthetist in private practise in Brisbane who achieved fellowship in 2011. Her specialty areas include neuroanaesthesia.

She trained in Cairns and Brisbane and has contributed broadly to ANZCA in events, professional affairs and gender equity. She was convenor of the ANZCA Annual Scientific Meeting (ASM) in 2017 and a former member of the Professional Affairs Executive Committee.

She has also been a member of the ASM and Events Planning Committee since 2015 and is a former chair of the Gender Equity Sub-Committee.

DR KATHERINE GOUGH (NEW FELLOW COUNCILLOR)

Dr Gough completed her anaesthesia fellowship in ear, nose and throat, head and neck surgery and neurosurgery. Her clinical roles include working across Royal Prince Alfred hospital in Sydney, Chris O'Brien Lifehouse, and St Vincent's Hospital.

Her interest in wellbeing, equity and education has been highlighted by her involvement with ANZCA as a trainee through multiple committees and working groups. As co-chair of the ANZCA Trainee Committee in 2020 she had first-hand experience working with the college to mitigate the impact of the COVID-19 pandemic on training and the workforce.

As new fellow councillor she was dedicated to working with ANZCA to promote equity and opportunity for new fellows in the Australian and New Zealand anaesthesia workforce.

DR KIERAN DAVIS (FPM DEAN)

Dr Davis works as a specialist pain medicine physician and anaesthetist at Auckland City Hospital. He has held key faculty positions including dean, vice-dean, founding chair of the FPM New Zealand National Committee, and has chaired both the FPM Examinations Committee, FPM Training and Assessment Executive Committee and the Training Unit Accreditation Committee.

He is a graduate of Leeds University and trained in anaesthesia in the north-west of England before undertaking further studies in pain medicine in Auckland. He was the clinical director of the Auckland Regional Pain Service from 2005-2017.

Farewell to a visionary leader

Michael John Cousins

MB BS, MD, DSc, FANZCA, FRCA, FFPMANZCA, FAChPM

1939 – 2024

ABOVE

Professor Michael Cousins was president of ANZCA from 2004 to 2006.

"As an intern, Michael became intensely interested in the problems of pain therapy when he treated two badly burned boys."

Michael Cousins, a doyen of Australian anaesthesia and pain medicine, died recently following a decline in his last years due to Parkinson's Disease. He was undoubtedly the internationally best-known ANZCA fellow.

His research career was established at Stanford University with studies of the toxicity of the volatile anaesthetic agent methoxyflurane, leading to 14 articles published between 1971 and 1974. These became the basis for his MD thesis from the University of Sydney (1975). This landmark research led to Michael becoming an internationally recognised name in anaesthesia and to the removal of methoxyflurane from general anaesthesia.

Ironically, given Michael's subsequent fame as a pain medicine specialist, it was almost 40 years before methoxyflurane returned to use in clinical medicine as a very effective analgesic for trauma victims, and is now an established acute analgesic agent (Penthrox®) used by paramedics.

Michael grew up in Killara in the leafy northern suburbs of Sydney. He attended Shore School where he was successful as a prefect and in rugby, rowing and athletics, followed by Sydney University medical school where he did his clinical years at Royal North Shore Hospital (RNS) and was for a number of these years the elected class representative.

Following graduation he spent two years as a resident at St George Hospital, Sydney, before returning to RNS for his anaesthesia training. He successfully completed this training and was awarded the Cecil Gray Prize for the highest marks in the final FFA examination.

As an intern, Michael became intensely interested in the problems of pain therapy when he treated two badly burned boys. He was troubled by the difficulty in achieving adequate analgesia and this event stimulated his lifelong commitment to improving the management of patients with pain.

In October 1967 Michael married Michele Old having met her the previous year. Uncharacteristically for Michael, they became engaged after only two weeks. His decision to marry Michele was undoubtedly an excellent one. Michele always supported Michael very strongly and was crucial to his professional and family successes. She was a great comfort to him in all his subsequent decisions and actions, and particularly at the very sad time when their eight-year-old second son, Richard, died from viral myocarditis in 1980.

LEFT

In 1987 Michael J Cousins was granted an audience with Pope John Paul II during a visit to Rome.

"His ability to gather influential people to his cause were hallmarks of Michael's ability to achieve his goals."

Following the completion of his anaesthesia training Michael was fortunate to meet Sir Gordon Robson, then Professor at McGill University in Montreal, when he was visiting Australia in 1968. Robson offered Michael a position in his McGill Department to work with Dr Phillip Bromage, a British anaesthetist renowned for his work in regional anaesthesia.

This began Michael's international journey in pain management with epidural analgesia/anaesthesia. At McGill Michael also met psychologist Associate Professor Ronald Melzack who, with British neuroanatomist Professor Patrick Wall, had published the famous "Gate Theory" of pain transmission in 1965.

Michael next moved to Stanford University for three more years in anaesthesia where he did collaborative research with Dr Richard Mazze on the toxicity of methoxyflurane. During this period he travelled to Seattle to meet Professor John Bonica at the University of Washington and to observe the pain clinic there.

Bonica was the acknowledged founder of modern multidisciplinary pain management and was renowned for his teaching and research in regional anaesthesia. Michael learnt two valuable lessons from his North American experiences – the significance of collaborative laboratory-based, clinically-oriented research, and Bonica's unrelenting style for achieving objectives.

In 1974 Michael returned to RNS in Sydney. Soon after, he was appointed to the Foundation Chair in Anaesthesia and Intensive Care at Flinders Medical Centre in Adelaide in 1975. There, he made two significant appointments. These were Professor Garry Phillips, who had graduated with Michael, and research scientist Professor Laurie Mather, a Sydney science graduate then working with Bonica, who was tasked with directing the new department's research.

Phillips joined the Flinders department to head the intensive care unit and later succeeded to the Flinders Chair when Michael accepted the Foundation Chair of Anaesthesia and Pain Management at RNS in 1990. In 1991 Mather was appointed to a research chair at Sydney University and continued his collaboration with Michael at RNS.

In 1980 Michael, with co-editor Professor Phillip Bridenbaugh, published the 749-page multi-authored textbook *Neural Blockade in Clinical Anesthesia and Management of Pain*[1] that ran to four editions. This text has become a major resource for regional anaesthesia and the management of acute and chronic pain. It was responsible for making Michael's name a byword in pain circles. He also published two other multi-authored textbooks on pain.[2,3] In 1984, Michael and his colleague Mather co-authored a review *Intrathecal and epidural administration of opioids* in *Anesthesiology*[4] which is still the most cited article published by that journal.

At both Flinders and RNS Michael devoted much time to advocating for the improvement of pain management and seeking the requisite funding support. In Adelaide he had persuaded John Cornwall, then South Australian health minister, to provide substantial funding to establish the Pain Management Unit at Flinders.

In Sydney, he had the strong support of Professor Tom Reeve, then chairman of the Northern Sydney Health District, who had appointed Michael to the chair at RNS. Reeve assisted Michael's objective to establish world-leading pain management clinical and research services. His ability to gather influential people to his cause were hallmarks of Michael's ability to achieve his goals. This ability has been rare among Australian anaesthetists, and it underpinned his great success as a medical leader.

Not long after arriving at Flinders Michael became treasurer of the International Association for the Study of Pain (IASP). The IASP formed an Australasian Chapter and Michael was appointed interim president at its first conference in 1979.

This Australasian chapter subsequently evolved into the Australian Pain Society (APS). The APS enabled medical practitioners interested in managing patients with pain to contact each other and was the first step in bringing together practitioners from different specialties, thereby improving services offered to patients.

"Michael was prolific in publishing his research and these publications consolidated his international renown."

LEFT

With ANZCA, Michael Cousins founded the Faculty of Pain Medicine (FPM) and became its first dean (1999-2002), establishing it so well that it is now the blueprint for other countries.

It has often been stated that the pain clinic at Flinders Medical Centre was the first Australian multidisciplinary pain clinic. After visiting Bonica anaesthetist Dr Brian Dwyer established the first multidisciplinary pain clinic at St Vincent's Hospital in Sydney in 1962.[5] This clinic also included two neurosurgeons, a neurologist and a psychiatrist. Michael, however, expanded further the clinical disciplines involved by including physiotherapists, occupational therapists and psychologists.

He also established the need for patients to recognise that psychological and social adjustments were necessary alongside the medical therapy to best manage chronic pain, and introduced educational aspects that encompassed training, examinations, and the development of protocols and statements including the *Declaration of Montreal*.[6]

In his departments, Michael fostered multidisciplinary basic and applied research that included pharmacological and toxicological studies of local, intravenous, and volatile anaesthetic agents, of pain mechanisms and the actions of analgesics, the effectiveness of epidural opioids, and spinal cord stimulation for patients with pain. Many of these studies involved students working towards postgraduate degrees, and so were especially valuable as educational activities for those students

Michael was prolific in publishing his research and these publications consolidated his international renown. This led to many academic honours – John Mitchell Crouch Award (Royal Australasian College of Surgeons), Mushin Medal (Welsh National University), Sir Arthur Sims Travelling Scholarship (the Royal College of Physicians and Surgeons of UK, Canada and South Africa), Carl Koller Gold Medal (European Society of Regional Anaesthesia and Pain Therapy), Gaston Labat Medal (American Society of Regional Anaesthesia and Pain Medicine), William Russ Pugh Medal (Australian Society of Anaesthetists), Robert Orton Medal (ANZCA), Distinguished Member Award (APS), Founders Award (AmAPM), Inaugural International Neuromodulation Society Lifetime Achievement Award (Aust), and too many named lectures to list here.

He was also elected to honorary fellowships of the Royal College of Anaesthetists and College of Anaesthetists of Ireland, and to the Australasian Chapter of Palliative Medicine (Royal Australasian College of Physicians). From 1987-1990 Michael was president of the International Association for the Study of Pain (IASP) – only the second anaesthetist after Bonica to hold that position and an immense recognition of his international status.

With his ambition to progress the professionalism of pain medicine Michael saw the need for strong professional bodies to educate and to set guidelines for the direction of pain medicine.

When Michael was elected to ANZCA Council it was reviewing its curriculum on pain management. Michael led an expansion of these plans to include chronic pain management and brought four other colleges to combine with ANZCA to found the Faculty of Pain Medicine (FPM). He became its first dean (1999-2002), establishing it so well that it is now the blueprint for other countries. The FPM and the APS were to provide the backing to support Michael's push that had pain medicine finally approved as a distinct specialty in Australia in November 2005.

At the same time as Michael was progressing FPM he also had other active projects – the National Health and Medical Research Council (NHMRC) publication *Acute Pain Management: Scientific Evidence*, and his successful application for funding for an NHMRC Centre of Excellence at RNS (1998-2000) enabling him to secure his research at RNS with the newly-formed Pain Management Research Institute.

Still on ANZCA Council, Michael became president of the college (2004-2006). There, he led governance changes to bring the council into line with commercial and legal requirements for company boards, and with encouragement for councillors to enrol in the Australian Institute of Company Directors (AICD) courses to obtain the relevant legal and commercial experience for membership of AICD.

In the latter part of his presidency he had to deal with the illness and later, death of ANZCA's founding chief executive officer, Mrs Joan Sheales. During this period, Professor Garry Phillips, who then was the only college Director of Professional Affairs and Michael's former colleague at Flinders, assisted him in appointing the next CEO (Dr Mike Richards) who helped drive the corporate changes Michael had been advocating.

Also during his presidency Michael began the process to enhance perioperative medicine which has recently become established with specific training and assessment enabling fellows of ANZCA, FPM, RNZCGP, RACGP, RACS, RACP, ACRRM and CICM to complete the postgraduate qualification of Graduate of the Chapter of Perioperative Medicine (GChPOM). This initiative parallels the establishment of the fellowship in pain medicine, and is due, in part, to Michael's foresight and leadership within the profession. In 2005, Michael was awarded the degree of DSc (Syd) for a thesis titled *Pain, Analgesia and Anaesthesia: Management of Acute, Chronic and Cancer Pain* based on his many and varied publications over five decades. A monumental collection!

Michael was twice recognised in the Australian honours system – firstly in June 1995 as a Member of the Order of Australia (AM) "in recognition of service to medicine, particularly in the fields of pain management and anaesthesia", and then in January 2014 as an Officer of the Order of Australia (AO) "for distinguished service to medicine through specialised tertiary curriculum development as a researcher and advocate for reform and human rights in the field of pain, and as an author and mentor".

Although Michael worked incredibly hard all his life, he also managed to have relaxing times. He had always been a keen swimmer and surfer and loved living near the sea. His enthusiasm for the sea led to him contracting "swimmer's ear" for which he needed surgery when in Adelaide. Later in Sydney he often spent happy times on his surf ski at Palm Beach and nearby beaches.

Michael Cousins was a giant figure in Australian anaesthesia – establishing pain medicine as an independent specialty, establishing the FPM within ANZCA as an educational and accreditation body, his strong advocacy for patients with chronic pain, his research collaborations, and by mentoring many pain medicine specialists.

He leaves a magnificent legacy, and the college extends to Michele, his children James, Jonathan, Chris and Jane, and his grandchildren our sincere condolences.

We remember a most productive life very well lived, and most importantly, of great value to future generations.

Professor Barry Baker
Emeritus Professor
University of Sydney
Honorary Historian ANZCA

Professor Laurie Mather
Emeritus Professor
University of Sydney

Dr David Jones
Former dean FPM, ANZCA

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A great mentor

ABOVE

Professor Michael Cousins, his wife Michele and Professor Damien Finniss.

I am honoured to have the opportunity to share some personal reflections on Professor Michael Cousins.

My first meeting with Prof was via a telephone call about 25 years ago. The context was of application to enrol in a master's degree in pain management, and I was having difficulty overlapping this with my current studies in physiotherapy (a university administration technicality). We spoke about my interest in the field, and I lamented the delay in progressing my career. Prof's answer was "I'll deal with it!". Before I knew it, I was enrolled in a bachelor's and a master's degree concurrently (on probation of course).

I moved back to Sydney to work with Prof and the team at RNS, and he was instrumental in helping to map out my clinical academic career, including co-supervising my PhD and giving important guidance and advice on some of the international collaborations I was fostering at the time. He did not bat an eyelid when I raised the idea of retraining in medicine and supported me through that process.

I reflect on the ensuing years as I retrained and realise that in addition to all the support and guidance, there was a deeper relationship that had developed. I fondly remember a trip to speak at the Irish Pain Society (circa 2007), where we co-presented a session. Rumour might have it we sampled some of Ireland's finest at a local pub watching a rugby game before running over to deliver the lecture. That trip ended with a few days exploring the North of Ireland with Prof and Michele, and this was a wonderful opportunity to get to know them better.

Prof had a knack of delivering quality and timely advice, and this stemmed from genuine care and investment in the people around him. I was the beneficiary both at work, and outside of work, including some wise words at my wedding to Anna. In very recent times there was both warm counsel about professional issues but also on waterproofing matters after he and Michele had done some renovation work for which he was very proud.

"Mentoring" comes in many forms. Prof was not only a brilliant clinician and leader but a wonderful person and family man. To me he is the epitome of a mentor – someone who genuinely invested in people around him, guiding them both professionally and personally in a caring and nurturing manner.

Professor Damien Finniss, FANZCA FFPMANZCA

ANZCA gender equity survey released

Equity ensures workplaces are most efficient and retain staff due to improved wellbeing.[1,2]

In seeking to demonstrate its commitment to gender equity, ANZCA conducted a survey of anaesthetists across Australia and New Zealand in 2022 asking whether gender equity is an issue in modern anaesthesia workplaces. Previous surveys administered by Dr Di Khursandi[3] in 1998 and Dr Smith and Dr Ashes[4] in 2014 had examined issues including attitudes towards women anaesthetists, part-time work, non-clinical commitments and access to private work. The results showed that our profession had much to improve upon. Limitations had included small respondent numbers as the surveys had been administered to Australian Society of Anaesthetists' members only.

The decision to review and repeat the survey through ANZCA reflected a belief that increased numbers of women anaesthetists (approaching parity in trainees, and 34 per cent of FANZCAs in 2021) would also mean gender equity is improving. Furthermore, ANZCA hoped to reach a more representative population of anaesthetists given their membership is binational.

THE 2022 SURVEY

The survey was sent to 1225 ANZCA fellows from the Clinical Trials Network (CTN) database – 49.5 per cent male, 49.5 per cent female and one per cent other genders as listed in membership profiles. Thirty-four questions were asked, all consisting of multiple-choice options divided into eight overall sections with optional free-text comment boxes at the end of each section.

The sections covered were:

- Demographics.
- Anaesthetic career.
- Discrimination, harassment and bullying.
- Leadership, mentors and research.
- Income.
- Relationships.
- Dependents and caregiving.

A final question asked: "In 2022, do you believe your gender is a barrier in the pursuit of a career in anaesthesia?"

We received 470 responses to the multiple-choice questions (38 per cent response rate) and 793 optional free-text comments. We divided these into "quantitative data" and "qualitative data" which have been analysed and published separately.

The quantitative summary of results was published in *Anaesthesia and Intensive Care (AIC)*.[5] Some of the main take-away points were:

1. The importance of **intersectionality**, as highlighted by reports of discrimination being higher in those with multiple sources of minority (see table top right – reproduced with permission of the authors).

Answers to the question 'During my anaesthetic career I have experienced discrimination due to my gender, ethnicity, relationship status, age, sexual orientation or religion' using logistic regression where agree and strongly agree is compared with neutral, disagree and strongly disagree.

During my anaesthetic career I have experienced discrimination due to my:

	Men Agree or strongly agree *n* (%) [95% CI]	Women Agree or strongly agree *n* (%) [95% CI]	Difference % (95% CI)	*P* value
Gender	22 (14%) [9–19%]	193 (68%) [62–73%]	54% (46–61%)	<0.001
Ethnicity	25 (16%) [10–22%]	59 (23%) [18–28%]	6% (–1–14%)	0.119
Relationship satus	7 (5%) [1–8%]	65 (23%) [18–28%]	19% (13–25%)	<0.001
Age	23 (15%) [9–20%]	70 (25%) [20–30%]	10% (3–18%)	0.012
Sexual orientation	6 (5%) [1–8%]	8 (4%) [1–6%]	–1% (–6–3%)	0.577
Religion	11 (8%) [4–13%]	8 (4%) [1–6%]	–5% (–10–1%)	0.064

CI: confidence interval.

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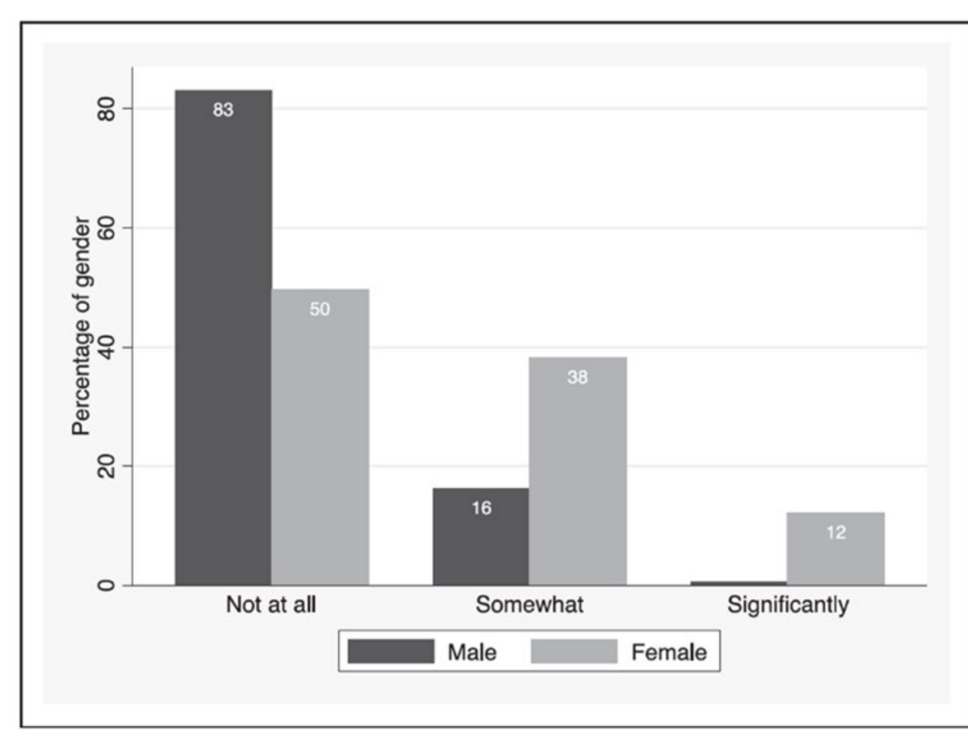
2. A **gender pay gap** of $67,000 less for women respondents (95 per cent CI $28,000 – $107,000) was found even when controlling for hours worked per week, age, region and decade of ANZCA fellowship qualification. Adding percentage of public work to the model did not remove the difference.
3. Women anaesthetists perceive **a sense of exclusion** – from leadership, mentoring and research opportunities – which is difficult to measure but persistent across all regions and age groups.
4. In answer to the final question, trying to summarise an overall gender effect on careers, there is a notable perceived difference between men and women respondents, where more women reported that their gender was a barrier to a career in anaesthesia (see graph below). While overall satisfaction rates reported by both genders were high, the difference likely reflects the **challenge of balancing career and family**, which had some quantitatively significant effects, but was more prominently represented in the free comments provided.

Responses to the final survey question 'In 2022, do you believe your gender is a barrier in the pursuit of a career in anaesthesia?' according to the gender of the respondent.



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The generosity of respondents in completing the free-text comments deserved further analysis. We were grateful that Dr Kara Allen was able to provide guidance as to how to analyse the qualitative responses to the survey. The qualitative summary of results has been published in *Anaesthesia*[6] and has an accompanying podcast. The three main thematic findings from this work are presented in this infographic.

Summary of the three main themes and sub-themes of thematic analysis

Gender equity changes the status quo
- "Lucky" to work in adaptive department
- Gender equity can benefit everyone
- Redefine success
- Women not supported adequately by current system

Women don't fit the mould
- Not a "good fit"
- Boys club
- Lack of professional respect
- Limited clinical opportunities
- Less leadership opportunities
- Less valued roles (welfare, "people management")

Family/career: OR for women, AND for men
- Maternity leave stops progression
- Return to work is challenging
- Caregiving differs by gender
- Part time = disengaged
- Women might get pregnant
- Men may want more family enjoyment

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FURTHER DIRECTIONS

ANZCA is committed to repeating the gender equity survey at five-year intervals to form a longitudinal body of data and ensure that continuous work towards improvements are effective.

