ANZCA
FPM

Bulletin

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

WINTER 2023

Flying the flag for rural practice

Trainees:
Meet the ANZCA Trainee Committee

Safety and Quality:
Gastric emptying and semaglutides

Lifelike 3D-printed tracheas

PAGE 44

Contents

Cover image: Anaesthetist and medical retrieval consultant Dr Min-Qi Lee on the helipad at Royal Adelaide Hospital. Photo: Jacqui Way.

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

Medical editor: Dr Tanya Selak
Editor: Clea Hincks
Production editor: Liane Reynolds
Feature writer: Carolyn Jones
Advertising manager: Vivienne Forbes
Designer: Michelle Nightingale

We encourage the submission of letters, news and feature stories. Please contact *Bulletin* editor Clea Hincks at chincks@anzca.edu.au if you would like to contribute. Letters should be no more than 300 words and must contain your full name, address and telephone number. They may be edited for clarity and length. To advertise please contact communications@anzca.edu.au.

ISSN: 1038-0981 (print) 2206-5423 (online).

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

FSC www.fsc.org MIX Paper from responsible sources FSC® C010983

The *ANZCA Bulletin* has been printed on FSC certified paper using vegetable-based inks by Southern Impact under ISO 14001 environmental certification. It is fully recyclable.

Support for Voice to Parliament

"The highlight of the ASM for me was the Saturday night convocation ceremony."

To begin my message, I would like to express my personal support for a "Yes" vote in the upcoming Voice to Parliament referendum, a hot subject of debate in Australia right now.

This topic has been discussed at ANZCA Council and at the Council of Presidents of Medical Colleges (CPMC), with a range of views expressed.

After a recent question and answer session at the ANZCA Annual Scientific Meeting (ASM) the discussion gained some momentum when five previous ANZCA presidents wrote to council and urged us to support the Voice as other colleges and organisations have recently done.

Since then, ANZCA Council and the FPM Board have decided to publish their own statement in support (see right).

Many fellows I have discussed this with over the last few weeks have asked why the statement is from the council and board and not from the college itself, which is similar to the approach we took for the marriage equality statement released in 2017. My response is that we understand there are a variety of views among our members some of which may not align with our statement.

I am happy to receive your feedback via president@anzca.edu.au.

ANNUAL SCIENTIFIC MEETING

On a less controversial matter the recent ANZCA Annual Scientific Meeting (ASM) in Sydney was a great success with nearly 2000 registrants in person and more than 550 attending virtually.

In the week before the ASM the Emerging Leaders Conference was held in the Hunter Valley and attended by 29 young fellows from Australia, New Zealand, Papua New Guinea, Timor-Leste, Ireland and Samoa. The mentors included ANZCA councillors, Irish, Hong Kong and Malaysian college presidents and the president of the World Federation of the Societies of Anaesthesiologists and FANZCA Dr Wayne Morriss, amongst others.

This gem of a meeting with its engaging and heartfelt speeches left us all with a strong sense of connection and a desire to change through leadership. The college sponsors this unique event for new fellows and it is so successful our international partner colleges are considering running their own.

The highlight of the ASM for me was the Saturday night convocation ceremony where we presented 260 new ANZCA and FPM fellows with their fellowship. We also presented the Robert Orton prize (ANZCA's highest honour) to Dr Amanda Baric and the Steuert Henderson award for education to Dr Joel Symons (2022 recipient) and Dr Melissa Viney (2023 recipient), the Ray Hader award for pastoral care to Dr Sally Wharton and an honorary fellowship (awarded in 2021) to Dr Lis Evered for her amazing contribution towards anaesthesia research.

Shaking all those hands was hard but enjoyable work and I was touched to see how many fellows were emotionally affected after the ceremony. Probably because I'm from Western Australia, and we have a rebellious streak, I've always been a bit ambivalent about the gowns and medals but I can now see how they add gravitas and a sense of ceremony to the occasion.

The launch of our new Diploma of Perioperative Medicine with a captivating video was also memorable.

Another stand out event for me was the Gala Dinner where, probably as a sign of recovery and relief, the dance floor was heaving with trainees and new and old fellows within about a second of the band starting. Looking at that energy and enthusiasm on the dance floor I thought the future looked pretty bright for our college.

It was also very pleasing to see so many trainees at the meeting which is a trend I hope we can promote and encourage in the future.

Many thanks again to Co-Convenors Dr Shanel Cameron and Dr Tanya Selak, Scientific Convenor Associate Professor Dr Stefan Dieleman and the Sydney Regional Organising Committee for a job well done and I'm looking forward to being "Limitless" in Brisbane in 2024.

OVERSEAS TRAVEL

I was also recently fortunate to be the guest of the Royal College of Anaesthetists National meeting in Birmingham followed by the College of Anaesthesiologists of Ireland Congress in Dublin.

These meetings were smaller in scale than our ASM but they still managed to attract an enthusiastic group of fellows and trainees and allowed us to renew our collaboration with the International Academy of Colleges of Anaesthesiologists (IACA) and reflect on the many common challenges we share in these post-COVID-19 times.

Dr Chris Cokis
ANZCA President

ANZCA COUNCIL AND THE FPM BOARD SUPPORT AN ABORIGINAL AND TORRES STRAIT ISLANDER VOICE TO PARLIAMENT

ANZCA Council and the FPM Board jointly release this statement in support of the "Yes" position for the Voice to Parliament in the upcoming Australian government referendum.

The Uluru Statement from the Heart was released in 2017 following a gathering of prominent Aboriginal and Torres Strait Islander people. It is a compelling statement that, amongst other things, asks for a First Nations Voice enshrined in the constitution. This request was the culmination of widespread consultation across Australia, going back many years and spanning many governments and political parties.

In 2022, the "Closing the Gap" annual report highlighted the ongoing inequity for Aboriginal and Torres Strait Islander people, including lower life expectancy, higher incarceration rates and higher suicide rates. Strategies to date have failed to substantially change these statistics.

We believe voting "Yes" for the Voice to Parliament has the potential to improve health for First Nations peoples. This is consistent with ANZCA's purpose of "optimising health" and ANZCA's constitution to "advance public education and awareness of health equity".

This position also aligns with ANZCA Council's 2019: "Statement on the role of ANZCA in advocating for the health and wellbeing of all people".

We encourage all fellows, trainees and specialist international medical graduates to consider the effects on the health, wellbeing, and right to self-determination of First Nations peoples when voting in the upcoming referendum.

Tackling workforce issues

"While we support a number of recommendations in the Kruk report, there are a number we do not."

Several issues have crossed my desk in recent weeks that indicate the Australian government is exploring ways to address the strains on the healthcare workforce stemming from the pandemic and the backlog of patients on surgical wait lists.

In April, an interim report, "Independent review of overseas health practitioner regulatory settings", by Ms Robyn Kruk, AO, was released. This report explores the role of colleges in the assessments of specialist international medical graduates (SIMGs).

The proposed reforms intend to improve the experience for overseas trained practitioners and expedite processes by reducing duplication and inefficiency, which of course is a good thing.

And while we support the aim of streamlining processes for those entering Australia to work, it is essential that this is not at the expense of the current high standards of care enjoyed in Australia and New Zealand.

While we support a number of recommendations in the Kruk report, there are a number we do not.

For example, one recommendation is for assessments of SIMG equivalence to be transitioned from the specialist colleges to the Australian Medical Council (AMC) to "improve consistency and reduce costs".

Assessing equivalence of SIMGs from a variety of countries requires expert knowledge of both the training, qualifications, specialist experience and continuing professional development (CPD) of a locally trained specialist, and the ability to reliably compare that with SIMG applicants.

Also worth noting is that ANZCA meets and exceeds all key performance indicators for response times set by the Medical Board of Australia (MBA) and the Australian Health Practitioner Regulation Agency (Ahpra) to assess SIMGs and has worked to streamline its own processes.

ANZCA has responded to the interim report, noting that the college was not consulted at any stage during the review and subsequent release of the interim report, despite undertaking the assessment of SIMGs for more than 20 years in Australia. We anticipate the final report and recommendations will be released in late 2023.

The specialist medical colleges have a meeting with Ms Kruk and government representatives in July.

There have also been discussions with the Department of Health and Aged Care about the role of the colleges in the accreditation of hospitals for training and how the AMC might be more involved.

The decision of colleges to withdraw accreditation from hospitals is never done lightly and only after months, sometimes years, of negotiation and support for hospitals to improve.

The college is aiming to work closely with the department on improving our processes so that relevant government agencies are made more aware of hospitals who have been asked to make changes and attending meetings with the department to address any concerns. It has become apparent that government is not always aware of accreditation deficits in training sites.

ANZCA is still at odds with the Tertiary Education Quality and Standards Agency (TEQSA) on the use of the term "diploma" (and "certificate") to describe education qualifications.

This issue affects a number of colleges who are not registered higher education providers.

This has implications for our Diploma of Perioperative Medicine, which is being piloted later this year ahead of a full roll-out in 2024, and our two diplomas already under way, our Diploma of Rural Generalist Anaesthesia and our Diploma of Hyperbaric Medicine.

To date the colleges have been advocating for legislative change to allow continued use of these terms, however this is looking increasingly unlikely to occur. Again, ongoing meetings are being held with the Australian Education department to resolve the situation.

Finally, the recent change to CPD homes and the introduction of the Australian Medical Association (AMA) in WA as a provider appears to have been a move designed to bring competition into this space.

The MBA report that there are about 30,000 doctors currently without a CPD home and there are reportedly about 10 other organisations awaiting to be approved as CPD homes in addition to the AMA WA. The MBA are seeking to ensure these 30,000 doctors are attached to a CPD home and complying with ongoing CPD requirements.

We have great confidence in our robust CPD program, but are "watching this space" with interest.

Nigel Fidgeon
ANZCA Chief Executive Officer

King's Birthday 2023 Honours

Six of our fellows have been recognised in the 2023 honours list.

Please join us in congratulating the following fellows for their achievements:

MEMBER (AM) IN THE GENERAL DIVISION

Dr James Bradley, AM, FANZCA, FFPMANZCA, Qld.
For significant service to medicine in the field of anaesthetics.

Dr Matthew Crawford, AM FANZCA FCICM FFPMANZCA, NSW.
For significant service to medicine, particularly chronic and complex pain management.

Dr Genevieve Goulding, AM, FANZCA, Qld.
For significant service to anaesthesiology through professional and clinical roles.

Dr Michele O'Brien, AM FANZCA, NSW.
For significant service to medicine, particularly as an anaesthetist.

MEDAL (OAM) IN THE GENERAL DIVISION

Associate Professor Forbes McGain, OAM, FANZCA, FCICM, Vic.
For service to medicine.

Dr Noel Roberts, OAM, FANZCA, Vic.
For service to anaesthesiology through a range of roles.

ANZCA staff awards

Earlier this year we held the annual ANZCA staff awards at ANZCA House in Melbourne. ANZCA Vice President, Professor David Story presented the awards along with service certificates to staff who achieved service milestones in 2022.

The sponsor of the ANZCA Joan Sheales Staff Education Award, Emeritus Professor Barry Baker, spoke before the presentation of the 2022 award to explain the history and purpose of the award.

Congratulations to the 2023 recipients:

Staff Excellence Award for Customer Service – Nadja Kaye

Staff Excellence Award for Innovation and Process Improvement – Fran Lalor

Staff Excellence Team Award – Australian Medical Council reaccreditation team
(Shilpa Bakare, Katy Elliott, Dr Lindy Roberts AM, Ellen Webber, Juliette Whittington)

ANZCA Joan Sheales Staff Education Award – Nadja Kaye
Ms Kaye will use her award to present her findings on continuing professional development (CPD) and wellbeing at the 2023 Australian and New Zealand Association of Health Professional Educators conference, where she hopes to "inspire other health professionals and CPD programs to include wellbeing within their programs".

Letters to the editor

POLLARD DEVICE REMEMBERED

I was interested to read the article "Preventing and recognising oesophageal intubation" by Associate Professor Stu Marshall which happened to coincide with an obituary that I am writing on Dr Brian Pollard (see page 82).

Dr Pollard was renowned worldwide in the 1970s and 1980s for two advances – his Pollard tube[1] for micro laryngeal surgery used around the world until the advent of jet ventilation with the Benjet tube and others superseded it[2]; and his method of detecting oesophageal intubation published in 1988[3].

The latter method was a very simple mechanical device which could be constructed by readily available equipment usually present in any operating theatre.

At approximately the same time an article was also published in *Anaesthesia* with a similar approach to recognising oesophageal intubation[4]. Only one of these two devices is mentioned in the article[5] by the Project for Universal Management of Airways (PUMA) which is a pity as they were both original discoveries independently published at approximately the same time.

The PUMA article[5] goes on to state that there are certain instances when these devices may "give a false-negative result in certain patient populations such as infants, parturients and morbidly obese patients"[6-8] just as any of their other recommended techniques may in certain circumstances.

This device by Pollard and his collaborators from the Concord Hospital in Sydney deserves to be much better remembered, and should also exist on any difficult to intubate trolley in all anaesthetising situations so that it can be accessed for any situation where there is doubt about the placement of an endotracheal tube, as it is so easy to use and in most situations will immediately determine if there is inadvertent oesophageal placement.

I am disappointed to find out that PUMA overlooked Pollard's contribution, but as a college we should recognise his contribution, which would undoubtedly have helped in the management of at least five of the seven Australian patients (2001-2019) and the one New Zealand patient (2017) outlined in the PUMA document[5].

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

References

1. Pollard BJ. Anaesthesia 1968; 23 (4): 534-542
2. Benjamin B & Gronow D. Anaesthesia Intensive Care 1979; 7 (3): 258-263
3. O'Leary JJ, Pollard BJ & Ryan MJ. Anaesthesia Intensive Care 1988; 16 (3): 299-301
4. Wee MYK. Anaesthesia 1988; 43 (1): 27-29
5. https://onlinelibrary.wiley.com/doi/10.1002/emp2.12951
6. Haynes SR, Morton NS. Anaesthesia 1990; 45 (12) 1067-1069
7. Baraka A, Khoury PJ, Siddik SS et al. Anesthesia Analgesia 1997; 84 (3): 533-537
8. Lang DJ, Wafai Y, Salem MR et al. Anesthesiology 1996; 85 (2): 246-253

PREVENTING AND RECOGNISING OESOPHAGEAL INTUBATION – A RESPONSE

I read, with interest, Associate Professor Stu Marshall's article in the Autumn *Bulletin*.

Eternal vigilance and continual suspicion of possible endotracheal tube misplacement is essential for safe anaesthetic practice.

However, the author highlights that the Project for the Universal Management of Airways (PUMA) recommendation that video laryngoscopy should be used for all intubations where feasible, as "most controversial".

I would strongly argue that hyperangulated video laryngoscopy (HAVL), which has revolutionised airway management and intubation, should be immediately available for all intubations, if current safest and best practice is to be adhered to.

In my opinion HAVL has been the most significant advance in modern anaesthesia since the pulse oximeter.

I now use the glidescope HAVL for all intubations, and have done so since it became readily available in Australia.

I can't remember the last time, using rocuronium, that I had a "difficult intubation" - ie did not have "first pass" intubation, with any need for BMV post induction.

The MacIntosh blade video laryngoscope (VL) is of no mechanical advantage for intubation, compared to the traditional laryngoscope. It is simply a more comfortable way of intubating, with better optics. This may explain the author's faint praise for VL as an adjunct to intubation. They are, however, very good as teaching aids, for traditional intubations.

Glottic impersonation is not uncommon, but awareness and capnography should circumvent this issue.

The HAVL requires a very different intubating technique, that can only be acquired by doing many "easy" intubations, before a genuinely difficult one is attempted.

The custom made, unmodified rigid introducer fitted inside the endotracheal tube, inserted with correct technique, compliments correct usage of the HAVL to facilitate intubation, simple or difficult – bougies are not necessary, and make the intubation cumbersome.

It is a mistake to attempt one's first HAVL intubation when confronted with a "difficult" intubation experienced using a MacIntosh blade; if traditional intubating technique is attempted, it will make a difficult intubation harder.

Airway management is a serious business, and not a "team sport", as the author asserts.

It is entirely the intubator's responsibility, and decision making must rest with them; if such a vital procedure becomes a consensus activity, this can only lead to confusion and delay.

Let responsibility rest with they who bear it.

Capnography should determine correct position of the tube... if not immediately confirmatory the tube must be removed forthwith.

In reality it is fanciful to defer action on removing an uncertainly placed tube whilst waiting for fibreoptic or ultrasound confirmation.

"If in doubt take it out" must be drummed into airway trainees as rule one from the start.

This reference provides further useful information – www.emra.org/emresident/article/opinions-and-history-on-laryngoscopy.

Dr Stuart Skyrme-Jones, FRCA(Eng) FANZCA

PRIDE MARCH NOT PART OF COLLEGE'S MISSION OR VISION

The 2023 Autumn *ANZCA Bulletin* reports on page 50 reports that three "college representatives" participated in the "inaugural Pride in Medicine and Surgery Float 2023 Mardi Gras".

The college website states that our 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".

Further the college website states our vision as a college is "to be a recognised world leader in training, education, research, and in setting standards for anaesthesia and pain medicine".

How does participating in the Mardi Gras fit with these statements?

ANZCA has gained an esteemed and prestigious status by following the principles of this mission statement over many years. Why should this hard-won status be used as a platform to promote an activity that has nothing to do with the college's stated mission or vision?

How can the three persons named, claim to be representatives of the college, and thus of college members, when there has been no vote of those college members authorising this action on their behalf?

To claim to represent the college and thereby its members, without such authorization is a misrepresentation of the facts.

Individuals are free to participate in the Mardi Gras or any other lawful activity as they see fit.

However, when those individuals participate, claiming to be representatives of others, they should have first consulted those persons and have their approval and consent.

If the college is to be used as a platform for activists then what consequences may follow to the college's status as an esteemed learned organization dedicated to the science and art of anaesthesia?

What other "woke" causes is the college to be used for and who will decide which?

Let our college stay true to its stated purpose and vision and thus retain its well-deserved status and esteem.

Dr Warren Millist, FANZCA

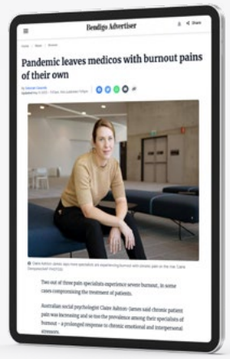
ANZCA and FPM media coverage

Highlights since the Autumn *ANZCA Bulletin* include:

Pandemic leaves medicos with burnout pains of their own

(AUSTRALIAN ASSOCIATED PRESS, 5 MAY)

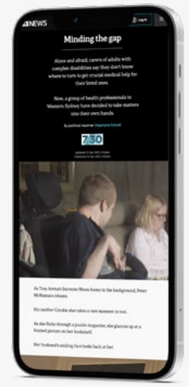
FPM Symposium presenter Dr Claire Ashton-James was interviewed in Sydney on 5 May by Australian Associated Press about her session on burnout in pain physicians. Dr Ashton-James said two out of three pain specialists experience severe burnout, which in some cases compromised the treatment of patients. The article by journalist Deborah Cassrels was syndicated to more than 80 online news sites in Australia including *The Canberra Times, Bendigo Advertiser* and *Perth Now* and reached more than one million readers.



"Volunteer anaesthetist helping care for adults with complex disabilities"

(ABC *7.30*, 12 APRIL)

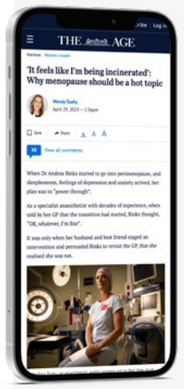
FANZCA Dr Pete Smith and rehabilitation physician Dr Rummana Afreen set up a "one-stop-shop" clinic in western Sydney at Westmead Hospital in 2020, after noticing people with complex disabilities were turning up in emergency departments with otherwise preventable conditions. "Several of my colleagues really noticed there was a bit of a gap in the health system in terms of heavily disabled people being able to access reasonable healthcare." The ABC's 7.30 program broadcast a segment called "Minding the gap" on 12 April and an online article about their clinic and how it is helping patients and their families.



"Why menopause should be a hot topic"

(*THE AGE*, *SYDNEY MORNING HERALD*, 29 APRIL)

FANZCAs Dr Andrea Binks and Dr Janette Wright were featured in a *Sunday Age* article on 29 May highlighting a series of workshops on menopause at the 2023 ANZCA Annual Scientific Meeting. The article included details of Dr Binks's survey of 100 anaesthetists and their experiences of menopause and was also syndicated to the *Sun Herald, WA Today* and *Brisbane Times* online. "So many people think, 'It's just me, I'm going crazy' ... but allowing people to have the discussion in the workplace will mean they feel more able to ask for the support they need." The article reached more than one million readers in print and online. Dr Binks was also interviewed on ABC Illawarra by breakfast host Melinda James on 2 May for a ten-minute segment.



Post-op is most deadly

(*HERALD SUN*, 8 MAY)

ANZCA's launch of its new Diploma of Perioperative Medicine and Professor David Story's Mary Burnell lecture at the ANZCA Annual Scientific Meeting featured in a syndicated package of print articles on 8 May in the *Herald Sun, The Adelaide Advertiser, Hobart Mercury, Daily Telegraph* and *The Courier Mail. The Courier Mail* ran a page 1 pointer to their "lead" article on page 3. Radio 3AW in Melbourne also mentioned the launch in its morning news bulletins on Monday. Professor Story was also interviewed by ABC Radio Adelaide's afternoon program host Sonya Feldhoff for a 10-minute segment on 8 May. The combined audience reach of the articles and the 3AW radio news segments is more than 1.5 million people.

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

A practical guide to managing dental damage

Nicole Golding, Solicitor & Medico-legal Case Manager, MDA National

MDA National

Dental damage is the leading cause of complaints and claims against anaesthetists. We examine the importance of consent, your duty to warn, and the steps you can take if damage occurs.

Case Study

Dr Singh, an anaesthetist, consulted with a patient in hospital the morning of her procedure. During the consultation, Dr Singh took a detailed medical history from the patient. No questions were asked regarding dentition, and the patient did not volunteer details of previous restoration. Dr Singh didn't discuss the risk of dental damage as part of his general consent process.

Dr Singh didn't encounter any difficulties with intubation. No dental damage was noted prior to the procedure, and although Dr Singh heard a cracking noise on extubation, he didn't check her teeth for damage.

The day after surgery, the patient reported to the surgeon that her left upper bridge was cracked. The surgeon recommended she seek urgent dental review. The patient consulted her usual dentist and subsequently advised Dr Singh that she had sustained a porcelain fracture on tooth 11, which had a full coverage crown.

The patient was unhappy that the damage had not been reported to her by Dr Singh immediately after her surgery, and that she had not been warned of the possibility of dental damage during her pre-operative consultation.

The patient requested Dr Singh to cover the costs of having her crown replaced.

Duty to warn

Dental damage is a well-recognised complication of anaesthesia, and there is a positive obligation to warn patients about this risk prior to a procedure.

During your pre-operative consultation, it's important to take a detailed medical history, including details of any pre-existing dental conditions. In the event the patient has had restorative dental work, an examination may be needed to enable you to consider the most appropriate airway management to minimise any potential risk during the procedure.

Informed consent must be obtained, and the general risk of dental damage should be discussed with every patient, regardless of their dentition. If you identify a patient as having a higher risk for dental damage, you should discuss ways in which you may be able to minimise the risk of damage.

Some anaesthetists provide patients with an information sheet outlining the risks of anaesthesia.

While this can be a useful tool to guide your discussion with the patient regarding risks, it should not be used in place of a discussion.

Documenting consent

It's important to document consent, because it provides a potential defence in the event of a claim. Contemporaneous records outlining all pre-existing dental conditions identified during the consultation should be documented clearly in the clinical records, together with a detailed account of your discussions regarding the risk of dental damage. If the patient is high risk, your clinical records should reflect a more extensive discussion. You should also document the patient's understanding of the risks and their willingness to proceed.

If damage occurs

If your patient experiences dental damage, and this is identified during or after the procedure, it should be clearly documented.

Talk to the patient as soon as practicable so they are aware of the damage. Open disclosure is encouraged, and while you can say you're sorry the patient has suffered damage, it's important you do not admit liability until you have sought advice. In the meantime, you can recommend that the patient seek an urgent review from their dentist.

If the patient asks you to pay for the cost of any dental treatment, you can suggest they put their request in writing and provide copies of any treatment quotes or invoices for you to consider. Do not agree to pay the costs of dental treatment without first seeking advice from MDA National. If the patient was appropriately warned, and there's no evidence that you've departed from accepted standards, there may not be any basis on which the patient can recover these costs.

Checklist

Take a detailed medical history from the patient, including any dental issues.

- ☑ Warn every patient about the risk of dental damage during anaesthesia.
- ☑ Obtain the patient's informed consent.
- ☑ Carefully document your discussion around risks and consent in the clinical records.
- ☑ If dental damage occurs during the procedure, engage in open disclosure with the patient as soon as practicable.
- ☑ Contact MDA National for advice.

The case study is fictitious. Any resemblance to real persons, living or dead is purely coincidental. This article is provided by MDA National. They recommend that you contact your indemnity provider if you need specific advice in relation to your insurance policy or medico-legal matters. Members can contact MDA National for specific advice on freecall 1800 011 255 or use the "contact us" form at mdanational.com.au. AD 508

Meeting with new health ministers in Australia and New Zealand

AUSTRALIA

Consultation with colleges to implement the National Medical Workforce Strategy commences

Following last year's release of the National Medical Workforce Strategy 2021-31, the Department of Health and Aged Care has commenced consultations with specialist medical colleges on the implementation of the strategy's 25 overarching actions. Cross-college workshops were recently held with the department focusing on a number of priority areas.

The first of these was a data workshop looking at strategy action 3 – to develop and implement a national medical workforce data strategy. During the workshop, the department and colleges shared information about the type, breadth and frequency of data collected and how data can be used to help address maldistribution and supply problems.

