Bulletin

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

WINTER 2021

Exploring the virtual world of the 2021 ANZCA ASM

Substance abuse: A personal account of one fellow’s journey

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

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Cover: Inside the engine room at the Melbourne Convention and Exhibition Centre which showcases the global virtual reach of the 2021 ANZCA ASM. Photo: Penny Stephens

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PRESIDENT'S MESSAGE

WHAT A DIFFERENCE A YEAR MAKES

This time last year, we had just started to understand that major restrictions on freedom would be with us for some time. Like all good anaesthetists, we wanted to know the rules, so that we could work with them, or around them, in an effort to re-establish life as we knew it.

Just as we thought we were over the worst, with the Trans-Tasman bubble opening, the vaccination program running (or plodding along), and days of no cases except in isolation or quarantine, more community outbreaks have struck in Victoria and now in Sydney. It could just have easily been Auckland or Adelaide.

The coronavirus has again shown how nimbly it can slip through any gap in the fence. Normality is fragile, and will remain so until vaccination coverage is wide enough. What is “wide enough” is no longer a domestic question. It is global. No one is safe until everyone is safe. That reality is confronting for societies where good healthcare has been primarily the preserve of the rich, who resist funding healthcare for the poor. It is a pandemic, that ethos no longer works for anyone, anywhere in the world.

The life or death reality of COVID-19 has raised the importance of good public policy. It has brought home to us the need to put people at the heart of healthcare. The mantra of “public health first” to which we have adhered throughout the pandemic has brought home to me how much I have missed the camaraderie and sense of purpose that brings everyone up. Enthusiasts get together in each other’s company. I wish us all a speedy return to the sense of community and fellowship that being a FANZCA brings.

Dr Vanessa Beavis
ANZCA President

MEANWHILE, BACK HOME…

Despite the disruptions, we have learnt to “pivot” and “regroup” (buzzwords of the day), and achieve what was planned, with COVID more of an inconvenience than a show-stopper. Triumphs include:

- **Exams** All 2020 and 2021.1 cohorts have completed them, thanks to a Herculean effort from examiners, staff and candidates alike.

- **ASM** “Amazing” can sound like a clichéd, breathless, hyperbolic expression, but in this case it aptly describes the achievement of putting together our first hybrid annual scientific meeting (ASM) (see page 50). The result was a meeting whose benefit will extend well into the future. Attendees could watch sessions “on demand”. The hubs for the College Ceremony, and for some talks, were a great innovation, which allowed small groups to get together and celebrate some of the freedoms we used to take for granted. The ASM was the product of a phenomenal effort by ANZCA’s Events team, with IT support that delivered all that was promised. Virtual meetings can be uninspiring, but not this time.

- **Virtual workshops** of the highest calibre is nothing short of amazing. I make special mention to the airway can’t intubate, can’t oxygenate or circulate workshop leaders, who completely reimagined how it could be presented virtually, and succeeded handsomely (see page 58).

ANZCA’s Council is looking forward to getting our other “big ticket” items under way again. These include the diploma of rural generalist anaesthesia, the clinical diploma of perioperative medicine, the combined College of Intensive Care Medicine and ANZCA program for dual fellowship, and all the things that have been paused, such as research.

Framework for international co-operation

The long-standing informal relationship between five international colleges of anaesthesiology now has a structure to support joint projects and other research and other projects. The Royal College of Anaesthetists (UK), the Royal College of Physicians and Surgeons of Canada, the College of Anaesthesiologists of Ireland, the Hong Kong College of Anaesthesiologists, and ANZCA have come together as the International Academy of Colleges of Anaesthesiologists – mercifully shortened to IAC.

AND FINALLY…

Being able to visit ANZCA’s Melbourne base, and especially Uluru, for the first time in 15 months has brought home to me how much I have missed the camaraderie and sense of purpose that brings everyone up. Enthusiasts get together in each other’s company. I wish us all a speedy return to the sense of community and fellowship that being a FANZCA brings.

Dr Vanessa Beavis
ANZCA President

Queen’s Birthday Honours

Congratulations to our fellows and and our long-serving community representative Helen Maxwell-Wright for being recognised in this year’s Queen’s Birthday Honours.