The Gender Equity Sub-Committee (GESC) of ANZCA consider the publications of these results as the starting point to ongoing work towards gender equity. Dr Natalie Purcell and Dr MaryAnne Balkin have developed a Gender Equity Survey Toolkit which can be downloaded and repeated at local institutions – find it at https://www.anzca.edu.au/news/ge-survey-toolkit. This includes a full document of guidance for ethics application so that the results can be shared with ANZCA and compared to the national benchmarks.

We strongly encourage all departments to examine their equity – good results can be advertised as a reason to work in your department!

Other projects that have been inspired by these results include the development of the ASM Equity Grants to improve access to conferences and a review of the ANZCA pregnancy, parental leave and less than fulltime work policies.

We are always seeking new projects and people to help with our work – please contact ge@anzca.edu.au. We would particularly like to promote diverse and allyship perspectives.

We acknowledge that our results had to be analysed as binary genders due to low response numbers of "other" genders. The GESC believe future iterations of the survey should ensure that the voices of more diverse genders are highlighted as their unique needs will need to be met in future equity projects.

We are grateful for the contributions of Dr Kara Allen to the qualitative publication.

We are also very thankful for the commitment of the ANZCA membership team – Gabby White, Alecia Savale, Hannah Sinclair and Nadja Kaye in supporting this research.

Dr Claire Stewart, Dr Jane Carter, Dr Greta Pearce, Dr Natalie Purcell, and **Dr Maryanne Balkin**
Gender equity survey team

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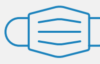

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Self matters

The Trojan mouse gets the wellbeing cheese

This edition's article focuses on how to affect change in our complex health systems, one small, focused experiment at a time!

My thanks to Dr Jo Sinclair for putting me in touch with the awesome wellbeing team from Tāmaki Makaurau Auckland. Drs Amber Chisholm, Nola Ng and Tom Fernandez are putting the Trojan mouse concept to good use. It's inspirational and motivating to read how they are going about making theatre-wide changes in support of their colleagues.

As always, if you, or someone you know, has a wellbeing story you'd like to tell, please email me at bulletin@anzca.edu.au.

Happy reading!

Dr Lindy Roberts, AM FANZCA FFPMANZCA

"The journey of a thousand steps starts with a cheese toastie," Amber said to fellow anaesthetist Nola. Her scrubs looked different today – because they were covered in cheese. It was wellbeing month, and cheese toastie day at Te Toka Tumai Auckland City Hospital.

"That's not how the saying goes," Nola replied. Her stack of toasties was much neater and more popular than Amber's. No surprise; her parents owned a takeaway shop, an unfair head start. What Amber meant was: *wellbeing improves by many small increments, not grand gestures.*

Issues of COVID burnout, lack of staff, rolling restructures stuck in limbo, and bullying in an overly hierarchical system were not going to be solved solely by the application of molten cheddar.

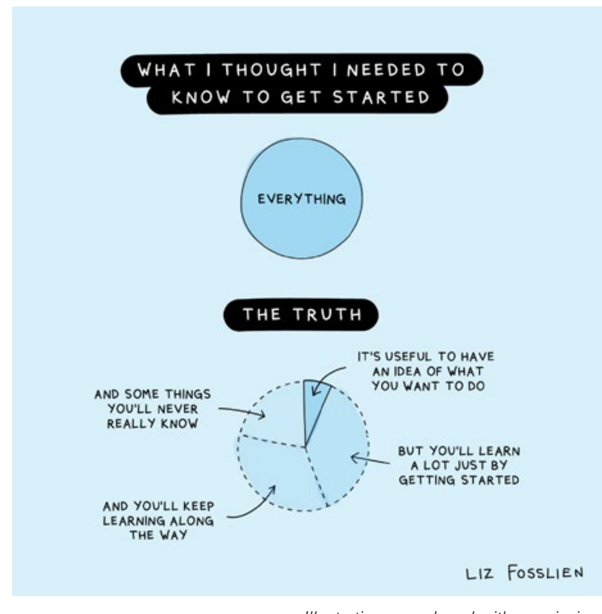
However, toasties, *and* training workplace respect, *and* critical debriefs, *and* events that fostered a sense of belonging – a sense of "us" – were all small steps in a better direction, and were beginning to have an effect.

The phrase "Trojan mice" is a metaphor borrowed from British consultant Peter Fryer.[1] It is particularly helpful in complex systems like health, which frequently change as we interact with them.[2]

Trojan mice represent small, focused experiments that probe how the system responds. They are multiple ideas that quickly feed back what works and what doesn't. Unlike a Trojan horse, Trojan mice don't win the war all at once. They test the waters and inform your next move. Failure isn't catastrophic, it helps you learn faster. It is often through failure that teams succeed.

We love Paul Batalden's quote "in healthcare everyone has two jobs; to do your work and improve it".[3] The system is us and we can improve it. This means creating a climate of belonging. When we belong, we thrive. As individuals we can do our best to look after our own wellbeing, but as we all well know, if the system we work in is broken we can never truly flourish. There is evidence in other industries and healthcare systems around the world that the most effective and long-lasting changes with respect to worker job satisfaction, productivity and wellbeing come from organisations themselves.

Next question: How do we start when the problem looks insurmountable? It is easy to get bogged down in the detail. We love Liz Fosslien's illustrations and found the following figure inspiring:



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We three anaesthetists – Amber, Nola, Tom – set up A.N.T. (antmed.nz), a platform to share our work and to deploy as many trojan mice as possible. We chose an ant as our logo. Tiny ants can move mountains.
We started by establishing a theatre-wide wellbeing month with educational sessions and low-cost morale boosters such as shared lunches, therapy dog visits and massage chairs.
We moved on once we gained confidence. "Working Well" was our inaugural meeting with invited experts on culture change, designed for all-cast theatre groups looking at how we can all work better together.

We curated a series of "Work-Life" interview videos, career stories from our departmental legends on how to manage a life in medicine. We had qualified psychologists and clinical coaches come and talk to staff groups about what we can do to optimise our wellbeing.

Finally, Nola and a theatre crew re-enacted a version of a daily theatre debrief, called an "End of List Recap" on video so everyone could pilot the system in action. We rolled out a scannable debrief form and "Kudos for Colleagues" feedback platform across the organisation during wellbeing month.

ABOVE
From left: Dr Tom Fernandez, Dr Nola Ng and Dr Amber Chisholm.

All of these were tiny increments but small changes add up (incidentally, A.N.T's motto). When we played a video from our work-life interviews at our departmental clinical forum meeting, everyone got to their feet and cheered. Many were emotional. We have been to many departmental meetings over the past 15 years and that has never happened before.

Stories are how we connect as social beings. They are the collaborative, authentic way in which we pass on knowledge. Seeing one of "us" sharing their story was a powerful way to inspire and remind us that we all have our own colourful complex lives – of which being a doctor is only a part. Social psychologists call this storytelling "narrative inquiry", and the benefits are not just for those who listen. Those who share their stories benefit from reflecting on their personal narrative which can emphasise their strengths, past victories and life purpose.

So this is our story so far, and this is what we've learnt: If you want to improve wellbeing, just make a start. It can be anything. No matter how small or insignificant it may seem – it all adds up. Send in an army of Trojan mice (ants!), see what works, repeat the good, learn from the failures. Find your tribe, smile at the eye-rollers, and if the horse you're riding dies, get off.

Oh – and don't order the shopping the night you need to put 500 cheese toasties in your fridge.

Dr Amber Chisholm, FANZCA
Dr Nola Ng, FANZCA
Dr Tom Fernandez, FANZCA
Te Toka Tumai Auckland City Hospital

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Australian Indigenous HealthInfoNet. Connection. Strength. Resilience. Social and Emotional Wellbeing Resources at https://healthinfonet.ecu.edu.au/learn/special-topics/voice-referendum-social-emotional-wellbeing-resources/

For Māori

Kaupapa Māori wellbeing services at https://www.wellbeingsupport.health.nz/available-wellbeing-support/kaupapa-maori-wellbeing-services/
Te Aka Whai Ora website at https://www.teakawhaiora.nz/our-work/advocating-for-change/rongoa/
Te Whare Tapa Whā at https://www.teakawhaiora.nz/nga-rauemi-resources/te-whare-tapa-wha/

Horsing around is precious for vet turned FANZCA Dr Jane Leadbeater

LEFT

Dr Leadbeater prepares a dog patient for a procedure during the ASM veterinary anaesthesia workshop in Brisbane.

Spending four years as a medical student by day while working as an emergency vet at night and on weekends is a serious commitment by anyone's measure.

Anaesthetist Dr Jane Leadbeater did just that when, after working as a veterinarian for eight years in Queensland, NSW and the US, including four years as an equine vet, she switched careers – and species.

"I would work up to 30 hours over the weekend as a small animal emergency vet finishing by 4.30am on Monday morning so I could get to medical school by 7.30am."

"As a vet I had done a lot of anaesthesia on horses, small animals and the odd farm animal so I already knew that I loved it. Throughout medical school and during my resident years my specialty selection became a process of exclusion. Anaesthesia was the yardstick and I compared everything to that."

Now a staff specialist anaesthetist at the Royal Brisbane and Women's Hospital, Dr Leadbeater was not only one of 300 new fellows who presented at the College Ceremony at the ANZCA 2024 Annual Scientific Meeting (ASM) in Brisbane but also the leader of one of the ASM's more unusual workshops.

Using her contacts at her alma mater, the University of Queensland's Veterinary School, Dr Leadbeater developed ANZCA's first veterinary anaesthesia ASM hands-on workshop with veterinary anaesthetist Dr Wendy Goodwin.

After getting full ethics approval from the university, Dr Leadbeater and Dr Goodwin led the "Anaesthesia for all creatures great and small" half-day workshop for 12 anaesthesia fellows and trainees at the school's veterinary hospital.

Dr Leadbeater had her heart set on training as an anaesthetist after she left veterinary practice and enrolled at Griffith University's School of Medicine in 2011.

Having practiced equine medicine, surgery and anaesthesia – first as an intern at the Marion duPont Scott Equine Medical Center in Virginia in the US and then at Scone Equine Hospital in the Hunter Valley in NSW – she was familiar with the principles of clinical anaesthesia. As a horse vet, Dr Leadbeater would perform both general and regional anaesthesia and assist with a wide variety of specialist surgeries including emergency laparotomies, caesareans, orthopaedic surgery and upper airway laser surgeries.

"I was often asked questions such as 'where do you put the cannula?', 'what drugs do you use?' and 'how do you intubate a horse?"

"During my rotating internship in the US, I was really fortunate to spend about a third of my time working in anaesthetics under the tutelage of specialist equine anaesthesiologists," Dr Leadbeater explains.

She spent her first year after medical school as an intern at Princess Alexandra Hospital in Brisbane and then moved to a junior house officer role at Redcliffe Hospital. She applied for the Queensland Anaesthetic Rotational Training Scheme (QARTS) and was accepted.

Once she began her anaesthesia training she realised that her colleagues were often keen to learn more about veterinary medicine, particularly animal anaesthesia and how it compared to human clinical practice.

"As I moved through eight different hospitals in my training years, it dawned on me that many of my colleagues were interested to find out more about veterinary anaesthesia. I was often asked questions such as 'where do you put the cannula?, what drugs do you use and how do you intubate a horse?' "

"While the pharmacology and technical skills were similar, as a general practice vet my anaesthesia knowledge was not as deep as it is now. It's amazing to think back now and realise how much I've learned over the past five years of specialist medical training."

When ASM co-scientific convenor Professor Victoria Eley sought expressions of interest from Brisbane fellows for meeting workshops, Dr Leadbeater approached her with an idea for the animal anaesthesia session.

"I then went to the head of the veterinary school and (Dr) Wendy (Goodwin). I came to them with this crazy idea to bring a group of human anaesthetists out to the veterinary hospital to do some animal anaesthetics and they got behind it! Their support in organising and delivering the day was absolutely integral to its success. I was thrilled to see all the delegates so engaged and hands-on."

RIGHT

From top: Dr Leadbeater leads preparations for one of the ASM veterinary anaesthesia workshop procedures.

Dr Leadbeater takes her horse Lily, a Warmblood mare, for a trot near her Brisbane home.

"Anaesthesia was the yardstick and I compared everything to that."

ABOVE

from top: A retired harness racehorse is readied for the treadmill assessment. A greyhound patient is given intravenous anaesthesia.

The workshop began with performing anaesthesia on two teaching dogs, a Greyhound and a Staffordshire Bull Terrier. The dogs had been sedated as part of their "pre-med" preparation. The delegates then placed cannulas, induced anaesthesia via the intravenous route, performed laryngoscopy, intubated the dogs and then learned about monitoring and maintenance options.

(It didn't take the participants long to bond with the canine patients and by the end of the session both had been earmarked for adoption by two of the attendees.)

It was the horses' turn next. Two colts from the university herd needed castrating. The procedure would usually be performed out in the field with a ketamine-based intravenous general anaesthetic but the workshop procedures were carried out in the hospital.

Two different anaesthesia techniques were used to demonstrate the various pharmacological and monitoring options available. The first colt underwent a total intravenous anaesthetic and had the entire surgery performed in a padded induction room, much as it would be in a field situation. The second colt was induced and intubated in the induction room and then winched onto the operating table for maintenance on sevoflurane via the anaesthetic machine in the operating theatre. Both were mildly sedated before the procedures to help them relax. Delegates jumped at the opportunity to intubate the horses and place arterial lines for blood pressure monitoring.

The final session of the workshop featured a retired harness racehorse on a treadmill. Functional nasal endoscopy was performed via a bronchoscope to assess laryngeal function during peak exertion.

Dr Leadbeater's transition from animal medicine and anaesthesia to the human form is now complete. While she revealed that she had wanted to become a vet after reading *All Creatures Great and Small* in high school, she reached a turning point after several years of practice.

"Veterinary medicine can be emotionally taxing due to high stress, long hours and sometimes unrealistic expectations of pet owners. We are so lucky to live in a country with access to free world-class healthcare but the downside of that for the vet profession is that few Australians actually understand the true cost of care for their pets. Everything has to be privately funded by the client and the reality is that high quality vet care *is* expensive.

"I really enjoy the wide variety of clinical practice I do now – I don't have a sub-specialty area within anaesthesia. I completed a fellowship in education and medical simulation and I will be running some simulation training this year at the Royal Brisbane and Women's Hospital."

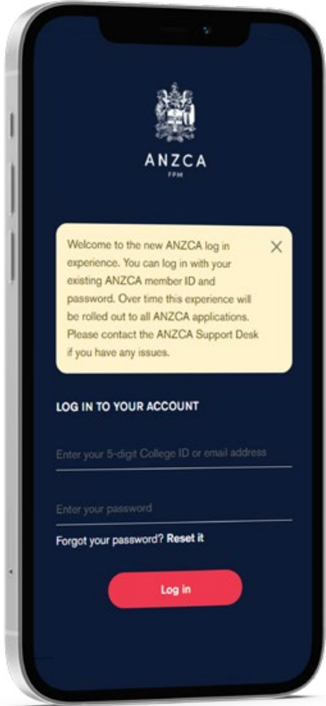
Though she no longer practices veterinary medicine, her husband Sam's vet practice in Brisbane and the family's pet dog and cat ensures animals are still very much a presence at home.

The newest addition to their human family of four is a seven-year-old Warmblood mare so Dr Leadbeater can re-ignite her passion for the equestrian sports of eventing and dressage.

"Lily is my fellowship present to myself and I'm so looking forward to developing a beautiful partnership with her."

Carolyn Jones
Media Manager, ANZCA

Protecting your data



We're committed to enhancing your user experience while ensuring the security of your personal and professional data. That's why we are introducing single sign-on (SSO) and multi-factor authentication (MFA) as a part of a new log in experience to strengthen access controls and make the ANZCA networks more secure.

ABOUT SSO AND MFA

Single Sign-On (SSO) is an authentication solution that simplifies access to password-protected services, applications, websites, and datasets. Think of it as having a single key to unlock multiple doors. With SSO, you'll only need to authenticate yourself once during a session. Once logged in to an ANZCA application, you won't be prompted to log in again when accessing other SSO-enabled ANZCA sites or services. This streamlines your workflow, reduces friction, and ensures seamless access to essential resources.

Multi-Factor Authentication (MFA) is when two or more different types of actions verify your identity to add an extra layer of protection.

Think of MFA as a double-lock system. In addition to your password, MFA requires a second form of authentication. At ANZCA, the Microsoft authenticator app will be used. After entering your password, the app generates a time-sensitive code that you must provide to complete the login process. This ensures that even if someone steals your password, they won't gain access without the additional code.

MFA defends against the majority of password-related cyber-attacks.

ENABLING SSO AND MFA – WHAT TO EXPECT

- SSO and MFA will be enabled for ANZCA systems in waves through 2024, beginning with the CPD Portfolio and CPD mobile application in June.
- ANZCA fellows, trainees and other system users will be supported to set up and start using the Microsoft Authenticator app for MFA.
- By ensuring clear and timely communication, leveraging change champions across the business, and allowing users to opt in at their convenience, these changes will be deployed in a considered manner and minimise disruption to critical activities.

Keep an eye on our monthly ANZCA E-newsletters for updates or visit the dedicated data protection page on the ANZCA website for more information, including a short video guide and frequently asked questions.

Safety & quality

We are the foremost authority on anaesthesia, pain medicine, and perioperative medicine in Australia and New Zealand, respected by governments and the healthcare sector to provide expert advice that ensures the safety of our patients.

Clinical guide for GLP-1/GIP receptor agonists developed

In March this year, a large retrospective study of 963,184 adults undergoing endoscopic procedures reported an association between the use of GLP-1RAs and an increased risk of aspiration pneumonia peri-procedurally.

Over the last 10 years, there has been an expansion in medications introduced for the management of patients with diabetes.

One specific class of medications are the glucagon-like peptide-1 receptor agonists (GLP-1RAs), which act through activation of physiological GLP pathways.

Endogenous GLP is released from L cells within the gastrointestinal tract in response to intraluminal nutrients. It acts through GLP-1Rs in the pancreas (to potentiate insulin release), in the gastrointestinal tract itself (to reduce gastric emptying and pancreatic secretions) and on the central nervous system (to increase satiety).

Additional GLP-1 activity is seen in both the cardiovascular (promotes glucose uptake and utilization) and renal (enhanced GFR and sodium excretion) systems. Endogenous GLP has a short half-life of less than 2 minutes due to rapid inactivation by dipeptidyl peptidase-4 (DPP-4), which is expressed on the surface of most cells.

GLP analogues with much longer half-lives have been developed and introduced into clinical practice. The first therapeutic GLP-1RA was exenatide (Byetta, Bydureon), licensed in New Zealand in 2007 and Australia in 2008.

Subsequently, other GLP-1RAs have been released, including Liraglutide (Victoza, Saxenda), Lixisenatide (Adlyxin), Dulaglutide (Trulicity), Semaglutide (Ozempic, Wegovy) and Tizapedide (Mounjaro).

All are injectable medications. A daily oral form of semaglutide has also been developed (Rybelsus) and has been approved by the Therapeutic Goods Administration in Australia.

Although initially developed for the treatment of diabetes, clinical studies consistently revealed a significant benefit of GLP-1 RAs on weight loss.

Subsequently, GLP-1RAs have been approved as an adjunct for weight loss in Australia. Semaglutide (Wegovy) and liraglutide (Saxenda) are currently approved for weight management in patients with a BMI>30, or BMI 27-30 with a weight related co-morbidity.

Many of the other GLP-1RAs and compounded GLP-1RAs are used off label in both Australia and New Zealand, with predictions that one in 10 Australians will be taking a GLP-1RAs by the year 2030.[1]

Since the introduction of GLP-1RAs, there have been increasing numbers of case reports of retained gastric contents and/or aspiration at the time of gastroscopy or anaesthesia, in people treated with GLP-1RAs.

In March this year, a large retrospective study of 963,184 adults undergoing endoscopic procedures reported an association between the use of GLP-1RAs and an increased risk of aspiration pneumonia peri-procedurally (0.83% vs 0.63%; hazard ratio 1.33; 95% confidence interval 1.02–1.74; p=0.036).[2]

In response to this, a panel of experts from the Australian Diabetes Society, the Australian and New Zealand College of Anaesthetists, the Gastroenterological Society of Australia and the National Association of Clinical Obesity Services met to develop guidelines for Australian and New Zealand primary health physicians, gastroenterologists, surgeons, endocrinologists, anaesthetists and peri-operative physicians to support clinical decisions in patients on GLP-1RAs

Many of the other GLP-1RAs and compounded GLP-1RAs are used off label in both Australia and New Zealand, with predictions that one in 10 Australians will be taking a GLP-1RAs by the year 2030.

presenting for medical and surgical procedures requiring sedation and anaesthesia.

While the overarching principle of patient safety directed the recommendations, the expert group considered a number of factors in the development of these guidelines, including:

- The relative lack of good quality evidence in patients on GLP-1RAs, with no large, well designed prospective studies measuring the overall risk:benefit analysis of cessation on continuation in patients on GLP-1RAs having medical and surgical procedures
- Multiple guidelines already being promoted by groups such as the American Society of Anesthesiologists [3], the American Gastroenterological Association[4] and the British Centre for Perioperative Care[5] are contradictory in their advice.
- The need for pragmatic and practical advice (for instance, cessation of medication for 4 weeks prior to an elective procedure is practically difficult in many clinical settings, and may lead to weight gain and poor glucose control)
- While the background risk of pulmonary aspiration is low, aspiration is potentially life-threatening in severity.

The finalised clinical practice recommendations are in the complete guidelines which are are publicly available on the ANZCA website.

www.anzca.edu.au/resources/professional-documents/endorsed-guidelines/periprocedural-glp-1-use-consensus-clinical-guide.pdf.

Given the uncertainty and the developing evidence surrounding GLP-1RAs and GLP-1/GIPRAs in the peri-procedural period, these guidelines will be reviewed in December 2024.

Dr Ben Olesnicky, FANZCA
Member, ANZCA Safety and Quality Committee
Royal North Shore Hospital

KEY POINTS

The key practice points from these guidelines can be summarised as:

- Any cessation of GLP1-RAs and GLP-1/GIPRAs potentially reduces an increased (but small) risk of retained gastric contents and aspiration, but requires consideration of the risks of cessation (poor glycaemic control, loss of cardio and reno-protective effects, weight gain), the urgency of the procedure and discussion with the patient.
- Recommended practice strategies differ for endoscopic and non-endoscopic procedures because of familiarity of gastroenterologists with managing prolonged liquid diets pre-procedurally, and the opportunity for direct visualisation of gastric contents and immediate risk assessment with endoscopic procedures.
- If long-acting (weekly dosing) GLP-1RAs are taken within four weeks prior to a procedure then management should be based on clinical judgement and the presumption of a risk of a full stomach, even with extended fasting times.
    - Intravenous erythromycin may reduce the risk of a full stomach if given time to take effect.
    - Gastric ultrasound, undertaken with appropriate expertise and good quality imaging, may provide clinical guidance.