The longer-term goal is to develop a whole-of-health workforce demand model, with work on a forecasting tool already under way. Relevant to the discussion about supply issues is a view expressed in the National Medical Workforce Strategy that there are signs of an oversupply in anaesthesia. This contrasts with anecdotal evidence from a number of anaesthesia heads of departments who are struggling to fill vacancies, including in metropolitan health services. The college continues to advise the department that more recent workforce data, particularly post-COVID, is needed to inform initiatives to address over-and under-supply issues.

The second workshop focussed on rural maldistribution and the potential for remote supervision and accredited networked training models to address this. The college was able to share learnings from some of our ongoing projects to increase training in rural areas including:

- A collaboration with the Royal Australasian College of Surgeons, the Royal Australasian College of Physicians, Royal Australasian College of Medical Administrators and the Royal Australian and New Zealand College of Ophthalmologists to develop a Northern Territory training network for implementation with the first intake of trainees in 2025.
- The establishment of a Tasmanian anaesthesia simulation, education and training network to strengthen educator capacity and address significant maldistribution issues throughout the state regarding both educators and key equipment.
- Securing Commonwealth funding to develop significant infrastructure and non-clinical coordination work to support a dedicated rural training pathway in Victoria.

Meetings with government

The Albanese government's first full-year budget delivered in May has placed significant emphasis on healthcare, particularly in primary care and better access for all Australians. The government has also shown an increased willingness to focus on the importance of specialist services. This is reflected in the growing and increasing correspondence with Minister Butler's office, with the minister writing formal letters to ANZCA and FPM, encouraging continued and detailed communications with his office and department.

The college has been working closely with the Department of Health and Aged Care, including with senior members of the Medicare Review Taskforce, to ensure that the practice of pain medicine and anaesthesia is better represented in future government decisions. Minister Butler also made a virtual appearance at the recent ASM closing plenary, reiterating his commitment to the improvement of specialist medicine in Australia.

The college has continued engagement with state ministerial and departmental offices. Victoria and New South Wales have relatively new governments, and as they continue to settle, they have shown increasing willingness and ability to engage with the college.

Chair of the Victorian Regional Committee, Dr Emma Goodyear, FPM Director of Professional Affairs and Immediate Past Dean, Associate Professor Michael Vagg, and Dr Joel Symons, Chair, Perioperative Medicine Content and Assessment Working Group, met with the Victorian Health Minister, the Hon Mary-Ann Thomas in June.Perioperative medicine, chronic pain services, workforce shortages and planned surgery waiting lists were discussed with the minister.

SUBMISSIONS

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

Australia

- Department of Health and Aged Care: Prostheses list post-listing review of spinal cord stimulators.
- Department of the Prime Minister and Cabinet: National strategy to achieve gender equity.
- Royal Australasian College of Physicians: Draft regional, rural and remote physician strategy.
- Senate Standing Committee on Community Affairs: Improving access to medicinal cannabis bill 2023.

New Zealand

- Pharmac: Opioid prescribing and dispensing

Colleges collaborate with AIDA to support trainees

In 2022 the Department of Health and Aged Care funded the Australian Indigenous Doctors' Association (AIDA) to work with the non-GP specialist medical colleges to deliver a support program for Aboriginal and Torres Strait Islander non-GP specialist trainees. The project will establish a multi-college support network for Aboriginal and Torres Strait Islander trainees as well as developing cultural safety resources and developing tailored strategies to support Aboriginal and Torres Strait Islander trainee selection.

In the first eight months of the program AIDA has supported college trainees and applicants with:

- Several two-day, face-to-face workshops for trainees with funding to cover travel, accommodation, registration and meals.
- Culturally appropriate one-on-one support provided to over 30 Aboriginal and Torres Strait Islander trainees.
- Performance coaching for five prevocational doctors to successfully apply to college training programs.
- Webinars for trainees on CV writing and job interview preparation skills.
- Webinars for supervisors on culturally safe clinical supervision and addressing racism.
- A number of "Yarn-ups" with Aboriginal and Torres Strait Islander medical students, prevocational doctors and trainees tailored to different specialities to provide career and entry pathway information.

In May the group met for two days in Newcastle on Awabakal Country, where there was continued discussion about results of the latest Ahpra Medical Training Survey which showed that 55 per cent of Aboriginal and Torres Strait Islander trainees have experienced or witnessed bullying, harassment, discrimination and racism compared with 34 per cent of all trainees. In response, a cross college statement on the eradication of racism led by the Royal Australasian College of Physicians, Royal Australasian College of Medical Administrators is now being prepared.

At ANZCA, we have worked with AIDA to introduce a new Aboriginal and/or Torres Strait Islander trainee education grant to support anaesthesia or pain medicine trainees. As of 31 January 2023, there are seven Aboriginal and/or Torres Strait Islander and 21 Māori trainees in the college's training programs. While this represents an improvement on recent years, the number of Aboriginal and/or Torres Strait Islander and Māori trainees is still low and we are striving to work towards population parity.

As part of our work under our Reconciliation Action Plan, Training Program Evolution Project and recent Australian Medical Council reaccreditation requirements, college trainee selection pathways are being reviewed to ensure the health workforce is more reflective of the community it serves.

NEW ZEALAND

Medical colleges collaborate to implement Cultural Safety Training Framework

Moving beyond *cultural competence* (where a doctor has the attitudes, skills and knowledge needed to function effectively and respectfully when working with, and treating, people of different cultural backgrounds) towards *culturally safe* practice was mandated by the Medical Council of New Zealand/Te Kaunihera Rata o Aotearoa in 2019. Culturally safe practice is where, in addition to cultural competency, doctors reflect on their own views and biases and how these could affect their decision making and health outcomes for the patient.

Developing cultural safety is expected to provide benefits for patients and communities across multiple cultural dimensions which may include Indigenous status, age or generation, gender, sexual orientation, socioeconomic status, ethnicity, religious or spiritual belief and disability. In New Zealand, cultural safety is of particular importance in the attainment of equitable health outcomes for Māori.

The Council of Medical Colleges/Te Kaunihera o Ngā Kāreti Rata o Aotearoa is coordinating collaboration between colleges to share resources and experience to implement the 2023 Cultural Safety Training Plan for Vocational Medicine in Aotearoa. Training materials, key resources and reflective practice case studies are being collected to guide any doctors who are unsure how to evidence cultural safety learning in their CPD portfolios.

Meeting with the new health minister

A delegation from the college and the New Zealand Society of Anaesthetists met Health Minister Ayesha Verrall on 4 April to advocate for the implementation of the Mamaenga Roa Model of Care pathway for chronic pain, for the creation of a pathway for emerging medical graduates to become pain specialists, and for the shortage of *accredited* pain clinics able to provide suitable training places (particularly on the South Island) to be urgently addressed.

New Zealand is experiencing an acute shortage of specialist pain medicine physicians and steps are urgently needed to train and preserve the workforce in this vocational specialty. Initiatives to attract and retain both new trainees and specialist international medical graduates are also essential to address this shortage. The meeting was positive and the offer to contribute expertise to the various working groups (including the Theatre Optimisation and Planned Care Working Groups) and the Tactical Anaesthetic Technician group and to partner with government to deliver on the potential of the health reforms and the development of the anaesthesia workforce was welcomed.

A recent submission was made to Pharmac on proposals to alter the regulations for the prescription and dispensing of opioids, and consultation is under way to respond to updated Medical Council of New Zealand/Te Kaunihera Rata o Aotearoa position statements on telehealth and the provision of medical certificates.

The future of health services reforms

Less than a year after coming into effect, the significant health services reforms under way in New Zealand have yet to get into full swing. With the general election in October poised to be a tight one, a project to establish the health policies and priorities of all the political parties, particularly in relation to the pace and direction of any change to services or funding has commenced. With the message from the recent ANZCA Annual Scientific Meeting heard loud and clear that advocacy for services and patients is an obligation for those who are concerned about health inequities, we aim to provide transparency about the implications of these policies and to prepare a briefing for the incoming minister.

What would you do?

Can the college enforce clinical compliance?

Dr Peter Roessler explains professional documents using practical examples. In this edition he examines the college's remit in clinical practice.

ANZCA, YOU NEED TO FIX THIS!

Scenario: You have been invited to provide anaesthesia/sedation in an unregistered/unlicenced facility. You are informed by the practice that (to keep the list going) you may be required to leave patients with a nurse while you prepare the next patient in an adjacent room with a window into theatre and a monitoring screen.

There are several issues here that raise alarm bells. One is regulatory pertaining to provision of services in an unregistered facility contrary to jurisdictional law, and the other is the expectation that sedated/anaesthetised patients will be "briefly" in the care of a nurse.

WHAT WOULD YOU DO?

As a result of your justified concerns, you alert the college and insist that the college should intervene to ban such practice.

This is a vexing situation because you have identified both a potential regulatory breach as well as a divergence from college guidelines, which indeed warrant action.

Regulatory breaches are outside the remit of the college and can be addressed only by the jurisdictional regulatory authority such as the Australian Health Practitioner Regulation Agency (Ahpra) and the Medical Council of New Zealand (MCNZ). These sorts of issues should be directed to the regulators for investigation and action.

The college does not have regulatory powers nor authority to mandate what healthcare facilities can and cannot do. It cannot enforce compliance with ANZCA guidelines with the one exception of accreditation requirements of facilities as a training site for training towards fellowship. Any matters that may impact the training environment are referred to one of the two accreditation committees, the Training Accreditation Committee (anaesthesia) and the Training Unit Accreditation Committee (pain medicine).

The college does, however, provide guidance into best practice with the intention that its recommendations are adopted by healthcare facilities and used to draft their local policies.

The core roles of the college are reflected in its constitution's purpose statement and consequent objectives, which aim to ensure the highest level of patient care with ANZCA and FPM being global leaders in these areas. The core roles include training, education, setting standards, and support of its fellows, specialist international medical graduates (SIMGs), and trainees, and community awareness.

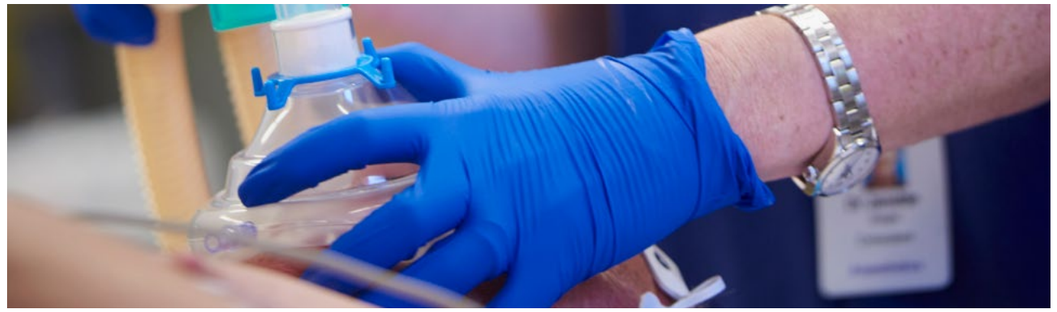
The college receives queries from diverse sources including, patients (complaints), healthcare facilities, other healthcare professionals, legal firms, regulators, fellows, SIMGs and trainees. Some examples include:

- Bullying and/or sexual harassment by colleagues in the workplace.
- Breaches of practice such as leaving patients unattended for whatever reasons.
- Patient complaints about their care.
- Dissatisfaction with outcomes of investigating bodies, either when no action is taken, or the outcome is not accepted by the fellow, SIMG or trainee.

Not infrequently, fellows, SIMGs and trainees identify instances of poor or potentially dangerous practices and want the college to intervene and mandate that such practices cease. In the absence of any regulatory authority, it "lacks the teeth" to be able to issue mandates and enforce them.

ANZCA has no legal, regulatory, enforceable jurisdiction or other such power to enforce a decision made by a health service.

What the college has done is develop a set of standards that identify benchmarks of performance against which outcomes can be gauged. In support of these standards, a raft of professional documents has been developed to guide practice towards achieving these standards. They are not mandatory and the way that regulatory authorities and legal systems interpret them is beyond the control of the college. However, the documents help to inform organisations that do have the power and may be referred to by them.



Support of fellows, SIMGs and trainees in distress, irrespective of the cause, is high on the priorities of the college as evidenced by the wellbeing initiatives developed and available through the college as well as the tripartite special interest group. It is recognised that being the subject of a complaint or even being the complainant can be stressful and merits support. There are many ways the college advances support including its promotion of collegiality and mentorship.

What the college can and cannot do is defined in CP28(G) *Policy on management of notifications 2022*, item 4.3 Notifications and management. The policy is comprehensive and includes detailed information about the process as well as potential outcomes.

Another relevant document is CP(01) *Bullying, discrimination, and harassment policy 2020*, which details the circumstances and conditions under which the college can act.

Identifying and alerting the college to workplace matters such as bullying, for example, helps to keep the college informed regarding the incidence and severity of problems. While the college may not have the authority to intervene or investigate, being informed of issues and concerns in general, may have a positive impact on the culture of our craft insofar as enhancing awareness and driving behavioural changes through aspirational recommendations in the college's professional documents.

Dr Peter Roessler FANZCA
Director of Professional Affairs, Professional Documents

Perioperative medicine

Diploma pilot to begin soon

PREPARING FOR OUR PILOT

In just a few weeks, on 4 September, we will begin piloting our Diploma of Perioperative Medicine (DipPOM) in up to 10 hospitals across Australia and New Zealand.

Each clinical site will host up to three participants who are fellows of ANZCA (including FPM), the Royal Australasian College of Surgeons, the College of Intensive Care Medicine, the Royal Australasian College of Physicians, the Royal Australian College of GPs, the Royal New Zealand College of GPs and the Australian College of Rural and Remote Medicine. Advanced trainees (who have passed the fellowship examination) can also apply.

The first of six units of study (topic areas) is preoperative assessment, and it will be piloted from 4 September and 17 November.

During that time, participants will undertake 20 online learning modules, attend a one-day workshop in Melbourne (21 October), and spend 40 hours experiencing the clinical immersion component of the diploma.

This hands-on clinical experience is what makes our diploma unique amongst other perioperative medicine qualifications around the world.

As the pilot approaches, the college is completing and uploading e-learning content to the ANZCA learning management system.

The college is also helping hospitals prepare to host the course. Supervisors (DipPOM holders awarded the diploma via the recognition pathway) will do an introductory workshop on 25 July.

More than 220 leaders in perioperative medicine have now applied for the diploma via the recognition pathways ("grandparenting") process with 88 now awarded the DipPOM by our Recognition Pathways Working Group chaired by ANZCA Immediate Past President Dr Vanessa Beavis and another 24 have been submitted for approval. Applications for the recognition process close on 1 December 2023.

"This hands-on clinical experience is what makes our diploma unique amongst other perioperative medicine qualifications around the world."

DIPLOMA FORMALLY LAUNCHED AT ANZCA ASM

We officially launched the DipPOM at the Sydney ANZCA Annual Scientific Meeting (ASM) in May.

A video shown at the launch included interviews with anaesthetists, physicians (pain, geriatric, internal and rehabilitation medicine), GPs, an intensivist and a surgeon. Also in the video was Perioperative Medicine Steering Committee member Heather Gunter who told her own personal story of the tragic consequences of an uncoordinated healthcare system.

The launch of the diploma received extensive media coverage, reaching more than 1.5 million people. POM Steering Committee Deputy Chair Professor David Story featuring in a syndicated package of print articles in the *Herald Sun, The Adelaide Advertiser, Hobart Mercury, Daily Telegraph* and *The Courier Mail*. Radio 3AW in Melbourne also mentioned the launch in its morning news bulletins and Professor Story was also interviewed by ABC Radio Adelaide's afternoon program for a 10-minute segment.

A workshop on best practice in perioperative service delivery at the ASM hosted by POM Steering Committee Co-Chair Dr Sean McManus was well attended.

A POM information booth received a lot of traffic with the majority of queries about the POM framework, the diploma, the recognition pathway and how to get involved.

Congratulations Dr Joel Symons, the chair of our Content and Assessment Working Group, who was presented with ANZCA's Steuart Henderson Award for his contributions to medical education, including the DipPOM.

PLANNING FOR 2024 – COURSE DATES AND FEES

Enrolments for 2024 open in November with trimester 1 (units of study 1 and 2) commencing on 12 February (see table for other dates). Each trimester there will be a two-day participants' workshop held in Melbourne and participants will be required to complete online activities.

Each unit of study will cost $A2185 or $NZ2714 in addition to fees for registration and to cover the issuing of the certificate.

More detail on dates and fees for our DipPOM in 2024 can be found on the ANZCA website –www.anzca.edu.au/education-training/perioperative-medicine-qualification/dip-pom.

In August, ANZCA will be calling for expressions of interest from hospitals – in addition to the pilot hospitals – who would like to host the diploma in Australia and New Zealand from February 2024. The six units of study are:

1. Preoperative assessment.
2. Preoperative planning.
3. Optimisation.
4. Intraoperative impacts on patient outcomes.
5. Postoperative assessment and management.
6. Discharge planning and rehabilitation.

CORE DOCUMENTS BEING FINALISED

We are in the final stages of completing key documents for the diploma.

The handbook, curriculum and regulation are being reviewed and will go to the POM Steering Committee and ANZCA Council for approval and will be published online in August.

The aim of the standards is to be simple, clear, non-repetitive, and measurable to ensure they are easily applicable across diverse healthcare settings as a minimum requirement. They are expected to be approved and available later this year.

A Content and Resource Review Working Group, established to keep the content of the Perioperative Care Framework and DipPOM Curriculum current and evidence-based, has now met. This group is led by Perioperative Medicine Special Interest Group Chair, Dr Jill Van Acker.

MOU WITH CPOC

In July, Dr Beavis and Dr Symons will meet with leaders at the Centre for Perioperative Care (CPOC) with whom we recently signed a memorandum of understanding (MOU). CPOC is a cross-organisational, multidisciplinary initiative led by the Royal College of Anaesthetists.

The MOU will ensure strong collaboration between the two organisations into the future and means resources and research relating to perioperative medicine will be shared between ANZCA and CPOC.

Materials associated with our DipPOM, including educational resources, such as the curriculum and the Perioperative Care Framework, and any educational resources developed by CPOC will be shared, as well as evidence-based research of each organisation.

CAN WE CALL OUR QUALIFICATION A DIPLOMA?

As previously mentioned, ANZCA and other medical colleges are in a dispute with the Tertiary Education Quality and Standards Agency (TEQSA) over the rights to use the term "diploma" (and "certificate") when describing a qualification. Colleges are not registered higher education providers.

The colleges, via the Committee of Presidents of Medical Colleges have been advocating for legislative change. The college is also exploring other options that will enable them to maintain the term diploma for our qualifications.

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

DipPOM – KEY DATES

2023

1 August – hospitals invited to apply to host the diploma in 2024

1 August – curriculum, handbook and regulation published online

4 September – DipPOM pilot commences

20 November – trimester 1 enrolments open

2024

12 February – trimester 1 commences

9-10 March – trimester 1 participants' workshop

19 February – trimester 2 enrolments open

27 May – trimester 2 commences

20-21 July – trimester 2 workshop

10 June – trimester 3 enrolments open

16 September – trimester 3 commences

16-17 November – trimester 3 participants' workshop

Supervisor workshops will be held in July (pilot) and November 2023, and in March, June and November in 2024.

Can you climb a flight of steps?

The introduction of the DASI questionnaire, an objective assessment of functional capacity, has had good results in one Christchurch hospital preadmission clinic.

BACKGROUND

Assessing functional capacity is considered to be an intrinsic part of a comprehensive pre-operative risk assessment[1]. Conventionally an estimate is made of a patient's functional capacity based on the answers to a series of subjective questions.

In 2018 the Measurement of Exercise Tolerance before Surgery (METS) study spotlighted the limited value of subjective questioning[2]. The study found that subjective assessments of functional capacity did not accurately identify patients with poor exercise tolerance, and did not correctly predict those patients at increased risk of peri-operative morbidity and mortality after major elective non-cardiac surgery[2].

The study concluded that subjective assessments should be supplanted by more objective assessments of functional capacity, such as the Duke Activity Status Index (DASI)2,3.

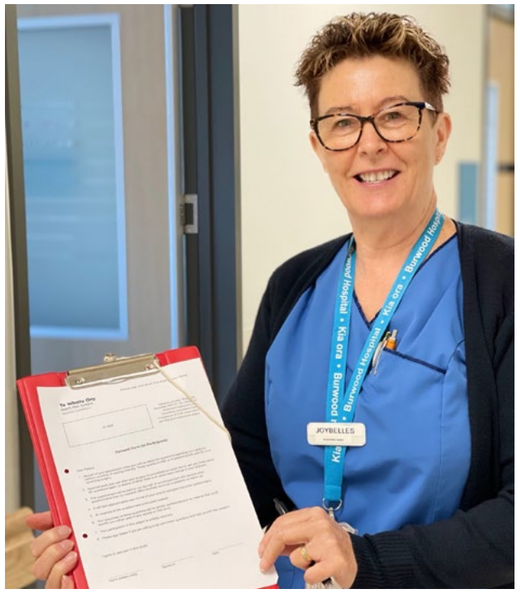
The DASI is a simple self-reported 12-item questionnaire[3]. It generates a score ranging from 0 to 58.2; higher scores indicate greater levels of activity. It has accepted validity as a measure of preoperative cardiopulmonary fitness and improved accuracy at predicting patients with an elevated risk of myocardial infarction or death within 30 days of surgery[2,3].

WHAT DID WE DO?

In 2021 all elective patients presenting to a preoperative anaesthesia clinic were asked to complete a paper copy of the DASI questionnaire. The patients were predominantly awaiting orthopaedic surgery for hip, knee or shoulder arthroplasty (82 per cent), smaller joint surgery (9 per cent) or spine surgery (5 per cent).

A 12-week audit prior to this had identified that >99 per cent of functional capacity assessments performed at this clinic were subjective. Indeed only one of the 207 patients in the audit sample had evidence of an objective assessment of functional capacity (a historic CPET result).

A quality improvement project was initiated. Patients were invited to complete the 12-item DASI questionnaire in the clinic reception room whilst awaiting their anaesthesia consultation. Completed questionnaires were then handed to the clinic anaesthetist who was invited to review the results and use it to calculate estimated metabolic equivalents (mets) and the Duke Activity Status Index (DASI), using a QR code linked to an online calculator[4].



A subsequent repeat 12-week audit found that 105 of the 211 (49.8 per cent) functional capacity assessments recorded by anaesthetists were now using objective results obtained from the DASI questionnaires.

A decision was made to automate the process. Contemporaneously, nurse assessments at the preoperative clinic were being transitioned from paper to electronic. The nurses became confident using the patient questionnaires and began recording DASI scores and estimated METS on the electronic assessment forms.

This change resulted in all patients presenting to this clinic having an objective functional capacity assessment. These results are available to review prior to each anaesthesia consultation and provide an additional and preliminary tool for risk stratification.

Image: DASI nurse Joy Maley

POSITIVE CHANGES

More accurate identification of both low and higher risk patients assists with the triage of patients, and aids decision-making on whether additional assessment is required. Earlier identification of higher risk patients also permits a more targeted anaesthesia consultation with the patient, improves efficiency, and allows for more individualised perioperative plans.

Objective functional capacity data is now being collected for every patient attending this clinic. Quantitatively and qualitatively, we have a new data set to explore. This is exciting, has opened up new possibilities for audit and understanding, and has sparked a follow-on research project.

This intervention has also gifted back valuable minutes during the anaesthesia consultation that were previously spent inquiring about walking, gardening and stair-climbing. Interpretations of patient responses often took time, were subjective, and prone to bias. To introduce an intervention

that is both quality-improving and time-saving is rare.

MORE QUESTIONS

Although metabolic equivalents are a familiar concept to anaesthetists, the DASI score and how best to interpret and apply it are less well known. Anecdotally, anaesthetists often refer to metabolic equivalents preferentially when decision-making. The recent proposition that a DASI score of 34 is useful as a threshold for distinguishing between low and higher risk patients may change this, and further guidance in this area would be helpful[5].

The question pertaining to sexual activity can be a source of discomfort. The authors hoped to mitigate this by allowing patients to complete their questionnaires pre-consultation and in private, and almost all patients answered this question. Although a higher number of incomplete responses was not observed in this study, we are nevertheless very interested in the pursuit of modified versions of the DASI questionnaire that can omit this question[6].

This questionnaire was introduced into a standalone anesthesia clinic for elective orthopaedic patients, presenting with a heterogenous mix of comorbidities and functional deficits. It is not clear if impairment from arthritis may be a confounder in this group.

Concerns were raised patients might score disproportionately lower on the DASI due to musculoskeletal incapacity, and this could affect its predictive validity in this group. In the METS study 21 per cent of patients were described as having significant arthritis, defined by previous or scheduled major joint replacement surgery[2]. We intend to explore the DASI score approximately one year after surgery with pre and post-surgery measures of joint function (Oxford scores) to try and ascertain how lower limb joint replacement might influence the pre-operative DASI score.

"This intervention has also gifted back valuable minutes during the anaesthesia consultation that were previously spent inquiring about walking, gardening and stair-climbing."

REFLECTIONS

Introducing the DASI questionnaire into this clinic has been a practical and pragmatic alternative to subjective functional capacity questioning. It is simple to use, low cost, and when completed pre-consultation it may save time during a clinic. With routine use objective functional capacity data for all patients attending the clinic is captured. This aids identifying both low and higher risk patients presenting for surgery.

Practice change is often difficult7. This quality improvement project demonstrates that changing practice from non-predictive subjective assessments of functional capacity to a more predictive objective assessment can be both low-cost and relatively easy to implement into an anaesthesia clinic.

We would like to acknowledge our colleagues, the pre-admission nurses, who have been key to being able to introduce this change.