**Member in the General Division (AM)**
- Professor Michael Heywood Barnett FANZCA (NSW).
- For significant service to medical education, and to medical education.

**Medal in the General Division (OAM)**
- Colonel Susan Kaye Winter FANZCA CSC.
- For meritorious service as a specialist anaesthetist and intensivist on multiple overseas deployments and specialist medical advisor to the 2nd General Health Battalion, 3rd Health Support Battalion and Army Health Services.

**Professor Nigel Ronald Jones FRACS, FFPMANZCA (SA)**
- For significant service to medical education, and to medical education.

**Professor Helen Maxwell-Wright**
- Community representative (Vic).
- For significant service to child welfare, to diabetes health services.

**Professor Steve Shafer**
- For significant service to child welfare, to diabetes health services.

**Professor Michael Heywood Barnett**
- For significant service to medical education, and to medical education.

**Professor Siouxsie Wiles MNZM (New Zealander of the Year)**
- For service to medicine, and to history.

**Professor Steve Shafer**
- For service to medicine, and to history.

**Medal in the Military Division (OAM)**

**President’s Message**

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- For service to medicine, and to history.

**Medal in the Military Division (OAM)**

**Dr Scott Comber Forrey FANZCA (NSW)**
- For service to medicine as an anaesthetist.
**Dr John David Paul FANZCA (Tas)**
- For service to medicine, and to history.
ANZCA Staff Recognition Awards

ANZCA fellows should be aware of several unfa ir provisions of the voluntary assisted dying acts of Victoria and Western Australia.

Both states have made self-administration the default option over practitioner administration. Yet there is no reason to remove one mode of administration from a patient’s control.

Intravenous self-administration is not excluded by either act. It finds favour because:
• The patient can be in complete control of timing.
• The practitioner is not called on to inject a lethal drug.
• It lessens disruption to normal working conditions, atmosphere and ambiance.

But this model is not supported by state and territory medical colleges. Separate authorizations for self-versus practitioner-administration mean that once self-administration is stated, the practitioner cannot intervene. If the procedure fails, the patient must be allowed to awaken. However, whichever model is chosen, this would be a cruel outcome.

Voluntary assisted dying is a significant medical procedure. Yet, it can be conducted without medical supervision. No facility may be available to manage any obstruction that is a complication of unconsciousness.

Practitioners require experience, training, and intrusive vetting (OVA), yet are given health department directives with respect to drug use; rather than autonomy within college guidelines. This may affect recruitment.

Pemotrubine is widely accepted for both oral and intravenous administration and works without a muscle relaxant. Yet, for reasons unrelated to its intravenous use is restricted in favour of a combination of propofol and rocuronium in questionable dosage. A patient cannot simply choose practitioner administration. It is the co-ordinating practitioner who must tell the patient that they are not suitable for self-administration. In a catch-22, the co-ordinating practitioner bases that decision on information provided by the patient.

Methadone can be used for induction with propofol, yet fentanyl, with equally useful actions, cannot be used. Failure to recommend an intravenous induction can lead to all cases, and a giving set for intravenous administration would not reach the expectations of an average anaesthetist.

These are just a sample of adverse provisions as they apply currently. They do not address the narrowly defined criteria that, for example, do not include patients with Alzheimer’s disease, those aged less than 18 years and facing a fatal illness, or very elderly, well patients who feel they have completed their lives.

Anaesthetists are well positioned to make a significant contribution to voluntary assisted dying, yet there has been no discussion or influence on its legislation or implementation. It is hoped this letter will encourage more interest.

Dr Peter G Rehan, FANZCA
(terminated anaesthetist from WA)
Online activities grow

Environmental sustainability in hospitals is a hot topic. Our feature on The Alfred ditching desflurane was met with a flurry of shares, likes and positive comments on Twitter, Facebook, Instagram and LinkedIn. And the ‘Operation Clean Up’ story with Dr Kerstin Wyss used showing us how she found alternatives for blueys to help reduce waste in her hospital was a hit on Instagram.