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2. Yeo YH, Gaddam S, Ng WH, Huang PC, Motility, Metabolic Pharmacoepidemiology G, et al. Increased Risk of Aspiration Pneumonia Associated With Endoscopic Procedures Among Patients With Glucagon-like Peptide 1 Receptor Agonist Use. Gastroenterology. 2024.
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Update on button battery hazards

Button battery ingestions and insertions remain a significant cause of morbidity and mortality in children. While some important safety strategies have been introduced in recent years, the incidence of severe button battery injuries has not decreased.

The lodgement of any battery in a moist environment will set up an electrical circuit. At the anode (negative pole), water is hydrolysed to produce hydroxide ions, creating a highly alkaline environment in the adjacent tissue. The resultant liquefactive necrosis continues to progress and can erode through tissue over several days, even after the battery's removal. A useful mnemonic for indicating the anatomical site of likely greatest injury is the rule of 3Ns: narrow-negative-necrosis.

A moving battery is highly unlikely to do damage whereas an immobile battery – classically a 20mm disc battery lodged in a young child's upper oesophagus – can cause a life-threatening injury in as little as two hours.

Recent developments have aimed to improve both public and medical awareness of the hazards of battery ingestion and the urgency of treatment. Algorithms for suspecting, diagnosing and treating dangerous battery ingestions are now readily available (https://www.poison.org/battery/guideline).

A recommendation has been introduced to give honey or jam as a temporising measure until removal. Central to anaesthesia care is the understanding that battery removal is a time-critical emergency and that endotracheal intubation is essential to allow battery removal, careful assessment of damage, and post-removal irrigation of the oesophagus with acetic acid to lessen ongoing damage. A useful recent update for anaesthetists is "Anesthetic Implications of the New Guidelines for Button Battery Ingestion in Children", Hoagland MA et al, *Anesthesia & Analgesia*, 2020, 130(3): 665-672 (DOI: 10.1213/ANE.0000000000004029)

Sadly, it is the unrecognised and unsuspected battery ingestion which carries the greatest risk of mortality. Depending on the battery's orientation, liquefactive necrosis anteriorly can lead to development of a trachea-oesophageal fistula; whereas posteriorly, the greatest danger is an aorto-oesophageal fistula. Once this latter complication is established, death is almost inevitable.

In Australia, three children have died from inserting or ingesting these batteries. These deaths can only be eliminated by actions to make batteries harmless and/or prevent young children from gaining access to them. An ABC Australia report (https://www.abc.net.au/news/2021-02-15/button-batteries-landmines-in-the-loungeroom/13041928) highlights the tragedy of these cases but also outlines the recent consumer protection legislative changes which have been driven by the advocacy of affected parents along with medical and child safety experts.

Through the Australian Competition and Consumer Commission (ACCC), it is now mandatory for consumer goods to be durable and have child-resistant battery compartments. The more hazardous disc batteries (lithium batteries and those of any chemistry with diameter > 16mm) must be sold in child-resistant packaging. Product Safety New Zealand, on the other hand, has issued voluntary advice but continues to evaluate the need for mandated requirements.

Nonetheless, unsuitably packaged batteries and dangerous devices continue to be widely available and are the subject of frequent recalls. It behoves any medical practitioner who becomes aware of a hazardous product to inform the retailer and/or report the problem to State product regulators, the ACCC or Product Safety New Zealand.

Unused batteries of course pose the greatest hazard, but even an apparently spent battery can generate the 1.2 volts necessary to cause an injury. Both new and used batteries should be handled like poisons and stored away from young children. Spent batteries should be taped with clear sticky-tape until they are recycled – this reduces both the ingestion risk as well as fire risk in the recycling stream.

There are always new, unanticipated challenges.

There are increasing numbers of deliberate battery ingestions, particularly amongst adolescent girls. In contrast to the diagnostic challenges with toddlers, deliberate exposures are usually declared, but complex and costly to manage, particularly if repeated battery exposure becomes an established part of health-service-seeking behaviour.

Some battery manufacturers have recently introduced batteries coated with a bitterant (to discourage ingestion) and/or a blue dye to aid diagnosis should ingestion occur. However, bitterant is unlikely to prevent a "one gulp" ingestion and, despite the dye facilitating diagnosis, time to battery removal may still be prolonged due to logistical challenges.

The most effective preventive measure would be the development of "safe" batteries, that is, batteries which are harmless if ingested. Several options are in the development phase, for example, a coating which allows current to flow only when the battery is compressed within its compartment. Such innovation comes at a cost of course, and industry has to date been unwilling or unable to bring such safe batteries to market.

Dr Richard Barnes, FANZCA
Paediatric anaesthetist, Melbourne

Dr Ruth Barker, FRACPaeds
Director Queensland Injury Surveillance Unit, Jamieson Trauma Institute

Why near-misses should be reported

This incident highlights the benefits of reporting all incidents (reportable circumstances, near misses, no-harm incident and harmful incidents) in risk management to maximise patient safety.

THE INCIDENT

You are asked to anaesthetise a well 54-year-old, fasted patient for an elective release of Dupytren's contracture.

On questioning the patient, he tells you he has had previous general anaesthetic with no problems, has recently been put on put on subcutaneous medication to help lose weight and is active and relatively fit.

You have worked with the surgeon for many years. Your usual technique is for general anaesthesia with a laryngeal mask and surgical local anaesthetic infiltration, which you aim to perform for this case.

About 10 minutes after the surgery begins, you notice brown fluid in the tube of the laryngeal mask. The patient then starts coughing. You pass a flexible suction catheter down the laryngeal mask and then begin to see obvious solid food particles in the tube.

The surgeon is told to stop, you remove the laryngeal mask and suction the oropharynx, paralyse the patient and intubate using a cuffed orotracheal tube. Suctioning down the endotracheal tube does not produce any fluid. The patient is stable, oxygenating well on 40 per cent FiO2 with low ventilatory pressures.

The case is completed, with uncomplicated extubation and a well, stable patient off oxygen after 90 minutes in recovery who is discharged home.

The junior registrar who has been working with you asks if you would like to log the event for the department morbidity and mortality meeting or in the hospital incident monitoring system and you tell them there is no need because there was no harm to the patient. The incident is not reported and no further investigation takes place.

REPORTING NEAR MISSES

Events similar to the above occur routinely in anaesthesia and perioperative medicine, where there is either a near miss (the incident does not reach the patient; for example labelling a syringe incorrectly, but identifying before injecting it to the patient) or a no-harm incident (similar to this event, where the incident reaches the patient, but no patient harm results).

Potentially harmful incidents and reportable circumstances (where there appears significant risk of patient harm) are classified as "incidents" by the World Health Organisation (WHO) (Conceptual Framework for the International Classification for Patient Safety Version 1.1 – www.who.int/publications/i/item/WHO-IER-PSP-2010.2).

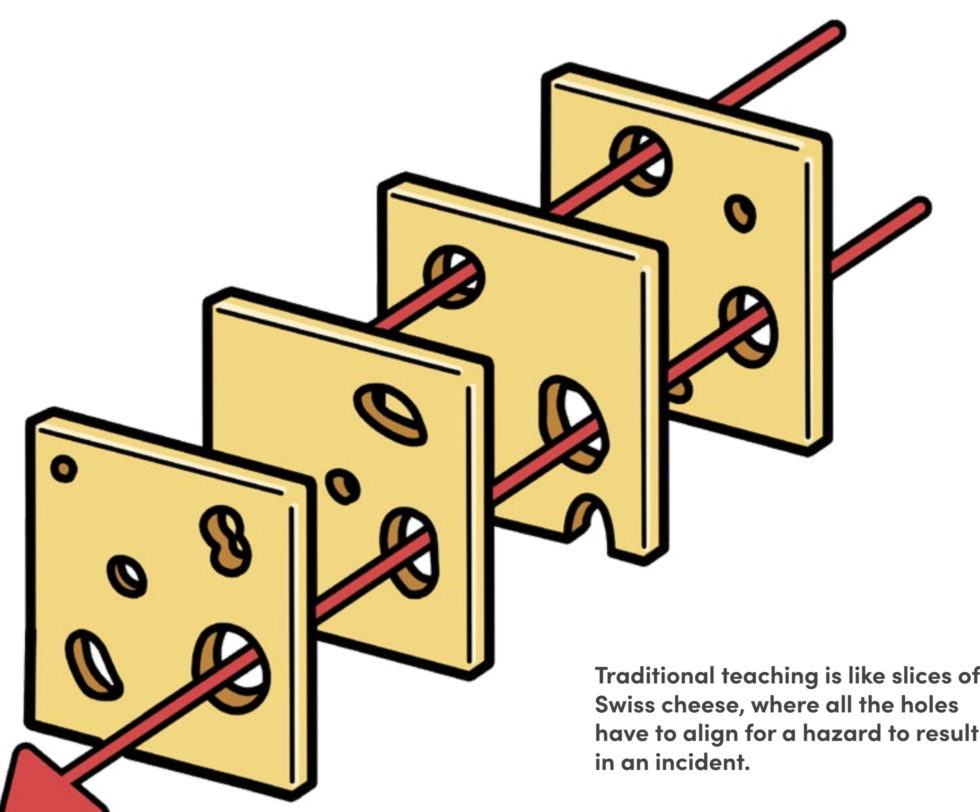
Furthermore, the WHO Global Safety Action Plan 2021-2030 (Global patient safety action plan 2021–2030: towards eliminating avoidable harm in health care. Geneva: World Health Organization; 2021. Licence: CC BY-NC-SA 3.0 IGO.) outlines that healthcare institutions, providers and governing bodies should raise awareness, and promote and strengthen incident reporting systems to identify all patient safety prevention events occurring in healthcare, with the aim of investigating incidents to maximise patient safety.

A similar report to the above case was reported to the Canadian Institute for Safe Medication Practices (ISMP Safety Bulletin Volume 23 Issue 9 September 27, 2023 – https://ismpcanada.ca/wp-content/uploads/ISMPCSB2023-i9-GLP-1.pdf), and when investigated it was identified that there was a potential association between the use of injectable GLP-1 agonists and retained gastric contents, despite adequate fasting preoperatively.

The investigation made a number of recommendations, covering the individual treating physicians, the drug manufacturer, primary care physicians, pharmacists, provincial health authorities and pharmacy informatics specialists, all with the aim of highlighting the risk of potentially devastating pulmonary aspiration and potentially preventing it before it occurs.

This incident highlights the benefits of reporting all incidents (reportable circumstances, near misses, no-harm incident and harmful incidents) in risk management to maximise patient safety.

This is especially important as data has shown that 1 in 6 hospital admissions in Australian hospitals are associated with an incident (of which 51% were classified as preventable) resulting in extended hospital length of stay or patient morbidity (PMID: 7476634).



Traditional teaching is like slices of Swiss cheese, where all the holes have to align for a hazard to result in an incident.

If you read the above clinical scenario and would chose not to report it as an incident, you are not alone, but rather in the majority of healthcare providers, similar to 58 per cent of respondents to a survey of trainee physicians who do not feel near misses were reportable (PMID: 30357000) and 65 per cent of consultant physicians who, despite 60 per cent of them witnessing at least three incidents in the previous year, had not reported them through any incident monitoring system (PMID: 16776388).

In a complex system, incidents very rarely occur due to a single causative factor, but due to a combination of various contributing hazards all of which have to align and pass through the barriers or mitigating factors.

Traditional teaching likens this to slices of Swiss cheese, where all the holes have to align for a hazard to result in an incident (PMID: 10720363).

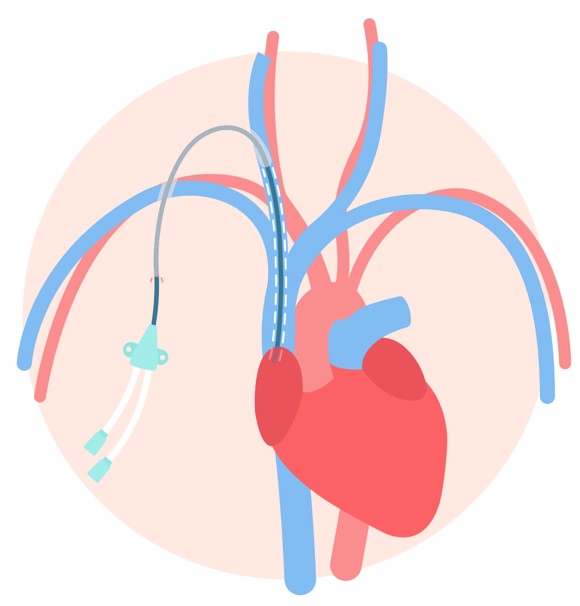
While it is tempting to only report accidents and harm-incidents with a (sometimes catastrophic) negative outcome, this only occurs when all the holes in the Swiss cheese align and investigations will then focus on identifying the holes themselves.

Investigations of near misses look at both the holes, as well as the "cheese" barriers to progression and aim to strengthen the barriers prior to an adverse event occurring.

A health service has a responsibility to both identify incidents within themselves and investigate those incidents to reduce the risk of future patient harm. This requires support for the establishment of a robust, practical and useful incident monitoring system as well as a culture that promotes reporting of incidents by practitioners as well as the infrastructure to investigate the reported incidents and make recommendations, and implement and embed them in the health service.

Dr Ben Olesnicky, FANZCA,
Member, ANZCA Safety and Quality Committee
Royal North Shore Hospital

webAIRS
Central venous access complications: An ongoing safety concern



Patient harm from complications associated with central venous access devices (CVAD) continues to feature in case reports and case series. The Australian and New Zealand Tripartite Anaesthetic Data Committee (ANZTADC) sought to review adverse events involving CVADs reported by anaesthetists across Australia and New Zealand.

An initial narrative search was conducted through 11,400 incidents reported to webAIRS since 2009, identifying 163 adverse events concerning the insertion or utilisation of CVADs. Peripherally inserted central catheters were the subject of 36 webAIRS reports. Anaphylaxis and inadvertent intra-arterial placement emerged as dominant themes. Other events include cardiac, pulmonary, and placement-related challenges, together with delayed complications including device malfunctions and line management complications. These events and reports are currently undergoing comprehensive analysis, and the findings will be presented at professional meetings and submitted to a peer-reviewed journal.

The following is an extract of one of the included cases with the aim of alerting the anaesthetic community about the ongoing issues and complications regarding anaphylaxis associated with CVAD insertions.

DE-IDENTIFIED CASE REPORT

A patient with a documented history of allergic reaction to chlorhexidine was scheduled for surgery. All theatre staff were aware of the patient's allergy and care was taken to remove chlorhexidine from the operating theatre. During placement of the central venous catheter, the patient suffered a severe anaphylactic reaction requiring prolonged extensive cardiopulmonary resuscitation. The central line was removed immediately.

The anaesthetic team had assumed that the central venous catheter was chlorhexidine-free because careful examination of the external package before insertion of the central venous line did not display any information or indication that the catheter was impregnated with chlorhexidine. However, on close examination after the event, the team detected that the package inserts, which are not visible via the external packaging but included with the catheter, stated that it was to be avoided for use in chlorhexidine sensitive patients.

Chlorhexidine allergy case reports date back over five decades, with cautionary advisories regarding its application on mucous membranes issued by Japanese authorities during the 1980s. Perioperative anaphylaxis can be caused by insertion of CVADs containing chlorhexidine, silver sulfadiazine, or latex. Pinnock et al performed a large historical cohort study of 39,505 central line insertions with potential and confirmed cases of perioperative anaphylactic reactions reviewed. There were 2937 patients with pre-existing allergies to chlorhexidine, sulfa, and/or latex who had central venous catheters inserted containing these allergens. Although there were only a few cases (59) of anaphylaxis attributed to these substances that were identified in their study, there still remained a considerable risk of complications.

The initial webAIRS analysis detected 18 events in which catheter-related allergy was implicated. Two of these involved insertion of chlorhexidine-coated lines in patients known to be allergic to chlorhexidine. In several others, chlorhexidine used during skin preparation solution was identified as a potential allergen. Difficulties were reported in identifying that catheters were coated with chlorhexidine. Even when non-coated lines are used, it has been proposed that anaphylaxis may be more severe when an allergen such as chlorhexidine in skin prep is introduced to the circulation centrally.

The preliminary findings of the webAIRS database analysis do not stand in isolation. Antiseptic coated central venous catheter anaphylaxis has been reported in Japan, Europe and the US. The discontinuation of impregnated chlorhexidine central venous catheters (CVC) in Japan transpired two decades ago, subsequently prompting a public health notice by the US Food and Drug Administration (FDA) in 1998 and a warning by the Australian Therapeutic Goods Administration (TGA) in 2012.

While chlorhexidine-coated or impregnated CVADs are intended to reduce catheter-associated infection, this introduces a new risk. Clinicians may not be aware of the chlorhexidine coating on these catheters. The lack of clear, visible labelling of chlorhexidine in medical products increases the risk to accidental exposure of an allergen, potentially with catastrophic consequences. This is particularly important for CVADs, as reactions to chlorhexidine-impregnated CVADs are often rapid in onset and severe, presumably due to the central exposure of the allergen. Prompt anaphylaxis treatment and removal of the catheter are required.

A second prominent category emerging from the webAIRS data is inadvertent intra-arterial placement of CVAD's, featuring in 30 incident reports. Consequences included thromboembolic stroke and death. In most of these cases, ultrasound had been used to identify the vessels and/or guide insertion. WebAIRS data clearly show that the use of ultrasound has a significant failure rate in preventing inadvertent arterial dilatation.

Consequently, it might be suggested that transduction of vascular pressure prior to vessel dilatation becomes standard practice. However, two reports also described false negative results from transduction, resulting in intra-arterial placement. The limitations of the use of ultrasound must be understood. There may be opportunities for improved training directed at these limitations, particularly out of plane approaches, and for clarification concerning the role of transduction prior to vessel dilatation.

The reported case of perioperative anaphylaxis after chlorhexidine coated central venous line placement is an important example where critical incident reporting may help to prompt the health care industry to improve product packaging design. Clear external package labelling of central venous catheters, including all potential allergens, is a requirement to increase patient safety. It may also be prudent to reconsider our use of coated catheters when intended for short-term perioperative monitoring.

The data also point to opportunities to explore a role for structured training and credentialling for the insertion and maintenance of CVADs including peripherally inserted central catheters and a specific pre-procedure checklist.

ANZTADC will be working in collaboration with the ANZCA Safety and Quality Committee to investigate methods to improve the safety of CVAD placement and maintenance.

Dr Fergus Davidson, Dr Heather Reynolds
and the **ANZTADC case report writing group**

www.anztadac.net

Reference

Pinnock TM, Volcheck GW, Smith MM, et al. Perioperative anaphylactic reactions to central venous and pulmonary artery catheters containing chlorhexidine, sulfadiazine, or latex: a historical cohort study. Can J Anaesth 2023; 70: 824-835. 20230224. DOI: 10.1007/s12630-023-02403-8.

Anaesthesia-related deaths

Death of 91-year-old patient following surgery, aspiration

The New South Wales Special Committee Investigating Deaths Under Anaesthesia (SCIDUA) has been reviewing deaths associated with anaesthesia and sedation since 1960. Example cases from the 2019 Special Report are being reproduced in the ANZCA Bulletin in an effort to enhance reporting back to the medical community

CASE 6: GENERAL SURGERY

A 91-year-old female for laparotomy and release of femoral hernia.

Background history

The patient was admitted with small bowel obstruction secondary to a femoral hernia on a background of atrial fibrillation and congestive cardiac failure.

Her INR was 3.4 at admission and this was reversed with Prothrombinex 1500 units and Vitamin K 1mg was given.

Anaesthetic details

A radial arterial line and 16 g IVC was inserted and a rapid sequence induction was executed with propofol 30 mg and suxamethonium 100 mg.

Post induction the patient suffered a massive aspiration event. She was intubated.

Bronchoscopy and lavage were performed, and surgery expedited.

During the case there were increasing inotropic requirements and the patient required 100 per cent oxygen to maintain saturations.

She was transferred to ICU post op where it was apparent that the patient was not going to survive. After discussion with the family treatment was withdrawn and the patient died four hours after surgery.

LEARNING POINT

- Even when everything is planned and executed perfectly, adverse outcomes can still occur.

Source:

Clinical Excellence Commission, 2021. Activities of the Special Committee Investigating Deaths Under Anaesthesia, 2019 Special Report. Sydney, Australia. SHPN: (CEC) 210176; ISBN: 978-1-76081-648-3.

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

Top honour for Papua New Guinea anaesthetist

Papua New Guinea anaesthetist Dr Gertrude Marun was recently honoured with the World Federation of Societies of Anaesthesiologists' (WFSA) Distinguished Service Award at its 2024 World Congress in Singapore.

The award is conferred on those who have made a special contribution to the arts and science of anaesthesiology, helped to promote or establish anaesthesia initiatives or provided distinguished service to the WFSA.

The award noted that Dr Marun has been an outstanding pioneer and role model for anaesthesia, intensive care and pain medicine in PNG and the wider Pacific for more than 30 years, working tirelessly to further anaesthesia and safety in her country.

She has held many influential positions in anaesthesia service and education in PNG since she first led the anaesthesia and intensive care service in Port Moresby in 1998. She has held senior anaesthesia positions in Madang and Lae and the position of honorary lecturer at the University of Papua New Guinea (UPNG).

Dr Marun was the third physician and the first woman in PNG to attain the Master of Medicine in Anaesthesiology from UNPG in 1994. She has been the country's chief anaesthetist – the most senior anaesthesia position in the country – and advises the government on policy and national requirements for safe surgery and anaesthesia.

She was also the co-designer of the Diploma of Anaesthetic Science course at UPNG. The two-year course is designed for non-physician anaesthesia providers (anaesthetic scientific officers) in PNG. This group provides 90 per cent of anaesthesia in remote areas of PNG at district and provincial hospitals.

Dr Marun was instrumental in getting the National Department of Health to place anaesthetist Dr Harry Aigeeleng on secondment to the UPNG School of Medicine and Health Sciences as head of anaesthesiology. Over her many years of leadership in the specialty she has attracted a core group of quality trainees who are now leading the provision of anaesthesia, intensive care and pain medicine in PNG.

In 2010, she and her colleagues pioneered the introduction of the Essential Pain Management (EPM) course in PNG. The structured pain management education program has enrolled registered nurses and other undergraduate disciplines in PNG along with physician and non-physician anaesthesia providers. The course is co-badged with the WFSA and ANZCA and is now an international standard for pain medicine education.