Dr John Shepherd FANZCA
Dr Richard Seigne FANZCA
Te Whatu Ora – Waitaha Canterbury

References

1. Fleisher LA, Fleischmann KE, Auerbach AD, et al. 2014 ACC/AHA guideline on perioperative cardiovascular evaluation and management of patients undergoing non-cardiac surgery: a report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines. Circulation 2014;130:278-333.
2. Wijeysundera DN, Pearse RM, Shulman MA, et al. Assessment of functional capacity before major non-cardiac surgery: an international, prospective cohort study. Lancet 2018;391:2631-40.
3. Hlatky MA, Boineau RE, Higginbotham MB, et al. A brief self-administered questionnaire to determine functional capacity (the Duke Activity Status Index). *Am J Cardiol* 1989;64:651–54.
4. MDCalc. https://www.mdcalc.com/duke-activity-status-index-dasi
5. Wijeysundera, D. M., Beattie, W. S., Hillis, G. S., Abbott, T.E.F., Shulman, M. Ackland, G. Lifford, R. (2020). Integration of the Duke Activity Status Index into preoperative risk evaluation: A multicentre prospective cohort study. BJA, 2020;124(3):261-270.
6. Riedel B, Li MH, Lee CHA, et al. A simplified (modified) Duke Activity Status Index (M-DASI) to characterise functional capacity: a secondary analysis of the Measurement of Ex- ercise Tolerance before Surgery (METS) study. Br J Anaesth 2021; 126: 181e90
7. Gupta D, Boland Jr R, Aron D. The physician's experience of changing clinical practice: a struggle to unlearn. Implementation Science 2017;12:28. DOI 10.1186/s13012-017-0555-2.

Continuing professional development

CPD improvements under way

Our aim this year is to enhance the ANZCA and FPM CPD Program and supporting resources to best meet fellows' and other CPD participants' needs. Members of the CPD review project group are enjoying engaging with the wider membership as part of this process.

Here are some of the ways we're enhancing the CPD program from 1 January 2024:

INTRODUCING CRITERIA FOR ALL CPD CATEGORIES

Each CPD category (emergency response, knowledge and skills, and practice evaluation) will have distinct criteria, to help you accurately categorise your activities and to facilitate the introduction of new activities into the program.

CPD review project group and CPD committee members are developing the criteria in collaboration with the CPD team. We've reviewed the existing emergency response criteria for contemporary relevance, working across anaesthesia and pain medicine to ensure applicability to both specialties.

We've also developed corresponding knowledge and skills and practice evaluation criteria. The practice evaluation criteria include definitions of reviewing performance and measuring outcomes, sub-categories added under the revised regulatory guidelines.

EXPANDING THE RANGE OF CPD ACTIVITIES OFFERED

We know that there are some activities which could count for CPD hours not now claimable under our CPD program. To help us identify new CPD activities, the CPD team completed a detailed scoping analysis, reviewing regulatory guidelines, other Australian and New Zealand specialist medical colleges' CPD programs, and feedback many of you have shared via the CPD email inbox.

We thank those who completed the 2023 CPD activities survey, which included an opportunity to rank the activities we identified and to suggest additional activities you'd like to see. Your valuable feedback helped us to prioritise CPD activities for development this year and to consider those for future development.

The new CPD activities will expand offerings across all three CPD categories. Given the updated CPD requirement to complete one emergency response per year, we recognise the importance of introducing additional emergency response activities. We're looking at including four new activities by 1 January 2024 for pain medicine and anaesthesia participants. We're also exploring opportunities to offer more emergency response activities online.

Additionally, we plan to deliver more knowledge and skills/practice evaluation activities applicable to the roles many of you undertake outside of direct patient care, including administration, education, and governance. We hope including these new activities will make the CPD program more inclusive by ensuring the CPD activities you can claim are relevant to the full range of contexts in which you work.

DEVELOPING A TOOLKIT FOR THOSE WHO PRACTICE WITHOUT DIRECT PATIENT CARE

Dr Lindy Roberts and Dr Stephanie Oak (CPD Practice Without Direct Patient Care Reference Group co-chairs) shared an update on the creation of this reference group in the Autumn *ANZCA Bulletin*.

Group members are developing a toolkit to assist fellows and other CPD participants who practice without direct patient care, particularly focusing on reviewing performance and measuring outcomes, a new requirement for this group.

Having brainstormed the broad range of work roles and responsibilities undertaken by those who practice without direct patient care, reference group members are focusing on each of the ANZCA and FPM roles in practice and the attendant work roles (for example, teaching, research, leadership, management, professionalism).

The group is working on the following toolkit structure:

Work role or responsibility	How to measure outcomes/ review performance	CPD activity	Tools, benchmarks and resources
What your work involves	How you might review performance or measure outcomes in this work role	How you will record this in the electronic CPD portfolio	These are the specific practical resources you can use for your CPD

This work and the toolkit will also support CPD for those in clinical practice who have clinical support roles to tailor CPD to their full scopes of practice. The reference group will consult on the draft toolkit mid-2023, so watch out for an invitation to provide your feedback.

INCORPORATING PRIVATE PRACTITIONERS' PERSPECTIVES

In April, we established a reference group of fellows and other CPD participants working in private practice. CPD review project group member and CPD committee deputy chair Dr Sarah Green leads the group, with members representing a range of work situations (including mixed private and public practice) and geographic locations. Our thanks to those who have volunteered their time for this group.

CPD PRIVATE PRACTICE REFERENCE GROUP MEMBERS

Member	Location
Dr Sarah Green (Chair)	NSW
Dr Catherine Caldwell	New Zealand
Dr Vicki Cohen	WA
Dr Bridget Efferney	Qld
Dr Phoebe Epstein	NSW
Dr David Findlow	New Zealand
Dr Sylvia How	Qld
Dr Babitha Kudakandira Basappa	Qld
Dr Anthony McGirr	NSW
Dr Michael Schurgott	SA
Dr Prasad Vutukuri	NSW

This reference group have also begun by identifying the specific contexts of private practitioners and how they approach and complete CPD. We aim to ensure the group's perspectives inform support resources and our communications, including guidance on the website and in the CPD handbook. Initial feedback from members indicates a desire to network with colleagues and that many of the new CPD activities flagged for development will be beneficial for those in private practice.

If you have ideas for this reference group that you wish to share, please email cpd@anzca.edu.au.

EMBEDDING CULTURAL SAFETY AND HEALTH EQUITY

We were proud to introduce cultural safety as a new requirement under the 2023 ANZCA and FPM CPD Program, and hope those already transitioned to the 2023 program are enjoying learning and reflecting in this space.

The 2023 CPD program requires fellows and other CPD participants to complete one cultural safety activity per year, with hours taken to complete the activity claimed under practice evaluation – reviewing performance. Please note there is no minimum annual hour requirement for cultural safety.

The college launched two Learn@ANZCA cultural safety modules in February 2023. The content is designed to help doctors in Australia provide a culturally safe environment for all Aboriginal and Torres Strait Islander people. Fellows and other CPD participants can complete these modules to satisfy the annual cultural safety activity requirement.

We are continuing work to develop a framework for embedding cultural safety and a focus on health equity across the CPD program, in collaboration with Aboriginal, Torres Strait Islander and Māori consultants. This work addresses the Medical Council of New Zealand (MCNZ) requirements and commitments under our Reconciliation Action Plan in Australia.

You can find more information about cultural safety in the CPD handbook and in the cultural safety activity guidance document, both on the college website.

Interested in more details on the CPD review project? Head to anzca.edu.au/cpd-updates

2020-2022 CPD END OF TRIENNIUM RESULTS

Our CPD program's most recent triennium process is complete, with 99.9 per cent of fellows and other CPD participants meeting all CPD requirements. Congratulations to the 3177 participants in the 2020 - 2022 CPD triennium for achieving this excellent result. This is an amazing achievement and shows your commitment to maintaining your professional development and online CPD portfolios.

Professional development is pivotal to supporting your patients and continuing to achieve medical excellence in your profession. We believe that such impressive completion rates demonstrate the versatility of our CPD program and the practical support of the ANZCA and FPM CPD Committee and team in anticipating members' needs.

2022 CPD VERIFICATION (AUDIT) RESULTS

The 2022 verification (audit) of CPD activities is complete with a 100 per cent successful verification. Thank you to the 472 fellows and CPD participants selected for this year's verification for updating your CPD portfolios with evidence by the 31 December 2022 submission date.

Our CPD program completes an annual audit to comply with Australian Medical Council (AMC) and Medical Council of New Zealand (MCNZ) requirements. A minimum of seven per cent of all fellows and other CPD participants are randomly selected through the online CPD portfolio system for CPD records verification each year.

Please note we have waived the 2023 verification (audit) process. This decision was made in August 2022 to best support fellows and CPD participants transiting to the updated Medical Board of Australia and MCNZ requirements.

We are committed to supporting you as we complete the staged transition to our annual CPD program and encourage you to reach out to the helpful CPD team with any questions.

CONVERSATIONS WITH CHRIS COKIS

ANZCA and FPM CPD Committee and CPD review project group chair Dr Debra Devonshire joined ANZCA President Dr Chris Cokis to discuss the CPD program updates. Listen via Soundcloud.

Self matters

ANZCA and FPM CPD wellbeing activities

This regular column explores doctors' health by highlighting practical ways to support anaesthetists' and pain specialists' wellbeing and how it impacts private lives. This edition examines wellbeing activities in the ANZCA and FPM Continuing Professional Development (CPD) program.

ANZCA's CPD team is ably led by Ms Nadja Kaye. Here she reports on what fellows, provisional fellows and others are doing to support their wellbeing in the ANZCA and FPM CPD program.

We are all fortunate to have ready access to Nadja and her experienced and ever-helpful CPD team. With the recent changes by the Medical Board of Australia and Medical Council of New Zealand, this support is more crucial now than ever before. If you're not sure what can be credited towards wellbeing activities, check out the CPD Handbook on the college website or contact Nadja and her team at cpd@anzca.edu.au or on +61 3 9510 6299.

As always, if you have ideas about future Self Matters columns (no matter how rudimentary – I welcome a chat!), please email me at lroberts@anzca.edu.au and I'll be in touch.

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

INTRODUCTION

Throughout training, and indeed your entire career, medical specialists' health and wellbeing may suffer as you acquire and maintain the skills to help others[1].

Given this link, in 2021, the CPD program introduced the *CPD Wellbeing Education Session* activity (CPD Wellbeing activity), an initiative acknowledging the bi-directional relationship between doctors' wellbeing and patient care[2]. Twelve months after the initiative was launched, Dr Mary O'Hare, Senior Research Officer in the college's Education and Research Department and I, with oversight from the ANZCA and FPM CPD Committee, conducted a project with the research question:

"The majority of CPD wellbeing activities were ANZCA and FPM run events (60%), with the remainder (40%) independently sourced by participants."

Sharing our findings from this analysis promotes awareness of the need to maintain and improve health and wellbeing among all CPD participants and assists you to provide the best in patient care. This article builds on the Summer 2021 *ANZCA Bulletin* Self Matters article "Supporting wellbeing through continuing professional development".[3]

APPROACH TO ANALYSIS

The data pool was all CPD wellbeing activities logged by fellows and other CPD participants in their online CPD portfolios from 22 April 2021 to 22 April 2022. The ANZCA and FPM privacy policy and relevant legislation informed the use of personal information handling practices (for example, no names or other identifying information were used).

Of the 1063 CPD wellbeing activities logged by 593 participants, 93% (n=992) were eligible for analysis (figure 1) as they met the following criteria:

1. The activity maintained or improved wellbeing through a structured educational session.
2. Participants provided sufficient detail to identify it as a CPD wellbeing activity.

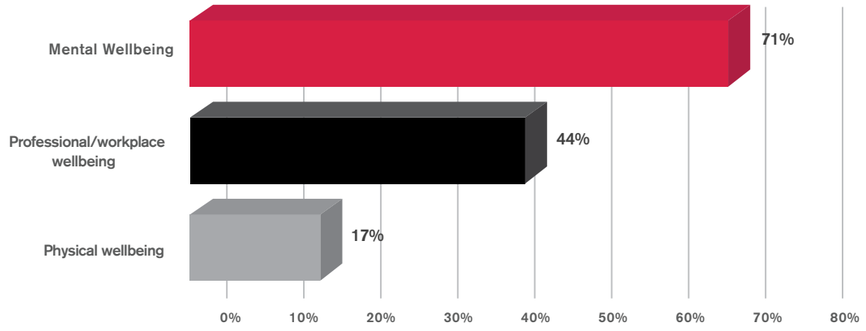
Figure 1. Schematic of eligible and ineligible CPD wellbeing activity records

FINDINGS

The majority of CPD wellbeing activities were ANZCA and FPM run events (60%), with the remainder (40%) independently sourced by participants. Overall, the topics covered in activities independently sourced were more heterogeneous than those organised by ANZCA and FPM.

Content analysis of CPD wellbeing activities identified major areas and topics within each area. From the 992 activities eligible for analysis, three major areas of activity were identified (figure 2). An activity could cover more than one area so percentages do not add up to 100.

Figure 2. Major areas of wellbeing activities accessed by CPD participants



The major topics within each area (table 1) provided insight into CPD participants' understanding of each wellbeing facet, and what they were undertaking to develop a greater understanding of and to support their own health and wellbeing.

TABLE 1.

Major topics of CPD wellbeing activities undertaken by participants in the ANZCA and FPM CPD program 2021-2022

Mental health wellbeing	Professional/workplace wellbeing	Physical health and safety
Emotional wellbeing (31%) Countermeasures (29%) Cognitive appraisal (26%) Clinical manifestations and harmful behaviours (26%)	Colleague and team wellbeing (60%) Healthy workplaces including BDSH (14%) Leadership, supervision and mentoring (11%) Work-life balance and transitions (11%)	COVID (63%) Non-COVID interventions (37%)

The emphasis on **mental health wellbeing** is consistent with the World Health Organization's (WHO) view that mental wellbeing is the 'foundation for wellbeing and effective functioning of an individual'[4]. Major topics within the mental wellbeing area (Table 1) addressed transient state-based emotions as well as the more enduring (and severe) clinical manifestations of mental (ill) health, such as burnout, post-traumatic stress disorder (PTSD) and suicide (see ANZCA resources at the end of this article if you are worried for yourself or a colleague).

Within the **professional/workplace wellbeing** area (table 1), most activities focused on colleague and team wellbeing. 260 participants recorded their attendance across two key college-run presentations:

- *Supporting conversations with colleagues*, a virtual workshop during the 2021 Annual Scientific Meeting (ASM) facilitated by Dr Antoinette Brennan, which focused on communication with peers.
- *Critical incident debriefing* at the Combined Special Interest Group (SIG) virtual meeting in October 2021. Facilitated by Dr Liz Crowe, this focused on debriefing anaesthetists following a critical incident, with the aim of providing an opportunity for learning, improvement and understanding, as well as acknowledging and addressing colleagues and team members' initial reaction to the event.

College-run activities continue to grow in this space, with the recent 2023 ASM offering nine wellbeing sessions and the June 2023 Combined SIG meeting supporting further work on the *Critical Incident debriefing toolkit*. User-identified CPD wellbeing activities, not run by the college, focused on peer support training, team building and recognition of teamwork competencies in supporting peers' wellbeing.

As exposure to respiratory infections is a recognised occupational hazard for anaesthetists[5], it is unsurprising that COVID-related wellbeing featured so strongly in the **physical health and safety** category, particularly for the time analysed. Non-COVID activities in the physical health and safety area focused on a wide range of preventative and ameliorative interventions that addressed fatigue prevention, sleep strategies, prevention and management of musculoskeletal disorders, hand hygiene and hazardous chemical safety.

CONCLUSIONS AND FUTURE DIRECTIONS

The activities chosen include psychological, social, physical, and environmental components, consistent with the definition of wellbeing as "individuals have the psychological, social and physical resources they need to meet a particular psychological, social and/or physical challenge"[6]. Results suggest CPD participants broadly understand wellbeing.

Findings will support college-led developments in all three areas of wellbeing – including guiding future events, courses and resources. The ANZCA and FPM CPD review project group plans to use these insights to update wellbeing resources, and refine the offerings that members want to see.

The application of our results extends beyond the college CPD program, with positive opportunities across other college departments (for example, collaboration on library resources and wellbeing networks) and other medical communities. The Australian and New Zealand Association for Health Professional Educators (ANZAHPE) recent conference was an exciting occasion to communicate and promote a culture of wellbeing in clinical and learning environments across professions.

LOOKING FOR A CPD WELLBEING EDUCATION SESSION ACTIVITY?

The ANZCA Wellbeing SIG Library Guide is designed so you can locate resources relevant to medical practitioner wellbeing. It includes the ANZCA Critical incident debriefing toolkit. Watch out for forthcoming events at SIG meetings and other college run-events.

Your CPD team is always excited to hear from you and we are here to help. We recognise the importance of health and wellbeing and are passionate about professional development.

Ms Nadja Kaye,
CPD Lead

References

3. Rama-Maceiras. Stress and burnout in anaesthesia: a real-world problem? Curr Opin Anaesthesiol 2015; 28:151.
4. ANZCA news, April 2022. *Wellbeing CPD education sessions activity.*-https://www.anzca.edu.au/news/cpd-news/new-wellbeing-cpd-education-sessions-activity
5. Devonshire, Green, Kaye (2021). ANZCA Bulletin, Summer 2021, 'Supporting wellbeing through continuing professional development, p.20.
6. World Health Organization (WHO), 2004. Promoting mental health: concepts, emerging evidence, practice (Summary Report). Geneva: World Health Organization. https://www.who.int/publications/i/item/9241562943.
7. Harrison. The ailing anaesthetist. Anaesthesia 2014; 69:9.
8. Wilson. Exploring the relationship between mentoring and doctors' health and wellbeing: A narrative review. J Royal Soc Medicine 2017; 110:188. https://doi.org/10.1177/0141076817700848

Acknowledgements:

Dr Mary O'Hare, ANZCA Education Senior Research Officer

Ms Ellen Webber, ANZCA Learning and Innovation Manager

Dr Debra Devonshire, CPD Committee Chair

Dr Sarah Green, Deputy CPD Committee Chair

Introducing your new member dashboard

This winter, we're replacing the ANZCA website portal with an exciting new personalised web experience for all fellows, trainees, SIMGs, and CPD participants.

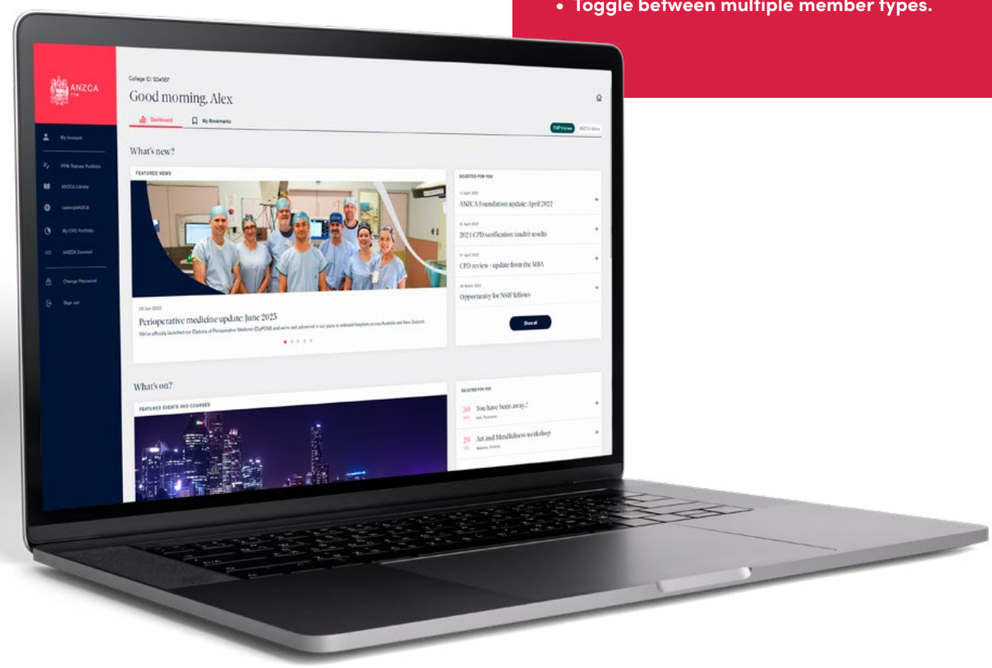
In addition to being a one-stop shop for all your online services, your member dashboard will also provide you with curated news and events content based on your specialty and member type; the ability to bookmark pages throughout the website; and personalised social media feeds.

Once it's launched, you'll access your dashboard in the same way that you currently access the portal – by logging on with your unique ANZCA ID and password.

Over the coming months, we'll be introducing a range of additional features including notifications and personalised job ads.

KEY FEATURES AT A GLANCE

- **Personalised quick links to your online services including Learn@ANZCA, CPD portfolio and trainee portfolio.**
- **Featured news and events content.**
- **Curated news and events content (based on your specialty and member type).**
- **Add and edit bookmarked content at the click of a button.**
- **Specialty-specific social media feeds.**
- **Toggle between multiple member types.**



Flying start for new exam committee chair

Dr Min-Qi Lee knows all too well the impact of the postcode lottery of health on patients living in regional, rural and remote areas.

While she lives in Adelaide on Kaurna Country and works as a consultant anaesthetist with an interest in trauma, obstetrics and perioperative medicine at the Royal Adelaide Hospital and the Adelaide Women's and Children's Hospital, she is also a medical retrieval consultant for the South Australian Ambulance Service's MedSTAR, the state's 24-hour emergency medical retrieval service.

As a medical retrieval specialist, Min-Qi's MedSTAR role involves bringing critical care services to rural and remote locations across South Australia. This can be as part of a team transporting patients who require transfer to a higher level of care or working with nursing and paramedic colleagues located in the ambulance service's nerve centre to provide clinical advice and logistical support for patients requiring critical care transport.

"It's a job that really opens your eyes to the inequalities of access to healthcare across the country," she explains.

"Some patients will of course need to have more specialised treatment in metropolitan centres, but I would love to see more patients be able to have prompt and appropriate care in their local communities, close to their support networks rather than having to wait long periods of time and travel vast distances to access care.

"Aeromedical transport is a limited resource and optimising its allocation can only be a positive for the patients, their families, the health system as a whole and also the environment."

Min-Qi completed her anaesthesia training through the South Australia and Northern Territory rotational anaesthesia training scheme and received fellowship in 2012. In addition to her clinical roles she has been an ANZCA Educators Program facilitator and an ANZCA Workplace-based Assessment regional lead since 2018.

On top of her MedSTAR role, she has been a visiting rural and regional anaesthetist since 2014. She has spent countless hours – often as the only anaesthetist – in Port Augusta, a town with a population of 14,000 located 300 kilometres north-west of Adelaide and South Australia's gateway to the outback.

"What I now know is that you don't have to live and work in a rural area to support rural practice," Min-Qi says.

A passionate supporter of rural access to healthcare Min-Qi is the newly appointed chair of the examination committee for the Diploma of Regional Anaesthesia (DipRGA), a joint initiative of ANZCA, the Royal Australian College of General Practitioners (RACGP) and the Australian College of Rural and Remote Medicine (ACRRM). The 12-month program covers the education, training, and assessment of rural generalist doctors providing anaesthesia services in rural locations.

"What I now know is that you don't have to live and work in a rural area to support rural practice."

"I'm very lucky to have such a diversity of practice in both metropolitan and regional South Australia," she says.

"I've always been interested in rural practice but it's not easy to practice a sub-specialty in rural areas. It has been nearly 10 years since I began working in Port Augusta and I have since been able to mentor practitioners and solo anaesthetists there and in other rural settings, so that side of my practice is very fulfilling.

"I was first contracted to a metropolitan hospital with links to a health network rural hospital in 2014 and this sparked my interest in rural medicine. Every 10 weeks I would do a week at a time in a rural or remote location so over time you not only end up building up a strong relationship with clinicians there but also an understanding of the needs of rural patients.

"We know there is a postcode lottery in health so it's important that we ensure the needs of those communities living outside metropolitan areas are well supported and patients are promptly transferred to metropolitan hospitals when needed. It can be challenging and expensive to transfer a patient with the retrieval service but most patients don't have a choice."

Min-Qi says health resourcing for patients outside metropolitan areas has worsened since the pandemic.

"We now have sicker and older patients who are finding it increasingly difficult to access appropriate healthcare close to home and consequently there is now increasing pressure on metropolitan health providers.

"I would love to see metropolitan health networks expand their outreach to regional areas because we know that 30 per cent of the population do not live in a metropolitan area."

In one example of how the provision of regional medical services has diminished over time she notes that an increasing number of small towns are losing their doctors especially those with advanced skills in anaesthesia, emergency medicine or obstetrics – meaning locals from those towns must travel hundreds of kilometres for surgery or to give birth.

Min-Qi believes the DipRGA will enhance clinical practice and benefit patients living in regional, rural and remote areas because of its stringent standards for safe anaesthesia and sedation.

"We need to support rural, remote and regional medical teams, not just anaesthetists, so patients receive the best healthcare.

"The DipRGA supports this with education, resourcing and continuing professional development and we have been able to do this because the collaboration between all three colleges has been fantastic."

Forty-seven candidates from across Australia have enrolled in the 2023 inaugural diploma intake. The first group of trainees who began the DipRGA program in February this year will sit for the new national exam in early December as part of the diploma's assessment process.

Min-Qi says there is a growing need for rural generalists with skills in anaesthesia practice.

Some rural generalists are already taking a proactive role and have established a network for collegiate support and posting job advertisements.

She encourages ANZCA fellows to consider how they can support their rural colleagues such as through visiting consultant posts or education and training activities.

Carolyn Jones
Media Manager, ANZCA

**Min-Qi preferred that her first name be used throughout this article*

Are you interested in becoming an Australian airway lead?

The Airway Special Interest Group (SIG) is looking to grow its Australian Airway Leads Network to more public and private hospitals.

New Zealand has maintained a robust network of airway leads since 2018. The SIG would like to strengthen the network in Australia with greater engagement and collaboration from nominated airway leads.

While the role is not a formal requirement in the ANZCA accreditation process or part of the curriculum, if your hospital is currently without an airway lead and you have a keen interest in the role, we encourage you to nominate.

For more information go to the college website.

ANZCA online

Wherever you go to for information, events, news, and networking, we've got you covered! Follow us...

@ANZCA and **@ANZCA_FPM** for daily updates on what's going on in the world of anaesthesia and pain medicine. Don't forget to tag us in tweets of interest and DM us if you have any questions or suggestions.

@ANZCA1992 for events and opportunities to get involved in your college. It's also the perfect platform for sharing stories about your specialist interests with family and friends.

@the_anzca for an intimate insight on college life; and tag us in your own ANZCA-related activities.