Dr Marun often works in some of the country's more remote regions as the sole physician anaesthesiologist and has published in local and international journals. She has been involved in promoting palliative care and effective pain management for individuals with cancer and those requiring end of life care.

More importantly she has been an outstanding role model for her junior colleagues, in particular women, with the result that anaesthesiology now has a respected standing in PNG.

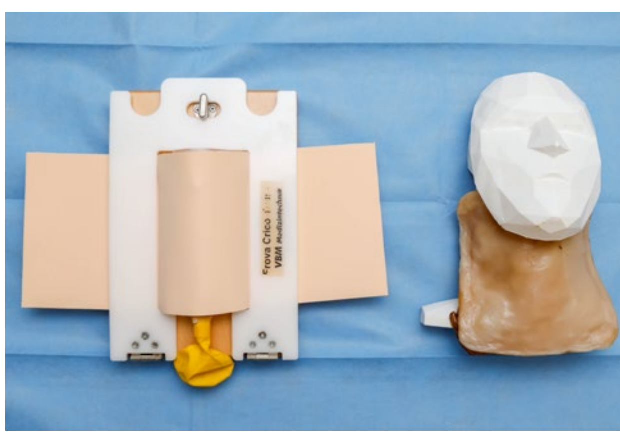
Carolyn Jones
Media Manager, ANZCA

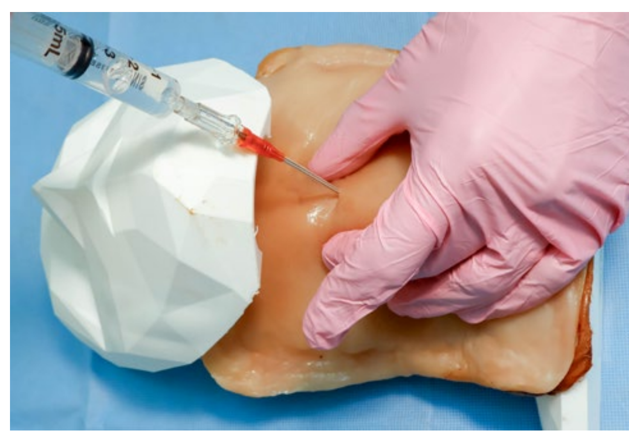
To support the work of the Global Development Committee through the ANZCA Foundation, please scan the QR code, or search 'ANZCA GiftOptions' to find the donation portal.

ABOVE

From left: Dr Marun receiving her award from WFSA President Dr Wayne Morriss.

Kombucha offshoot brews up fresh approach to training





ABOVE

From top: Anaesthetists Dr Jeremy Young and Dr Raj Palepu, alongside Wellington Regional Hospital simulation service manager Melita Macdonald, with some of the hospital's SCOBYs. SCOBYs are more realistic than traditional Can't Intubate Can't Oxygenate training models. No matter how many times a SCOBY is used, it can be regrown and used again.

You smell Wellington Regional Hospital's SCOBY farm before you see it.

In a small room tucked away in the main hospital of New Zealand's capital city, sits a collection of more than 30 different-sized containers, each growing a SCOBY – or symbiotic culture of bacteria in yeast.

More commonly known as a byproduct of brewing kombucha, the slimy – and slightly smelly – SCOBY is finding an unexpected new use as a tool for training anaesthetists.

The brainchild of Melita Macdonald, the manager of the hospital's simulation service, alongside anaesthetists Raj Palepu and Jeremy Young, the SCOBY project began with a conversation with simulation colleagues at Waitaha Canterbury in the country's South Island, and a donation from a nearby kombucha brewery.

The hospital's anaesthesia department had been running regular Can't Intubate Can't Oxygenate (CICO) training sessions, using commercially available artificial skin models.

But following feedback from participants about the low quality of the skins, they were looking for an alternative and settled on using SCOBYs, dried for 6-10 hours after growing in sweetened tea.

SCOBYs are integral to the kombucha brewing process. As the kombucha ferments, the SCOBY forms layers, creating a progressively thicker membrane with high tensile strength.

Mrs Macdonald says using the SCOBY as replica human tissue for training provides an increased level of realism.

"Under ultrasound, it actually looks more like human tissue than any of the other models that we've come across."

"With CICO situations where some institutes use the needle or canula technique, when you're aspirating back and you're going through the SCOBY, it's exactly like human tissue where you're unable to aspirate anything back until you pop through into the trachea and that's when you can aspirate air. And there's nothing else really like that in the CICO dry lab world," Dr Young says.

There are also other benefits, according to Dr Palepu.

"We've looked at a range of CICO training models, and all of them have issues – from poor fidelity, cost and environmental issues with commercially available models, to ethical issues with live animal workshops.

"When we looked to renew our commercial models, they were going to cost about $900 each. We were looking for a solution that was cost effective but much more realistic, because the commercial models were pretty poor fidelity."

Using the SCOBY is also good for the environment.

"Our old commercial models largely go to landfill whereas all the SCOBY we use, no matter how many times we use it, you chuck it back in the tea, the SCOBY will start to grow again, and it's reusable. I don't think we've binned any SCOBY we've used over the past year," Dr Palepu says.

A paper summarising the group's findings has recently been published in the *Anaesthesia and Intensive Care* journal.

The SCOBY is proving to be versatile – aside from its use in Wellington, staff at Christchurch Hospital use it for teaching suturing, it's central to the creation of vegan leather, and in Australia it's being investigated for potential use in mopping up oil spills.

Mrs Macdonald says the SCOBYs need to be stored out of direct sunlight and at about 25 degrees celsius to facilitate fermentation.

"They're not labour intensive but it's a commitment – like a pet."

Mrs Macdonald is now running trials on different shapes, sizes and depths of containers to see how they affect SCOBY growth. In particular, the team is looking to cultivate SCOBYs of varying textures and levels of moisture, to allow them to be used in different training scenarios.

Already, they are able to use different SCOBYs to simulate necks of varying thickness.

The group is considering formalised partnerships with universities and other organisations, as well as applying for research funding, to learn more about the training potential of SCOBY, the best way to grow it, and the types of models it can be applied to.

As Health New Zealand increasingly takes a nationalised approach to health education, Mrs Macdonald is hopeful their SCOBY research may be able to play a part in reducing inequity in training.

"They are going to want to be able to increase equity of access to health education, and I'm aware of areas that just can't afford what we have in Wellington, so if we can help them access valid training tools at less cost, that'd be good."

They've already taken the first step themselves, by donating two batches of their SCOBY to other hospitals in New Zealand.

The team in Wellington would like to see their innovative use of the SCOBY spread worldwide.

"We hope that people not just in Australasia but around the world take up having their own SCOBY farms to use for medical education," Dr Young says.

But first, there's the small matter of dealing with that smell – but Mrs Macdonald says there's a plan.

"We do get a lot of complaints about the smell – we're wondering about experimenting with mint tea."

Reon Suddaby
Senior Communications Advisor New Zealand
ANZCA

LIMITLESS

ANZCA ASM 2024 3–7 May, Brisbane

ABOVE

2024 Co-convenors Dr Sarah Bowman and Associate Professor Paul Lee-Archer.

The wrap up

On behalf of #ASM24BRIS we would like to say a massive thanks to all those who joined us as speakers, delegates, workshop organisers and all the behind-the-scenes ANZCA staff.

This was a very successful ANZCA Annual Scientific Meeting (ASM) with 2165 in person delegates and a further 200 people joining us online for the on-demand package. We ran the largest ever CICO workshop to help our colleagues fulfil their annual continuing professional development requirements which was very well received.

Our international speakers were inspiring and presented on a variety of topics from the latest in obstetric care to the effects of altitude on human oxygen delivery.

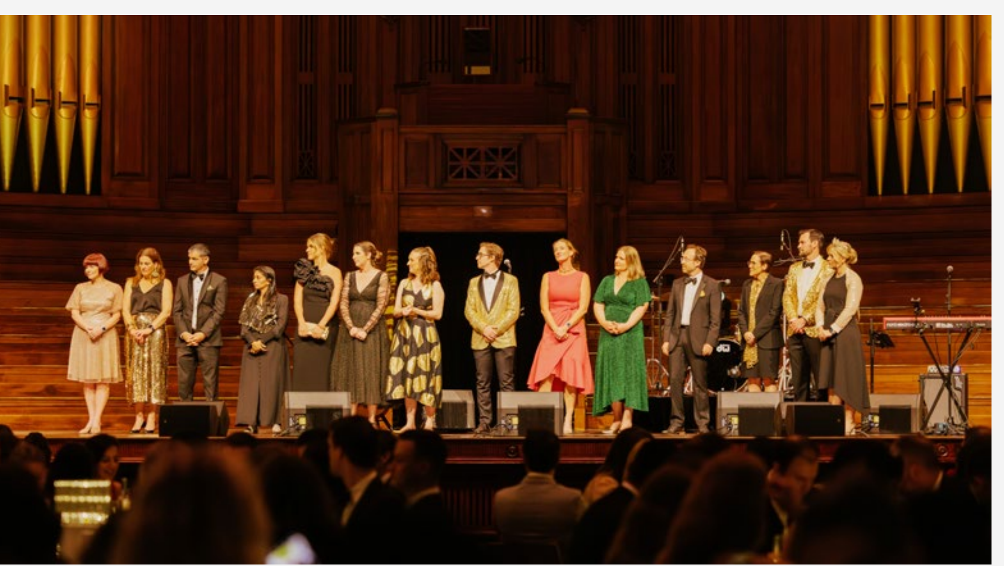
Brisbane turned on the glorious weather, with crisp starts and sunny days that enabled delegates to enjoy the scientific content and also explore our wonderful city on foot, bike or even kayak!

We had an amazing and dedicated regional organising committee who pulled out all the stops and truly enabled us to deliver this high-quality meeting.

We are all turning our attention to Cairns now and are super excited to see what their "future proof" conference will deliver.

Thanks to all who joined and supported the ASM. We are so proud and pleased and hope we have inspired you to be limitless.

Dr Sarah Bowman
Associate Professor Paul Lee-Archer
Co-convenors, Regional Organising Committee
2024 ANZCA ASM



ASM PHOTO GALLERY

Opposite page, clockwise from top left:
Our regional organising committee "ROC" stars take to the stage at the Gala Dinner; ANZCA Vice President Dr Tanya Selak stands between two of her former registrars, now fellows, Dr Ash Davis and Dr Sam Stewart – Dr Davis and Dr Stewart are now married (to each other!) and have two children; Thousands of people from around the world watched the College Ceremony livestreamed on Facebook; The 2025 ASM ROC can't wait to welcome you to Cairns for next year's ASM; The Deep Breaths podcast did a live record with Dr Chris Cokis, Professor David Story, Professor Kate Leslie AO, Dr Andrew Cumpstey, Dr Lahiru Amaratunge and Professor Eugenie Kayak.

This page from top:
Members of the Faculty of Pain Medicine stage party; Congratulations to all of our new fellows.

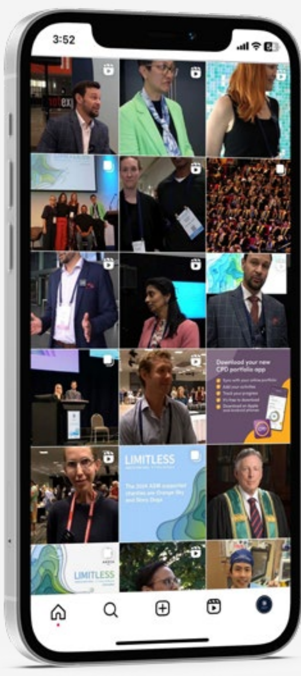
ASM STATS

- 2165 in-person delegates
- Five plenary sessions
- 52 concurrent sessions
- 134 workshops.
- 60 HCI exhibitors
- 18 social events

ASM ON THE WEBSITE

See and read more about the ASM at www.anzca.edu.au/news/it-s-a-wrap-on-the-2024-asm

Connecting online



Nearly 250 people "joined the conversation" on Twitter/X via the hashtag #ASM24Bris which, as of Tuesday 7 May, had been used in more than 1600 tweets totalling more than 10.3 million impressions. The College Ceremony livestream has had more than 20,000 plays on Facebook. In the week of the ASM, our YouTube channel clocked up more than 2300 views and our Instagram had nearly 40,000 impressions.

#ASM24BRIS

10.302M Impressions

1,645 Tweets

238 Participants

2 Avg Tweets/hour

7 Avg Tweets/participant

X Post

Award support for PNG anaesthetists

Each year Karl Storz Endoscopy Australia supports a prize for the best thesis presentation by a Masters of Medicine in Anaesthesiology (MMEDII) candidate at the University of Papua New Guinea (UPNG).

The purpose of the Trainee Thesis Presentation STORZ Prize is to support the professional development of anaesthesia consultants from Papua New Guinea through attendance at an international conference.

In 2023, Dr Joyce Lawrence from Port Moresby General Hospital (PMGH) was selected as the winner of the best thesis presentation and in 2024 Dr Priscilla Nonge, also from PMGH, was selected. They both attended the recent ANZCA Annual Scientific Meeting in Brisbane supported by their award.

Storz have supported emerging anaesthetists in Papua New Guinea through the Trainee Thesis Presentation prize since 2013. The winner is selected by an independent panel of members from University of Papua New Guinea examiners and the ANZCA Global Development Committee.

ABOVE

From left: Dr Pauline Wake (University of Papua New Guinea), Storz Prize 2024 winner Dr Priscilla Nonge, Storz Prize 2023 winner Dr Joyce Lawrence, Dr Yasmin Endlich (Chair, ANZCA Global Development Committee) and Dr Hilbert Tovirika (PMGH) at the ASM.

CPD app launched at ANZCA ASM

The ANZCA CPD app quickly became one of the most downloaded medical apps when it was launched at the ANZCA Annual Scientific Meeting (ASM) in May.

The app, which is free to download from the Apple Store and Google Play, has many great functions including:

- Keeping track of your annual progress, critical deficiencies and overall CPD requirements.
- Uploading CPD activities "on the go" (including taking screenshots and pictures to upload as evidence of completion of CPD activities).
- Accessing ANZCA Library Guides and online learning opportunities (such as courses on Learn@ANZCA).

The app was developed by the CPD Committee (CPDC) and ANZCA and FPM staff to help address the challenges our fellows and CPD participants face in meeting their annual requirements, while recognising the complexity of keeping up with both the demands of your job and your CPD requirements.

In 2023, the CPD review project group convened two reference groups to support and deepen our understanding of two unique cohorts – practice without direct patient care and private practice. Both groups reported that, while CPD should be an exciting opportunity, the demands placed on fellows are great and can lead to an overwhelming experience.

"The CPD program aims to encourage us as specialists to embrace lifelong learning and continue to spark curiosity for knowledge".

"Private practitioners, rural anaesthetists, practice without direct patient care and solo practitioners, are benefitting greatly from this new CPD app."

Our tech experts, CPDC and staff have worked hard to help you keep ahead of CPD requirements through technology. The CPD app lessens the administrative burden for fellows and CPD participants, allowing for a much smoother and more enjoyable experience.

Some cohorts, such as private practitioners, rural anaesthetists, practice without direct patient care and solo practitioners, are benefitting greatly from this new CPD app, and the app has value for our whole fellowship as it reduces data entry and supports time-poor anaesthetists and pain medicine specialists.

The CPD app shares the familiar circular dials with the online CPD portfolio, using visual aids to help you track your progress without fuss. You can always access a breakdown of your completed CPD activities, edit them, and review details entered on a previous occasion. You can also take a picture or a screenshot of a certificate of attendance, or an attendance register, and upload it to the app in just a couple of clicks

The CPD app is fully synchronised with the online CPD portfolio, meaning these tools communicate and update simultaneously.

Download the app and track your overall hourly progress or check your category-based requirements for the year. The app will alert you if there are any critical deficiencies that you should address ahead of your deadline for the current annual CPD cycle (31 December 2024).

The ANZCA and FPM Continuing Professional Development program aims to encourage us as specialists to embrace lifelong learning and continue to spark curiosity for knowledge.

We aspire for CPD to be a positive learning experience that allows us to deliver considered care to patients and communities and build resilient structures in health care.

The CPDC and the CPD team strive to understand the needs of our fellows and CPD participants and continue to evolve to meet those needs. We are working with you and for you.

Dr Debra Devonshire
Chair, ANZCA and FPM CPD Committee

First Nations fellow reflects on deepening college connections

Anaesthetist Dr Angus McNally attended his first ANZCA annual scientific meeting in Brisbane in 2017 as an Aboriginal and Torres Strait Islander sponsorship recipient.

Seven years later he attended this year's ANZCA Emerging Leaders Conference (ELC) in Mt Tamborine Queensland and, with another 300 trainees, presented for fellowship at the College Ceremony in Brisbane.

"ELC was fantastic, the networking there was incredible. It was challenging and incredibly insightful, both professionally and personally. Hard questions were asked and answers given. It was incredibly inspiring to hear so many stories over the three days."

Each year, ANZCA's Indigenous Health Committee nominates two new Aboriginal, Torres Strait Islander or Māori fellows to attend the ELC.

A Garambilbarra Country person from Queensland Dr McNally is a specialist anaesthetist at Royal Prince Alfred Hospital in Sydney and in private practice. Dr McNally's history is difficult to put together but his great grandfather was likely part of the Stolen Generation. Dr McNally says his great grandfather hid his Aboriginal heritage to fit in to the times, hoping this would allow him to marry and own land.

As a member of the ANZCA Reconciliation Action Plan (RAP) working group Dr McNally supports the college's reconciliation initiatives and hopes his own experiences can help influence positive pathways for ANZCA's Aboriginal and Torres Strait Islander anaesthesia trainees.

With three children under six and a partner who is a perioperative nurse Dr McNally's spare time away from clinical practice is precious but he values opportunities to help other Aboriginal and Torres Strait Islander trainees.

Dr McNally hopes more Aboriginal and Torres Strait Islander medical students will pursue anaesthesia training over the next few years. ANZCA has seven Aboriginal and Torres Strait Islander anaesthesia trainees and Dr McNally believes more structured mentoring support is one way the specialty can increase its First Nations representation in Australia.

"My main interest is trainees and increasing our Aboriginal and Torres Strait Islander trainee numbers. I felt quite isolated during my training as I didn't have any contact with any Indigenous consultants so I don't want that to be the case for newer trainees," he told the *ANZCA Bulletin* in Brisbane.

"It felt isolating and quite difficult at times for me during my training because of the lack of opportunity to engage with other Indigenous trainees or consultants. Now that I have finished my training I'm hoping to get more involved in the college as it focuses more on improving its Aboriginal and Torres Strait Islander representation."

Dr McNally completed his medical degree at the University of Western Sydney in 2012 and began training in intensive care medicine before switching to anaesthesia.

"Training is a very difficult time and very demanding but I knew that at the end of it I would start thinking more about how to get involved and encourage more positive interaction between the college and Indigenous medical students and trainees."

Carolyn Jones
Media Manager, ANZCA

Emerging Leaders Conference

The 2024 ANZCA Emerging Leaders Conference (ELC) saw 31 delegates and 10 college leaders from Australia, New Zealand, PNG, Malaysia, Singapore, Hong Kong, Ireland and the UK meet at Cedar Creek, Mount Tamborine from 30 April to 2 May.

ABOVE

From top: delegates, college leaders and speakers at Cedar Creek Lodges, Delegates and college leaders travelling to the 2024 ELC.

"Breaking barriers" was the theme of the conference which inspired delegates to consider challenges facing themselves, their colleagues, their patients and communities as well as strategies to overcome these barriers.

We developed a program with the aim to inspire, challenge and provide practical strategies and advice to new fellow leaders.

Following a moving Welcome to Country on the banks of Cedar Creek, the delegates were inspired by the leadership journeys and challenges faced by Dr Jillann Farmer and Dr Jenny Stedmon OAM. This was followed by a panel discussion on global healthcare leadership where Dr Farmer and Dr Stedmon were joined by our international college leaders including Dr Arvin Karu (PNG), Professor Dr Ina Ismiarti Shariffudin (Malaysia), Dr Hing-Yu So (Hong Kong) and Professor Donal Buggy (Ireland) to consider challenges facing healthcare leaders internationally.

Day two of the conference saw one of the program highlights – Dr Liz Crowe chaired a panel on breaking barriers. Delegates were inspired to hear Dr Dinesh Palipana OAM speak about his experience as a patient, a healthcare professional, an advocate and a son including some of the significant barriers he has faced during his journey from medical student and as a doctor working with a physical disability. Dr Palipana was joined by Dr Dash Newington, Dr Gene Slockee, Dr Ed Pilling and Dr Bridget Effeney for an honest and emotional discussion about the importance of supporting diversity within our health systems.

The final day opened with a panel discussion with our college leaders allowing an opportunity for delegates to question ANZCA and FPM leaders about anything and everything. Topics included the college's role in advocacy on socio-political issues both locally and globally, how to support diversity and equity in anaesthesia and how to promote anaesthesia training to First Nations doctors.

Delegates attended the conference with enthusiasm and open-mindedness. They were prepared to listen, to learn from each other, to challenge and be challenged. Fast friendships were formed across the three days and support networks created to continue the development of delegates into future college leaders. The support provided by college leaders was invaluable in fostering these mentoring and support networks.

We are grateful for the opportunity to plan this inspirational program and for the participation and enthusiasm shown by all delegates. We're also thankful for the support of the college leaders, the ANZCA events team and the 2024 Regional Organising Committee for ensuring a successful 2024 ELC. We wish the 2025 ELC convenors all the best.

Dr Claire Maxwell and **Dr Shannon Morrison**
2024 ELC Co-convenors

Robert Orton Medal

The Robert Orton Medal is awarded at the discretion of ANZCA Council, the sole criterion being distinguished service to anaesthesia, perioperative medicine and/or pain medicine.

DR LINDY ROBERTS AM

Dr Lindy Roberts AM attended the University of Queensland and undertook anaesthesia training. She travelled to WA where she worked with Associate Professor Roger Goucke developing an interest in opioid-induced hypogonadism and low testosterone in patients receiving intrathecal opioids.

The Faculty of Pain Medicine (FPM) was then in an embryonic form but on its inception, she was elected to the faculty and enjoyed a 25-year career at Perth's Sir Charles Gairdner Hospital. Dr Roberts became the true renaissance anaesthetist, developing her skills in scholarship, education, leadership, advocacy, communication and collaboration. It is fitting that she was integral to the development and implementation of the 2013 anaesthesia curriculum which assumed the CanMeds framework incorporating these roles into the "medical expert".

Dr Roberts was elected to ANZCA Council in 2006 and to the ANZCA presidency in 2013. She oversaw the introduction of the continuing professional development program, ensuring its compliance with changed standards in Australia and New Zealand.

As president, she managed a five-year strategic plan and greater internal governance with faculty delegations, council and committee protocols and educational oversight. She was later appointed as an ANZCA director of professional affairs, leading the team responsible for the college being reaccredited by the Australian Medical Council and Medical Council of New Zealand.

Dr Roberts has advocated at all levels for the specialty – for gender equity and inclusion, particularly for Indigenous populations. She has worked tirelessly to promote trainee wellbeing and the challenges facing those approaching retirement.

Although retired from the college, she continues to participate in accreditation and monitoring of specialist medical education providers.

Dr Roberts' distinguished service has been achieved by balancing her clinical practice, governance and educational activities with the support of her partner Rob and her interest in music and film noir.

Dr Melissa Viney
Director of Professional Affairs, FPM Education

PROFESSOR DAVID A SCOTT

Professor Scott has made distinguished contributions to anaesthesia and pain medicine, nationally and internationally, through leadership roles, engagement in research, collaboration with peak bodies, editorship of influential publications, and as an exemplar of clinical excellence and professionalism.

He was a specialist anaesthetist at St Vincent's Hospital in Melbourne throughout his clinical career, with interests in cardiac anaesthesia, perfusion, regional anaesthesia and acute pain medicine. As director of anaesthesia he fostered diversity, mentored researchers and ensured high standards of clinical practice. At the college, he has served as councillor, chair of numerous committees, editor of *Acute Pain Management: Scientific Evidence*, president and now director of professional affairs.

During his presidential term he championed the college's first Bullying, Discrimination and Sexual Harassment Policy, led the college's statement on marriage equality and developed relationships with sister organisations in Asia. Professor Scott has also served on numerous governmental committees and is currently chair of the Victorian Perioperative Consultative Council.

He has also been a highly productive and influential researcher. He has investigated perioperative cognitive disorders, playing a pivotal role in national and international multi-disciplinary collaborations and committees. He has also been a pioneer of research into cardiopulmonary bypass, patient blood management during cardiac surgery and the optimal use of opioid drugs for acute pain management.

His research contributions have been recognised by appointment as a professorial fellow at the University of Melbourne.

Professor Scott is one of the great intellects and outstanding leaders of our specialty. His direct contributions to patient safety and workplace culture have been wide-ranging in nature and exemplary in calibre.

As a leader he has fostered decision making based on thoughtfulness, respect and kindness, as well as attention to detail and process.

Professor Kate Leslie AO
Former ANZCA President

DR PETER ROESSLER

Dr Peter Roessler has given a lifetime of service to anaesthesia and our community. Throughout his anaesthesia career he demonstrated his standout personal qualities of humility, respect for others and even temperedness, along with his thoughtfulness, analytical skills and in-depth knowledge of English language usage.

He led and professionalised the ANZCA professional document development process and has brought new insights to the role of professional documents, having advocated for and then led the development of the framework for all ANZCA's documents. He then produced the Standards for Anaesthesia. As a result of his involvement, ANZCA now has a suite of documents that are of a very high standard and internal consistency.

With his specialist international medical graduate (SIMG) activities, Dr Roessler has shown compassion tempered with astute assessment of their cases. He is a senior member and frequent chair of the interview panels, also taking part in the appeal processes of the original decisions. He brings in depth knowledge of the international educational programs, as well as that of ours, and treats all SIMGs with respect and kindness.

These skills have also come to the foreground in his communications with patients and their families as they bring their concerns about anaesthesia care to the attention of the college. He talks with them respectfully, taking their concerns seriously and being honest about what the college can (and can't) do. While this can only ever be with a few patients, it helps put a human face on the college and our profession.

At earlier stages of his anaesthesia career, he was a supervisor of training, education officer for Victoria, primary examiner and chair of the panel of primary examiners (having introduced and developed the first syllabus for the primary exam basic sciences) and visiting examiner for the Hong Kong College of Anaesthesiologists.

Despite his considerable achievements, he has never been guilty of self-promotion, in fact quite the opposite.

He is a role model as an example of selfless service to the college and our profession, bringing his considerable skills to whatever is needed.

Dr Leona Wilson ONZM
Executive Director of Professional Affairs

LEFT
2024 Robert Orton Medal recipients Dr Lindy Roberts, Professor David A Scott and Dr Peter Roessler.

ANZCA Medal

The ANZCA Medal is awarded at the discretion of ANZCA Council in recognition of major contributions to the status of anaesthesia, pain medicine or related specialties.

DR ALLAN CYNA

Dr Cyna began his career in the UK and moved to Australia to become a consultant anaesthetist at the Women's and Children's Hospital in Adelaide in 1997. He has dedicated his career to researching and teaching the use of simple hypnotic communication to enhance patient experience.

The growing awareness of the importance of communication as a tool to reduce anxiety and improve the patient experience is in no small part due to the innovation and energy he has placed into this field in Australia. As the inaugural chair of the ANZCA Communication Special Interest Group, he continued to spread the message of the power of language and hypnotic techniques to reduce the trauma associated with hospital visits for children, indeed for patients of all ages.

Recognising that he needed to add to the evidence for the effectiveness of these techniques, he turned to research, and in doing so, expanded the positive influence he has had on our specialty. With a PhD and more than 130 peer reviewed publications, he has shared his passion and expertise to anaesthetists across Australia, encouraging them to pursue research to improve the care we deliver to patients.

A large proportion of South Australian anaesthetists who completed training after his arrival have a publication supervised by him, and while for many this is their only publication, for others this was their introduction to a career of research.

This support was expanded to Nepean Hospital in NSW, where he worked two days a fortnight for more than four years to foster their research program, facilitating half a dozen publications.

Dr Cyna has had an enormous impact in South Australia, throughout the country and internationally through his work in communication, hypnosis, and research.

Dr Rowan Ousley, FANZCA

DR HELEN KOLAWOLE

Dr Kolawole has made significant and ongoing contributions to local, Australian, New Zealand and international anaesthesia during her career. She is a globally recognised expert in perioperative allergy and anaphylaxis where her personal experience of latex allergy has led her to work collaboratively to deepen understanding and education in the field.

She was a founding member of the Australian and New Zealand Anaesthetic Allergy Group (ANZAAG), not only coordinating the group but also chairing a working group that created the guidelines for management of perioperative allergy. These guidelines have had a profound effect on the management of anaesthetic anaphylaxis worldwide, having been cited multiple times as a standard of practice in international research.

Locally, she has been the driving force for the anaesthetic allergy clinic in Monash Health and Peninsula Health and is always available as the local expert in allergy for many of her colleagues.

Her passion for education has been demonstrated by being a primary examiner for 12 years, a supervisor of training for 10, and an EMAC instructor and primary course lecturer. Dr Kolawole has provided outreach to remote and regional areas, particularly Alice Springs Hospital. She has undertaken extended locum positions which have involved clinical teaching and the design and delivery of a comprehensive examination preparation program for trainees in the Northern Territory.

Moreover, she has been a champion of wellbeing in the Peninsula Health anaesthesia department. Her care for colleagues and trainees is shown on a daily basis where this is taken beyond the theoretical to the very practical and heartfelt.

Dr Kolawole is the essence of what being an anaesthetist is about – individual specialised patient care, which she continues to deliver with skill and compassion.

Associate Professor Stu Marshall, FANZCA
Dr Tzung Ding, FANZCA

ASSOCIATE PROFESSOR MICHAEL STEYN

Associate Professor Steyn worked as a consultant in the NHS in the major burns centre in Chelmsford, Essex before arriving in Australia in 2003. He was awarded FANZCA in 2004 after fulfilling all the rigorous requirements of the specialist international medical graduate (SIMG) process. After 18 months as a staff specialist at the Royal Brisbane and Women's hospital and University of Queensland, he was appointed director and associate professor and served in this capacity between 2005 and 2015.

He has been a remarkable contributor and innovator for more than 20 years. As director of Queensland's largest teaching and research hospital, he was also co-founder of the Overseas Trained Specialist Anaesthetists Network (OTSAN), which provided support and advocated for SIMGs.

At a state level, he participated on numerous Queensland Health committees and projects. In addition to being respected as an expert and caring clinician, he has excelled as a leader and manager with a positive impact on both trainee education and SIMGs, having served on the SIMG Committee for 16 years, including eight as chair. He initiated immeasurable advances for both ANZCA and the Faculty of Pain Medicine during this time.

He has contributed to the broader areas of anaesthesia and healthcare through his involvement in research, collaboration with the New Zealand National Committee and Medical Council of New Zealand, Medical Board of Australia and Australian Medical Council.

Associate Professor Steyn's lasting contributions to patient safety and access to quality care along with his immense efforts towards SIMG advocacy have formed a solid foundation for future advances.

Dr Peter Roessler, FANZCA

ASSOCIATE PROFESSOR RICHARD RILEY

Associate Professor Riley has made outstanding contributions to our clinical services, teaching, training, research and innovation over his 32-year career as consultant anaesthetist at Royal Perth Hospital.

His contribution to national and international simulation and training covers the entire spectrum – advocate, collaborator, convenor, investigator, builder, inventor, director, manager, teacher, inspector and editor of the definitive global text *Manual of Simulation in Healthcare*. Australia and New Zealand's mandatory effective management of anaesthetic crises (EMAC) course stands testament to his towering achievements. The Centre for Anaesthesia Skills and Medical Simulation at the University of Western Australia (UWA) was an extraordinary advancement for simulation and training in anaesthesia in WA. Its success led directly to facilities and programs at our universities and hospitals.

Associate Professor Riley has also advanced our national academic life through the college special interest groups and its publications, particularly as chief editor of *Australasian Anaesthesia* (the Blue Book) from 2007 until 2021. He has more than 150 publications to his name. He also served our college as Training Accreditation Committee inspector, specialist international medical graduate assessor and EMAC accreditor for more than 10 years.

While "retired", his contributions continue to accrue. He is undertaking a PhD at the UWA School of Population Health and acts as clinical supervisor and now sub-dean of the School of Medicine, Notre Dame University.

Associate Professor Riley has provided mentorship, wisdom, and friendship to a generation of anaesthetists. He is a well-respected and highly regarded anaesthetist, who is known for his kind and caring nature, his wise words and unflappable demeanour. He is a true pioneer and leader in anaesthesia and has dedicated his working life to improving the quality and standards of anaesthesia through his many varied roles.

Dr Marlene Johnson, FANZCA

DR NEIL MACLENNAN

Throughout more than 30 years of anaesthesia practice, Dr MacLennan has been a valued colleague and inspirational mentor and teacher for countless anaesthetists in New Zealand.

His areas of clinical expertise include liver transplant anaesthesia, anaesthesia for complex vascular surgery, regional anaesthesia, and the use of ultrasound in anaesthesia. He helped set up the anaesthesia service for the New Zealand Liver Transplant Service. As the clinical lead for vascular anaesthesia, he helped establish regular multidisciplinary vascular case conference meetings long before the term perioperative medicine had even been coined. He has been a pioneer of regional anaesthesia and the use of ultrasound in other areas of anaesthesia.

Dr MacLennan's excellence and innovation in clinical practice is paired with a tireless dedication to education. Teaching trainees in the operating room, supervising fellows in vascular anaesthesia, countless workshops and presentations, the organisation of high quality anaesthesia meetings, his work as a member and past chair of the regional anaesthesia SIG, always being willing to answer questions and help a colleague with a difficult case – the list goes on and on.

He was one of the founding trustees of the JAFA trust which funds anaesthesia research fellowships, supports early career anaesthetists working towards higher degrees and provides funding for trainees.

Dr MacLennan's passion and commitment to clinical anaesthesia and education have shaped the careers of numerous ANZCA trainees and fellows. He has contributed significantly to elevating the standard of care provided to our sickest patients.

Dr Karen Pedersen, FANZCA

Dr Tom Fernandez, FANZCA

PROFESSOR ANDRÉ VAN ZUNDERT

Professor Van Zundert is a superb clinician, a consummate anaesthesia researcher, a fine teacher, an author, mentor and a visionary. He has a singular focus on improving patient care and safety for all patients and has established the award winning Centre for Excellence and Innovation in Anaesthesia, a centre for teaching, training, testing, quality care and research in anaesthesia.

He's made contributions to improvements in obstetric anaesthesia, regional anaesthesia and airway management. With the publication of four major textbooks, 76 book chapters and over 500 scientific publications he is ranked in the top 2 per cent of world scientists (Stanford). He has given 850 international lectures.

He was the 2023 ANZCA Lennard Travers Professor of Anaesthesia. The University of Queensland honoured Andre's dedication to teaching and education with a Higher Education Academy Fellowship.

He has served with NATO peacekeepers as military medical director as Lieutenant Colonel and holds multiple civil and military awards from both Belgium and the Netherlands.

He is a valued member of the Patient Safety Committee of the Queensland Clinical Excellence Commission. The Queensland ANZCA registrars in anaesthesia elected Professor Van Zundert patron of the Queensland Anaesthesia Registrars Research Collaborate.

Professor Van Zundert volunteers to support the homeless citizens of Brisbane, in a safe environment free from the harshness, chaos and isolation of the streets.

Professor Stephen Gatt, FANZCA

Australasian Anaesthesia submissions

We're seeking expressions of interest for contributions to the next edition of Australasian Anaesthesia (the Blue Book).

Before starting your article, we ask you to submit a form to the editorial team for review. This is intended to avoid unintentional duplication of submissions, and ensure the topic and format proposed are appropriate for the scope of the Blue Book.

This form must be completed, with the topic approved and an editor assigned, prior to an article being submitted for review. Please send the completed form to bluebook@anzca.edu.au.

Visit anzca.edu.au for more information and the form.

ANZCA Council Citation

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

DR INDU KAPOOR

Dr Kapoor is an exceptional member of our college, her actions align with the values and purpose of ANZCA, to promote professional standards, education and advance the practice of anaesthesia. She exemplifies the roles of a specialist anaesthetist in all areas of medical expert, collaborator and communicator, health advocate, manager, professional and scholar.

She was the inaugural chair and founding member of the Paediatric Anaesthesia Network of New Zealand (PANNZ). Dr Kapoor spent countless hours gaining support to get the network off the ground in 2016. She has been an active member since her term as chair and the network has flourished since its inception, gaining involvement from almost every public hospital in New Zealand as well as the private sector.

Alongside this, she has single-handedly set up and successfully run PACMAC – a paediatric crisis simulation course. She keeps an energetic and engaged faculty and continues to have enthusiasm to improve and shape the course. More recently she has driven a small group to start up IS-PACMAC where the simulation course travels to hospitals within New Zealand to run crisis scenarios with multidisciplinary teams within their own environments. Dr Kapoor's work has improved the care of children throughout New Zealand by enabling and uplifting others, this award is well deserved.

Dr Allanah Scott, FANZCA

DR MARTIN MISUR

Dr Misur played a pivotal role in revolutionising workplace assessment tools and IT systems within ANZCA. Initially, he collaborated on developing an online mini-clinical evaluation exercise (CEX) form, a novel concept at the time, which proved invaluable for the formal trial of mini-CEX and generated crucial data on its efficacy.

His expertise in translating educational concepts into user-friendly software was evident in the success of this project.

Beyond his clinical proficiency, his significant contributions include designing software platforms for workplace-based assessments, transforming ANZCA's curriculum implementation. He gifted his intellectual property to the college, leaving a lasting legacy in advancing assessment practices. His achievements extend to local initiatives like designing complex databases for liver transplant services and enhancing hospital-wide rostering systems. Dr Misur's solutions streamline processes, ensuring accurate data management and improving patient care.

Moreover, he demonstrated a unique understanding of real-world clinical practices, integrating legal requirements seamlessly into electronic record systems, thus ensuring compliance and patient safety.

Dr Misur's leadership in projects like the elective preoperative patient preparation pathway showcases his commitment to enhancing patient care and operational efficiency.

Despite his extensive contributions, he has received little formal recognition, highlighting his selfless dedication to improving healthcare without personal gain.

Dr Vanessa Beavis, CNZM

DR LIA FREESTONE

Dr Freestone lives in Hobart and is a cardiac anaesthetist in public and private practice. Her contributions to clinical anaesthesia, education and training, and ANZCA activities is remarkable.

A highly active member of the Tasmanian Regional Committee for more than 12 years and committee chair for a number of those years, she has also managed to support and engage with many other college activities. Most notably chair of the Tasmanian Anaesthetic Training Program, rotational supervisor, education officer, supervisor of training and as a Training Accreditation Committee member. Dr Freestone remains passionate and committed to education reflected by formal departmental roles in training and simulation, and the ANZCA Educators Program.

While this list is by no means exhaustive, her recent success in securing a $A1 million specialist training program-funded grant for an education and simulation training network in Tasmania is a great example of her vision, tenacity and dedication to her state, colleagues, and local health system. These sorts of achievements stand as a testament to her college citation.

Despite incredible dedication to her vocation, most importantly, Dr Freestone remains a warm-hearted, generous and utterly decent person.

Dr Bruce Newman, FANZCA

DR GREGORY O'SULLIVAN OAM

Dr O'Sullivan will be presented with the ANZCA Council Citation at the 2025 ANZCA and FPM College Ceremony in Cairns.

ANZCA Recognition

The ANZCA Recognition is made at the discretion of ANZCA Council in recognition of significant contributions at a state or regional level to the college in the fields of anaesthesia, perioperative medicine and/or pain medicine. Significant contributions are defined as distinguishing themselves conspicuously at a state or regional level.

ASSOCIATE PROFESSOR IRENE NG

Associate Professor Ng is a highly respected anaesthetist and outstanding clinical academic. She has a longstanding association with ANZCA, providing valuable contributions to many committees and dedicated involvement in educational roles. She has served as a member of the ANZCA Victorian Regional Committee, ANZCA Emerging Investigators Sub-committee and ANZCA Scholar Role Sub-committee – first as deputy chair and now chair.

She has been an exam preparation course lecturer in neuroanaesthesia, presided at the ANZCA Victorian Registrars Scientific Meeting as a judge and participated as an ANZCA Research Grant reviewer. She has been a member of the ANZCA Annual Scientific Meeting (ASM) Regional Organising Committee and Problem based learning discussions (PBLD)/ Workshop Co-convenor, ANZCA/ASA Combined CME Meeting co-convenor, ANZCA ASM chair of the regional SIG session and PBLD workshop presenter and an ANZCA ASM Trainee Academic Prize session chair/judge.

Associate Professor Ng holds important leadership positions at both a regional and national level. She is an expert in quality improvement, leading many collaborative projects of significant clinical value. She is widely admired at the Royal Melbourne Hospital for her dedication and clinical skill, and is recognised as a successful leader, clinician and innovator.

Dr Elizabeth Pemberton, FANZCA

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FUTURE PROOF

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Training & education

We're responsible for training, assessing and the continuing education of anaesthetists and specialist pain medicine physicians in Australia and New Zealand.

Meet the ANZCA Trainee Committee

The next generation of anaesthetists are already making their mark at the college. Here, the members of our all-female ANZCA Trainee Committee tell us a bit more about themselves and the college committees they're on.

Co-chairs

DR JENNA DONALDSON (NZ)

Jenna is a provisional fellow in Dunedin, New Zealand and has joined the ANZCA Trainee Committee as co-chair for 2024. She looks forward to advocating for trainees and making positive changes to training issues.

Jenna is also co-chair of the New Zealand Trainee Committee, and represents trainees at ANZCA Council, the Education Executive Management Committee, the New Zealand National Sub-committee, the ANZCA Educators Sub-committee, and the Training Accreditation Committee (TAC).

DR SUKHI HEGDE (NSW)

Sukhi has been part of the Prince of Wales/Sydney Children's Hospital training program over the past few years and as part of her training worked in numerous metropolitan and rural hospitals in NSW and interstate. Sukhi is passionate about improving conditions for independent and rural trainees and helping address concerns such as job progression, access to education/formal college exam preparation and networking between hospitals.

Sukhi has been a member of numerous local, state and national committees including the NSW Trainee Committee, TRA2SH (Trainee-Led Research and Audit in Anaesthesia for Sustainable Healthcare), the Australian Medical Students' Association Global Health Committee and hospital resuscitation committees.

She is very passionate about sustainability and improving trainee welfare – particularly in relation to exams and critical incidents encountered during training. She believes there's room to improve support of trainees who have encountered professional and personal challenges during training and to advocate for their wellbeing.

Members

DR CRISTY ROWE (ACT)

Cristy is an advanced trainee in the ACT. She chose anaesthesia as a specialty as she enjoys working in a team environment, the procedural aspect of the job and patient centred care.

She is the current chair of the ACT Trainee Committee, a member of the ACT Regional Committee and is also a member of the Australian Army Reserve.

Outside of work Cristy enjoys running and amateur mountain biking and combined these to help organise the inaugural ACT Anaesthetics team in the 2023 Sri Chimnoy Triple – Triathlon. In 2024 she is optimistic that the anaesthetic team may beat the retrieval team.

DR STEPHANIE JONES (ACT)

Stephanie is an advanced trainee at Canberra Health Services and is involved in medical education and doctor wellbeing. In her spare time, she enjoys swimming, running and team sport. Last year, in conjunction with her ACT chair colleague she enjoyed helping organise the inaugural ACT Anaesthetic team in the Sri Chinmoy Triple — Triathlon.

She is currently deputy chair of the ACT Trainee Committee and a member of the SOT-DM working group.

DR PRIYA MAHESHWARI (NSW)

Priya is a co-chair of the NSW Trainee Committee and a member of the ANZCA Trainee Committee. She has been a member of the NSW Trainee Committee since 2022.

She is currently a provisional fellow in Sydney with a subspecialty interest in regional anaesthesia. She feels very privileged to be in a position to be able to advocate for trainee colleagues.

DR GERALDINE KONG (Qld)

Geraldine is currently working at the Royal Brisbane and Women's Hospital in Queensland. She likes providing individualised care for her patients and utilising her knowledge of physiology and pharmacology. She likes that anaesthesia encompasses a great breadth of analytical and procedural skills.

Geraldine is also a member of the Effective Management of Anaesthetic Crises Sub-committee.

DR LOIS MACKLEY (Qld)

Lois is a provisional fellow and co-chair of the Queensland Trainee Committee. She ooks forward to advocating for trainees on the issues that matter to them most. Lois also sits on the ANZCA Education Development and Evaluation Committee (EDEC) and the 2024 ANZCA ASM Regional Organising Committee. Her main interests are equitable access to training and supporting trainees as they navigate busy lives with the challenges and achievements of the ANZCA training scheme.

Lois lives with her husband and young son and outside of work enjoys kite surfing, long dinners with friends and a good book.