Australian and New Zealand College of Anaesthetists to connect and collaborate with your college community.

Australian and New Zealand College of Anaesthetists and **Faculty of Pain Medicine** for all our latest video content, including presentations, patient information, interviews, and oral histories.

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

NATIONAL ANAESTHESIA DAY 2023
16 OCTOBER

Anaesthetists – driving integrated, planned and personalised surgical patient care

Celebrate National Anaesthesia Day on 16 October

- **Mark Monday 16 October in your diaries.**
- **Book your hospital foyer space.**

National Anaesthesia Day is held each year to raise awareness of the crucial role anaesthetists play in healthcare.

An ANZCA initiative, National Anaesthesia Day is usually held each year on 16 October to mark the anniversary of the day in 1846 that ether anaesthesia was first publicly demonstrated.

This year our theme is perioperative medicine.

At the 2023 ANZCA Annual Scientific Meeting in Sydney, we launched our Diploma of Perioperative Medicine (DipPOM) to our fellows and trainees as well as those from the colleges of physicians (geriatricians, internal medicine and rehabilitation specialists), surgeons, intensivists and GPs.

Now it is time to explain to our patients how our work will benefit them.

We will explain that perioperative medicine involves a wide range of healthcare professionals working together to improve the patient experience, reduce postoperative complications, reduce inpatient hospital days and reduce early re-admissions following surgery.

Our approach emphasises the importance of an integrated, planned, and personalised approach to patient care before, during, and after any surgical procedure involving anaesthesia.

We are creating videos to explain perioperative medicine to our patients and we will send posters and other material to hospitals in September.

Please contact communications@anzca.edu.au for more information about National Anaesthesia Day and for more information about perioperative medicine go to www.anzca.edu.au/education-training/perioperative-medicine-qualification.

From the contemplation of surgery to an optimal outcome

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

Medical pantry turns waste into a lifeline for many

Images from left: The Medical Pantry team inside their Melbourne warehouse; Dr Martin Nguyen, Medical Pantry founder.

Sending 60 million N95 masks to India and helping local car mechanics in inner Melbourne to repurpose plastic tubing for brake liners is a passion for anaesthetist Dr Martin Nguyen.

In addition to working full-time as a specialist anaesthetist, Dr Nguyen is the founder of Medical Pantry, an organisation that rescues unused medical supplies and equipment and works with partner charities to deliver them to communities that need them. The group's mission statement is to make healthcare environmentally sustainable and divert unused medical supplies from landfill.

It was while he was working as an anaesthesia registrar a decade ago with sustainable healthcare expert anaesthetist Associate Professor Forbes McGain OAM, that he came up with the idea of the pantry. Earlier in his medical training as a medical resident Dr Nguyen had spent time in Vietnam helping local communities and cataract patients where medical supplies were scarce or in short supply.

"Healthcare is the second largest contributor to landfill in Australia and Medical Pantry is trying to address this," he explains.

"In Victoria alone, 35,000 tonnes of waste are sent to landfill so we are hoping to deliver the most medical supplies to underserved communities throughout the world in the most efficient and effective ways possible.

"We do this by working with Australian hospitals, research facilities and universities to rescue unused medical supplies and equipment. With the support of our charitable partners, we donate these supplies to improve the health of those most vulnerable."

A team of 40 dedicated volunteers runs Medical Pantry and all financial donations are used to fund the program and pay for the lease on a warehouse in Melbourne's inner west.

Communities, charities and ministries of health – the pantry's "partners" – are encouraged to "browse" the pantry inventory online to see if there are any supplies or equipment they need. If they can't find what they need they can request help from the pantry which then approaches their suppliers.

The organisation accepts all medical supplies and equipment that can be used for wildlife care or humanitarian aid. As the aim of the pantry is to keep items out of landfill they not only provide much needed equipment offshore but also supply suture equipment for medical simulation courses for medical students in Australia.

"Despite all our hard work, we estimate that less than one per cent of potential items are rescued by Medical Pantry. Pallets and container loads of valuable supplies are dumped into landfill most of which originate from pre-clinical supply chains," Dr Nguyen explains.

One million dollars' worth of consumables was recently sent to Ukraine and three container loads of equipment from the decommissioning of the Epworth Cliveden private hospital in Melbourne were sent to Fiji, Pacific Islands and Zimbabwe.

So far, Medical Pantry has diverted 15,000 tonnes of surplus medical supplies and equipment from landfill.

Friends and supporters include the Royal Melbourne Hospital, Western Health, St Vincent's Hospital Melbourne, Cabrini Health and the Peter MacCallum Cancer Centre.

Dr Nguyen and his team hope to attract more volunteers and financial donors through a new patron program. With additional funding, they aim to hire key staff to establish the charity in Victoria and expand to neighbouring states.

**Medical Pantry is a registered Australian charity and all donations over $A2 are tax deductible. For more information email: martin@medicalpantry.org*

Carolyn Jones
Media Manager, ANZCA

Safety and quality

GLP-1 agonists and gastric emptying

There is good evidence that glucagon-like peptide 1 (GLP-1) agonists, used to treat diabetes and for weight loss, can delay gastric emptying, creating potential safety implications for anaesthetists.

The issue was discussed at a recent ANZCA Safety and Quality Committee meeting following a report from a fellow about two patients undergoing endoscopic gastroscopy who had had significant gastric contents, despite adequate fasting.

GLP-1 is a naturally occurring peptide, produced in intestinal endocrine cells, predominantly in the terminal ileum and proximal colon.

Ingestion of nutrients leads to the rapid release of GLP-1 which acts via cAMP-linked GLP-1 receptors in the pancreas (stimulates insulin release), in the hypothalamus (stimulates satiety centres) and in gastric neuronal cells (slows gastric emptying).

Endogenous GLP-1 is inactivated rapidly with a half-life of two to three minutes.

Pharmacological GLP-1 agonist analogues with a much longer duration of action have been developed and are licensed in Australia for both the treatment of diabetes mellitus – semaglutide (Ozempic), duraglutide (Trulicity) liraglutide (Victoza) and for weight management – semaglutide (Wegovy), liraglutide (Saxenda).

There is good evidence that GLP-1 agonists delay gastric emptying[1-3]. There is also good evidence that diabetics may have reduced gastric emptying, with 30-50 per cent of long-standing diabetics exhibiting abnormally slow gastric emptying.

A recent review of the perioperative implications of GLP-1 use in diabetic patients showed that, with intravenous infusions of rapidly acting GLP-1 the inhibition of gastric emptying may reduce over time[4], however longer acting GLP-1 analogues maintain an impairment of gastric emptying at least out to eight weeks[5].

Additionally, patients using these medications for weight management may have recurrent periods of use with drug "holidays" in between. Intermittent GLP-1 use has been shown to be associated with similar impairment of gastric emptying to acute use[6].

In diabetics, one can consider that there is a significant risk of delayed gastric emptying due to diabetes itself. Cessation of GLP-1 drugs does not change this risk profile and can lead to unwanted periods of hyperglycaemia perioperatively.

In patients using GLP-1 inhibitors for weight management, the use of GLP-1 agonists probably slows gastric emptying.

The clinical significance of this is poorly understood. It may be prudent to cease these drugs, but consideration needs to be given to the duration of effect and the lack of evidence concerning when gastric emptying returns to normal following drug cessation.

Gastric ultrasound can be used as a risk stratification tool to guide perioperative management if prolonged gastric emptying is suspected (BJA Educ. 2019 Jul;19(7): 219–226).

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

References

1. Nakatani Y, Maeda M, Matsumura M, Shimizu R, Banba N, Aso Y, et al. Effect of GLP-1 receptor agonist on gastrointestinal tract motility and residue rates as evaluated by capsule endoscopy. Diabetes Metab. 2017;43(5):430-7.
2. Rayner CK, Watson LE, Phillips LK, Lange K, Bound MJ, Grivell J, et al. Effects of Sustained Treatment With Lixisenatide on Gastric Emptying and Postprandial Glucose Metabolism in Type 2 Diabetes: A Randomized Controlled Trial. Diabetes Care. 2020;43(8):1813-21.
3. Maselli DB, Camilleri M. Effects of GLP-1 and Its Analogs on Gastric Physiology in Diabetes Mellitus and Obesity. Adv Exp Med Biol. 2021;1307:171-92.
4. Hulst AH, Polderman JAW, Siegelaar SE, van Raalte DH, DeVries JH, Preckel B, et al. Preoperative considerations of new long-acting glucagon-like peptide-1 receptor agonists in diabetes mellitus. Br J Anaesth. 2021;126(3):567-71.
5. Meier JJ, Rosenstock J, Hincelin-Mery A, Roy-Duval C, Delfolie A, Coester HV, et al. Contrasting Effects of Lixisenatide and Liraglutide on Postprandial Glycemic Control, Gastric Emptying, and Safety Parameters in Patients With Type 2 Diabetes on Optimized Insulin Glargine With or Without Metformin: A Randomized, Open-Label Trial. Diabetes Care. 2015;38(7):1263-73.
6. Umapathysivam MM, Lee MY, Jones KL, Annink CE, Cousins CE, Trahair LG, et al. Comparative effects of prolonged and intermittent stimulation of the glucagon-like peptide 1 receptor on gastric emptying and glycemia. Diabetes. 2014;63(2):785-90.

Extravasation injury during surgery

This Health Quality and Safety Commission New Zealand report alerts providers to the key findings of a 2021 review. It emphasises the changes implemented to prevent future similar events. Please consider this report, and whether the changes being made are relevant to your own systems.

This report is relevant to:

- Operating theatre staff and team members.
- Quality improvement, clinical risk and patient safety managers.

INCIDENT

A patient suffered an extravasation injury that required skin grafts to repair. The patient has been left with intermittent pain and loss of muscle strength, which has had long-term effects on their working life.

CHRONOLOGY

Mr B had two peripheral intravenous cannulas (PIVCs) inserted (one in each hand) before surgery.

During surgery, both PIVCs were covered by wraps used to secure Mr B's arms and surgical drapes, making it difficult to monitor the PIVC sites for extravasation.

When the surgical drapes were removed post-surgery, it was discovered that Mr B's left wrist and forearm were swollen and discoloured from an extravasation of intravenous fluid and anaesthetic drugs (see image 1).

Mr B subsequently underwent a surgical debridement, a split thickness skin graft and prolonged rehabilitation (see image 2).

Mr B has been left with intermittent forearm pain and reduced muscle strength, which has impacted on his working life.

Image 1.

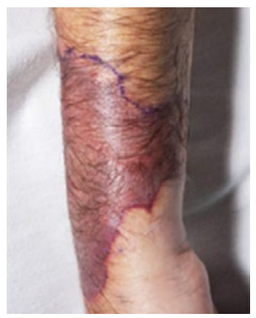
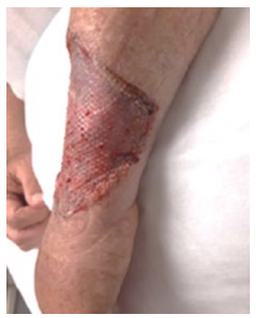


Image 2.



REVIEW FINDINGS

The mechanism that caused the injury was likely multifactorial, however three primary contributing factors were identified:

- The mode of wrapping and securing the arms resulted in venous constriction thereby limiting dilution of drugs administered.
- The peripheral administration of vesicant medicines such as calcium chloride.
- Direct inspection of an intravenous insertion site during surgery is deterred by requiring complicated disruption of sterile surgical drapes and the operating field, and can in turn increase risk of infection

Actions subsequently taken:

- A standardised arm-tucking process was added to the organisation's policy "Positioning the patient in the operating room". Implementation of the policy by perioperative staff was supported by perioperative nurse educators/anaesthetists.
- PIVC checking times to be discussed at "time-out" briefings for any lengthy surgery where PIVC sites are not easily accessible.
- Communication has been sent to anaesthetists and intensivists to highlight the danger of peripherally administered calcium chloride and other vesicant drugs, including to administer through a running intravenous fluid line for dilution if being given via a PIVC rather than a central line.
- A standard operating procedure was developed regarding how to administer necessary vesicant drugs when PIVC sites are not visible during surgery.
- Anaesthesiology and surgical services developed a process for perioperative management of extravasation injury, including review of the intravenous catheter guideline and introduction to perioperative extravasation injury first aid kits.
- The use of ivWatch™ continuous intravenous site monitoring for real-time infiltration detection to be trialled.

COMMISSION COMMENT

- A meta-analysis[1] found that extravasation/infiltration was reported in 13.7 per cent of PIVCs placed in the included studies.
- The PIVC sites most often implicated in extravasation injuries are those where there is little soft tissue protection for underlying structures, such as the hand[2].
- The effects of unrecognised extravasation, as seen in this case, can be severe, resulting in long-term morbidity for patients[3].
- Building regular observation into pre-operative checklists is recommended.

References

1. Marsh N, Webster J, Ullman AJ, et al. 2020. Peripheral intravenous catheter non-infectious complications in adults: A systematic review and meta-analysis. *Journal of Advanced Nursing* 76(12), 3346-62.
2. Al-Benna S, O'Boyle C, Holley J. 2013. *Extravasation injuries in adults.* International Scholarly Research Notices, 2013.
3. Alexander L. 2020. Extravasation Injuries: A Trivial Injury Often Overlooked with Disastrous Consequences. *World Journal of Plastic Surgery* 9(3): 326.

Safety alerts

Safety alerts appear in the "Safety and quality news" section of the ANZCA E-newsletter each month.

A full list is available on the ANZCA website: www.anzca.edu.au/safety-advocacy/safety-alerts.

Recent alerts:

- Dexamethasone brand change contains propylene glycol.
- TGA warns consumers of Ozempic pill scams.
- Transition to sole medicine ingredient names in Australia.

EXTRAVASATION INJURIES REPORTED TO WEBAIRS

The webAIRS database holds 146 reports related to extravasation. Almost all resulted from displaced peripheral intra-venous cannulae. A few were related to central venous or arterial access which have the same propensity to cause subcutaneous swelling. Where the location was specified, the great majority of the cannulae were in the forearm, hand or wrist, and about one in six were in the neck.

In about half of the reports, extravasation was detected during induction of anaesthesia with failure or partial failure of the hypnotics or relaxants to take effect. In one case where the relaxant failed, pulmonary aspiration of gastric contents occurred.

In almost a of third incidents the cannula failed during maintenance and in the cases involving total intravenous anaesthesia this was often detected by signs of possible awareness. Some cases occurred during emergence when reversal of relaxants failed and a small number were reported post-operatively. Several reports noted significant swelling and in one of these there were signs of arterial compromise.

Most of the outcomes were coded by the reporter as no harm (62 per cent) and just over 30 per cent were reported as temporary harm. There were three deaths, but these appeared to be unrelated to the extravasation event.

These initial results provide an overview of the data reported. WebAIRS collects data from de-identified voluntary reports and the ANZTADC committee encourages further reporting of arterial and venous extravasation incidents to provide more insight into problems arising from these events.

Anaesthetists should warn about contraception effectiveness

The effectiveness of hormonal contraception (HC) can be compromised in multiple ways in the perioperative period.

Despite widespread knowledge of the potential for HC to be ineffective following surgery, studies suggest that few anaesthetists counsel patients regarding this[1-3].

Therefore, appropriate education and policies are required to overcome discrepancies between knowledge and practice.

HC is commonly used in Australia and New Zealand, with 50-80 per cent of Australian and New Zealand women using the oral contraceptive pill at some stage during their life[4].

There are a broad range of HC products including oral contraceptive pills, injectables, implants, and other delivery devices such as vaginal rings. The contraceptive effect of these products is reliant on the maintenance of adequate levels of progesterone and/or oestrogen.

In the perioperative period, numerous factors may impede the effectiveness of HC. Fasting, nausea, vomiting, and other changes in enteral absorption may interfere with absorption. Large fluid shifts and the surgical stress response can alter the pharmacokinetics of HC.

Some healthcare providers may advise patients to stop using oestrogen-containing contraceptives due to the risk of venous thromboembolism. Human factors such as perioperative anxiety or fatigue may also lead patients to forget to take their HC.

Many medications can also interfere with HC levels. Sugammadex exhibits one of the most significant pharmacologic interactions with HC, causing a 40 per cent reduction in oestrogen levels and 20 per cent change in progesterone levels[5].

The administration of corticosteroids such as dexamethasone during the perioperative period induces CYP450 enzymes, leading to reduced levels of oestrogens. Antibiotics, antiemetics, barbiturates, and many other drugs used in the perioperative period may potentially interact with HC absorption or metabolism. The impact of these factors on individual patients is difficult to quantify and not always possible to predict.

Both the pharmaceutical company Merck and the Society for Obstetric Anesthesia and Perinatology recommends the use of alternative contraception methods for seven days following the perioperative use of drugs that may interact with HC absorption or metabolism[6,7].

As there is a lack of high-quality evidence regarding HC failure in the perioperative period, a pragmatic approach may be to recommend that patients use alternative contraceptive methods for seven days following recovery from surgery and be informed of other effects of HC withdrawal.

"Sugammadex (causes) a 40 per cent reduction in oestrogen levels and 20 per cent change in progesterone levels."

It is important this is effectively communicated to patients and not lost amongst the enormity of information provided to them around the time of their surgery.

Dr Mincho Marroquin-Harris FANZCA
Dr Ben Olesnicky FANZCA
Royal North Shore Hospital

References

1. Passi NN, Mutebi M, Tan M, Oliver CM. Contraceptive failure and sugammadex administration: a single centre survey and audit of professional knowledge and practice. Br J Anaesth. 2023 Mar;130(3):e412-e414.
2. Dwan RL, Raymond BL, Richardson MG. Unanticipated Consequences of Switching to Sugammadex: Anesthesia Provider Survey on the Hormone Contraceptive Drug Interaction. Anesth Analg. 2021 Oct 1;133(4):958-966.
3. Lazorwitz A, Dindinger E, Aguirre N, Sheeder J. Pre- and post-operative counseling for women on hormonal contraceptives receiving sugammadex at an academic hospital. J Anesth. 2020 Apr;34(2):294-297.
4. Richters J, Grulich AE, de Visser RO, Smith AM, Rissel CE. Sex in Australia: contraceptive practices among a representative sample of women. Aust N Z J Public Health. 2003;27(2):210-
5. Devoy T, Hunter, M and Smith NA. A prospective observational study of the effects of sugammadex on peri-operative oestrogen and progesterone levels in women who take hormonal contraception. Anaesthesia. 2023 Feb;78(2):180-187.
6. US Food and Drug Administration. Prescribing Information: Bridion (sugammadex). Vol Reference ID: 3860969. December 2015. Accessed 20/5/2023 https://www.accessdata.fda.gov/drugsatfda_docs/ label/2015/022225lbl.pdf
7. Willett AW, Butwick AJ, Togioka B, Bensadigh B, Hofer J, Zakowski M. Society for Obstetric Anesthesia and Perinatology Statement on sugammadex during pregnancy and lactation. 2019. Accessed 20/5/2023. https://www.soap.org/assets/docs/SOAP_Statement_Sugammadex_During_Pregnancy_Lactation_APPROVED.pdf

Anaesthesia-related deaths

Example case from SCIDUA's 2019 Special Report

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

CASE 2: ORTHOPAEDIC SURGERY

An 89-year-old female – Short Gamma Nail of the hip.

Background history

She had multiple co-morbidities: Congestive cardiac failure, ischaemic heart disease, pulmonary hypertension, chronic renal failure, Type 2 diabetes and dementia.

Anaesthetic details

An 18 g IVC and arterial line was inserted and 250 mls of Plasmalyte was given prior to induction. Induction consisted of sevoflurane 1%, fentanyl 25 µg and vecuronium.

The patient was intubated. Approximately five minutes post induction a steady drop in blood pressure was noted – she was unresponsive to fluids or metaraminol, leading to loss of cardiac output.

CPR was commenced and Adrenaline boluses were given (2 mg total). Three minutes later ROSCO.

A discussion was held with surgeons and intensive care physicians, and a decision made to palliate. A fascia iliaca block was performed for pain control and the patient was extubated. She died five hours later.

Learning points

- In elderly frail patients even the smallest amount of anaesthesia can cause compromise.
- Pulmonary hypertension is a major cause of morbidity and mortality and needs to be appreciated.
- Positive pressure ventilation does cause a major haemodynamic shift and compromise in the underfilled patient.
- Consider a transthoracic echocardiogram preoperatively – this will help guide fluid loading and determine the severity of pulmonary hypertension.
- Having invasive monitoring present during the induction phase and prior to the establishment of positive pressure ventilation in these patients will help detect compromise early.
- Sick patients may benefit from the institution of vasopressors with induction agents.
- If one vasopressor fails (for example, metaraminol), try another (for example, ephedrine).
- It is well worth having end of life discussions with family preoperatively to guide management in these situations.

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.

WebAIRS: Jaw dislocations not uncommon

Jaw dislocations are rarely reported in the general population. However, they are not an uncommon complication of general anaesthesia requiring airway manipulation.

Eighteen incidents of jaw dislocation were identified in 3497 airway incidents reported to the webAIRS database (0.5 per cent of airway incidents). These incidents occurred during anaesthesia for gastroscopy, colonoscopy, laryngeal mask airway (LMA) insertion and with yawning on induction.

Jaw dislocation has also been reported in the medical literature with laryngoscopy and intubation, however, the exact prevalence of temporomandibular joint (TMJ) dislocation following laryngoscopy is not known. Serious complications of TMJ dislocation are rare.

The TMJ is an articulation between the mandible and the temporal bone of the skull and consists of a mandibular condyle and the glenoid fossa. An intra-articular disc sits between these two concavities.

The mechanics of the TMJ are under the control of the muscles of mastication (masseter, medial and lateral pterygoids, temporalis muscle) and ligaments (stylomandibular, sphenomandibular, pterygomandibular), while nervous control is by the mandibular division of the trigeminal nerve via the masseteric and auriculotemporal nerves. Blood supply is via the superficial temporal branch of the external carotid artery.

The normal movements of the TMJ are rotational and translational. Dislocation occurs when the mandibular condylar head moves outside the glenoid fossa and cannot move back into its normal position within the fossa. Dislocation can be either unilateral, bilateral, partial (subluxation) or complete. There is no age or gender predilection. The most common is an anterior dislocation which can be spontaneous or associated with airway manipulation.

The most common clinical feature of dislocation is an open mouth lock (see table 1). Severe pain associated with a dislocation nearly always indicates a mandibular fracture and is a contraindication for re-location attempts. Recurrent dislocations may be seen in connective tissue syndromes such as Ehlers-Danlos, Marfans and Oro-facial dystonia.

ASSOCIATED FACTORS REPORTED IN WEBAIRS

- No incident was associated with the management of a difficult airway.
- Past history of jaw clicking or dislocation of the TMJ and other joints was obtained in five cases prior to anaesthesia. In these patients, no previous investigation was mentioned as to the cause of these joint problems. In four cases a past history of TMJ dislocation was obtained after it had occurred. TMJ function was not asked about during the pre-anaesthesia consult in the remaining incidents.
- Forceful insertion of a mouth guard, LMA or oropharyngeal airway was not reported, however, forceful jaw thrust was. TMJ dislocation can occur after any airway manipulation whether forceful or not.
- Yawning during induction.
- Only one dislocation was successfully reduced by an anaesthetist, the rest by surgeons or other non-anaesthesia consultants.
- Patient demographics were not contributing factors.
- The majority were diagnosed in the post anaesthetic care unit (PACU) or in the hospital ward and not by the anaesthetist.
- Careful, gentle airway management did not prevent a further dislocation in patients with a previous history of TMJ dislocation.
- Any dislocation needs to be reduced as soon as possible because prolonged spasms of the muscles of mastication may make a surgical reduction necessary.

The traditional method of jaw reduction was first described by Hippocrates and is called the “Bimanual method”. With the patient sitting, the operator is positioned facing the patient. The operator's gloved-wrapped thumbs (wrapped with gauze to prevent biting trauma) are placed on the posterior molar teeth and are pushed downwards, while the other fingers grasp the lower edge of the anterior mandible and are lifted upwards, while the entire mandible is being pushed backwards.

The mandible will be felt to move posteriorly over the anterior eminence of the glenoid fossa relocating the condyle to its normal position. If the reduction proves difficult an injection of LA into the muscles may help. Additional sedation might be required. An irreducible dislocation may indicate soft tissue between the condyle and glenoid fossa, requiring an open surgical reduction.

If the dislocation is due to jaw thrust or during laryngoscopy, continuation of general anaesthesia will allow relocation of the jaw. The insertion of a laryngeal mask (LM) may be required for airway control until the mandible has been relocated. A rigid curved second generation LM may have limited application in these cases because of the difficulty in passing a rigid device through a very limited mouth opening, hence the Classic LM is the one of choice.

Occasionally the joint can re-dislocate, so a Barton bandage should be applied if this occurs.

RECOMMENDATIONS FROM THE WEBAIRS REPORTS

These incidents indicate that TMJ dislocation is not a rare complication of upper airway manipulation. Anaesthetists should be aware of this problem and be prepared for its occurrence and immediate management which involves airway rescue and reduction of the dislocation. Anaesthetists should know at least one method of TMJ dislocation reduction.

The PACU discharge check must include a demonstration that the patient can open and close their mouth.

Gentle airway management in any patient with a history of TMJ problems may not prevent dislocation.

During the pre-anaesthesia check, assessing the TMJ's function should be a routine part of the airway examination. If questions related to a history of jaw dislocation or jaw clicking are negative then a question concerning dislocations of other joints should be asked. During the Mallampati assessment, and during jaw protrusion the patient should also be asked if the manoeuvres are painful or if there is a sensation of jaw clicking.

All patients with a history of TMJ dislocation should be referred for investigation to exclude myotonia, muscular dystrophies, Parkinson's disease, multiple sclerosis and told that it is important to alert the anaesthetist should they require any further anaesthesia.

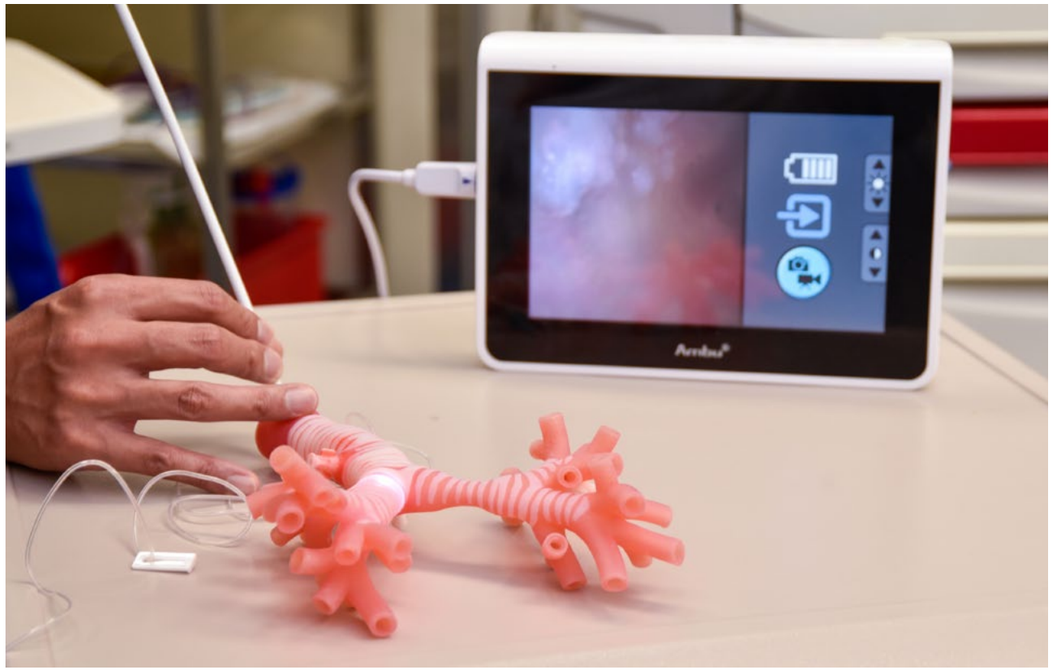
A non-rigid LMA should be available for airway rescue.

Table 1. The clinical signs and symptoms of TMJ dislocation

1. Discomfort – severe pain indicates an associated mandibular fracture.
2. Inability to open or close the mouth.
3. Speech difficulty.
4. Drooling.
5. The mandible is locked in a forward position.
6. TMJ space is empty and painful to palpation.

Dr Chris Acott AM, FANZCA and the ANZTADC Case Report Writing Group

3D model drives new era for anaesthesia



In a move that could revolutionise anaesthesia practice and training, two New Zealand anaesthetists have teamed up with industrial designers to produce lifelike 3D-printed tracheas.

The brainchild of Wellington Hospital anaesthetists Dr Jeremy Young and Dr James Broadbent, the replica tracheas represent a massive leap forward in realism – specifically appearance, texture and flexibility.

Dr Young's interest in 3D printing tracheas goes as far back as 2014 when he was working as a simulation fellow.

"I felt the models we were using at the time for CICO (can't intubate, can't oxygenate) were unrealistic and low fidelity."

He began discussions with Bernard Guy from Victoria University of Wellington's design school about creating a 3D-printed trachea, however an early model was extremely basic, falling apart whenever it was cleaned.

Following a move to Melbourne, Dr Young continued to explore the possibilities of 3D-printed tracheas, including publications and presentations on the topic.

Returning to New Zealand in 2017 Dr Young resumed work on the project alongside Dr Broadbent, who was also keen to explore the possibilities of 3D printing tracheas, with a particular focus on paediatrics.

Reconnecting with Mr Guy, the team developed improved prototypes leading to a high-fidelity 3D-printed paediatric trachea based on a CT scan.

With the help of students on the university's summer scholarships program, they have refined the trachea designs, and now have a 3D-printed trachea which Dr Young describes as being "dynamic in its properties".

"People have printed tracheas before, but where our model stands out is its dynamic features, which we believe are unique.

"If you want, you can have aspects of it moving, potentially showing breathing, normal physiological movements, or dynamic pathology.

"You can effectively create cysts within the lumen of the trachea and fill them with fluid simulating blood or pus, and then make an incision and suction the contents.

"We've also created a way to inject fluid through a tiny hole in the wall of the trachea which could be used to simulate active bleeding of a tumour, for example.

"No one else that I can find in anaesthesia has anything like this, a trachea that has moving parts – we're excited about the potential to build on this and create more novel prints," Dr Young says.

The pair's latest research highlighting the dynamic 3D-printed trachea has just been published in *Anaesthesia and Intensive Care*.

The collaboration with Victoria University has been critical to the success of the project, Dr Broadbent says.

"We have the clinical ideas and applications and are able to review and test the prototypes, but they have the technical knowledge that very few people have, to be able to create these amazing products."

The technology is still in its infancy, and both doctors are excited by its potential.

Already they can create 3D-printed tracheas of almost any colour and any degree of hardness or softness, as well as flexibility. The cost of making each trachea depends on size, complexity and usage.

Alongside helping to train the next generation of anaesthetists, Dr Young says 3D-printed tracheas will help patients and their whānau understand their illnesses.

"Patients would love to be able to see what's going on, what needs to be done, and how the surgeons are going to fix it up."

Dr Young and Dr Broadbent have already sent some of their tracheas away for others to incorporate into their training models. They've also used a 3D-printed trachea of a four-year-old child in a simulation course in Wellington Hospital at the end of last year, and a paediatric anaesthesia emergency course included a trachea printed to resemble that of a six-month-old child.

"It's been an amazing educational tool for people to realise 'this is a lot smaller than I thought it was' and it's really compressible, it just gives the context of what you're dealing with. There's nothing available like this, where you can get your hands on it," Dr Young says.

Looking to the future, the pair want to examine ways to incorporate the tracheas into existing simulation models, as well as designing and 3D printing a larynx with moving vocal cords.

"One of the things that lets us down a little bit is that we haven't yet incorporated vocal cords and the larynx, so it's something we've been talking about – creating a larynx that's associated with our trachea," Dr Broadbent says.

Another potential new project is designing a trachea with a removable segment, which can be cut open as part of a simulation and easily replaced, saving on cost, time and wastage.

As the technology develops, the pair hope that doctors may one day be able to take scans of patients they're about to operate on, 3D print the relevant body part, and practice before the real-life procedure.

Reon Suddaby
Senior Communications Advisor
New Zealand, ANZCA

Images from left: The 3D-printed tracheas set a new standard in realism; Anaesthetists Dr James Broadbent and Dr Jeremy Young are excited by the potential of their 3D-printed tracheas.

Global development

ANZCA launches new global development strategic priorities

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 winner is selected by an independent panel of members from UPNG examiners and the ANZCA Global Development Committee. Pictured are (from left) recent winners Dr Lyanne Painap (2018), Dr Alu Kali (2019) and Dr Indira Vele (2021) who travelled to the 2023 ANZCA Annual Scientific Meeting in Sydney as part of their prize.

ANZCA has a long history of training, education and related support initiatives in low- and middle-income countries. Dr Michael Cooper, chair of the Global Development Committee from 2012 to 2022 has written a comprehensive history of the committee which is available upon request from the college library or by emailing globaldevelopment@anzca.edu.au.

In 2017 the committee launched its 2017-2022 strategic priorities which identified four areas of focus for committee activities – training and education, medical and educational equipment, advocacy and collaboration and evaluation. The limitations on travel for more than half of the five-year period of this plan due to COVID-19 significantly impacted activities. However, the pandemic also presented new opportunities for partnerships, collaboration and education and learning modalities.

The committee worked with other colleges, societies and government departments to provide practical support such as online forums, developing educational resources and donating equipment and consumables. Highlights from the committee's 2018-2022 activities include:

- The establishment of the Pacific Online Learning and Education (POLE) collaboration to continue our support and maintain our connection with our overseas colleagues. The first online education sessions commenced in February 2021. Since then, nearly 40 sessions covering numerous topics (identified by participants and working group members) have been delivered to participants from countries including Papua New Guinea, Timor-Leste, Solomon Islands, Samoa, Micronesia and Fiji.

Read more about the strategy on our website.

Left: Operating room, Port Moresby General Hospital. Credit: Roger Thornton.

- Supported attendance for trainees and consultants in the region to attend meetings including the ANZCA Annual Scientific Meeting and the World Federation of Societies of Anaesthesiologists (WFSA) World Congress of Anaesthesiology, with over 20 anaesthetists from the Pacific funded to participate in both major educational events.
- Collaboration with Interplast Australia and New Zealand to bring a series of anaesthesia and pain medicine-related education webinars to clinicians across the Asia-Pacific. The inaugural webinar in the series, *ICU management of paediatric patients*, saw 88 clinicians across 18 countries participate.
- With support from the WFSA, the Australian Society of Anaesthetists, the International Association for the Study of Pain and the Northern Hospital, a virtual Essential Pain Management (EPM) course was developed in partnership with Interplast and housed on the Praxhub learning network site. EPM online has received over 21,000 views since its launch at the virtual WFSA World Congress in September 2021.
- In 2020 the college committed to supporting a doctor in Timor-Leste to train and complete their master of Anaesthesia at the Fiji National University. Training continued throughout COVID-19, however training was conducted in Timor-Leste rather than Fiji for most of 2021. Dr Maria da Piedade is completing her third year in 2023 and will return to Timor-Leste to complete her final research project year.
- Continued education visits to Papua New Guinea including teaching visits, the annual Medical Symposium and Society of Anaesthetists of Papua New Guinea workshop and support for external examiners.
- Working with the ANZCA library team to research access to journals through Hinari and develop an easily accessible Asia-Pacific resources library guide.

Building on this work, the committee now looks to the next five years with the launch of our 2023-2027 strategic priorities. Focusing on three overarching areas, the committee continues its commitment to support colleagues in Papua New Guinea, Timor-Leste and other Pacific nations as we work towards ensuring access to safe, affordable surgical and anaesthesia care when needed.

"The Global Development Committee continues its commitment to support colleagues in Papua New Guinea, Timor-Leste and other Pacific nations."

The areas of focus for 2023-2027 are:

Workforce and capacity building

The college will work alongside colleagues in Papua New Guinea and other Pacific nations to help build and support their workforce and capacity through educational and support initiatives as guided by colleagues in-country.

Partnerships and collaboration

The college will develop, maintain and build partnerships with societies, hospitals and universities in the Pacific and like-minded colleges, societies and organisations in Australia and New Zealand to expand opportunities and ensure a collaborative approach is taken to initiatives.

Advocacy and evaluation

The college will advocate for the importance of anaesthesia, perioperative medicine and pain medicine in the Pacific at various levels within its sphere of influence. The college will evaluate its programs to ensure aims and objectives are being met.

I invite you to review our latest strategic priorities paper which includes a detailed review of the committee's 2018-2022 activities and our plans for the next five years. Thank you to all the committee members and friends of the committee who generously volunteer their time to help build a sustainable anaesthesia and pain medicine workforce with our nearest neighbours.

Dr Yasmin Endlich
Chair, Global Development Committee

Pacific anaesthesia training program unites Timor-Leste and Fiji

Image: Dr Maria da Piedade and Dr Meg Walmsley

Dr Maria da Piedade will be one of only seven local anaesthetists in Timor-Leste when she completes her training next year.

As the tiny Pacific nation of 1.4 million people does not have an anaesthesia training program, she has spent the last three years living and working in Suva, Fiji where she is in the final stages of Fiji National University's (FNU) anaesthesia training program. Her training in Fiji is jointly funded by ANZCA through its Global Development Committee and the Timor-Leste government.

Dr da Piedade spent four years in Cuba for the start of her medical degree, before returning to Dili for another two years to complete her studies. She then spent several years working as an anaesthesia registrar in Dili before starting formal training in Fiji. She is one of 36 anaesthesia trainees from eight Pacific countries including the Solomon Islands, Samoa, Tonga, the Cook Islands, Tuvalu and Kiribati who are enrolled in Fiji's Masters of Medicine in Anaesthesia training program. Two trainee anaesthetists from Timor-Leste are enrolled in the FNU program.

When the onset of COVID-19 in 2020 interrupted her training, she was able to return to Dili to see her husband and two children, now aged six and eight, during the height of the pandemic before returning to Suva last year.

Dr da Piedade was in Sydney recently with ANZCA fellow Dr Meg Walmsley to attend the 2023 ANZCA Annual Scientific Meeting. ANZCA's Global Development Committee sponsored Dr da Piedade's attendance at the meeting.

Dr da Piedade says there are many challenges to providing much needed anaesthesia services in her country.

"At our main hospital in Dili is we have only three operating theatres and a lack of equipment and anaesthetic drugs is part of everyday practice," she explains.

Dili, with a population of about 250,000, is the main referral hospital for the country.

Timor-Leste has six local consultant anaesthetists, all working in the Guido Valadares National Hospital (GVNH) in Dili which admits about 300 patients each month for general surgical, paediatric, obstetric and gynaecological procedures and some neurological cases. Another five regional hospitals provide basic medical care throughout the country with anaesthesia nurses.

The World Federation of Societies of Anaesthesiologists (WFSA) estimates Timor-Leste has approximately one anaesthesia provider per 100,000 population, compared to Australia's rate of 23 per 100,000.

"In Timor-Leste, we have no access to CO2 monitoring or end tidal agent monitoring. The anaesthetic halothane, an agent no longer available in Australia, is the mainstay of anaesthesia in Dili," Dr da Piedade explains.

"In Suva where I am training, many patients at the Colonial War Memorial Hospital have high ASAs with advanced and late presenting co-morbidities. Diseases like hypertension, rheumatic heart disease with mitral stenosis and diabetes are common. That too is a challenge in terms of how we treat them."

Dr Walmsley, an associate professor of anaesthesia at the Fiji National University, works clinically at the Colonial War Memorial Hospital and oversees the registrar training, teaching and exam process in Suva. She has lived there since January 2022 having moved from Darwin to take up her role.

Carolyn Jones
Media Manager, ANZCA

Support these programs through the foundation by scanning this QR code to donate.

Connecting in Sydney

at the ANZCA ASM

IT'S A WRAP!

At the closing plenary we could barely believe that the whirlwind of the past few days was over.

Our vision that we could "Be Connected" in person in Sydney had been realised.

After the separation and uncertainty of the last few years due to the COVID-19 pandemic, we believe we also represented the ANZCA Annual Scientific Meeting (ASM) teams before us who missed out on delivering their own in-person conference. We loved being able to be together again – in the workshops, the scientific sessions, the healthcare industry exhibition, the social program and even in the corridors of the International Convention Centre.

It was a wonderful reminder of what makes the ANZCA ASM unique – excellence in scientific education and collaboration, world-class workshops, and the feelings of connectedness within our community. We were very fortunate to have had the opportunity to work with our amazing ANZCA professionals and our Regional Organising Committee and we will miss them all.

Being part of this ASM was one of the most professionally satisfying events of our careers and we will fondly remember it for years to come.

Our deepest gratitude extends to the hundreds of volunteer speakers, teachers and facilitators who shared their knowledge and expertise with all of us. And overall, our thanks to the whole fellowship, for joining us in person and online. Looking forward to a Limitless Brisbane 2024!

Dr Tanya Selak and Dr Shanel Cameron
ASM Co-Convenors

Getting connected in Sydney

WELCOME TO OUR NEW FELLOWS

On Saturday 6 May we held our 2023 College Ceremony – the biggest on record, with more than 260 new ANZCA and FPM fellows presenting. Nearly 900 people around the world watched the College Ceremony livestream on Facebook.

BY THE NUMBERS

Over five fabulous days we hosted 2489 delegates including 494 virtual (about 60 more registered after the ASM) who heard 176 speakers in six plenary and 40 concurrent sessions; attended 137 workshops, masterclasses, and small group discussions; met with 47 healthcare industry exhibitors; and enjoyed an incredible array of social activities from fun runs to the gala dinner.

From top: ANZCA trainees Dr Felicity Fletcher and Dr Sarah Correa, who sang the Australian and New Zealand national anthems respectively at the College Ceremony; After the College Ceremony the welcome reception was held at the Sydney Modern.

ROC STARS!

Thank you to the wonderful Sydney 2023 Regional Organising Committee for hosting such a great meeting.

GALA DINNER

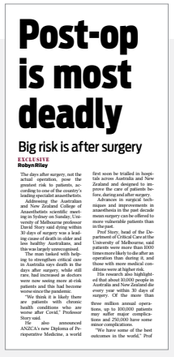
The Gala Dinner on Monday night was a big success.

SATELLITE MEETINGS

In addition to the ASM we held three satellite meetings in and around Sydney. The 2023 FPM Symposium had more than 260 delegates (68 virtual), and the Obstetric Anaesthesia Special Interest Group Meeting (pictured) had 274 delegates in person and 189 virtual. The Emerging Leaders Conference had 50 delegates, mentors and speakers.

CONNECTING ONLINE

Nearly 500 people "joined the conversation" via the hashtag #ASM23SYD which has more than 21 million impressions. Watch behind the scenes interviews and our ASM "hot takes" over on our Instagram to find out all the top sessions to go back and watch OnDemand.



Post-op is most deadly

Big risk is after surgery

EXCLUSIVE
Robyn Riley

The days after surgery, not the actual operation, pose the greatest risk to patients according to one of the country's leading specialist anaesthetists.

Addressing the Australian and New Zealand College of Anaesthetists annual meeting in Sydney on Sunday, University of Melbourne professor Michael Peyton said the first 30 days of surgery was a leading cause of death in older and less healthy Australians, and this was largely unrecognised.

Prof Peyton is also campaigning to strengthen critical care in Australia says death in the days after surgery, in intensive care, had increased as doctors were now seeing more at-risk patients and this had become worse since the pandemic.

"We know that there are patients with chronic health conditions who are worse after Covid," Professor Story said.

He also announced ANZCA's new Diploma of Perioperative Medicine, a world first soon be trialled in hospitals across Australia and New Zealand to help doctors improve the care of patients before, during and after surgery.

The diploma will focus on risk, risk reduction and improvements in anaesthesia in the past decade means surgery can be offered to more vulnerable patients than ever before.

Prof Story, head of the Department of Critical Care of the University of Melbourne, said patients were more than 1000 times more likely to die after an operation than during it, and those with more medical conditions were at greater risk.

His research also highlighted that about 85,000 people in Australia and New Zealand die every year within 30 days of surgery. That is more than three million annual operations, up to 100,000 patients may suffer major complications and 250,000 have some kind of complication.

"We have some of the best outcomes in the world," Prof

ASM AND THE MEDIA

ANZCA released seven media releases in Australia and New Zealand on a diverse range of topics including the perioperative medicine diploma launch, doctors' burnout, menopause, the language of pain and the museum oral archive project.

Nearly 500 articles and radio broadcasts were syndicated to print and online news mastheads and nearly five million people read or listened to articles and broadcasts about ASM presentations.

The Numbers

21.702M Impressions
3,506 Tweets
494 Participants
5 Avg Tweets/hour
7 Avg Tweets/participant
Tweet

2023 College Oration – Polar expeditioner Dr Gareth Andrews

"It was this expedition to Antarctica that really saw the skills I have acquired as an anaesthetist to complement my experience as an explorer. To allow us to plan and execute a safe and successful expedition involves meticulous planning, attention to detail, leadership, teamwork and resilience, our role as medical experts and our skills as scientists and researchers.

"These would help us keep safe over an arduous two and a half months on the ice." Dr Gareth Andrews, FANZCA, presenter of the 2023 ANZCA College Ceremony oration.

Anaesthetist Dr Gareth Andrews gave the audience at the 2023 ANZCA College Ceremony in Sydney a thrilling insight into his feats of endurance and exploration in Greenland, Iceland, the Magnetic North Pole and most recently Antarctica.

The 2023 orator spoke candidly about his epic journeys and how tens of thousands of young scouts in Australia and New Zealand followed him and teammate Dr Richard Stephenson on their unsupported south pole ski expedition of 1404 kilometres over 66 days earlier this year.

The Scottish-born clinician told those presenting for fellowship that they "stand on the edge of wonderful careers" and encouraged them to "go forward and dare greatly."

"I love being an anaesthetist and feel immensely privileged to be able to practise this profession. Alongside this I have endeavoured to combine my career in medicine with my passion and curiosity for the natural world. Over the last 10 years I have travelled over 3000 kilometres though the Arctic and Antarctic sometimes as expedition doctor, other times in a quest for adventure driven by the innate curiosity of discovering new places and the secrets they hold.

"This journey led to our attempt to become the first people to cross the Antarctic continent on foot without support or assistance, a journey of 2000 kilometres and to return with scientific data that will advance our knowledge of the world's changing climate. And physiological data that will advance our knowledge of the impact of extreme endurance on the human body."

"After returning from these far-off places I often get asked why? Why go through the pain and suffering of months alone at minus 40 degrees on an arctic icesheet or adrift on the arctic ocean dodging polar bears and battling violent polar storms – the answer is simple – we are fulfilling our basic human instinct to wonder what is over the horizon."

Dr Andrews recalled how his early years exploring the mountains on the west coast of Scotland with his father instilled a passion for adventure and a love for wild places. He later decided to combine his medical career with exploration so he could "use this unique set of skills to open the door to the world's wild places."

"It is through such exploration that scientific and medical innovations occur," he said.

Dr Andrews explained that while he and Dr Stephenson did not achieve their goal of completing an unsupported ski crossing of Antarctica, they had achieved results beyond what they had hoped – bolstered by four sleds, each with 175 kilograms of food and equipment

"Our aims were to be the first people to traverse Antarctica on foot under human power alone – no dogs, kites or vehicles – and to bring back a unique scientific data set over 70 days of meteorological and atmospheric measurements for the scientists at the Australian Antarctic division."

Carolyn Jones
Media Manager, ANZCA

Images from top clockwise: Trekking through the Antarctic ice with supplies; Dr Gareth Andrews (left) and Dr Richard Stephenson at the south pole; Dr Andrews giving the College Oration.

Robert Orton Medal

The Robert Orton Medal is the highest award the college can bestow on its fellows.

It recognises distinguished service to anaesthesia, perioperative medicine and/or pain medicine.

Dr Amanda Baric was awarded the Orton Medal in 2022.

Dr Amanda Baric

Dr Amanda Baric is admired as an expert and caring clinician, a dedicated and skilled educator, an innovator in undergraduate and vocational curriculum design and a leader in international anaesthesia training. Amanda has made an exceptional contribution to education, training, and patient safety in Australia and internationally.

Amanda has led extensive innovations in the University of Melbourne postgraduate medical program, including online programs for the MD2 anaesthesia rotation and simulation programs for MD2 and MD4 students. In 2016, Amanda introduced the first interdisciplinary course in pain management.

Beyond Australian borders, Amanda has significantly contributed to the advancement of anaesthesia training, education, and continuing professional development in low-resource countries. In brief, she is part of the faculty for the Real-World Anaesthesia Course, Emergencies in Anaesthesia course (Myanmar), Essential Pain Management course (Myanmar, Mongolia) and Initial Emergency Care course (Mongolia). She is a member of Kybele (Croatia, Romania, and Mongolia), a committee member of ASA ODEC, publication committee member of the WFSA, editor of WFSA Anaesthesia Tutorial of the Week and co-facilitator of the Annual Mongolian Society of Anaesthesiologists/Australian Society of Anaesthetists conference.

Amanda's contribution to improving health and promoting communities of practice in low-resource countries is second to none. In 2019 Amanda was awarded the Letter of Honour by the Myanmar Society of Anaesthetists in recognition of her efforts in anaesthesia education. Last year Amanda was awarded the Order of the Polar Star of Mongolia, the highest civilian award and the only Australian to ever receive this honour. (Previous recipients include Hillary Clinton and Barak Obama).

Amanda's enthusiasm, commitment, and generosity have inspired and empowered colleagues in resource-poor countries – especially her female counterparts.

Amanda embodies the fundamentals of the Robert Orton Medal. She has, and continues to demonstrate outstanding service – internationally, nationally and to our local community.

Associate Professor David Pescod AO

Ray Hader Award
Dr Sally Wharton

The 2021 award recipient Dr Sally Wharton FANZCA (NSW) was nominated by her peers for her contribution to the welfare of many trainees and fellows at the Children's Hospital, Westmead. In making the award, ANZCA Council noted Dr Wharton's direct personal support and encouragement of trainees; the development of a formal mentoring program within the department; and raising awareness of mental health issues and the value of personal and team support for trainees and fellows.

Steuart Henderson Award 2023

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.

Dr Melissa Ann Viney

Dr Viney has been an enormous influence on trainees and new fellows across two decades in anaesthesia and pain medicine. She has supervised and mentored more than 20 trainees and remained for many of them an important source of career and personal advice. One of her mentees once described her as "the most influential faculty person you haven't heard of".

Dr Viney's membership of the Curriculum Redesign Project Steering Group for the Faculty of Pain Medicine resulted in a world-leading curriculum for pain medicine. This formed the basis of the curricula for the European Diploma of Pain Medicine, the FPM fellowship of the College of Anaesthesiologists of Ireland, and the Hong Kong Board of Pain Medicine fellowship.

In addition to her seminal contribution to pain medicine education, Dr Viney was also an ANZCA examiner and educator. She was one of the first supervisors of training for pain medicine in Victoria and a founding member of the 'Geelong Course' in 2008 as a long-case preparation workshop.

In 2015 this program became the Basic Clinical Skills Course and Dr Viney continued to contribute to the program until 2021 when it was replaced by the bi-national centralised trainee tutorial program.

Dr Viney has been an examiner for the fellowship clinical examination and long cases, and a member of the FPM Examination Committee where she has been pivotal in providing leadership to ensure fairness and validity of the examination processes.

Dr Viney chaired the Training Unit Assessment Committee for three years. She has been a member and/or chair of all the major FPM educational committees and FPM Assessor for the last two years. She has also worked as a specialist international medical graduate (SIMG) assessor, bringing to the faculty board's attention the critical issue of reforming the process for SIMG practitioners seeking FPM fellowship.

Dr Viney has displayed exemplary attributes that this citation seeks to highlight and we commend her as eminently worthy of the Steuart Henderson Award.

Associate Professor Michael Vagg and
Associate Professor Meredith Craigie

Steuart Henderson Award 2022
Dr Joel Symons

Dr Symons was awarded the Steuart Henderson Award in 2022. As there was no in-person ASM last year he was presented with the award in Sydney this year. Professor Paul Myles' citation was published in the Winter 2022 *ANZCA Bulletin*.