DR ALYSSA GARDNER (SA/NT)

Alyssa is an advanced trainee in Adelaide who's juggling studying for the final exam, fulltime work, a toddler, and the voices (internal and external) that tell her it'll all be worth it soon! Alyssa has been involved with our SA/NT Trainee Committee for a few years and is a trainee representative on the Training and Accreditation Committee.

She loves the recent surge in enthusiasm for sustainability in anaesthesia and is excited to see how we can harness this to create change.

She is a trainee representative on the Training Accreditation Committee.

DR BRIANNA (BREE) MARTIN (SA/NT)

Bree is in her first year as one of the SA/NT representatives on the ANZCA Trainee Committee. She looks forward to continuing to support and advocate for the training experience, education and welfare of trainees in Australia and New Zealand. She is an advanced trainee in Adelaide and is married to another anaesthetic registrar (the cycle of exams is never-ending in their house!)

She is a member of the ANZCA Trainee Committee, ANZCA Curriculum Review Sub-committee, the South Australian and Northern Territory Trainee Committee, the South Australian and Northern Territory Regional Committee and the South Australian and Northern Territory Regional Education Committee.

DR IMOGEN ACKERLY (Vic)

Imogen is an advanced trainee in Victoria, returning this year from maternity leave. She enjoys advocating on behalf of her fellow trainees and has been a member of the Victorian Trainee Committee since 2022. This year she is a part time trainee and looks forward to completing her volume of practice and exam over the next year or so.

Outside of anaesthesia she enjoys visiting wineries, relaxing with friends and spending time with her family (including Odin, her energetic Husky).

DR REBECCA WOOD (WA)

Rebecca shares the WA Trainee Committee co-chair role with Dr O'Brien for 2024 after having been involved in the committee for the preceding two years. Her committee interests have been in supporting trainees to get through training and exams and using her knowledge and experience from previous roles with the Australian Society of Anaesthetists, the Australian Medical Council and the Australian Medical Association (WA and federal) to creatively progress training and workplace issues. Other extra-curricular interests include human factors, systems and QI, and learning from excellence.

This year as a provisional fellow Rebecca will be honing her skills in obstetric anaesthesia and regional anaesthesia. Outside of work she enjoys playing tennis, working on craft projects, walking the dogs and travel.

DR SARAH O'BRIEN (WA)

Sarah is co-chair of the WA Trainee Committee which she has been involved with since 2022. Her main interests are education, peer support, and promoting collaborative learning. She is now an advanced trainee preparing for the fellowship exam next year.

Sarah, who is originally from Ireland, lives with her husband and pup Bailey. Outside of work she enjoys walks with Bailey, trying out new restaurants, and anything Harry Potter related.

DR TESS BRIAN (NZ)

Tess is a New Zealand trainee at Auckland Hospital. She is interested in diving and hyperbaric medicine as well as regional anaesthesia. She also thoroughly enjoys obstetric anaesthesia.

Tess is a co-chair of the New Zealand Training Committee.

Establishing a chapter as course rolls on

We are now well into the second trimester of our Course in Perioperative Medicine, with one new participant joining the cohort commencing unit of study 3 (optimisation) and/or unit of study 4 (intraoperative impacts on patient outcomes).

The course has been designed so that units of study can be taken either one or two at a time and in any order, so participants can start the course at the commencement of trimester 1,2 or 3.

Altogether, 30 anaesthetists, surgeons and physicians have started the course in this inaugural year.

There are 19 host hospitals across Australia and New Zealand and we are hearing from more who are wanting to host participants for their 40 hours of clinical immersion that is required for the course, along with the 40 hours of online learning and a workshop. Those successfully completing the course qualify as graduates of our Chapter of Perioperative Medicine and receive the GChPOM postnominals.

Nearly all of the 800-plus clinicians who have applied to receive the GChPOM via the recognition pathway have been processed, with about 30 not meeting requirements and 115 others asked to provide more information.

Most recognition pathway applicants and course participants are anaesthetists but it is pleasing to see other specialties represented in what is very much a cross-specialty collaboration.

About 60 graduates of the course have now completed workshops on becoming a supervisor and many others have contributed to writing course content.

Applications for trimester 3 (from 16 September to 1 December) are now open and will close on 18 August. Trimester 3 covers unit of study 5 (postoperative assessment and management) and unit of study 6 (discharge planning and rehabilitation).

Meanwhile, we are seeing some firm advocacy plans take shape and the development of the online content and assessments is nearing completion.

Chapter of Perioperative Medicine

The college is now steadily working on the establishment of a Chapter of Perioperative Medicine to be in place by the end of the year.

Creating a chapter is new to ANZCA, although there are some parallels and learnings from establishing the Faculty of Pain Medicine. We are also asking colleges who have established chapters, such as the Royal Australasian College of Physicians, for advice.

Functions of the chapter will include, amongst other aspects, advocacy and engagement activities, delivery of the course, maintaining the quality and standards of the qualification and overseeing the process for awarding the qualification.

Other activities include establishing a Chapter of Perioperative Medicine Board with solid regulations and terms of reference that address working collaboratively with other specialist colleges.

We are also exploring the establishment of fellowship of the Chapter of Perioperative Medicine.

Maintaining our standards

To ensure resources and reference links are up to date and determine if new evidence should be added, a review of the Perioperative Medicine Care Framework is under way.

Leading this work is Dr Jill Van Acker who chairs the Perioperative Medicine Content and Resource Review Working Group.

The group is also exploring writing journal articles, for example, about the development of the perioperative care framework and training future perioperative medicine clinicians.

POM SIG and summit

Be sure to register for the Perioperative Medicine Special Interest Group (SIG) meeting being held in Melbourne from 22-24 November, where we will be launching our Chapter of Perioperative Medicine.

This year's SIG will be held in partnership with Summit III, convened by Professor Guy Ludbrook, which for the first time is being held outside Adelaide.

The summit series was created to trigger a shift in perioperative care and reduce morbidity and mortality, shorten hospital stays and save valuable health dollars. It aims to bring together a range of stakeholders including healthcare professionals, their representative bodies, government agencies, private and public healthcare providers, payers, and consumers.

Also partnering with the SIG is the Perioperative Quality Initiative (POQI), an international, multidisciplinary non-profit organisation that organises conferences on topics related to perioperative medicine.

Days one and three of the SIG meeting will address how perioperative medicine adds quality and enhances the value of perioperative care in plenary sessions combined with Summit III and POQI. Day two is a full day of concurrent sessions, including a stream dedicated to in-depth perioperative medicine topics and an advanced recovery room care (ARRC) workshop.

To register, go to www.anzca.edu.au/events-courses/events/sig-events/2024-perioperative-medicine-sig-meeting.

Dr Vanessa Beavis and **Dr Sean McManus**
Co-chairs, Perioperative Medicine Steering Committee

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Case study:
Virtual Anaesthetic Billing

Dr Erfan Hedayati:
Zento transformed my anaesthetic practice.

Dr Erfan Hedayati, an anaesthetist with over 20 years of experience in Nowra, NSW, revolutionised his practice by partnering with Zento. Before Zento, Dr Hedayati managed anaesthetic billing and secretarial tasks, which were time-consuming and prone to errors. Everything changed when he began using Zento's services and innovative system, Zentobox.

"Zentobox consolidates all my billing, scheduling, and patient information into one organised place. The system automatically updates and corrects entries, significantly reducing the chances of errors."

Zento's virtual practice administration and reception services significantly improved Dr Hedayati's communication and workflow. *"I appreciate the additional Zento services, which include managing patient inquiries, forwarding clinical information, and facilitating communication between myself and my patients."*

With a virtual Zento practice manager available at his fingertips, Dr Hedayati can easily reach out for assistance or guidance, even after hours. *"The time difference between Sydney and Zento's head office in Perth works to my advantage. When I have a question at 6 pm my time, I can still count on support."*

Dr Hedayati believes Zento is very cost-effective, with an affordable fee based on his monthly income. *"Most other providers charge 4 to 5%. I currently pay much less which helps keep costs down. Zento's responsive service is crucial for the success of my anaesthetic practice."*

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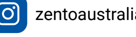

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“Ready for surgery” perioperative pathways at SCUH

The Sunshine Coast University Hospital (SCUH) has seen significant change since its inception in 2017.

It has transitioned from a smaller regional hospital (Nambour General Hospital) to a larger tertiary centre with increased surgical and patient complexity, as well as becoming a digital hospital with increased utilisation of virtual healthcare.

During its evolution, the Sunshine Coast Hospital and Health Service (SCHHS) surgical pathways grew organically resulting in a very complex system that had lost its focus on preparing patients and their families for surgery at the correct facility.

To embark on change, the existing system needed to be understood, and an external body was tasked with mapping the patient journey.

It became apparent that there were many clinician groups and digital systems that co-existed along the patient journey, and understanding their roles was critical. This mapping helped inform opportunities for improvement.

Our system was overly arduous, lacked standardisation and focused time and effort on the incorrect patient group.

Local consumers were also consulted to ensure all changes maintained the core patient focus. The consumer feedback highlighted that communication needed significant improvement.

The other opportunities for redesign were to focus on efficient, high-value and protocolised care. This was made more urgent (and indeed possible) due to the renewed emphasis post-COVID on doing more with less.

More episodes of patient care to meet the increase in theatre utilisation, with less physical space as the footprint of our clinic was reduced, and less FTE of nursing staff.

The biggest learning for us in this initial phase was that the anaesthesia clinic is a small part of a complex system, from being booked for surgery in the surgical clinic to the day of discharge from post-surgical care.

Three important changes were designed into in the new perioperative “Ready for Surgery” pathway, which mirrors the ANZCA perioperative care framework.

The first significant change was in the nursing structure. A business case for change was submitted by our nursing leaders.

No longer were the nursing roles centred around just the anaesthesia clinic, but they encompassed patient screening, theatre list preparation and waitlist management.

The second significant advance was early (within 48 hours of decision for surgery) high-quality screening that was evidence based, locally adapted and adjusted for different surgical and patient cohorts.

Thirdly, a traffic light system that divided the patients into three pathways was instituted. A green pathway for low-risk patients having low risk surgery, an amber pathway that required patients to be seen in the anaesthesia clinic, and a red pathway for high-risk patients.

The traffic light system has simplified the way we cohort patients but has also clarified the way we communicate within the perioperative team.

No longer were the nursing roles centred around just the anaesthesia clinic, but they encompassed patient screening, theatre list preparation and waitlist management.

LEFT
Clinical nurse Jessica Juster does the "red nurse" role.

In addition to the changes in the surgical pathways, we have specifically focused on standardisation of care. This required development of a revised adult health questionnaire and companion decision matrix for allocation of patient pathway and facility.

Perioperative standardisation also required the development of evidence based perioperative procedures for patient evaluation and optimisation.

The development of the high-risk pathway, or “red pathway”, has seen the biggest gains in our most vulnerable patient cohort.

These medically complex patients are referred to a clinical nurse, who can provide an early assessment and co-ordinate preoperative care. Patients on the red pathway can, for example, be referred for endocrinology optimisation of HBA1c, see an asthma nurse practitioner for inhaler education or have further investigations for low exercise tolerance.

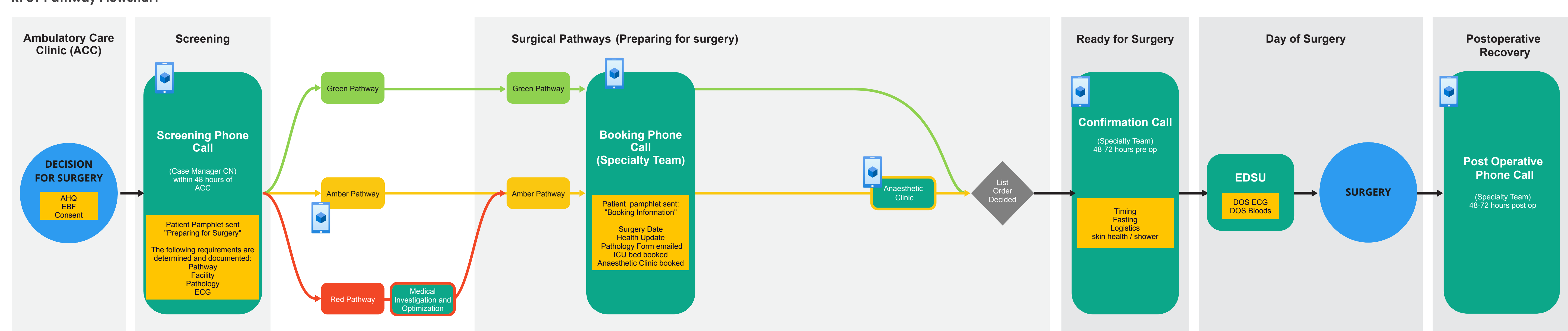
We are currently launching our high-risk anaesthesia clinic and perioperative MDT, which will augment and compliment this pathway.

The low-risk pathway, or “green pathway”, has moved a significant volume of lower complexity patients to a completely nurse-led model. This allows the anaesthesia clinic to focus on the correct patient group. Patients on the green pathway are frequently available at short notice, with little required preoperative preparation which also facilitates better theatre utilisation.

A significant challenge of this organisational transformation has been communication.

Improvement in the way we communicate externally with our patients is an ongoing priority. We are enhancing the information patients receive while preparing for surgery, including providing simplified methods for patients to reach out to the hospital with questions and updates.

RFST Pathway Flowchart



A traffic light system that divided the patients into three pathways was instituted. A green pathway for low-risk patients having low risk surgery, an amber pathway that required patients to be seen in the anaesthesia clinic, and a red pathway for high-risk patients.

LEFT
Dr Jillian Streitberg and Dr Anna Pietzsch.

Internal communication has been challenging due to the large number and variety of clinical and non-clinical teams involved. We found this was best managed with regular executive stakeholder meetings with a central and agreed update.

There are many improvements yet to be completed in this area, and we aspire to have better connections with primary care physicians in the future. A central aim of the redevelopment was to design a pathway that would easily translate to a digital solution. This is our next exciting challenge.

The redesign of our SCHHS "Ready for Surgery" perioperative pathways has been a wonderful adventure.

Our perioperative teams have grown with us and have shown great flexibility and stamina for change.

What would we say to any team contemplating similar? Our top tips are outlined below, but the most important message is to persevere. You will meet many obstacles, but there is always a way forward, you just need to find it (or find the person who can)!

Dr Anna Pietzsch, FANZCA and
Dr Jillian Streitberg, FANZCA

Anna and Jill would like to acknowledge the efforts of all the people involved in the organisational change. Specifically our nursing leaders Marli Millas and Gillian King and all the Ready for Surgery nursing, pharmacy, administrative and medical staff.

Tips for re-inventing the perioperative journey:

1. Map out your current process. Include maps for all clinical and nonclinical teams.
2. Write local evidence-based procedures and protocols wherever possible
3. Involve your consumers.
4. Early patient screening for pathway and facility at the time of decision for surgery
5. Stream based on medical and surgical risk and then manage them appropriate to their disparate needs. Don't waste your resources on low value care or "busy work".
6. Critically evaluate who you need to see in person. Don't waste physical, financial and environmental resources on getting patients to hospital unnecessarily.
7. Limit perioperative investigations
8. Bring all team leaders together on a regular basis for centralised decision making and communication.
9. Audit your practice (e.g. day of surgery cancellations) and review cases that don't go well
10. Tenacity

Steuart Henderson Award

The Steuart Henderson Award is 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.

ASSOCIATE PROFESSOR KARA ALLEN

Associate Professor Kara Allen is an accomplished medical educator worthy of ANZCA's recognition.

Her educational achievements are numerous and varied throughout her career and span the breadth of anaesthesia education including simulation training, mentoring, research, resource development and educational leadership.

She has achieved her impressive outputs without compromising her complex sub-specialty clinical commitments. Her academic work has translated into tangible benefits for anaesthetists managing career transitions and for those in challenging stages of training.

This award recognises an anaesthesia educator who is truly invested in developing and expanding educational tools, programs, methods and fostering diversity in training and diversity in faculty and leadership. The manner in which she has modelled excellence in both her clinical and academic work, along with a healthy work/life balance, is particularly inspirational for women in anaesthesia.

Kara contributes to college educational activities as an ANZCA educators program facilitator and was a member of the ANZCA Educators Sub-committee until 2016. She is the current deputy chair of the Education Development Evaluation Committee and previously served as a committee member.

Ten years ago she co-developed the first return-to work course for Australian critical care practitioners following a practice break. To date, the CRASH (Critical Care Resuscitation and Airway Skills in High Fidelity Simulation) course has helped more than 300 anaesthetists, specialist pain medicine physicians, intensive care physicians and emergency medicine specialists to successfully return to work.

Her commitment to equity and diversity has driven her to fostering opportunities for anaesthetists facing career challenges. This includes supporting colleagues through key transitions to consultancy, returning to work and the specialist international medical graduate process.

DR ALEX KONSTANTATOS

Dr Alex Konstantatos is a deserving recipient who shows not just excellence in the fields that make up the eligibility criteria for this award but breadth to his contributions in education in anaesthesia and pain medicine.

His enthusiasm and love of teaching is highly valued by his colleagues and he is an inspiration to generations of trainees and consultants. Alex has inspired dozens of anaesthesia trainees with his passion and experience in pain medicine and many have gone on to complete pain fellowships with his support. His ability to make time for supportive and collaborative conversations is well known, appreciated, and loved by the staff at The Alfred.

Alex's passion for primary exam preparation for registrars is legendary as he gives up his time freely after hours and on weekends to provide practice vivas and tutorials. He has been a long-term contributor to the Christchurch primary exam preparation course and a primary examiner and has been a significant contributor and editor of the World Federation of Societies of Anaesthesiologists (WFSA) publication, *Anaesthesia tutorial of the week.*

He is flexible in his approach to teaching and his curriculum vitae attests to a wide range of teaching in different contexts and to different audiences in Australia, New Zealand and China. For more than a decade he worked with and trained local doctors in pain medicine in China with annual supplementary visits and accreditation assessments. He has since been awarded an honorary professorial position with the University of Zhejiang School of Medicine, Sir Run Run Shaw hospital in Hangzhou.

**Both citations were prepared using information and testimonials from award nominators*

For more information, updated eligibility criteria and the nomination process please visit our website.

Nominations close on 15 November 2024.

ANZCA primary fellowship examination

2024.1 Exam

The primary fellowship examination was successfully completed by 142 candidates.

AUSTRALIA

Australian Capital Territory
James Laurence Garrard
Margot Corbett Gemmell-Smith
Nikhil Nitin Kharwadkar
Zidao Michael Wang

New South Wales
James Roan Bulman
Eddy Chan
Nicholas Augustin Barnard Duce
Rehmina Farha
Stacey Bella Gelgor
Adelaide Lily Irish
Anup Manjunath Kaluve
Shin Kim
Andrew David Lange
Kelvin Shyi-En Lo
Ye Sheng Brian Lung
Jack George Mangos
Maxwell Isaac Margalit
Samuel Michael Mathias
Amir Mehanna
Brendan James Miles
Aakash Nanda
Rachel Weng Yue Ng
Skye Propsting Perkins
Julie Phan
Leanne Qian
Tianyun Qiang
Claire Elizabeth Raper
Amy Susan Reid
Charlotte Marie Rollo
Milonee Shah
Sherman Siu
Bianca Weng-Yun So
Anthony Solomon
Alice Xinyue Sun
Joshua Wei Seong Tong
Carmen My-Nhi Tran
Martin Carl Wensing
Rachel Hui Ting Yeong
Joanna Yu
Angie Run-Zhi Zhang

Northern Territory
Laura Jayne Grave
Leah Therese Jordan
Tandeep Singh
Tarren Sherwin Zimsen

Queensland
James Matthew Armston
Mitchell Pita Baker
Brian Richard Beaver
Vichaya Champreeda
Damen Jeffrey Fagg
Lachlan James Fairley
Melissa Shannon Fry
Frederick Hulme Gott
Lewis Shane Ireland
Douglas Peter James
Timothy Andrew Jones
Danielle Monique Kennedy
Jin Wook Kim
Jordan Mark Lavigne
Heidi Hoi-Yee Lui
Vimoksalehi Lukoschek
Linda Nhi Mai
Jillian Cornelia McCool
Clark Mei
Basem Mourad
Gota Nakamura
Timothy Edmund Nolan
Rochelle Alfia Patane
Alanna Rachel Platz
Rory Marcus Preisler
Amanda Maree Raty
Gino Luciano Sarri
Fiona Pamela Schleyer
Adrian Din Sam Sia
Tommy Tseng

South Australia
Mahanoor Baig
Penelope Anne Evans
Emily Victoria Jordan
Edward Yuan-Pei Ku
Lynette Jun Ping Lau
Kostyantyn Naumenko
Donald Dineish Shivakkumar
Nikolina Sladojevic

Tasmania
Cassandra Therese Brown
Daniel James Brownstein
Duncan Joseph Galloway
Elle Taraire Maulder
William Eli Polglase
Shaobai Wang

Victoria
Ahmad Al Helwani
Shahad Emad Al-Badri
Adam Xavier Calzone Bisiani
Carla Lenaire Borg Caruana
Chun Ling Chan
Tessa Lee Clegg
Rodolfo Mahain Comandari
Carina Rose Hadden
Erin Lai
Sarah Laing
Melissa Ying Ngo Lee
Maleck Louis
Richard John Maguire
Mitchell Aaron Nicholas
Bianca Jean Fe San Juan
Ebony Lee Selers
Julian Zi Hao Soh
Hannah Yen Ling Soon
Lisa Yee-Ming Toh
Ryan William Van Hoorn

Western Australia
Ashleigh Louise Cargill
James David Charleson
Lauren Mary Green
Alice Jia Xuan Ho
Oliver James Johnston
Kennia Lotter
Georgina Clara Martin
Gareth Hamon Massy
Angela Estelle McLelland
Kee Ping Ng
Andrew James Nienaber
Michelle Anne Sherwood
Jonathon Ernest Stewart

NEW ZEALAND

Tess Asmara Brian
Fiona Judith Carey
Connor Adam Christensen
Darragh Connell
Sarah Mary Correa
Holly Olive Ruth Curtis
Sarah Elizabeth Dwyer
Erika Maria Fernandes
Alexander James Fraser
Isobella Suttie Henzell
Sophie Claire Howell
Nicholas Robert James
Maegen Charlotte Johnson
Apoorv Narang
Eunice Yen Yen Ng
Angel Nurdjaja
Matthew James Page
Olivia Louise Mason Smeele
Ching Pui Denise So
Antonia Jane Steed
How-Shin Tsao

ABOVE
Primary Exam Court of Examiners

MERIT CERTIFICATES

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

Daniel James Brownstein, Tasmania
Vichaya Champreeda, Queensland
Darragh Connell, New Zealand
Sarah Mary Correa, New Zealand
Lachlan James Fairley, Queensland
Sophie Claire Howell, New Zealand
Nicholas Robert James, New Zealand
Clark Mei, Queensland
Gota Nakamura, Queensland
Carmen My-Nhi Tran, New South Wales

RENTON PRIZE

The Court of Examiners recommended that the Renton Prize for the half year ended 30 June 2024 be awarded to:

Maleck Louis, Victoria

"I grew up in the Emirates and moved to Australia in 2013 to pursue my tertiary studies at the University of Melbourne.