Honorary Fellowship
Lis Evered

Associate Professor Lis Evered was presented with a diploma of honorary fellowship at the ASM. She is a PhD scientist and international leader in perioperative clinical cognitive science and perioperative medicine. She has been a longstanding contributor to ANZCA's academic activities including most recently being Deputy Scientific Convenor and also a judge for the Gilbert Brown Prize at the 2021 ANZCA Annual Scientific Meeting in Melbourne. The fellowship was awarded in 2021.

Only 38 honorary fellowships have been awarded in the history of ANZCA and its predecessor. It remains one of ANZCA's most esteemed awards, with an impressive list of recipients.

Read an article on Associate Professor Lis Evered from the Summer 2021 edition of the *ANZCA Bulletin*.

LAUNCH OF THE ANZCA DIPPOM

ANZCA President Dr Chris Cokis launched our new, world-first Diploma of Perioperative Medicine (DipPOM) at the Sunday morning plenary session.

We heard from anaesthetists, physicians (pain, geriatric, internal and rehabilitation medicine), GPs, an intensivist and a surgeon in a short video played at the launch. POM Steering Committee member Heather Gunter was compelling as she spoke in the video about her own tragic experiences of an unco-ordinated healthcare system. View the video on our YouTube channel.

The perioperative medicine booth in the healthcare industry area was well attended throughout the meeting.

For more information visit the website – anzca.edu.au/pom

The perioperative medicine booth at the ASM was inundated with people wanting to find out more about perioperative medicine.

Emerging Leaders Conference

"Leading through shared experience" was the theme for the 2023 ANZCA Emerging Leaders Conference (ELC) led by co-convenors Dr Jessica Lim and Dr Chris Yong at voco Kirkton Park in the NSW Hunter Valley.

Twenty-nine ANZCA and FPM delegates from Australia, New Zealand, Papua New Guinea, Hong Kong, and Ireland attended the meeting, the first face-to-face ELC since 2019. College presidents from Ireland, Malaysia and Hong Kong also attended the conference while their counterparts from Fiji and Papua New Guinea joined virtually for a 'Leadership with a global perspective' panel discussion.

In addition to guest speaker presentations and panel events, social "ice-breaker" and team building activities were embedded in the two-and-a-half-day program. Speakers included Olympian Dr Jana Pittman with a presentation on "Peaks, troughs and chasing goals" and Dr Karen Nicholls, Specialist Trainee Support Lead from the Australian Indigenous Doctors Association who spoke about empowerment and diversity.

An ANZCA and FPM leadership panel discussion featuring ANZCA President, Dr Chris Cokis, FPM Dean, Dr Kieran Davis, ANZCA Councillors, Professor Leonie Watterson and Dr Katherine Gough and FPM Board members, Dr Susie Lord and Dr Gretel Davidson was a great opportunity for delegates to ask some tough questions they always wanted to know but wouldn't necessarily get the chance to ask.

Thank you to all our delegates, mentors and speakers and congratulations to Dr Jessica Lim and Dr Chris Yong for all their hard work on organising a throughly engaging and inspiring conference!

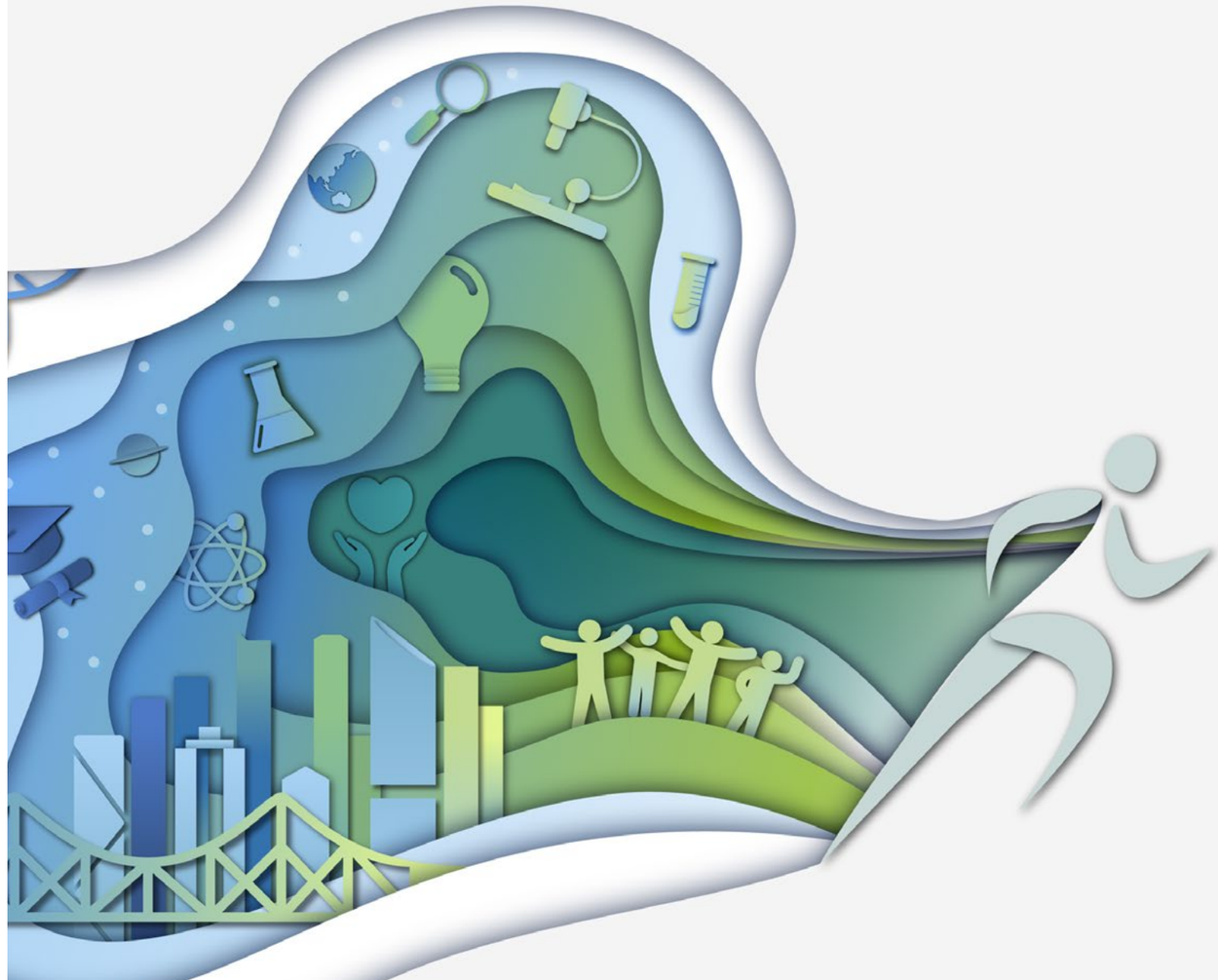
Images from top: Welcome dinner, Pizzeria; ELC Co-convenors, Dr Jessica Lim and Dr Chris Yong, deliver the opening address; Delegates and mentors on their way to the conference; ELC delegates and mentors.

ANZCA
FPM

LIMITLESS

ANZCA ASM 2024 3–7 May, Brisbane

#ASM24BRIS | Save the date!



Training and education

Meet the ANZCA Trainee Committee

The next generation of anaesthetists is already making its mark at the college. Here, the members of the ANZCA Trainee Committee tell us a bit more about themselves and the college committees they're on.

Co-chairs

DR ALEC BERESFORD (NZ)

Alec is in his second year as committee co-chair and has been involved with trainee committees since basic training. He is a provisional fellow in Christchurch, a father of three and says his wife is amazing.

He is a member of ANZCA Council, the Education Executive Management Committee (EEMC), the IAAC MCQ Working Group, the ANZCA Educators Sub-committee, the New Zealand Trainee Committee (NZTC), New Zealand National Committee (NZNC), the Training Accreditation Committee (TAC), and the Trainee Assessment Working Group.

DR ANTHONY NOTARAS (NSW)

Anthony has recently joined the ANZCA Training Committee as co-chair and is the NSW trainee representative. He's a provisional fellow based at Wollongong Hospital undertaking his regional anaesthesia fellowship and is a proud dad of two. Anthony has been involved in the NSW committee for the past three years and is excited to continue to advocate for trainees.

He is a member of the EEMC, the Trainee Selection Working Group, the NSW Regional Committee, the NSW Trainee Committee, and ANZCA Council.

Members

DR SHRUTI KRISHNAN (ACT)

Shruti is an advanced trainee in the ACT. She chose anaesthesia as a specialty because she enjoys its procedural and practical aspects, along with the daily need for collaboration and teamwork. Outside medicine, Shruti is passionate about photography and photo-editing, and is also a huge sports fan.

Shruti is also chair of the ACT Trainee Committee and a member of the ACT Regional Committee.

DR TESS BRIAN (NZ)

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

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

DR SIOBHAN LANE (QLD)

Siobhan is an advanced trainee in Brisbane who will be starting her provisional fellowship at Sunshine Coast University Hospital in August 2023. She is a keen advocate for trainee wellbeing and has an interest in maternity leave during training and returning to work, having recently navigated this herself.

Siobhan is the current co-chair of the Queensland Trainee Committee, and a trainee representative for the Wellbeing Special Interest Group and the Education Development and Evaluation Committee (EDEC).

DR GERALDINE KONG (QLD)

Geraldine works at the Royal Brisbane and Women's Hospital. She enjoys providing individualised care for her patients, using her knowledge of physiology and pharmacology. She likes that anaesthesia encompasses a breadth of analytical and procedural skills.

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

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.

She loves the surge in interest for sustainability in anaesthesia and is excited to see how it can be harnessed to create change.

She is a trainee representative on the Training Accreditation Committee.

DR HELEN BROWNE (TAS)

Helen is one of the co-chairs of the Tasmanian Trainee Committee alongside Georgia Mohler. She is doing her basic training this year in Launceston and enjoys swimming and trialling new activities outside work.

DR GEORGIA MOHLER (TAS)

Georgia is doing her basic training and has undertaken all her medical training in Tasmania. She has a keen interest in education and is looking forward to representing her fellow trainees.

Georgia is the co-chair of the Tasmanian Trainee Committee and is a member of the EDEC.

DR NONI HAROLD (VIC)

Noni is an advanced trainee in Victoria who is looking towards a regional, retrieval or sustainability fellowship and is interested in leadership positions. She has a newly found appreciation for anaesthesia and sees many rewarding clinical and non-clinical opportunities that can be pursued with the specialty.

Noni co-chairs the Victorian Training Committee.

DR KAS WICKRAMARACHCHI (VIC)

Kas is an advanced trainee at Royal Melbourne Hospital and one of the Victorian chairs. When he's not working he's usually trying to keep his Australian Shepherd puppy out of trouble and spending time camping or hiking. He says: "Feel free to get in touch if we can help you at all during your training!"

He sits on the Victorian Regional Committee and the Competency-based Medical Education (CBME) Workplace-based Assessment Working Group.

DR CLAUDIA VON PELTZ (WA)

Claudia is a provisional fellow in WA, doing fellowships in obstetrics and perioperative medicine. She completed half her training in London before returning to Perth, receiving recognition of prior learning and completing the balance of her training in Australia. She chose anaesthesia as she enjoys the camaraderie of the theatre environment, procedural aspects of the specialty and being able to see the real-time effects of physiology and pharmacology. Claudia was also inspired by several anaesthetists she met in her early career who demonstrated great kindness, enthusiasm for their work and maintained a well curated work-life balance that she still aspires to achieve one day.

She sits on the WA Training Committee, WA Regional Committee, Safety and Quality Committee, the Trainee Assessment Working Group and the Provisional Fellowship Program Sub-committee.

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 work she enjoys walks with Bailey, trying out new restaurants, and anything Harry Potter related.

ANZCA primary fellowship examination

2023.1 Exam

One hundred and fifty-eight candidates successfully completed the primary fellowship examination:

AUSTRALIA

Australian Capital Territory
Tayla Grace Coles
Stephanie Louise Jones
David Lam
Cristy Jane Rowe
Francesca Loren Sadnick

New South Wales
Glen William Abbott
Edward Thomas Aczel
Kyrolos Assaad
Ashley Katherine Creighton
Tarra Elizabeth Booth
Hannah Mary Bruce
Louise Theresa Buckley
Elisabeth Kate Burns
Brendan John Carney
Gabriella Claire Charlton
Rachel Anne Clifford
Richard Philip Davey
James Walter Fredrick Deacon
Shane Douglas Digby
Amanda Vianne Margaret Farrell
Amelia Lucy Fitzgerald
Pierre Goorkiz
Stella Maris Catharine Graham
Angus Leslie Hardy
Dominic John Horne
Rose Khosh
Anthony Peter Klironomos
Steven Polis Lazar
Ann May Lee
Rachel Ruth Ping Lee
Han Liu
Laura Catherine Mackenzie
Christopher James Kuang Masters
Jacob Alexander McDonald
Veronique Anna Molan
Conor Thomas Keeper Moylan
David Christopher Mulder
Gowsikan Nageswaran
Grazia Hoang Anh Thu Nguyen
Jason Jaeseong Oh
Megan Oliver
Matthew James Palmer
Praneeth Parasu
Jonathan Andrew Perry
Daniel Paul Roberts
Elsa Louisa Margarita Russell
Joel Andrew Ervin Selby
Andrew Thomas Shannon
James David Shaw
Alexandra May Robertson Sheather
Erica Sorn
Jason Sritharan
Jovana Stojkov
San-Rene Tan
Alistair David Thomson
Stephanie Alice Warner
Graeme Arnold Wertheimer
Ashleigh Xie
Christine Shaoning Zhang
Esther Ya Qun Zhou

Northern Territory
Nilesh Shekhar Kumta
Thomas Ross McFarlane

Queensland
Ali Abbosh
Ganashyam Arunagiri
Morvarid Ashtari
Erica Mae Barton
Phoebe Jane Brandis
Kevin Chun Kit Chan
Tenglong Chen
Rachel Zie Ting Efendy
Tahlia Ashleigh Gentle
Charles Hamish Grey
Christopher Michael Hewitt
Darragh Peter Hickey
Ari Paul Isman
Karen Joseph
Joel Mugambi Kiburi
Harrison George Brook King
Christine Rose Lowe
Julian Manuel Luna
Utsav Malla
Ethan Oskar Duncan Mar
Evan Oliver Matthews
Rushan Lakitha Gonaduwage Perera
Lachlan Ian Poiner
Claire Ellen Rose
Pablo Luan Scherl Dight
Jeremy Cheuk Kin Sin
Aaron Keith Kopeke Smith
Lisa Kate Stevens
Jerome Wei Jian Tan
Stephanie Nathania Tan
Christopher Yuan Cheng Thang
Edward William Thornely
Lalethadevi Velayutham
Timothy On Yin Wong
Nathan Yan-Li Yii

South Australia
Oliver James Barker
Kate Louise Brown-Beresford
Alexandra Claire Fawcett
Tristan Leigh Frank
Alyaa Nadzirah Kamaruzman
Damien Bernard Kearney
Susan Joanne Kelly
Kenny Kok Keong Lean
Michael James Rankine
Edwina Jane Stenner
Corinne Lee Tching Teh

Tasmania
Christopher Edmund Etherington

Victoria
Sophie Anna Cerutti
Kavinay Narayan Chand
Boris Pui Leung Cheung
Elliot James Duong
Alexandra Ruth Gray
Naomi Jane Hughes
Claire Danielle Ishak
Rebecca Mardi Johnstone
Wison Vien Khoi Le
Saras Anil Mane
Diana Ioana Munteanu
Ai Phuong Annalisa Phan
Nicholas John Piper
Angus Gerardus Pritchard
Darcy Neil Tupper-Creed
Victor Yuan

Western Australia
Matthew Avery
Merredith Johanna Cully
Ethan Peter Fitzclarence
Teegan Elise Hartwig
Mark Sidantha Ihagama Ihagama Mudiyanselage
Isabella Marie King
Kelly Lee Shepherd
Zollie Fromont Sutton
Pramod Shivram Vasantharao
Anika Lauren Weightman

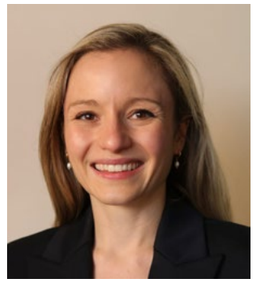
NEW ZEALAND

Simone Jane Besseling
Jignal Bhagvandas
Peter Nicholas Cameron
Reuben Josiah Cash
Isabella Ka Yan Chan
Thomas Ashwin Chima
Hanne Jane Ertman
Kijun Lee
Adele Lennie MacGregor
Andrew Stewart Eric Macpherson
Liam John McAskie
Ciara McCarthy
Erin Mary McKergow
Olivia Margaret Nicholson
Annabell Katy Norton-Rozen
Ezra Frederick Ritchie
David Michael Roberts
Timothy Najam Salam
Arkar Ian Thein
Sarah Louise Tomlinson
Rebecca Susan Tynas
Danni Wang
Antonia Phoebe Yarnton

Primary Exam Court of Examiners

RENTON PRIZE

The Court of Examiners recommended that the Renton Prize for the half year ended 30 June 2023 be awarded to:

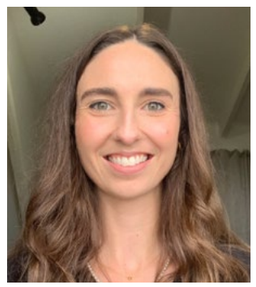


Hannah Mary Bruce, NSW

"I grew up in Sydney with five siblings who have given me lifelong practice in developing convincing arguments. After studying at UNSW, I initially pursued a surgical pathway and completed the Surgical Primary in 2019. I decided on anaesthesia following a term with the Westmead anaesthesia department in 2021 and am very lucky to now be training there.

I can't thank my mentors Jessie Ly and Steve Williams enough for the brilliant Westmead teaching program, and for inspiring me to love the content of the primary almost as much as they do. Despite the hard work of the past year, I have wonderful memories from my Tamworth study group 'the Pendellufts', panicked SAQ practice with Pierre, and weekly vivas with Blair Munford. The support and sense of perspective from my friends and family has been invaluable. Most of all, I'm grateful to my partner Ned who has kept me fed and in clean clothes this year.

Now that I'm through the exam, I'm looking forward to leaving Miller's on the bookshelf and fitting in a little more hiking, Scuba diving, and some long overdue catch ups."



Olivia Margaret Nicholson, New Zealand

"I am still in shock about being awarded the Renton Prize. It is a huge honour and I am excited to represent New Zealand and Middlemore Hospital. I grew up in Dunedin and after doing a science degree at The University of Otago I went into medicine. I worked as a junior doctor in Tauranga then moved to Auckland for anaesthesia training.

The Part One exam was a gruelling experience that pushed me to my absolute limits. I am extremely thankful and owe my success to my study group, a supportive supervisor of training, and department, and my mum who was my biggest cheerleader throughout!

I am excited to have this exam behind me and to get back to my hobbies including van trips/camping, swimming and trying to surf, skiing and generally anything except study."

MERIT PRIZE

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

Christine Shaoning Zhang, New South Wales

David Michael Roberts, New Zealand

Christopher James Kuang Masters, New South Wales

Peter Nicholas Cameron, New Zealand

Matthew James Palmer, New South Wales

ANZCA final fellowship examination

2023.1 Exam

The final fellowship examination was completed by 178 candidates.

AUSTRALIA

Australian Capital Territory
Manil Lakshan Abeygunasekara
Elizabeth Heather Dalton
Shruti Krishnan
Darcy Mark McFarland
Dharan William Sukumar
Edward Charles White

New South Wales
Harrison Ray Bell
Andrew Stephen Casey
Vanessa Shwen Yuen Chen
Yuanjing Cheng
Marena Cosman
Andrew Do
Kieran Raleigh Easter
Byron John Economos
Catherine Rose Epstein
Sophie Therese Faehrmann
Rory Giles Gillingham
Alexander Henry Goswell
Lucien Joel Hackett
Anna Amelia Hines
Anthony Hodsdon
Christopher James Hudson
Matthew Mackenzie James
Eunmaro Ju
Kasia Kulinski
Dulitha Lakwin Kumarasinghe
Rebecca Frances Landers
Thomas Charles Lang
Qiushuang Susan Li
Kyle John Lindfield
Priya Maheshwari
Simon Paul Minns
Daniel Crawford Moore
Sian Louise Myers
Kelly Elizabeth O'Shea
Li Ching Ooi
Daniel Joseph Pearce
Julia Faye Rouse
Saipriyadharshan Ruthirakumar
Annie Shi Ruo Shaw
Melissa Cathryn Smith
Siobhan Rachel Stone
Lucy Cameron Sutherland
Laura Simone Thomas
Rosie Elizabeth Trumper
Boris Waldman
Laltaksh Wangoo
Oscar Yuan Ti Wen
Julian Robert Nicholas Wicks
Daniel Zardawi

Queensland
Stephen Brian Alvarado
Neeban Balayasoderan
Janjovenjit Bassi
Margaret Anne Blanco
Sophie Margaret Boast
Matthew Ralph Bright
Alyce Jane Burgess
Jordan Rita Rose Casey
Xavier Douglas Chadwick
Samuel Joseph Cook
Brett William Delahunty
Gareth Edward Evans
Mustansir Farooq
Zenan Michael Franks
Megan Wendy Elaine Grigg
Tarrant Blythe Kenman
Lamont Tsochang Chongwi Lee
Amy Chien-Ho Lin
Rohan John Lynham
Nathan Paul Murray
Kathryn Noakes
Jerry Jiajun Qian
Louise Marie Rafter
Daniel Thomas Robertson
Laura Elizabeth Staples
Ben Steve Steiger
Emma Jennifer Walker
Siqi Wang
Rachael Maree Weir
Hannah Marie Woodcock
Garry Yang

South Australia
Steven Mark Alderson
Alexander David Kimpton
Sally Christina Perks
Luke Aiden Proctor
Vimal Sekhar
Henry David Upton

Tasmania
Benjamin Arthur Rose
Simon Matthew Yates

Victoria
Claire Elizabeth Attwood
Kieran Peter Bates
Patrick Lloyd Beall
William Thomas Birkett
Alexandra Amy Bolger
Angus Elliot Brown
Charles Martin Chilvers
Madeline Grace Corke
Gregory David Evans-McKendry
Stefanie Fabris
Margaret Ellen Forbes
Gerard Kenneth Harrop
Aswathy James
Robert Joffe
Yasmean Kalam
Hamish Westcott Lanyon
Janette Law
Natalie Lok Hunn Law
Dustin Viet Anh Le
Simon Paul Leckenby
Edward Vern Khan Lim
Patryck Julian Lloyd-Donald
Kathleen Rose Macintire
Efstratios Maglogiannis
Thomas Patrick Mullaney
Luke Daniel Nelson
Darren Yong Ooi Ong
Maria Fernanda Perez Miranda
Braden Lee Preston
Andrew Rabinovich
Emily Jane Robson
Keiran James Rowan
Thomas Robert Scodellaro
Ashleigh Joan Sellar
James Leigh Sgroi
Andrew Harald Talman
Heidi Helene Graham Thies
Kasun Shaminda Wickramarachchi
Annie Xin
Marcus Jia-Sheng Yip
Julia Jiewen Zhu

Western Australia
Keat Meng Chan
Erin Anne Chevis
Katherine Anne Collins
Michael James Connelly
Aileen Therese Fenelon
Susanna Rose Hoffmann
Si Ying Lim
David Andrew Robertson
Kieran Patrick Robinson
Emily Catherine Scott
Ilan Sean Silberstein
Natalie Sarah Elizabeth Smith
Nicholas Thomas Ward

NEW ZEALAND

Helen Frances Abbott
Siddhi Gopal Ayyar
Thomas Matthew Barr
Alexander Edward Bewick
Karen Mu-Hsuan Chiu
Joseph William Collinson
Andrew Neil Curtis
Jenna Elizabeth Donaldson
Keith Donald Green
Natalie Irving
Dominic Michael Johnpillai
Saoirse Rachel Kelly
Jiyeon Kwon
Charlotte Elizabeth Legge
Jonathon Neil MacColl
Clare Louise McConnell
Jonathan Richard Paulin
Saleimoa Bill Sami
Persis Anne Hepzibah Samuel
Sarah-Jayne Anderson Stevenson
Lucinda Jane Wahlers
Thomas George Walker
Aidan Ian Norman Ward
Chooi Ling Wong
Annie Gia-Mun Yau

Final Exam Court of Examiners

SIMG EXAMINATION

Three candidates successfully completed the specialist international medical graduate examination:

Chetan Swamy Amberkar, Victoria

Viktor Duzel, Victoria

Megha Kohli Mehrotra, Victoria

CECIL GRAY PRIZE

No candidates were awarded the Cecil Gray Prize for the 2023.1 final examination.

MERIT CERTIFICATES

Merit certificates were awarded to:

Louise Marie Rafter, Queensland

Rachael Maree Weir, Queensland

Darcy Mark McFarland, ACT

College communications pioneer looks back

Ask retired fellow and former ANZCA councillor Dr Mike Martyn what he remembers most about the birth of the college and its communication tools in its early years he cites index cards and floppy discs.

A true "agent of change" Dr Martyn was at the vanguard of ANZCA's transition to digital communications even before the "world wide web" was in its infancy.

Dr Martyn served on council from 1993 to 2005 and played a pivotal role in the introduction of the college's modern communications system as its first (unpaid) communications officer.

He also spearheaded other initiatives that are now a mainstay of the college's communications calendar such as National Anaesthesia Day and the regular fellows' survey.

He helped establish the template for the ANZCA Annual Scientific Meeting (ASM) as convenor of the first independent ANZCA ASM held in Launceston in May 1994.

In 1995 he registered the college's domain name, wrote the code for the college's first website and oversaw the ANZCA website development until 2005.

A strong believer in the value of good communication skills for anaesthetists he also encouraged fellows to be more open in being interviewed by print and broadcast media about their clinical skills when relevant and appropriate.

"This became a regular feature of the ASM," he explained.

"When I suggested allowing health journalists to sit in on sessions at the ANZCA ASM some fellows were quite unhappy about it. I had to persuade them that it would be helpful for us as a specialty to promote the strength of our clinical work.

"Training anaesthetists to be better communicators was, and still is, important. Anaesthesia used to be a speciality where you didn't need to talk to patients. That is totally different now and certainly made my practice much more satisfying and effective."

Now retired after 33 years in private practice in Hobart Dr Martyn shared some of his recollections with the *ANZCA Bulletin*.

"It really was a fun and exciting time in the early 1990s when the college was established with Joan Sheales as the first CEO of ANZCA" he recalled.

"ANZCA was founded in 1992 after operating as the Faculty of Anaesthetists of the Royal Australasian College of Surgeons (RACS) and the timing was significant – not just for the specialty but also because it coincided with an explosion of information technology."

When Dr Martyn began his time on council just four of the 12 councillors had email addresses. Council agendas were posted before the council meetings as thick packages of reams of paper. By the time he left council in 2005 the agenda was online to all councillors.

His connection with the college began in 1983 when it was still a faculty of the Royal Australasian College of Surgeons (RACS). He presented a paper on computer simulation at an anaesthesia registrars' meeting in Melbourne and it was there that he was "recruited" by Joan Sheales, the then registrar of the faculty.

"Joan told me she wanted to 'buy a computer' for the faculty. I was interested in computers and technology so that eventually led to me overseeing the development of information technology at the college from then until I left council in 2005."

As part of the transition process from RACS the college had to separate its separate financial system from the RACS legacy mainframe program. Dr Martyn then went onto create the first electronic ANZCA database for training hospitals, fellows and trainees.

"Little did I realise that this would lead to 20 years of fun times working with many fellows, trainees and staff," he said.

Carolyn Jones
Media Manager, ANZCA

Faculty of

Pain Medicine

New FPM Board sets agenda for the year ahead

Winter is here and I seem to be cycling to and from work in the dark more often than not, so it was exciting to go to sunny NSW and attend the Emerging Leaders Conference (ELC), the FPM Symposium and the ANZCA Annual Scientific Meeting (ASM).

I cannot speak highly enough of the ELC in the Hunter Valley which allowed for calm reflection and engaged conversations. The program developed by convenors Dr Chris Yong and Dr Jessica Lim was broad, without being eclectic, and challenging but in a safe emotional and intellectual place.

Professor George Shorten, president of the College of Anaesthesiologists of Ireland was effusive in his praise of the concept and delivery of the ELC and the quality of the attendees.

This is something that as a college we should be proud of. For me, the highlight of the ELC were the attendees: representing FPM were Dr Hannah Bennett (Qld), Dr Kate Drummond (NSW), Dr Jennifer Hudson (NZ) and Dr Dana Webber (WA). They were not only active participants in the ELC but are also clearly emerging leaders at an early stage in their careers.

The first in-person FPM Symposium since Kuala Lumpur in 2019 was a great success and my thanks go to Associate Professor Kok Eng Khor and Dr Candice Wallman for all their hard work.

Whenever I go to a local conference I have a list of people I need to talk to face-to-face, usually on topics that aren't suited to email. But it is also the chance to meet up with old friends and for me, that was seeing if my wit could still keep up with Dr Barry Slon. I would also like to thank our events team, especially events officer Rebecca Hull. Until you see behind the scenes you do not realise all the effort that goes in to make these days work.

The ANZCA ASM was again a monster of an event and thank you to all the organisers and presenters. Sydney put on a good show. What I hadn't realised beforehand was that as FPM dean, my time during the ASM was not my own. My time was divided up with presenting, chairing, meeting people and fronting the college ceremony. By the end of the event, I was exhausted. Trust me, it is far more fun being a delegate!

One of my take-aways from this first post-pandemic symposium/ASM is that with our new CPD requirements we need to provide options across the CPD categories within our conferences. All delegates should be able to undertake an emergency response and we need to look for novel ways of providing the other annual requirements, as well as the CPD components outside of knowledge and skills. For some, the content and lectures are more conveniently done online from home and they may question if conferences can be sustained in the long term.

During the ASM the new FPM Board met and it is a pleasure to welcome our new board members Dr Amanda Wiseley and Dr Amrita Prasad. The board and the faculty have a heavy load of objectives to achieve over the next 12 months.

On the training side, we will deliver on our assessment review and the other requirements of the Australian Medical Council (AMC) and Medical Council of New Zealand (MCNZ) re-accreditation. One of the key requirements from the AMC/MCNZ review is that we need to have more trainee involvement within our governance structures.

This is particularly essential not only in our education facing committees but also our national and regional committees. We have already advertised an expression of interest to trainees and we are in the process of changing by-laws and terms of reference to ensure compliance.

The other work of the new board will be directed by the college-wide three-year strategic plan, and from a practical perspective, by the production component of this plan. This plan has been published and is available on the website. I appreciate all feedback from the fellowship, as without it, we don't know whether we are leading our specialty or heading off on a tangent.

Spring will follow winter and with that comes the FPM Spring Meeting in Adelaide where delegates will have the opportunity to celebrate the faculty's 25-year anniversary.

I look forward to seeing you all there.

Dr Kieran Davis
FPM Dean

Changes to the FPM Board

Dr Amanda Wisely and Dr Amrita Prasad were elected to the FPM Board following the retirement of Associate Professor Mick Vagg, Dr Stephanie Oak and Dr Gretel Davidson. Dr Prasad replaces Dr Davidson as the new fellow board representative.

Departing FPM Board members

Associate Professor Michael (Mick) Vagg joined the FPM Board in May 2012 and resigned in October 2022 following his appointment as the Director of Professional Affairs, FPM Professional Affairs. During his time on the board, Mick held a number of roles, including the role of vice-dean from 2018-2020, and then as the FPM dean from 2020 to 2022. In addition, he was the scientific convenor for the 2013 ASM and Symposium, a member of the ANZCA and FPM CPD Committee between 2013-2016, the FPM ASM officer between 2014-2017 and the chair of the FPM Professional Affairs Executive Committee. He has also been a training unit accreditation reviewer, and an examiner for a number of years. Mick chairs the Procedures in Pain Medicine Committee and is a member of the FPM Professional Affairs Executive Committee.

Dr Stephanie Oak was co-opted to the FPM Board in May 2021, and resigned in May 2023. During her time on the board she chaired the Professional Standards Committee and was a member of the FPM Professional Affairs Executive Committee and the ANZCA and FPM CPD Committee. Stephanie is a member of the CPD Review Group for the development of CPD activities for those who practise without direct patient care; is a member Document Development Group on developing the new OIVI Emergency Response activity; and has ongoing involvement in redefining the emergency response activity criteria.

Dr Gretel Davidson was the elected new fellow representative, joining the board in May 2021 and concluding her term in May 2023. Gretel was involved in the Direct Entry Pathway Working Group, was one of the FPM representatives as a facilitator at the Emerging Leaders Conference in 2021, 2022 and 2023. Gretel also participated in the 2022 ANZCA and FPM accreditation assessment process by AMC/NZMC as one of the FPM representatives and was the FPM representative to the APS Pain in Children Special Interest Group. Since stepping down from the board, Gretel has joined the executive of ANZCA's Environmental Sustainability Network as an FPM representative and hopes to become more involved in the Training Unit Accreditation Committee.

Meet our new FPM Board members

Dr Amrita Prasad is a specialist pain medicine physician and rehabilitation medicine physician at Pain Matrix based in Geelong, Victoria. She is an experienced rehabilitation medicine physician, working within a multidisciplinary team for almost 10 years. She has also worked in regional and metropolitan hospitals, trained in interventional procedures and is one of the first physicians to successfully complete the Procedures Endorsement Program and be endorsed to the highest level. A key goal is help foster more cultural diversity and gender equality within pain medicine. Amrita was elected to the FPM Board as the new fellow representative and commenced her role in May 2023.

Dr Amanda Wisely is staff specialist at Gosford Hospital in New South Wales; a palliative care physician, and a fellow of the Australian College of Rural and Remote Medicine. Amanda is committed to advocating for health access and equity for rural and remote communities, including for culturally appropriate Aboriginal health. Amanda is passionate about providing evidence-based high-value care in resource poor settings and her nonclinical roles include research, education (including as a conjoint lecturer at the University of Newcastle) and pastoral care of trainees, particularly of the trainee in difficulty. Amanda was elected as an FPM Board member and joined the board in May 2023.

Moving forward in Sydney

This year's FPM Symposium was held on Friday 5 May with the theme of "Moving Forward". It was well attended with 194 registrants.

Our keynotes speakers were Professor Curtis Nickel from Canada and Professor Amanda C de C Williams from UK. They were well complemented by other international speakers from the US (Professor Clifford Woolf), Hong Kong (Professor Chi Wai Cheung), Singapore (Associate Professor Kian Hian Tan) and New Zealand (Dr Hemakumar Devan and Cheryl Davis) and local experts from NSW and other states.

Topics that were covered at the symposium included societal issues (what patients want, improving access to pain and burnout in physicians); neuromodulation (for headache, back pain and cautionary perspective); urogenital pain syndromes (general, hormonal and psychological) and patient outcomes. In the FPM stream, the topics covered included cancer pain; acute pain; provision of inclusive and equitable care (focussing on transgender patients, refugees and Māori people); pharmacology; interventional pain management and opioid therapy (focussing on criminal aspects, forced reduction of opioids, monitoring and regulatory update and strategies to reduce opioid reliance).

Workshops were also offered on acute behavioural disturbance; breathing techniques; when pain is not pain; interventional pain cadaver workshop (jointly run with NSANZ); acute pain research; mentoring; microbiome in health and disease; and interventional cancer pain.

We would like to thank all those involved in this year's FPM Symposium and ASM. It was great to be back in person and reconnect. See you in Brisbane in 2024!

Associate Professor Kok Eng Khor
FPM ASM Scientific Convenor and FPM Symposium Convenor

Dr Candice Wallman
FPM ASM Deputy Scientific Convenor

2023 FPM Symposium convenors Associate Professor Kok Eng Khor and Dr Candice Wallman

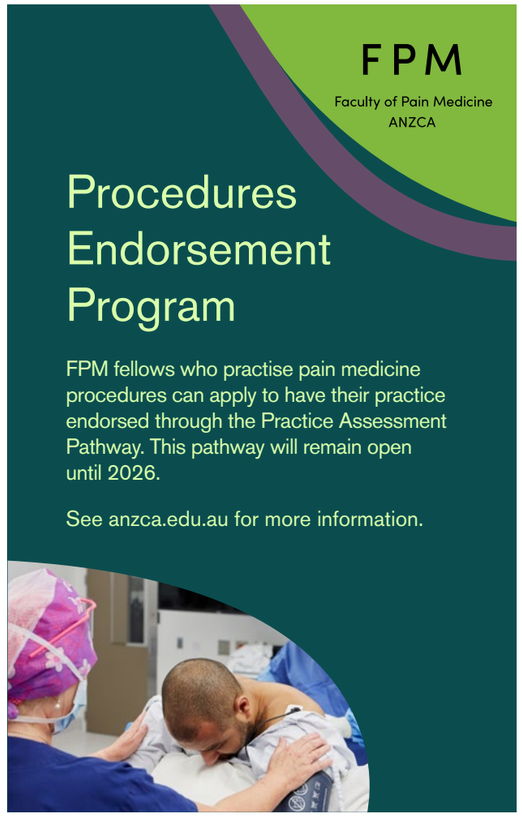
New fellows

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

- Dr Benjamin Adeyemi, FRACGP, FFPMANZCA (Qld)
- Dr Priyadarshini Arvind, DNB Anaesthesia, FFPMANZCA (Vic)
- Dr Supriya Chowdhury, FANZCA, FFPMANZCA (NSW)
- Dr Luke Mercer, FANZCA, FFPMANZCA (NZ)
- Dr Helen Newman, FRACGP, FFPMANZCA (Qld)
- Dr Belinda Oddy, FRANZCP, FFPMANZCA (Qld)

We congratulate the following doctors on their admission to FPM fellowship through completion of the Specialist International Medical Graduate (SIMG) pathway:

- Dr Martyna Berwertz, FRCA, FFPMANZCA (Vic)
- Dr Rajiv Chawla, FRCA, FFPMANZCA (Vic)
- Dr Kevin McCarthy, FANZCA, FFPMANZCA (Qld)
- Dr Vinay Siddannagari Anjana Reddy, FRCA, FFPMANZCA (Vic)
- Dr Cillian Suiter, FCAI, FFPMANZCA (NSW)



TELL US YOUR STORY!

Do you have a story you would like to share on *Pins and Needles* – the blog of the Geoffrey Kaye museum? You might like to reminisce on what (or who) made you choose pain medicine as a career. How your local area has benefited from the specialty. Where you hope to see the faculty in another 25 years. Or any other weird and wonderful story which encapsulates being a pain medicine physician. It could be sad, life-changing, hilarious or any other combination of emotions. We also welcome your accompanying photos (jpeg format). Please send through to fpm@anzca.edu.au.

A special 25th anniversary fellowship logo for use on email signatures is now available to download in the fellows' toolkit on the college website.

NEW PROFESSIONAL DOCUMENTS TO PILOT

The faculty board recently approved two new professional documents:

- *PG13(PM) Guideline on return to pain medicine practice for specialist pain medicine physicians* along with its background paper *PG13(PM) BP*
- *PG14(PM) Statement on the responsibility of specialist pain medicine physicians for overall opioid management in patients with chronic non-cancer pain who have an intrathecal opioid delivery device in situ*

These professional documents, available on the website, are being piloted and will be reviewed again in October 2023. We welcome your feedback during this time.

For further information or to provide feedback, please email fpm@anzca.edu.au.

BECOME AN ACCREDITED PROCEDURAL SUPERVISOR

We encourage fellows looking to become an accredited procedural supervisor to start the application process which includes endorsement through the practice assessment pathway. For further information please see the website or contact the faculty office.

MBS BILLING FOR TRAINEES

As part of our ongoing engagement with the Australian Medicare Benefits Schedule team we asked for clarification about which MBS items trainees can bill for. You can read the MBS response on our website at: www.anzca.edu.au/news/fpm-news/medicare-items-relevant-to-patient-consultations-p.

For further information please contact fpmdean@anazca.edu.au.

Library news

AIRR UPGRADE – CREATE YOUR OWN RESEARCHER PROFILE

An upgrade to the existing ANZCA Institutional Research Repository (AIRR) has now been completed, with a number of exciting new features now in place.

Enhanced researcher profiles

As part of the upgrade, we have rolled out an enhanced researcher profile solution. It is now possible for any registered AIRR user to immediately set up a self-managed research profile which they can then edit at any time. The profiles have been expanded to allow users to provide a comprehensive overview of their research-related endeavours and is the perfect way for emerging researchers to create a consolidated research "footprint." An example researcher profile can be seen here: https://airr.anzca.edu.au/anzcacrisjspui/cris/rp/rp00027. Note: It is also possible for library staff to link a pre-existing profile to any registered AIRR user.

New grants section

It is now possible for ANZCA-related grants to be added to AIRR with links to associated research profiles and article outcomes. An example grant can be seen here: https://airr.anzca.edu.au/anzcacrisjspui/cris/project/pj00034

Linked publications

Enhanced linking between articles and profiles has been added, making it easier to navigate between articles and associated researchers and grants. An example submission can be seen here: https://hdl.handle.net/11055/1162

Updated home page

The home page has been refreshed to provide a clearer snapshot of recent submissions and most-viewed entries, as well as making it easier for users to submit new content.

Analytics

Various metrics have been embedded in both submissions and profiles to provide a clearer sense of your research impact.

The upgraded AIRR interface can be accessed at: https://airr.anzca.edu.au/. The updated library guide can be accessed at: http://libguides.anzca.edu.au/research/airr.

Any queries can be directed to library@anzca.edu.au.

ANZCA LIBRARY AT THE ASM

On Monday 8 May, library staff were delighted to be joined at the ANZCA & FPM Lounge by representatives from LWW Ovid – providers of many of our key anaesthesia and pain journals. LWW Ovid publications include Anesthesia & Analgesia, *Anesthesiology,* European Journal of Anesthesiology, Pain and Critical Care Medicine. LWW Ovid's Allan Finn and Kathleen Quilter were present to help promote these journals, as well as the ANZCA library's recently updated Audio-Digest subscription. Whilst in attendance, they were joined by *Anesthesiology* editor Associate Professor Kristin Schreiber and executive editor Professor Andrew Davison.
It is possible to access all these journals using BrowZine.

ANZCA Library Manager, John Prentice, presented a well-received workshop on the library services and resources available to ANZCA fellows and trainees. Highlights of the session included a live demonstration of the LibKey Nomad web extension with PubMed – which can be used to provide instant full-text access/two-click document delivery requests.

SCAN ME

Library staff were also available at the ANZCA & FPM Lounge throughout the ASM to chat with delegates about the ANZCA library. It was a great opportunity to get some structured feedback from our users – giving us a clearer idea of library priorities moving forward. If you'd like to give your own constructive feedback on library resources or your experience using the services, you can use the QR code to access the feedback form.

Above: *Anesthesiology* editor Associate Professor Kristin Schreiber and executive editor Professor Andrew Davison with LWW Ovid's Kathleen Quilter and Allan Finn.

Recently updated library guides

The library has recently refreshed a number of guides including the Apps and Drug Information guides.

Apps are a very popular way for ANZCA users to access our resources, and the updated Apps guide spotlights all of ANZCA's key subscription apps including Audio-Digest, BrowZine, ClinicalKey and Read by QxMD. In addition, there is a comprehensive A-Z list which highlights apps – both paid and freely available – which our fellows and trainees have recommended or may find useful. If you know of an app that should be added, then please let us know.

The Drug Information guide brings together the college's various drug information resources. This includes access to AusDI (Australian Drug Information) and Therapeutic Guidelines. In addition, it is also possible to access various international drug-related portals, key e-books, drug-related podcasts, and a number of drug-related apps including the FPM ANZCA Opioid Calculator.

New books

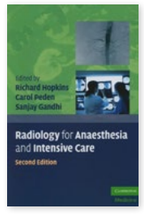
Access the complete list of newly added titles on our website: https://libguides.anzca.edu.au/latest.

NEW TRAINING BOOKS

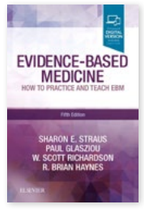
A number of new training-related titles are now available online: **https://libguides.anzca.edu.au/training-hub**

Essentials of equipment in anaesthesia, critical care and perioperative medicine, 6e
Al-Shaikh B, Stacey S. Edinburgh:

MCQs and SBAs in intensive care medicine
Eyre L, Bodenham A [eds]. Oxford: Oxford University Press, 2021.



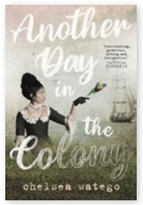
Radiology for anaesthesia and intensive care, 2e
Hopkins R, Peden C, Gandhi S [eds]. Cambridge, UK: Cambridge University Press, 2010.



Evidence-based medicine: how to practice and teach EBM, 5e
Straus SE, Glasziou P, Richardson WS, Haynes RB. Philadelphia: Elsevier, 2018.

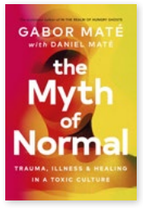
NEW BOOKS FOR LOAN

Books can be requested via the *ANZCA Library discovery service:* **http://www.anzca.edu.au/resources/library/borrowing**



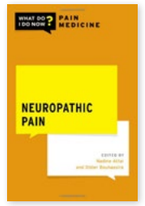
Another day in the colony
Watego C, Watson LJ. St Lucia, Queensland: University Queensland Press, 2021.

Australia's toxic medical culture: international medical graduates and structural power
Pascoe VA. Singapore: Springer, 2019.

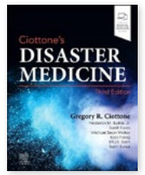


The Myth of normal: trauma, illness & healing in a toxic culture
Maté Gabor, Maté Daniel. London, UK: Vermilion; 2022.

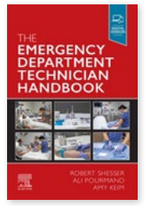
NEW EBOOKS



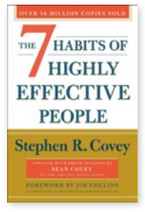
Neuropathic pain
Bouhassira D, Attal N [eds]. New York, NY: Oxford University Press, 2023.



Ciottone's disaster medicine, 3e
Ciottone GR [ed]. Amsterdam: Elsevier, 2023.



The Emergency department technician handbook
Shesser R, Pourmand A, Keim A [eds]. Amsterdam: Elsevier, 2023.



The 7 Habits of highly effective people: powerful lessons in personal change, 30th anniversary ed
Covey SR, Collins JC, Covey S. New York: Simon & Schuster; 2020.

Foundation update

ANZCA RESEARCH COMMENDED AT FOUNDATION RECEPTION

Dr Emily Colvin, president of the Australian Society for Medical Research (ASMR), has commended ANZCA and the ANZCA Foundation's support for medical research through its annual research grants program and the ANZCA Clinical Trials Network.

Speaking at the ANZCA Foundation Reception at the ANZCA Annual Scientific Meeting in Sydney in May, Dr Colvin said small grant research support programs such as ANZCA's were vital for driving discoveries in medical science which are the basis for further research and clinical trials that deliver evidence for improvements clinical practice and patient outcomes.

Dr Colvin also spoke on ASMR's advocacy program, especially the need for the Australian government to increase its annual funding for medical research from 0.7% to 3% of GDP.

She delivered a powerful message on why this funding is critical for supporting a range of high-quality research, which supports medical practitioners in everyday clinical practice.

Images from top: Dr Emily Colvin, President ASMR;
Associate Professor Matthew Doane (right) presenting the Russell Cole Memorial ANZCA Research Award to Dr Ben Moran.

INSPIRATIONAL ANZCA RESEARCHERS RECOGNISED

ANZCA Research Committee Acting Chair Associate Professor Matthew Doane presented the prestigious ANZCA Foundation named research awards at the foundation reception.

The awards are funded by generous supporters, and established either in memory of notable individuals, many who made significant career contributions to the specialties, or in support of specific areas of research interest.

The recipients included: Professor André van Zundert (Lennard Travers Professor of Anaesthesia); Professor Bernd Froessler (Harry Daly Research Award, highest ranked project grant); Professor Victoria Eley (John Boyd Craig ANZCA Research Award, pain medicine); Dr Ben Moran (Russell Cole Memorial ANZCA Research Award, pain medicine); Professor Andrew Davidson (Robin Smallwood Bequest); Associate Professor Venkatesan Thiruvenkatarajan (Elaine Lillian Kluver ANZCA Research Award); Dr Edith Waugh (Patricia Mackay Memorial ANZCA Research Award, patient safety); and Dr Patrick Tan (Skantha Vallipuram ANZCA Research Scholarship).

Associate Professor Doane also warmly congratulated all 25 ANZCA principal investigators and their teams who were successful in their applications for ANZCA funding grants for 2023.

RECOGNISING AN OUTSTANDING CHAIR

The end of 2022 saw the retirement of Professor David A Scott as chair of the ANZCA Research Committee.

Professor Scott succeeded Professor Alan Merry of Auckland University in May 2018. During their tenures, Professor Merry and Professor Scott presided over growth in annual ANZCA research funding from $A865,000 to over $A1.7 million at its peak and worked with the foundation to establish 11 new ANZCA Foundation named research awards bringing that total to 13.

Professor Scott's term saw the ANZCA Research Strategy developed, the Emerging Investigators Sub-committee and Professional Practice Network established, a collaborative ANZCA and *British Journal of Anaesthesia* international collaborative grant delivered, and the ANZCA research grants program successfully steered through the COVID-19 crisis. Importantly, the committee's robust and equitable peer-review process and high-quality standards for funded research were maintained and enhanced.

The foundation warmly thanks David for his outstanding service.

The foundation also welcomes our incoming chair, Professor Britta Regli-Von Ungern Sternberg from Perth Children's Hospital and the University of Western Australia.

ENVIRONMENT AND SUSTAINABILITY GRANT

We are still urgently seeking donations to support a research and sustainabilty research grant . Please consider being part of the solution by donating via our online giving portal.

THANKS TO OUR PRESIDENT'S PATRONS AND DONORS

The foundation warmly thanks all our donors and patrons for their ongoing generous support. These close friends of the foundation regularly support our efforts to assist the work of our fellows in research, and global and Indigenous health.

If you are not a patron, please consider joining this program of inspiring philanthropists who regularly support excellence in research and education in the specialties.

Mr Rob Packer
General Manager, ANZCA Foundation
rpacker@anzca.edu.au
+61 3 (0)409 481 295

To donate, search "GiftOptions – ANZCA" in your browser or contact Rachel Kibblewhite, Fundraising Administration Officer, rkibblewhite@anzca.edu.au

For information on the research grants program contact Susan Collins, Research and Administration Co-ordinator, scollins@anzca.edu.au.

Scan this code to donate directly from your phone or device.

GOVERNOR PATRON SUPPORTS NEW RESEARCH AWARD AND WOMEN IN ANAESTHESIA RESEARCH

Dr Stanley Tay, FANZCA, the ANZCA Foundation's youngest governor patron, has pledged $100,000 to the ANZCA Foundation. In recognition of this extraordinary generosity, a new ANZCA Foundation honorary research award will be established for technological innovation in anaesthesia, pain medicine and perioperative medicine research.

The foundation's new ANZCA Innovation and Technology Research Award will honour Dr Tay's support as a respected anaesthetist and medical technology entrepreneur.

The award's purpose is to support and encourage research involving the innovative development or use of technology. It will be awarded each year to the grant application in this area achieving the highest ranking in the ANZCA Research Committee peer-review process.

A passionate advocate for diversity and inclusion in medical research, Dr Tay asked the foundation to amplify the voices of and opportunities for women researchers when announcing the new award.

"Gender diversity in research is not just about equity. It's about richness of perspective and the creation of a holistic understanding. Supporting women researchers is paramount in driving progress in anaesthesia and beyond," he said.

Image above: Mr Rob Packer and Dr Stanley Tay.

As well as his passion for research, Dr Tay has a strong interest in information technology. Working with Dr Joshua Szental, he developed and co-founded an innovative billing application called Anaemate. "The app utilises digital technology to simplify, streamline and automate the process of anaesthetic billing, while driving improved efficiency," said Dr Tay.