My passion for anaesthesia started during my second year as a medical student at Austin Health. I then began my journey as a junior doctor at Western Health, where incredible support paved the way for me to commence anaesthesia training in the NorthWest Training Scheme in 2023. Through these experiences, I've developed a strong interest in research, obstetric anaesthesia and perioperative medicine.

Receiving the Renton Prize is an incredible honour and privilege. The primary exam was one of the toughest challenges I've faced. This success is a testament to the amazing people around me who got me through: my study group on whom I relied so heavily, and the consultants at the Werribee, Western, and Austin hospitals who shared so much of their knowledge and time. A special mention goes to Dr Louise Ellard and Dr Stanley Tay whose dedication to our entire cohort was invaluable.

Above all, my deepest gratitude goes to my family and especially my wife, Nadia. I could never have gotten to where I am without the unwavering support and care that I've had in every step of this journey."

ANZCA final fellowship examination

2024.1 Exam

The final fellowship examination was successfully completed by 170 candidates.

AUSTRALIA

New South Wales
Mariam Habib Awad
Marko Vojislav Bajic
Sjorjina Nichole Crowther
Thomas Zac Curtis
Simon Luke Danieletto
Timothy Jack Peter Durack
Simon William Graham Ellis
Jared William Bowdern Ellsmore
Nicola Alana Fraser
Shobha Rani Halavudara Gururaja Rao
Shun Hin Kenjo Ho
Edward Bing Kee Ho
Brigitte Claire Holt
Archie Cameron Hughes
Jaeni Huynh
Bahaven Jeyaratnam
Alek Kiran Kumar
Kathleen Anne Leaper
Joshua Wen-Jun Lin
Luke Daniel McCarthy
Johnson Chi Wa Ng
Laura Jayne Noble
Adam Patrick Pasfield
Alexander Zi Ying Peng
Eric Donald Quin
David Peter Rohl
Stephen James Sanchez
Adam Skelton
Patrick Michael Murray Smith
Kelly Teneile Stallard
Katie Ann Sullivan
Jason Yuk Hei Tang
Darren Kenneth Tiao
Catriona Isabelle Walker
Shelly Ying Bin Wen
Chloe Una Won

Northern Territory
Polly Clare Marshall-Brown

Queensland
Patrick William Abbott
Jonathan Alexander Alcock
Anirudh Bhardwaj
Aisha Safia Bouhafs
James Alexander Lachlan Boyle
Victoria Anne Burgess
Lynsey Maree Cochrane
Conor Mackenzie Dalby
Faraaz Richard de Belder
Kate Nicole Engelke
Timothy Douglas Gilmour
Matthew Thomas Greber
Abir Guha
Steven Alexander Hocken
Robert Charles Hoffman
Jimin Kang
Alexandra Peta Grace Kanowski
Gabriela Diana Kelly
Maggie Tess Keys
Lillian King
Tommy Lam
Dickson Bacon Chi Woo Lee
Justin Er Wenn Lim
Paul Cheng Chee Lim
Angus Loraine
Rebecca Anne Martin
Elizabeth Alice Parkinson
Hamish Raniga
Rajiv Sanjay Rooplalsingh
Alexander James Francis Smithers
Robert Kyle Thomson
Susanna Angela Van Haeringen
Gert Benjamin Van Heerden
Matthew Robert Walker
Jessie Ruijun Wang
Lachlan Horton Young
Joanna Hui Li Yu

South Australia
Matthew Lyndon Pitkin
Lara Christina Schemeczko
Bridget Alexandra Sigurdson
Christopher Fong-Man Yu

Tasmania
Terence Guan Hui Kwok
Alexandra Rose Lyons
Sandeepal Singh Sidhu

Victoria
Joseph Ross Annetta
Nigel Thomas Arulanandam
Daniel Alexander Axelsson
Henry Bear
Jacqui Bell
Hannah Elizabeth Vereker Bergin
Hamish Lewis Brown
Millicent Kuczynska Burggraf
Brandon Guan-Fu Chan
Yunn Li Chen
Ru Dee Chung
Olivia Meredith Coleman
Meredith Anne Davies
Katherine Ann Davis
Amy Eleanor Dodd
Laura Mary Elliot-Jones
Mark Patrick Engelbrecht
Rudi Daniel Falovic
Adam Fambiatos
Samuel William Fraser
Tyler James Goodall
Mason Ross Habel
Michael Handscombe
Sean Angus Harris
David Edward Heelan
Mark Yan-Nan Huang
James Cheng Jiang
Lisa Jane John
Ifrah Afreen Khan
Bridget Lesley King
Bi Wen Lau
Thomas Donald James Martin
Andrew McNiece
Bradley Andrew Mereine
Philip John Moore
Andy Ding Li Ngoi
Mary Thien-An Nguyen
Zachary Phillip O'Brien
Marie Domenique Palumbo
Victor Solka Pasternacki
Jennifer Kate Preddy
Divya Rattan
Queennie Faye Reyes
Mina Selim
Stephen James Edward Sharp
Matthew Alastair Stewart
Deniz Tat
Kelsey Elyse Caitlyn Turner
George Li Yi
Bryan Sing Hung Yip
Annetta Yang Yang Zheng
James Francis Zwirs

Western Australia
Nathan David Blakely
Alexandra Lauren Carle
Elizabeth May Carr
Rowan Derrick Ellis
Julie Isbill
Amy Louise Lumb
Timothy James Marmion
Craig Michael McLaughlin
Sarah Catherine O'Brien
Justin William Payne
Declan Alexander Thomas Scott
Lee Thompson

NEW ZEALAND

Edward Peter Andree Wiltens
Jayden Charles Ball
Xavier Benito Bergantino-Mitu
Yinman Chan
Devika Chandra
Sean Cox
Timothy Clarence Crampton
Ben Drinkwater
Nathan Luey
Brittany Mary MacDonald
Jack Bartholomew McNally
Monica Eileen Mullally
Robyn Merle Scott
Philip Charles Sugden
Sami Harith Swadi
Svetlana Alekseyevna Treshina
Pranav Raj Varma
Henry James Watson
Louis Yin

ABOVE
Final Exam Court of Examiners

SIMG EXAMINATION

Six candidates successfully completed the specialist international medical graduate examination:

Saman Tauheed Ali, ACT
Amirhossein Dehghanian, Victoria
Derek M Garne, NSW
Kathrin Leitner, Western Australia
Komella A Sooria Prakasam, Western Australia
Wojciech Wierzejski,NSW

MERIT CERTIFICATES

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

Philip John Moore, Victoria
Alexander Zi Ying Peng, NSW
Kelsey Elyse Caitlyn Turner, Victoria

CECIL GRAY PRIZE

The Court of Examiners recommended that the Cecil Gray Prize for the half year ended 30 June 2024 be awarded to:

Stephen Sanchez, New South Wales

"I am an AT2 at St Vincent's Hospital Sydney.

When I started university, I thought I wanted a career in mathematics. However, after I completed my PhD, I realised that I wanted a career with more teamwork and tangible outcomes. So I made the decision to pursue medicine and while studying at the University of Sydney, I identified anaesthesia as the ideal specialty for me.

My PGY 1 and 2 were at St George and Sutherland Hospitals. I moved to St Vincent's Hospital Sydney for my senior resident medical officer year and I was fortunate to continue with scheme training there. I enjoyed spending six months on rotation at Wagga Wagga Base Hospital, and have also rotated through the Royal Hospital for Women and The Children's Hospital at Westmead.

Preparing for the fellowship exam was challenging but I am grateful to have been supported by my clinical experience and the mentoring in my department at St Vincent's Hospital Sydney. I am also grateful to have been part of a group of fellow Vinnies trainees who have been supporting each other through this long process.

I couldn't have done it without the support of my partner, Sikeli, and look forward to non-study activities: first item on the agenda is a trip to Europe."

The challenges facing unaccredited anaesthesia trainees

Being an unaccredited anaesthesia resident in Australia is a challenging and often uncertain journey. FANZCAs Dr Brett Pearce and Dr Lahiru Amaratunge explain why they have established a collaboration of critical care training supervisors to improve the unaccredited pathway.

In the competitive and highly specialised field of anaesthesia in Australia becoming an accredited anaesthetist is a coveted goal pursued by many. Each year, numerous doctors aspire to enter the anaesthesia training program, yet only a select few succeed.

This creates a significant group of unaccredited anaesthesia residents who find themselves in a state of professional uncertainty, striving to secure a future in this demanding yet rewarding specialty. Furthermore, there is a lack of advocacy and protection for this group who are not formally under the care of ANZCA.

A collaboration of critical care supervisors is aiming to address this.

The interest in anaesthesia as a career is substantial with hundreds of doctors vying for a place in the accredited training programs annually. However, the number of positions available is limited, often accepting only a fraction of the applicants.

At Western Health for example we receive about 250 applications for four unaccredited positions. This bottleneck leaves many doctors in unaccredited positions, working diligently in hospitals across the country without the formal recognition of their training and an uncertain road to a specialist career.

Several systematic challenges exist. The application process for unaccredited anaesthesia positions in Australia is variable, with different states and institutions employing different criteria, processes and selection methods. Additionally, without a centralised system, each applicant is often applying to multiple hospitals.

Each selection panel also selects with variable criteria – some may heavily weigh academic achievements, while others might prioritise clinical experience or interview performance. This lack of uniformity can lead to confusion and frustration among applicants, who may struggle to understand how best to position themselves for success.

For those who do not enter an accredited program, the path forward is often unclear. Unaccredited anaesthesia residents perform many of the same duties as their accredited peers, including preoperative assessments, administering anaesthesia, and managing postoperative care.

However, without the formal backing of an accredited program, their career progression can feel precarious and the uncertainty about future opportunities can be a significant source of stress as these doctors navigate the complexities of gaining the necessary experience and recognition to reapply successfully.

To address these challenges we have set up a collaboration of critical care training supervisors. It currently includes eight hospitals in Victoria and our aim is to involve all interested hospitals and departments and consider what measures could improve education, the application process and support unaccredited for anaesthesia residents. Some specific areas could include:

- Introducing a more standardised and transparent application process.
- Clearer guidelines on selection criteria and expectations could reduce confusion and ensure that candidates are better prepared.
- Providing structured support and mentorship for unaccredited residents to help them develop their skills and navigate their career paths more effectively.
- Access to professional development resources and guidance from experienced anaesthetists.
- Access to educational resources.
- Establishing more defined pathways for unaccredited residents to transition into accredited programs would provide much-needed clarity and motivation.
- Providing support for critical care supervisors by sharing experience, ideas and resources.
- Providing advocacy for unaccredited anaesthesia residents.

Being an unaccredited anaesthesia resident in Australia is a challenging and often uncertain journey. Despite the lack of formal recognition these residents play a crucial role in the healthcare system, gaining valuable experience and contributing to patient care.

If you are a supervisor of unaccredited anaesthesia residents and would like to engage in further conversations and collaboration, please email **critcareaus@gmail.com** for more information.

Dr Brett Pearce, FANZCA
Critical care supervisor, Western Health

Dr Lahiru Amaratunge, FANZCA
Critical care supervisor, Austin Health

Library news

NEW LIBCHAT TRIAL

ANZCA Library has begun trialling a brand-new chat service that will allow you to chat directly to library staff to discuss your library and research consultation-related queries. Access ANZCA LibChat in the following places:

- **Library help page** – click on the Start Chat link.
- **LibKey** – click on the chat icon in the on-screen logo to begin a chat session.
- **Library discovery service** – click on the chat icon at the bottom-right of screen to begin a chat session.
- Library resource guide pages – click on the Chat with a Librarian slide-out at the right of screen.

This trial concludes on 31 October 2024.

NEW ARTIFICIAL INTELLIGENCE IN HEALTH GUIDE

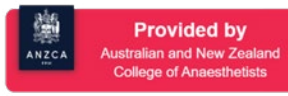
The ANZCA library has just launched a new guide looking at AI in health. This guide spotlights emerging information on AI-related health technologies and guidelines, and includes articles, books and journals, podcasts, AI search tools, position statements, and state/national guidelines. We've also highlighted a new AI in Anesthesiology book!

You can access the full guide here: libguides.anzca.edu.au/ai-health

UPDATED PODCASTS GUIDE

Podcasts are an excellent way to keep up-to-date on the run, and the ANZCA library recently revamped its Podcasts guide to spotlight the latest anaesthesia and pain medicine podcasts out on the web. We also spotlight audio lecture resources like the Audio-Digest collection, available free to ANZCA and FPM fellows and trainees. Note: You can claim podcasts for CPD participation purposes.

You can access the full guide here: libguides.anzca.edu.au/podcasts



ACCESS EVEN MORE WITH LIBKEY NOMAD++

This year the library is trialing *LibKey Nomad++* which extends the core functionality of *LibKey Nomad* giving our users an enhanced access experience outside of the college website.

One-click access to articles from ANZCA's subscribed journal content *anywhere* on the web.

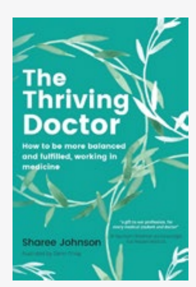
On screen messaging and prompts – if you visit any online resource where the ANZCA Library has set up access, you will be prompted to authenticate, allowing you to access the full range of services available via that site. This includes journal sites such as *LWW*, e-book sites such as *Cambridge Online*, and resource sites such as *Therapeutic Guidelines* and *Trip*. We'll even let you know if we have access via a different platform, such as with *The Lancet* and *BJA Education*.

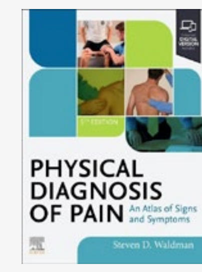
- **Access the Chat widget** – this is being trialled until the end of October.
- **New citation tool** – use the mortar cap icon in the *LibKey* button to download citations to your preferred citation manager.
- **Enhanced PubMed experience** – view journal covers and in-line full-text access buttons.
- **Coming soon: e-book access** – by the end of this year, you will also be able to access our e-books anywhere on the web using the LibKey Nomad web extension.

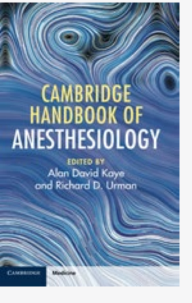
Learn more about *LibKey* Nomad and how easy it is to set up access today! libguides.anzca.edu.au/browserext

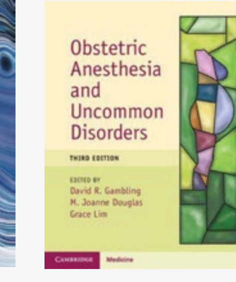
Latest books

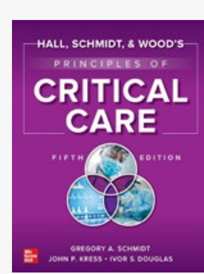
For the latest updates and a complete list of new titles check out the library news page: libguides.anzca.edu.au/news











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

Faculty of Pain Medicine

Established in 1998, the Faculty of Pain Medicine (FPM) is the first multidisciplinary medical academy in the world devoted to education and training in pain medicine.

Welfare of fellows requires proactive approach

Taking on the post of dean of the faculty is always a daunting experience. I was doubly reminded of the responsibility when, in the week prior to the handover from Kieran Davis, we sadly lost our founder, Professor Michael Cousins. Looking back across the quarter-century since Michael founded our organisation, the immensity of what has been achieved can only inspire the greatest respect.

The relationship with the college remains at the foundation of the faculty's status. We have been honoured to enjoy great support from the previous president of the college, Dr Chris Cokis and our CEO, Nigel Fidgeon. Kieran Davis returned their commitment and support, being a respected member of ANZCA Council where he represented the faculty's interests in addition to providing advice to the college on important shared initiatives. My meetings to date with the new college president, Professor David Story, have been open and cordial. I look forward to developing our most important professional relationship.

As always, there are many challenges facing us. But each of these comes with opportunities to improve the care we provide to patients and to enhance our profile in the healthcare domain.

We have a number of areas for development, but I would like to focus on some projects especially close to me.

In my own work, I have built up a busy pain medicine practice in rural South Australia. Pain medicine in rural locations carries specific challenges, but the rewards are unique. Managing complex disease in remote locations is a perfect match for our skills. The work requires that we assist colleagues in general practice and allied health to manage persistent pain presentations. It requires special effort to enhance skills and monitor outcomes. The great reward is that our colleagues are keen to learn. A genuine commitment to multidisciplinary care can arise in such environments.

The faculty has recently secured funding from the Australian federal government as part of the Flexible Approach to Training in Expanded Settings (FATES) project. This will allow us to examine options for training in rural settings and I am optimistic that this will enhance our treatment options in underserved communities.

Through my rural work, I was also invited to provide clinical services to Aboriginal communities in the Lower Eyre Peninsula region of South Australia. I do not exaggerate when I say that this has been one of the most rewarding developments of my professional life. I have been welcomed into a community with great warmth. Correspondingly, I have found myself in an environment where our special skillset can serve as a force for good. Our First Nations deserve healthcare that is at least the equal of that provided to other groups. My hope is that an expansion of our roles into rural areas will increase opportunities for our skills to be applied to First Nations' health needs.

I have had many concerns regarding the welfare of doctors, particularly in the demanding environment of pain medicine. I was pleased to contribute to an article on this topic for the Autumn edition of the ANZCA *Bulletin*. There are very specific stressors impacting pain medicine specialists and these threaten the sustainability of our discipline. I believe the potential impacts are manageable, but we need to take a proactive approach to maintaining the wellbeing and motivation of our fellows.

Two years is a short period in which to achieve solid goals. But I hope that I will be able to set the processes in motion to achieve these aims.

I look forward to meeting as many of you as possible through my term as dean.

Dr Dilip Kapur
FPM Dean

Dr Kieran Davis a hard act to follow

Recording a tribute to my friend and esteemed colleague, Kieran Davis, is a daunting task. Through his 12 years of board membership, Kieran has shaped the Faculty of Pain Medicine substantially.

Kieran's time on the board has seen great change in the structure and maturity of the faculty. His focus on professionalism and pragmatism has been a driving force in bringing the faculty to its envied position as the world's premier pain medicine training organisation.

Many people are unaware of the enormous amount of work required to develop, monitor and maintain standards across the many professional areas for which the faculty carries responsibility. Kieran has been involved at the highest level in all the faculty's major committees. He carried a wealth of experience with him into the dean's role. This was evident in his competence when handling the many conflicting pressures placed upon himself and the board.

At the start of his term as dean, Kieran had the daunting task of handling an Australian Medical Council (AMC) accreditation process. Through a gruelling sequence of data collection, interviews and feedback meetings, Kieran maintained the focus of colleagues through the senior levels of the faculty. Whilst the subsequent accreditation conditions seemed extensive, many were in areas where there had been much prior work by the faculty's high-level committees, with Kieran leading much of the development.

Through 2023, Kieran adopted a strong leadership role in advancing the faculty's longstanding goal of developing a pain device implant registry (PDIR). The PDIR had been an aspiration of several faculty boards, but development had stalled. As dean, Kieran took charge of the project in 2023 and has guided it to the current stage where the faculty is in a very strong position to launch and maintain the PDIR.

Being the third dean from New Zealand, Kieran has maintained the tradition of close engagement in the faculty from both sides of the Tasman. What has been especially impressive has been Kieran's commitment to engage with the Australian Medicare Benefits Schedule (MBS) to develop multidisciplinary funding models in Australia. Kieran has

provided strong representation for the faculty in his meetings with MBS staff. His regular engagement in this area has seen the faculty's stock rise in government circles. My own meetings with MBS staff have revealed how well Kieran has been regarded in his advocacy.

The dean chairs meetings of the faculty board. The board is the key decision-making component of the faculty and effective management of board meetings is a critical factor in maintaining the faculty's capacity across its many roles. His wide experience across all areas of the faculty has allowed him to condense complex issues into their components. Always respectful, but always precise, Kieran has managed very effective board meetings with a high throughput. This has been no small achievement, given the extra burden of work added by the AMC accreditation conditions.

Kieran will be a hard act to follow, but he has prepared a clear path. I sincerely hope I can honour his legacy.

Dr Dilip Kapur
FPM Dean

Meet our new FPM Board member

Dr Irina Hollington

Dr Hollington is a consultant pain physician at Royal Adelaide Hospital and Queen Elizabeth Hospital in Adelaide who was appointed to the board in May. She chairs the FPM SA/NT Regional Committee and is a member of the FPM Learning and Development Committee.
Dr Hollington is also an FPM supervisor of training and FPM examiner.

She is a former board member at Pelvic Pain Foundation Australia (2018-2022) and in 2023 co-convened the FPM Spring Meeting in Adelaide. Dr Hollington is passionate about mentoring those facing challenges, enhancing training pathways and supporting diversity in the specialty.

NEW FELLOWS

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

- **Dr Chantelle Berenger,** FRACGP, FFPMANZCA (NSW)
- **Dr Michael Carpenter,** FANZCA, FFPMANZCA (Vic)
- **Dr Thomas Chalk,** FANZCA, FFPMANZCA (Qld)
- **Dr Karen Chan,** FRANZCOG, FFPMANZCA (NSW)
- **Dr Meredith Daff,** FAFRM (RACP), FFPMANZCA (SA)
- **Dr Arina Dan,** FCICM, FFPMANZCA (NSW)
- **Dr Ashika George,** FAFRM (RACP), FFPMANZCA (Qld)
- **Dr Sophia Grobler,** FANZCA, FFPMANZCA (Vic)
- **Dr Emily Farrell,** FRACGP, FFPMANZCA (Qld)
- **Dr Jin Hyuk Kang,** FANZCA, FFPMANZCA (Qld)
- **Dr Chi Wai Eric Ng,** FHKCA (Anaesthesiology), FFPMANZCA (Hong Kong)
- **Dr Yang Hwa Ng,** FRACGP, FFPMANZCA (Vic)
- **Dr Akilan Velayudhan,** FANZCA, FFPMANZCA (Vic)

We also congratulate **Dr David Gore,** FRCA, FFPMANZCA (Qld) on admission to FPM fellowship via the PM Specialist International Medical Graduate (SIMG) pathway.