His contribution combines these interests and his commitment to advancing safer surgery, improving pain treatment, and improving quality of life for patients, through research and education projects aiming to advance medical knowledge, procedures, and outcomes.

Dr Tay is keen to recognise the work ethic and devotion of several notable anaesthetists as his source of inspiration, including Dr Amanda Baric, Professor David Story, Professor Laurence Weinberg, Associate Professor Elizabeth Hessian, and Dr David Bramley.

He cites several contributions from these "trailblazers", such as the dedication to education that led to Dr Baric receiving the Robert Orton Medal, the pioneering research of Professor Story and Professor Weinberg and Associate Professor Hessian, and Dr Bramley's relentless focus on safety and quality in anaesthesia, as profoundly shaping his professional philosophy and approach.

Dr Tay's activities now extend beyond his clinical work. As a governor patron, philanthropist, and supporter of the foundation and its cause, he is a significant contributor to fostering a culture of research and quality improvement. In his staff specialist role at Melbourne's Western Health and as manager of his private practice, his personal aims are to extend boundaries and set new standards to continually improve patient experiences and outcomes.

To further support these goals, he is also a prolific educational content creator. He collaborates with Dr Lahiru Amaratunge on an ANZCA primary exam podcast titled "Anaesthesia Coffee Break" providing insights and learning for anaesthesia trainees. He has also founded "Adrenaline Memories" for further anaesthesia education and learning, on the Patreon social platform.

The support of patrons like Dr Tay is testament to the beneficial impact individuals can make through passion, dedication, and commitment to enhancing patient care.

ANZCA Clinical Trials Network news

GRANT FUNDING

To date, the ANZCA Clinical Trials Network has secured more than 63 million dollars in competitive grant funding to run large multicentre clinical trials and pilot and feasibility studies. A team led by Professor Kate Leslie AO from the University of Melbourne and Royal Melbourne Hospital, is getting the latest funded SNAPP study under way. The start-up meeting will be held at the CTN workshop in Coogee, NSW in August. Visit anzca.edu.au/ctn for more information on how you can be involved in this study and other trials.

THE SNAPP STUDY: SUGAMMADEX, NEOSTIGMINE AND POSTOPERATIVE PULMONARY COMPLICATIONS

A hidden pandemic of postoperative complications affects up to one in five of the 300 million patients having surgery each year. Complications after surgery are the third greatest contributor to death worldwide (after heart disease and stroke and before cancer and infectious disease). Furthermore, postoperative complications can lead to prolonged illness, increased dependency and impaired quality of life for patients and families. Postoperative lung complications, such as pneumonia, are among the most common, serious, distressing and costly complications of surgery and anaesthesia, costing Australians more than $A200 million each year. Nevertheless postoperative lung complications have not received the same attention as other complications. The SNaPP Study aims to fill this gap.

The SNaPP Study will evaluate the effect of sugammadex versus neostigmine on postoperative pulmonary complications. Residual weakness is a common and well-described risk factor for postoperative lung complications and sugammadex reduces the incidence of residual weakness compared to neostigmine. However whether sugammadex decreases the incidence of postoperative pulmonary complications is unknown. Furthermore, sugammadex is much more expensive than neostigmine, so a cost effectiveness analysis is required to demonstrate value.

SNaPP is an initiative of the Department of Critical Care, University of Melbourne, and the ANZCA Clinical Trials Network. The trial recently received funding from the Australian Medical Research Future Fund ($A2.9 million over four years). Professor Kate Leslie AO FAHMS, a former ANZCA president and CTN executive chair, is leading a team of clinical trialists, biostatisticians and health economists, in Australia, New Zealand and Hong Kong. The trial will be managed by Ms Sofia Sidiropoulos, an Anaesthesia Research Co-ordinators Network member and current ROCKet trial manager.

Patients aged 40 years and over, scheduled for abdominal or thoracic surgery under relaxant general anaesthesia with an endotracheal tube, will be randomised to sugammadex or neostigmine for reversal of neuromuscular blockade. The primary outcome is death or postoperative pulmonary complications up to hospital discharge (or postoperative day seven if still in hospital). Secondary outcomes include postoperative nausea and vomiting, unplanned intensive care unit stay and days alive and at home at 30 days.

The SNaPP Study will answer one of the most hotly debated questions in clinical anaesthesia.

Image: Ms Vi Ha (Trial Coordinator), Ms Sofia Sidiropoulos (Trial Manager) and Ms Bhavita Patel (Trial Administrator).

The new kids on the Block: Professional Practice Research Network Executive (PPRNE)

The Professional Practice Research Network Executive (PPRNE) is a sub-committee that operates under the ANZCA Research Committee. Recognising the need for a dedicated research sub-committee to focus on professional practice domains within anaesthesia, perioperative medicine, and pain medicine, the committee established the PPRNE. This decision came after witnessing the tremendous success of the ANZCA Clinical Trials Network (CTN).

The executive is driven by the objective of promoting and advancing research in various professional practice domains, including communication, collaboration, leadership, scholarship, education, health advocacy, and professionalism. While the CTN primarily engages in quantitative research and clinical trials, the exective has a distinct interest in the social sciences and qualitative research methodologies.

This enables them to delve into important areas such as understanding the factors that influence practitioner well-being, investigating equity issues in healthcare and training, examining cognitive processes in clinical reasoning and decision-making, studying the development of expertise, exploring socio-cultural influences on communication, translation and implementation research, and researching human factors, ergonomics, and systems design in healthcare.

The PPRNE was initially formed in 2020 under the leadership of Professor Jennifer Weller, through the ANZCA Research Committee and the ANZCA Foundation. The torch has since been passed to Professor Kirsty Forrest, who now leads the executive. The executive oversees and supports the Professional Practice Research Network (PPRN), which serves as a platform for researchers in the field.

To provide support for research in professional practice, the executive has introduced dedicated professional practice research grants. These grants are made available through ANZCA's annual research grant funding round and offer valuable financial support to eligible applicants. In collaboration with the ANZCA Library, the executive has also developed a comprehensive library guide containing relevant research resources for researchers in the field.

The PPRNE actively organises research sessions at various events to provide researchers with opportunities to present their work and collaborate with peers. They have successfully held research presentations at the past three Combined SIG meetings, including a session on the Gold Coast in June 2023.

These sessions serve as valuable platforms for sharing research findings and fostering collaborations. Moving forward, the network aims to expand mentorship opportunities for researchers, facilitate multicentre studies through networking, organise more developmental research workshops at ANZCA Annual Scientific Meeting, and encourage fellows and trainees to engage in PPRN activities.

Overall, the executive is making significant strides in advancing research and promoting excellence within the professional practice domains of anaesthesia, perioperative, and pain medicine. If you are interested in getting involved or learning more, We encourage you to visit the Professional Practice Research Network on the ANZCA website, which provides comprehensive details about its initiatives and activities.

The network's dedication to research and commitment to enhancing professional practice in the field is fantastic to be a part of – come join the fun!

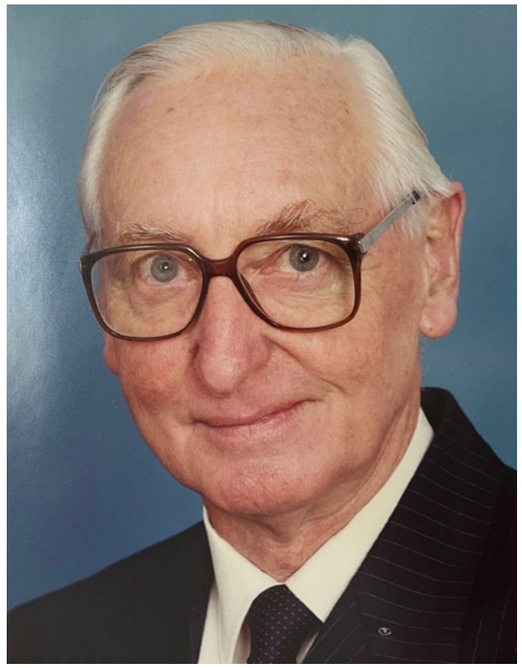
Dr Tim Marshall, trainee
Professor Kirsty Forrest, FANZCA

Committee members of the Professional Practice Research Network Executive:

Chair: Professor Kirsty Forrest (Qld)
Dr Kara Allen (Vic)
Dr Thy Do (WA)
Dr Andrew Huang (Vic)
Associate Professor Stuart Marshall (Vic) (ANZCA Council)
Dr Tim Marshall (Trainee Representative) (NSW)
Dr Cate McIntosh (NSW)
Dr Kerry Warner (NSW)
Professor Jennifer Weller (NZ)
Dr Su-Jen Yap (NSW)
Associate Professor Robert O'Brien (Executive Director, ANZCA Education and Research) (Vic)
Mr Robert Packer (General Manager, ANZCA Foundation) (Vic)
Dr Chris Cokis (ANZCA President, ex officio) (WA)

Dr Brian Pollard

1925 – 2023



Recently ANZCA lost its longest standing fellow when Brian Pollard died following a relatively short decline in his health that had been excellent until approximately six months prior to his death. Brian was born to James (Jim) and Mary Muriel (née Callaghan) Pollard at Punchbowl, Sydney.

An only child, who did not attend school until he was seven, he attended Marist Brothers, Darlinghurst for secondary education. His first attempt at the HSC examination in 1941 achieved matriculation for medical studies which he had decided upon, but at the age of just 16 he was declared too young to start the course and so returned to repeat the HSC in which he improved his marks.

Again misfortune intervened as, although he had matriculated for medicine the previous year and had improved his marks, he was refused entry because WW2 quotas had been introduced and he did not make the cut. So back again to school but with an intensity to do much better and this time he succeeded. At last off to Sydney University Medical School in 1944 finishing in 1950 with Class II Honours.

Brian married Carmel O'Sullivan, a trainee opera singer, in November 1950, interned at Sydney Hospital, and then transferred to Newcastle where there was married accommodation and where he was influenced by Ivan Schalit into anaesthesia. He then obtained a training position at St Vincent's Hospital, Sydney (October 1953), where 18 months later Brian Dwyer started as Director of Anaesthetics. The following year in December 1956 Pollard was admitted to his FFARACS.

In July of that year he was invited by Len Shea, one of Sydney's then doyens of anaesthesia, to join the eminent group established in 1944 by Harry Daly and Stuart Marshall, the "Elizabeth Bay Group". Brian's joining of the group by then expanded to eight sparked a tetchy comment from a rival – "I hear the octopus has grown another arm"! This move into private practice was aided by a notable coroner's case concerning a death under anaesthesia where it was stated that "in the interests of public safety" specialists should administer anaesthesia after it was disclosed that GPs were giving anaesthesia when specialists were available but underemployed! Pollard often told the story of his early relationship with Daly as it didn't seem right to be calling a partner "Sir" or "Dr Daly".

This embarrassment was sensed by Daly and one day when Harry was cutting bread for lunch said, as recorded by Brian, "Come over here Brian and go down on one knee. Not knowing him well, I thought perhaps he had lost his senses, but he had a slight smile, so I did as asked. Placing the blade on one of my shoulders he said 'Arise Sir Brian'. You may call me Harry"[1].

In 1958 Brian became the NSW Secretary of the ASA without knowing that the next AGM was to be held in Sydney and that he would have to organise it. This involvement with the ASA eventually led to his presidency (1974-1976).

Pollard made two contributions to world anaesthesia. The first in 1968 was the introduction of the "Pollard Tube" which he developed to cope with the new micro-laryngeal surgery developed in Germany. The Pollard tube had different smaller sizes for the distal section of the tube to allow better access for surgery[2].

This tube was used around the world until replaced about 10 years later by a better idea[3]. Pollard's second idea which was taken up worldwide was a method to detect oesophageal intubation instead of the intended tracheal intubation4. These two innovations meant that for a generation of anaesthetists the name Pollard was recognised by anaesthetists around the world, which facilitated visiting world anaesthetic experts.

In October 1972 sensing an opportunity Brian retired from a very successful private practice, much to the surprise of his colleagues, to take up the position of Director of Anaesthetics at Concord Repatriation Hospital and lead it to become a popular training department for registrars. In 1976 he was invited to join the Consultants' Committee of the Department of Veterans Affairs enabling him to represent anaesthetists' interests around Australia.

At St Vincent's Brian had learnt from Dwyer the value of a Pain Clinic, and at Concord he occasionally stood in for the regular doctor. During these periods he became aware of the issues surrounding dying for some patients. In 1980 when visiting the World Congress of Anaesthesiology, he did a world tour which included a visit to Dr Cicely Saunders (the earliest person to establish palliative care as a specialty) at St Christopher's Hospice in London. On his return Brian took leave from his anaesthetic directorship to set up a Palliative Care Ward at Concord Hospital.

This ward commenced in January 1982 becoming the second such full-time facility in Australia (following an earlier unit in Perth headed by Dr Rosalie Shaw). That year his youngest child, aged 13, developed an osteogenic sarcoma and his palliative care knowledge helped considerably nursing her at home during this terminal illness. In 1983 he ceased his directorship but remained running the Palliative Care Ward, finally retiring in December 1986 at the age of 61.

He was also associated with the development, together with Dr Fred Ganz, of the Palliative Care Association of NSW, and succeeded Ganz as the second president (1986-1988), and in 1998 was elected to life membership of the association. Because of his involvement in palliative care Brian almost inevitably was drawn into the debate on euthanasia which had become an issue in the late 1980s and escalated to the *Northern Territory Rights of the Terminally Ill III Act 1995*, and its subsequent overrule by the Federal Parliament enacting the *Euthanasia Laws Act 1997* but with on-going debate in both state and federal jurisdictions up to the present time, when all states have now passed acts to permit voluntary assisted dying.

Pollard was very active in his opposition with many publications and speeches. He also published a small book *Should we kill the dying* (1989) later updated in 1994 as *The Challenge of Euthanasia*, and in 1993 obtained an Honours Graduate Certificate in Bioethics from UTS specifically to enhance his opposition to the proposals for legalised euthanasia.

As a result of his involvement in palliative care and his intense opposition to euthanasia a number of awards were bestowed – Knight Commander of the Order of St Gregory the Great (1994); the Mother Teresa Pro-Life Award (1995); the 1998 Annual Award of the Society of St Thomas More; the Order of Commander of Merit of the Sovereign Military Hospitaller Order of the Knights of Malta (2001); the Commonwealth Centenary Medal which citation reads "for service to the community through the care of terminally-ill patients"; and the NSW Right to Life Association Medallion (2003) inscribed "In appreciation of your dedication in the service of all life issues".

Since 1947 Brian had given anaesthesia for ECT at Mount St Margaret's Psychiatric Hospital at Ryde, Sydney, and in 1986 he was appointed to the advisory board of the hospital and then chair in 1987.

He presided over the closure of the hospital in 1992 in its centenary year, retiring when the board was required to oversee transition of the site to a retirement complex. In a slight quirk of fate, Brian later became a resident of this Calvary Retirement Community where he died.

In 2004 he revisited palliative care by publishing *The Principles of Palliative Care* which is a small book intended as an introduction to palliative care for medical students.

Pollard will probably be most remembered for his passionate campaigning on behalf of the Right to Life groups opposing euthanasia, but should be equally remembered for his establishment in Australia of palliative care as a much appreciated and necessary specialty.

He should also be remembered by anaesthetists for his Pollard Tube, and importantly for his method for checking the placement of an endotracheal tube to ensure it is in the trachea and not the oesophagus. This simple method applies today as much as it did when first published.

Brian's wife predeceased him in 2018, and he is survived by five of his six children to whom we extend condolences and share the joy on a long life lived enthusiastically.

AB Baker
Emeritus Professor, University of Sydney.
Honorary Historian, ANZCA.

Acknowledgement to Geoffrey Pollard who provided access to *Life of Brian* by Brian Pollard.

References

1. BJ Pollard. *Life of Brian*. Private publication. 2003
2. BJ Pollard. *Anaesthesia for laryngeal microsurgery*. Anaesthesia 1968; 23 (4): 534-542
3. B Benjamin & D Gronow. *A new tube for microlaryngeal surgery*. Anaesthesia Intensive Care 1979; 7 (3): 258-263
4. JJ O'Leary, BJ Pollard & MJ Ryan. *A Method of Detecting Oesophageal Intubation or Confirming Tracheal Intubation*. Anaesthesia intensive Care 1988; 16 (3): 299-301

Photo courtesy of Dr John Quoyle, Director of Anaesthesia, Concord Hospital.

Marise Anne Thacker

1941 – 2023

Marise Anne Thacker was a wonderful, warm woman who was meticulously organised, with an eye for detail, and who made an important contribution to Anaesthetic Allergy Investigation.

Dr Marise Anne Thacker, registration number 05653, gained conditional registration in 1966 and full registration as a medical practitioner in 1967.

After graduation from medical school, in Dunedin, MBChB Otago, 1966; Marise travelled to the UK where she gained some anaesthetic experience and the Diploma of Anaesthesia in 1969. In 1973 she returned to Christchurch to nurse her mother. Once her mother passed away, she joined the Anaesthetic Department at Christchurch Hospital, as an anaesthetic registrar; gaining fellowship of the Faculty of Anaesthetists of the Royal College of Surgeons of England, in 1978.

A colleague Dr Margaret Chacko recalls Dr Gwenda Lewis (who conducted anaesthesia from a wheelchair) teaching herself and Marise, in addition to anaesthetic clinical skills, about what they considered was a "humanitarian approach" to anaesthesia, which included holding an anxious patient's hand and looking at patients at eye level, rather than from the end of the bed. During the training years, Marise and Margaret attended the Part 1 course and exam in Dunedin, and the Part 2, which they undertook in Auckland.

In addition to being a competent and respected colleague in her role as a specialist anaesthetist, Marise began allergy investigation in the Department of Anaesthesia, in 1977. She was strongly supported in this role by the Director of Anaesthesia Dr Doug Chisholm and in preparation travelled to visit Dr Fisher in Sydney, Australia, Professor Marie-Claire Laxenaire in Nancy, France, Dr Watkins in Sheffield, UK and Dr Clarke in Belfast, Ireland.

On returning to Christchurch, the first skin testing for allergy was undertaken by Marise in August 1977, for an adverse event experienced in June 1977. Initially in an anaesthetic room, later at Christchurch Women's Hospital, each drug dilution was prepared, with drug name and dilution written on the syringe and only one patient booked for the Friday afternoon clinic. This was in order to allow time to talk to patients about their experience and prepare their minds for future anaesthesia.

At that time, the ability to explain and identify the cause of an allergic reaction which occurred during anaesthesia, resulting in a near death experience for the patient, was new knowledge. What Marise provided was a sensitive, well-informed debrief opportunity for the patient and their family, in service to future anaesthetists. She had a comprehensive system to record the results and disseminate the information to the patient, GP, the medic alert foundation, personally filed letters in all volumes of the medical record and her anaesthetic department records were colour coded by category, filed by year and annual summaries were prepared.

From the outset, Marise would ask subsequent anaesthetists to forward records of anaesthesia, seeking to determine the reliability and value of skin testing and during her transition to retirement from as early as 1995, Marise laboriously worked back through all the patients she had ever investigated and sent them a request to forward information about subsequent anaesthetics received and any adverse events. She then requested the old records and with the assistance of Dr Mike Davis, published her paper in April 1999, on "Subsequent General Anaesthesia in Patients with a History of Previous Anaphylactoid/Anaphylactic Reaction to Muscle Relaxant", which is still one of the most comprehensive publications ever on the value of skin testing.

Marise with Dr Buff Maycock, was a founding member of the NZ Adverse Reactions Group which first met in Christchurch on 22 February 1991, attended by nine anaesthetists from around New Zealand. This group later combined with Australian anaesthetists following a meeting organised in Christchurch at the Annual Scientific Meeting in 2010, which became the Australian and NZ Anaesthetic Allergy Group (ANZAAG) which supports this work today.

During her time working in anaesthetic allergy, in the Christchurch department, Marise was initially supported by Dr Male, later being joined in 1985 by Dr Maycock, who remembers their time together and particularly the mentorship of Marise very fondly and with whom Marise remained in contact after Dr Maycock moved to Brisbane in 1992. Subsequently Marise worked with Dr Allison Powell and in 1997 she handed over to Dr Susan Nicoll. It was expected that she would continue to work for a longer time, as she was then only 55 years young, but she decided to leave to have more time for her nieces and other family, including preparation of the Thacker family history and to be able to complete the subsequent anaesthesia project.

Her joy in compiling the Thacker family history, generation one and two, and in her water colour painting and time spent with the group of friends she enjoyed painting with, was apparent in her retirement, and in the fairies and pixies she painted for young children of friends. At Ngaio Marsh Retirement Village after her stroke, she continued to exercise her legs on a stationary walker, to keep herself mobile. When asked whether she had any recollections or stories to share, she said, "Dear Girl, you can make up whatever you like."

Marise was a wonderful, warm woman, who retained a deep but girlish giggle and a sense of joy.

Fortunately for the anaesthesia community, and for her many patients, the anaesthesia and allergy care she delivered was modelled early, on a humanistic or compassionate approach, combined with clarity of purpose and the discipline and determination to complete a task. She was a very humble, ladylike giantess, on whose shoulders we stand, and it is with sadness, and with immense respect that we remember her.

Dr Susan Nicoll FANZCA
Specialist Anaesthetist Christchurch,
New Zealand

**This obituary has been compiled based on the eulogy*

Professor Michael Bennett AM

1956 – 2023

Professor Michael Bennett AM, recently retired academic head of anaesthesia at the Prince of Wales Hospital, Sydney passed away unexpectedly at the age of 67. Professor Bennett (Mike) was a fellow of the Australian and New Zealand College of Anaesthetists (FANZCA) and a world recognised expert in diving and hyperbaric medicine.

Mike was a student at the University of New South Wales (UNSW) and graduated in 1979, beginning his career as a medical officer at the Prince of Wales and Prince Henry Hospitals. In 1982, he moved to the United Kingdom where two important events ensued. First, he met Dr Sue Pugh, his future wife. Second, he trained in anaesthesia, gaining fellowship of the Faculty of Anaesthetists of the Royal College of Surgeons in Ireland in 1986.

Mike returned to Australia in 1990 where he completed several years of retrieval medicine and further anaesthesia training. He was appointed as a staff specialist anaesthetist in 1993, marking the beginning of a very successful clinical and academic career at Prince of Wales Hospital (POWH) and the UNSW, until his retirement earlier this year.

In 1998, Mike was awarded a Masters of Epidemiology (University of Sydney) and a Doctorate of Medicine (UNSW) in 2006, coinciding with his appointment as a conjoint Associate Professor (UNSW) the same year. In 2012 he was appointed academic head of anaesthesia at POWH and in 2015 was appointed as a full conjoint professor in anaesthesia and hyperbaric medicine (UNSW). Under Mike's stewardship, the department of anaesthesia at POWH contributed significantly to local and international research projects in the field of anaesthesia and diving and hyperbaric medicine.

Mike was the medical director of the department of diving and hyperbaric medicine (POWH) for more than 10 years. Throughout his career, Mike had strived to promote evidence-based practice and campaigned against poor science and charlatans in the field. He was a sought-after speaker and an accomplished scuba diver in his own right. Many of his presentations started with stories of his diving adventures under the ice in Antarctica.

Mike contributed enormously to anaesthesia and diving and hyperbaric medicine by his representation on numerous professional medical bodies. Some of his notable achievements include chair of the Australian and New Zealand Hyperbaric Medicine Group, vice president of the Undersea and Hyperbaric Medical Society (UHMS) and president of the South Pacific Underwater Medical Society. He had also held numerous appointments as a committee member of various societies and as a member of editorial review boards, including the Cochrane Anaesthesia Review Group.

Mike contributed significantly to education in ANZCA, being a member of the ANZCA NSW Continuing Education Committee, chair, Court of Examiners in Diving and Hyperbaric Medicine, as well as a member of various other ANZCA committees and sub-committees.

Mike's contribution has been recognised by numerous awards including:

- The Albert Behnke Award for outstanding scientific achievement.
- The ANZCA Citation for services to anaesthesia and hyperbaric medicine.
- The Foundation Fellowship of UHMS.
- The DAN contribution to Dive Safety Award.
- The UHMS Excellence in Hyperbaric Medicine Award.

In 2021 he was conferred a Member of the Order of Australia for excellence and significant service to medical education and hyperbaric medicine.

Mike's academic, clinical and leadership achievements are well recognised. However, for those that knew him, he was not defined by these, but rather his warmth, friendship, and humanity.

Mike was extraordinarily generous with his time – his advice could always be relied upon and was never tainted with self-interest. His passion for public health and social justice was legendary, as was his passion for life. His adventures had the habit of pulling in those around him – from the Siberian railway to shipwrecks in New Guinea, no one who knew him escaped completely unscathed. Mike's intellect was matched only by his sense of fun, and his irreverent sense of humour.

Mike's passing is a significant loss. I am sure those who knew him are thinking of things that will be missed, including the clinical discussions, his irrepressible sense of humour, philosophical and political debates, movie reviews, English grammar corrections, and witty cynicism. Mike was a brilliant colleague, a wise voice when guidance was required and a great friend. Most importantly, he will be desperately missed by his life partner and loving wife Sue Pugh.

Life without Mike won't be the same. His death leaves a great vacuum, and I take this opportunity to offer my sincere condolences to Sue, his family and his many friends and colleagues that he has left behind.

Dr Robert Turner FANZCA
Administrative Head, Anaesthesia, Prince of Wales Hospital
Commander, Royal Australian Navy

Medtronic

Innovation. Validation.

What makes a true Microstream™ sampling line?

1

0.2 Micron Filter

Sterilising-grade filter designed to reduce risk of contamination of the monitor.

2

Quick Connect

Easy and quick connection to Microstream™ monitors.

3

O_2 Delivery

(May be used with or without oxygen delivery) O_2 delivery separate from CO_2 sampling.

4

Oral Scoop

Provides enhanced sampling for mouth breathers.

5

Uni-junction™ Technology

Enables etCO_2 sampling from either the nares or the mouth.

6

Dual Nare Sampling

Designed to ensure proper sampling from either nare.