SAVE THE DATE

FPM
Faculty of Pain Medicine
ANZCA

Committee news

FPM BOARD AND COMMITTEE APPOINTMENTS

At the FPM New Board meeting held on 16 May, members warmly welcomed:

- FPM Vice-Dean, Dr Leinani Aiono-Le-Tagaloa (from New Zealand)
- New board member Dr Irina Hollington (from South Australia)
- Re-elected board member Associate Professor Susie Lord (from New South Wales)
- Co-opted board member Dr Tipu Aamir (from New Zealand)

In addition, the following key changes in appointments were made:

- Chair, FPM Executive Committee – Dr Dilip Kapur
- Chair, FPM Training and Assessment Executive Committee - Dr Leinani Aiono-Le-Tagaloa
- Chair, FPM Professional Affairs Executive Committee – Professor Michael Veltman
- Chair, FPM Training Unit Accreditation Committee – Dr Louise Brennan

The faculty would like to acknowledge and thank the many FPM fellows for their continued support in progressing the work of the faculty and the board.

COMMITTEE RESTRUCTURE

Following a review in 2023, the board made the decision at the April 2024 board meeting to retire the Professional Standards Committee. A key driver of this decision was to strengthen the relationship between the board and the FPM national and regional committees. The committee chairs will be invited to attend FPM board meetings, on rotation. In addition, a session will be held during the Spring meeting which will provide an opportunity to highlight key activities, issues and achievements within each region.

The membership of the FPM Professional Affairs Executive Committee (FPM PAEC) has been expanded to include the Safety and Quality Officer, the Continuing Professional Development Officer and the FPM Professional Affairs Coordinator. The Mentoring Program Officer will become a member of the Training, Accreditation Executive Committee.

The development of faculty professional documents along with submissions to government will become a function of FPM PAEC, guided by the DPA FPM Professional Affairs, with regional input.

Flexible accreditation pathways for pain medicine training in rural settings

The faculty has received a federal grant through the Flexible Approach to Training in Expanded Settings (FATES) Fund to explore flexible accreditation pathways for pain medicine training in regional and rural Australia.

The aim of the funding is to increase the number of specialists working in regional areas and ensure high-quality care is accessible to all Australians. Supporting rural training pathways is a sustainable approach to strengthening our rural workforce and meeting local needs and this grant will help us develop ways to address this through accreditation of rural pain training units.

FPM is seeking contributions from fellows, trainees and specialist international medical graduates (SIMGs) for two key activities:

- A survey to identify the size and distribution of our rural Australian pain specialist workforce.
- Focus groups to understand the barriers and enablers for rural pain medicine training and accreditation.

If you are an FPM fellow, trainee or SIMG working in regional or rural Australia your support of this initiative would be greatly appreciated.

Please contact us at fpm@anzca.edu.au to hear more about the project and register your interest in our focus groups.

How I passed my FPM fellowship exam

Dr Jonathan Ramachenderan reflects on his FPM exam path

I only had one goal in 2023 – to pass my fellowship exam.

We'd moved as a family from our idyllic country life in Albany to Perth for me to pursue a fellowship in pain medicine.

Overnight, I was a trainee again. Scrambling to keep up with the chasing, calling, consults and chaos that come from being a sub-specialty registrar in a tertiary hospital.

As study began in mid-April, a gloominess, dread and guilt crept over me, coinciding with the cool autumn change.

"My winter is coming," I thought as I sized up the enormity of my task ahead. But this wasn't the first exam campaign or medical challenge I'd faced.

Seventeen years after graduating with a medical degree I'd learnt a few lessons through the experience of failing and falling short at exams, both at medical school and as a registrar. I was familiar with the temptations and distractions of life, and I had acquired a few skills that served me well.

One of those skills was developing a clear vision of what I wanted, and being certain about what I would do to achieve that goal. And it all starts for me with the power of visualisation.

Visualisation is a powerful tool, especially if you use it to steer your life towards what you want and the person you want to be. Visualisation can help connect our conscious thoughts with our subconscious mind. We all visualise outcomes, whether we know it or not.

If you've ever been anxious about anything, or excited about something – such as a potential experience or result – you've practised visualisation. You've more than likely created an image in your head, with the accompanying emotion, about how you will feel and what you may do, as you interact with this experience.

Our mind serves as a powerful engine of thought, imagination and blue-sky dreaming that, if used correctly can help us through our long years of medical training and practice.

As the days became shorter and the workload intensified, I practised visualising two goals each day before I started studying:

- The post-fellowship ceremony with my name being called.
- A hot Christmas day in Perth where shade was a premium but despite the heat, I was immensely grateful for having passed my exam and not needing to study anymore!

Both these goals filled me with a positive and deeply satisfying feeling of achievement that helped to quell my worry.

More potently, this visualisation of the person I wanted to be –"Dr Ramachenderan, who passed his fellowship examination" – helped shape what I needed to do each day to achieve this goal.

LESSONS I LEARNT

Our words to ourselves matter

Shad Helmstetter in his book, *What to Say When You Talk to Yourself*, describes the relationship between the conscious and subconscious as that of a captain on the ship and the engine room worker. The captain gives the order and the worker follows his command.

If we are unkind and speak negatively to ourselves, for example, "I'm not very good at procedures" or "I'm not smart enough to pass that exam", our subconscious mind will work to help achieve these outcomes.

Being careful with your language is the first practice in visualising the future you want.

In those winter months, I spoke to myself almost every day: "Jonathan, keep going. You are on the right track. This will be over soon." And it was!

Be clear about what you want

The second lesson in effective visualisation is founded on what Stephen Covey famously said, "everything is created twice".

Firstly, it is imagined and birthed in our minds; and secondly, it is created and brought to life in our physical world. Just like an architect creates the vision for a home in their mind, and then sketches the design. Months to years later, the house is complete – the second creation.

Likewise, everything we desire and hope for is created in our minds first, before it is created in our physical world. What is it that you specifically want? How do you want your working and home life to look? How do you want your clinical practice to look like?

For me, in 2023, it was passing my exam, and being a good dad and wonderful husband. This shaped every decision, helping me to say "no" to several things and "yes" to only a few, which got me what I wanted.

Saturday 11 November 2023 was one perfect day. When Associate Professor Charles Brooker called my name as the winner of the Merit Award for the 2023 FPM Exam, it was the culmination of hard work, sacrifice and a clear goal I had set and visualised many months before.

What a powerful moment!

I'd encourage all trainees who are facing exams at every level to be clear about the specific future they want, the work-life they desire, and the exact goals they wish to achieve – because it all begins in our mind before we can savour them in the world.

Dr Jonathan Ramachenderan, FRACGP, DipRGA
Pain medicine trainee
Dr Roger Goucke Pain Management Centre,
Osborne Park Hospital, WA

Foundation update

ANNUAL SCIENTIFIC MEETING FOUNDATION COCKTAIL RECEPTION

The foundation's reception at the 2024 ANZCA Annual Scientific Meeting (ASM) in Brisbane attracted record attendance, with more than 180 registrations. ANZCA President Dr Chris Cokis welcomed guests including emerging and advanced researchers, international speakers, and foundation donors and patrons. Incoming president Professor David Story reflected on the growth of ANZCA-supported research and global health equity programs, and how leadership in research is an essential part of playing a leading role in perioperative medicine training, education, and advancement.

Donor-funded named research awards

The ANZCA Foundation named research awards for 2024 were presented at the reception by Research Committee Chair Professor Britta Regli-von Ungern-Sternberg. Since 2014, the foundation and donors have created 12 new annual named research awards, grants and scholarships.

The prestigious awards presented included the recently established ANZCA Innovation & Technology Research Award, established in 2023 thanks to Governor Patron Dr Stanley Tay, the Emerging Investigator ANZCA Research Grant, and the ANZCA Professional Practice Research Grant.

Supporting fellows' research in professional practice supplements our existing strong support of basic science and clinical research across anaesthesia, perioperative, and pain medicine.

ABOVE

From left: Guests mingle at the foundation reception, ANZCA President Professor Dave Story talking about the growth of ANZCA-supported research.

Environment and sustainability

For 2025 we again offered the new Environment and Sustainability Research Grant of $A25,000. Pending research committee assessment of applications we hope to confirm our first grant later this year.

World-first techniques lead to discoveries in CRPS study

A foundation-funded Chronic Regional Pain Syndrome (CPRS) study has found that specific immune cells (Langerhans cells and CXCR3+ lymphocyte cells) were closer to nerves in the affected skin of CRPS patients, which may contribute to persistent pain.

It also found that the sensory cortex, thalamus and hypothalamus – brain regions responsible for pain and autonomic responses – respond differently to heat pain in patients with CRPS suggesting these brain changes are responsible for propagating ongoing pain and autonomic symptoms in CRPS patients.

The study, "Immune-to-brain signalling in CRPS: unravelling the detrimental relationship between inflammation and autonomic dysfunction", led by the University of Sydney's Associate Professor Marc Russo and Associate Professor Paul Austin, was completed this year. It included two technical world-firsts: the first ever ultra-high resolution functional MRI study in CRPS, and the first high-parameter assessment of neuroimmune interactions in CRPS affected tissues.

These insights may lead to changes in clinical practice in treating CRPS. Understanding the pathogenic immune cell-nerve interactions could lead to targeted anti-inflammatory pain treatment strategies. Appreciating the pain pathway changes in specific brain regions could help to develop therapies to alter aberrant activity. Finally, identification of predictive immune biomarkers could enhance earlier diagnosis and treatment before long standing changes occur in the brain.

Future communications will provide more detailed reporting on these and other outcomes from foundation-supported research.

From basic science to multi-centre clinical trials

Smaller ANZCA Foundation grants made possible by our donors continue to support ANZCA investigators' ability to secure government funding for large ANZCA Clinical Trials Network-endorsed multi-centre clinical trials. The historic total funding generated for ANZCA CTN trials last year surpassed $A73 million.

Following Medical Research Future Fund grants of $A8 million in 2022 for the CALIPSO trial on cardiac postoperative sepsis and $A2.9 million for the SNaPP comparison of neostigmine and sugammadex for pulmonary complications, in August 2023 a National Health and Medical Research Council grant of $A4.1 million was awarded for the DECIDE trial on dexmedetomidine and delirium in cardiac surgery, led by Professor Robert Sanders (FANZCA), University of Sydney.

Foundation donors and bequestors are vital to this success and that of other foundation-supported programs enhancing the quality of and access to anaesthesia, pain and perioperative medicine.

Why should we support research?

At the foundation's ASM reception incoming ANZCA President Professor David Story reflected on the close connection between ANZCA's leadership in perioperative medicine, and leadership in academic and clinical research in our specialties.

Growth in anaesthetists' and pain medicine physicians' contributions to high-quality medical research is expanding the published science in the specialties and in perioperative medicine, and the evidence base that supports our clinicians on the "frontline" of healthcare, as they implement new knowledge and translate it into better clinical practice and outcomes for patients.

These academic contributions drive better representation of the specialties in university medical schools and provide study outcomes and evidence validated in local contexts and populations.

Foundation donors supporting this research are helping continue a heritage of anaesthetist and pain medicine physician-driven advancement in perioperative healthcare.

"A research-active health workforce underpins an integrated, continuously improving health system. At the heart of this...is a cohort of world-class clinician researchers..."

Australian Academy of Health and Medical Sciences[1]

Global and Indigenous health

Our donors continue to support grants, scholarships, training and education visits to advance safe and effective anaesthesia and pain medicine in low and middle-income countries.

With far fewer specialists and anaesthetic facilities per head of population in these places, our ANZCA fellow volunteer-led programs are helping to meet urgent needs. Nine projects have now been funded through the Foundation-funded ANZCA Health Equity Project Fund.

Reference

1. Australian Academy of Health and Medical Sciences (2022). Research and Innovation as Core Functions in Transforming the Health System: A Vision for the Future of Health in Australia. www.aahms.org

CONTACT AND SUPPORT

To donate, please use the 2024 subscriptions form, search 'GiftOptions – ANZCA' in your browser, or scan the QR code.

For queries, contact:

Rob Packer, General Manager – ANZCA Foundation, +61 (0)409 481 295, or at rpacker@anzca.edu.au

Rachel Kibblewhite, Fundraising Administration Officer, rkibblewhite@anzca.edu.au

Research grants program:

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

ANZCA Clinical Trials Network:

Karen Goulding, CTN Manager, karen.goulding@monash.edu

Landmark HAMSTER trial findings

LEFT

Team HAMSTER (from left): Professor Andreas Schibler, Dr Fiona Taverner, Associate Professor Justin Skowno, Professor Britta von Ungern-Sternberg, Associate Professor Susan Humphreys, Associate Professor David Sommerfield, Ms Tara Williams, Ms Samantha Wade, Ms Melanie Kennedy and Ms Susan Spall.

The publication of the high-flow oxygen during children's airway surgery (HAMSTER) study results in *The Lancet Respiratory Medicine* builds on the exceptional track record of the ANZCA CTN of conducting high-impact research enhancing patient safety and outcomes.

This landmark study led by Associate Professor Susan Humphreys from the Queensland Children's Hospital is the largest airway study in children assessing oxygenation techniques and has shown nasal high-flow to be an alternative safe option in tubeless airway procedures in children. Collaborative efforts from paediatric anaesthetists from the five Australian sites have paved the way for further innovative research studies.

Background

Tubeless upper airway surgery in children is a complex procedure in which surgeons and anaesthetists share the same operating field. These procedures are often interrupted for rescue oxygen therapy. The efficacy of nasal high-flow oxygen to decrease the frequency of rescue interruptions in children undergoing upper airway surgery is unknown.

Methods

In this multicentre randomised trial conducted in five tertiary hospitals in Australia, children aged 0–16 years who required tubeless upper airway surgery were randomised (1:1) to either nasal high-flow oxygen delivery or standard oxygen therapy (oxygen flows of up to six L/min). Randomisation was stratified by site and age.

The primary outcome was successful anaesthesia without interruption of the surgical procedure for rescue oxygenation. A rescue oxygenation event was defined as an interruption to deliver positive pressure ventilation using either bag mask technique, insertion of an endotracheal tube, or laryngeal mask to improve oxygenation. There were ten secondary outcomes, including the proportion of procedures with a hypoxaemic event ($SpO_2 < 90$ per cent).

Findings

The primary outcome of successful anaesthesia without interruption for tubeless airway surgery was achieved in 236 (88 per cent) of 267 procedures on high-flow oxygen and in 229 (88 per cent) of 261 procedures on standard care (adjusted risk ratio [RR] 1·02, 95 per cent CI 0·96–1·08, p=0·82). There were 51 (19 per cent) procedures with a hypoxaemic event in the high-flow oxygen group and 57 (22 per cent) in the standard care group (RR 0·86, 95 per cent CI 0·58–1·24). Secondary outcomes, including hypoxemic events, length of PICU stay, and length of hospital stay, were similar between the two groups. Minor and major adverse events were rare with similar incidence in both groups.

Interpretation

Nasal high-flow oxygen during tubeless upper airway surgery did not reduce the proportion of rescue interruptions of the procedures compared with standard care. There were no differences in adverse events between the intervention groups. These results suggest that both approaches, nasal high-flow or standard oxygen, are suitable alternatives to maintain oxygenation in children undergoing upper airway surgery.

Funding

This trial was funded by the ANZCA Foundation, the Society for Paediatric Anaesthesia in New Zealand and Australia and Thrasher Foundation, US.

Associate Professor Susan Humphreys, FANZCA
Chief Investigator, HAMSTER

Art builds positive culture and restores natural environment

Clay and pottery.
Afternoon tea in the backyard.
Carbon sequestration.
Community of anaesthetists and friends.

These all came together in Spring 2023, in an inaugural "sleep and restore" project, which culminated in close to 200 native trees being planted in South East Queensland. These trees, protected and maintained for up to 100 years by Greenfleet, will sequester 101.19 tonnes of carbon and contribute to the restoration of our natural environment.

In 2022, two anaesthesia registrars, one anaesthetist and one anaesthetic nurse decided to form a "Clay Club" to inspire each other to learn new skills in pottery. The group has grown to include other anaesthesia registrars, nurses, surgical colleagues, and friends. After meeting at a few studios and growing our skills at the wheel, our group decided to embark on a project that brought our medical community together to create art, celebrate human creativity and ultimately make a positive impact on our natural environment.

The "sleep and restore" event was hosted in a member's backyard, using discarded curtains as cushions on the grass. Anaesthetists, surgeons, nurses, a gastroenterologist, a radiologist, two radiographers and partners and friends sat under gum trees and focused their creative energy to make unique pieces of ceramic art.

We enjoyed a few laughs and grew a bit closer as a community over messy clay and afternoon tea. The pieces were fired in a kiln powered by solar energy over the next few months, and were launched for sale in December on our website – www.sleepandrestore.org

We sold 57 artworks, raised $A1820, and offset 101.19 tonnes of carbon in Southeast Queensland. Not to mention we had fun, got to know each other better (both artists and benefactors), and collectively contributed to the restoration of native forest and animal habitats in our state.

In April 2024, we were invited to plant our trees on a site in Kabi Kabi Country. We helped plant a total of 750 trees to restore a former tree plantation site to native forest (protected as National Park) in the Noosa hinterland.

Following positive feedback from our community, we plan to host the event again on Sunday 1 September 2024, and are pleased to welcome Avant as our sponsor. We will aim to launch our artworks for sale from 1 December 2024, and invite you to see them (and perhaps be inspired!) at www.sleepandrestore.org.

We hope our project inspires you to combine community, wellbeing and the restoration of our natural environment.

Dr Shelly Lee, FANZCA
Currently working in Cambridge, UK

Dr Shital Patel, FANZCA
Princess Alexandra Hospital, Brisbane

Dr Agustina Frankel, FANZCA
Princess Alexandra Hospital, Brisbane

ABOVE

Scenes from the "sleep and restore project" including a ceramic cup that was made by one of the participants.

Robert (Bob) Albert Boas, ONZM

1938 – 2024

When I began my anaesthesia training in 1980, Associate Professor Bob Boas was the only university-based academic leader in anaesthesia and pain management in Auckland. He substantially influenced my career, and that of many Auckland anaesthetists both directly and indirectly through his commitment to advancing both academic anaesthesia and pain management. Yet, it is only now, in reflecting on his life, that I really begin to understand the extraordinary vision, determination and hard work that underpinned Bob's dedication to improving the care of patients in New Zealand and beyond.

Bob's parents came to New Zealand as refugees from Germany in 1938. Bob was conceived on the voyage and born in Lower Hutt. The family faced considerable hardship establishing themselves in the new country and Bob had to work to put himself through Otago Medical School, graduating MbChB in 1962.

Bob was attracted to anaesthesia as a rapidly developing field in which clinical practice was underpinned by basic science. In 1967 he married Sue Shenkin and also became New Zealand's first fellow of the new Faculty of Anaesthetists of the Royal Australasian College of Surgeons. Auckland's Director of Anaesthetic Services, Dr Jack Watt, persuaded him to undertake further training with the then world leader in pain management, Dr John Bonica, at Harbourview Medical Centre in Seattle.

In Seattle, Bob started a new pain service and developed a method for determining the pharmacokinetics of local anaesthetic agents. He also established an ongoing opportunity for young Auckland anaesthetists to do fellowships in Seattle, thus adding to their expertise and experience and enhancing the standard of anaesthesia in Auckland.

In 1972 after time in the US, Sweden and England, Bob and Sue returned home with their two children and Bob established a specialty pain service in the Department of Anaesthesia. This service became the Auckland Pain Clinic, now the Auckland Regional Pain Service. He brought together an excellent team of clinicians who developed a state-of-the-art, multidisciplinary approach to managing chronic pain with a strong scientific foundation.

His colleague and friend Dr Vasu Hatangadi, recalls how, at the end of the day's work, he and Bob would often get together in their office to discuss research ideas to advance knowledge of pain management and improve patient care. Bob's 54 publications, which include two co-authored books, have received more than 2500 citations.

In 1974 Bob became a founder member of the International Association for the Study of Pain and, not long after, moved to the University of Massachusetts in Worcester, US, where he and Dr Michael Stanton-Hicks set up a multi-disciplinary pain service similar to the ones in Auckland and Seattle. Due to Sue's brother's death in an accident in 1978 they returned to New Zealand to help family.

Bob became founding head of the Division of Anaesthesia, University of Auckland, with half his time for administration, teaching and research, and half for clinical anaesthesia and pain management. Importantly to Bob this position was located in the scientifically-oriented Department of Pharmacology. Among other achievements Bob established resuscitation as a mandatory subject in the medical curriculum. Bob, in collaboration with pharmacology and clinical colleagues respectively, studied pharmacodynamics of opiate analgesia and started a post-operative and acute pain service at Auckland Hospital.

Early in 1988, Bob left this position, having recruited Stephan Schug, from Germany, to continue building the academic department of anaesthesia. This baton later passed to my hands and then to Simon Mitchell's. The now independent and well-established Department of Anaesthesiology at the University of Auckland, with its strong record of undergraduate and postgraduate teaching and research, is a legacy of Bob's pioneering academic leadership.

Bob spent 1988-89 in Seattle on a final sabbatical and then returned to Auckland to start a new private practice group while continuing to pursue interests in acute care, anaesthesia and pain treatment, with on-going publications on complex regional pain disorders.

Bob and Sue's son, Andy, died climbing Distaghil Sar in the Karakorum mountain range in 1996 and their daughter Debbie's husband, Alistair, died in a traffic accident in 2011. Bob retired from public hospital practice in 2001 and all practice in 2005 because of health and family commitments.

In retirement Bob remained as active as possible, gregarious and positive, with activities that included photography, fishing, gardening and charity work. He was passionate about everything he did. One of my early memories is of Bob taking me fishing from his then home on the banks of the Tamaki Estuary: unlike me, Bob actually caught fish!

Bob's strength of character and dedication to medicine and improving the lives of others has been recognised by many honours and appointments. These include the John Bonica Award of the American Society of Regional Anesthesia (1996), a term as a council member of the International Association for the Study of Pain and inclusion on editorial boards of several major international journals, including *Pain*.

He received honorary fellowships of the Royal College of Anaesthetists (1995) and the Faculty of Pain Medicine of ANZCA (2005), and in 2010 became an Officer of the New Zealand Order of Merit for services to medicine. He is greatly missed by his wife Sue, his daughter Debbie, his grandchildren Natasha, Aidan and Stefanie, and his many friends and colleagues.

Professor Emeritus Alan Merry ONZM FANZCA FFPMANZCA, FRSNZ
University of Auckland

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