Inclusion and diversity is another important issue to many of you. For International Women’s Day we asked you to post your questions on things like unconscious bias and gender balance to our Instagram page. Our Facebook account has almost 6500 followers, and is supported by the ever-growing number of ANZCA councillors and FPM board members with active accounts.

Our Facebook account has almost 6500 followers, and is one of the best ways to keep in the loop about upcoming events and courses. If you’re looking to connect with the college community professionally, join the increasing number of fellows, trainees, and specialist international medical graduates associating themselves with ANZCA on LinkedIn.

For a uniquely intimate insight on college life, follow us on Instagram. It’s proving to be a popular platform for us.

Since we launched our account last October 2020, we’ve reached an audience of 750,000 people.

ANZCA New South Wales National Committee Chair Dr Sally Watterson (@LeonieWatterson), and ANZCA New Zealand National Committee Chair Dr Sally  Ure were interviewed for TVNZ on 11 May for a three-minute segment about COVID-19 causing delays in the global supply chain for anaesthetic drugs. The segment was broadcast in the US, reaching 90,000 listeners.

Unsurprisingly, doctors’ health and wellbeing continues to create conversation and cause change. It was inspiring to see how many of you took part in the ‘Crazy socks for docs day’ to help raise awareness about mental health in the medical profession.

We’ve grown our online engagement activities considerably over the past 12 months. ANZCA now has well-established and active profiles on all the key social media platforms: meaning we’re connecting and communicating with more members and promoting the college and our achievements more widely than ever.

Twitter continues to be our most active platform, with nearly 10,000 people following our @ANZCA and @ANZCA_FPM accounts. It’s a really easy way for us to send out instant updates about things like exams and events, especially with all the disruptions we’re experiencing at the moment. In the last three months we received 6381 tweet impressions and posted 294 tweets from both the ANZCA and FPM accounts. Our followers are supported by the ever-growing number of ANZCA councillors and FPM board members with active accounts.

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Our new combined college website turns one this month. Digital Communications Manager Al Dicks discusses what we’ve been working on since go-live and what’s to come in the year ahead.

BEDDING DOWN A brand new website in the middle of a global pandemic was never going to be easy; especially when your core users are frontline healthcare workers; your entire project team is in lockdown; and your developers are 10,000 kilometres away!

Transitioning to new technologies can be a taxing experience, even in the easiest of circumstances. So firstly, thank you all for your patience; your feedback; and for finding the time to familiarise yourselves with yet another “new normal.”

WHAT’S TO COME Phase two focuses on delivering a range of exciting new functions and features for fellows, trainees, specialist international medical graduates, and other authenticated users that is, anyone with a college ID, such as continuing professional development (CPD) program participants and staff, designed to save you time and make sure you don’t miss out on the information and opportunities that matter most to you. By the end of phase two, every logged-in user will be taken directly to a personalised dashboard not dissimilar to ones we’re familiar with from online banking and retail sites like Amazon and eBay (albeit on a much smaller scale).

Your MyANZCA dashboard will display a selection of specially curated content and notifications such as safety alerts; news; events and courses; job vacancies; and leadership opportunities based on your location; training stage; specialist status; special interest group and committee memberships; and supervisory roles.

As an authenticated user, you’ll be able to bookmark, content from across the site that you can then access and manage at the click of a button through your dashboard. This will also be where you access other online services such as Networks, your CPD portfolio, the training portfolio system, and updating your details.

Other new features you can look forward to in the year ahead include an interactive, easily searchable map and accompanying database of accredited training sites; enhanced search and filtering functionality; and a more consistent approach to downloading documents.

Work is already well underway on this exciting new evolution in our online services. But we still have a long way to go, and progress has been slower than anticipated due to the ongoing impacts of India’s COVID-19 crisis on our offshore development team. So please bear with us a little longer.

Who to follow on Twitter

If you’re new to Twitter and don’t know who to follow; some of our college leaders accounts are a good place to start:

Dr Vanessa Bavis (@VBAvis); Associate Professor Michael Vagg (@MichaelVagg); Dr Nigel Fielding @NFfielding; Dr Debra Davidsen (@davidsenndebra); Dr Michael Jones (@Michael27044912); Dr Scott Maa (@Kangaroo7); Dr Shilpa Mashelkar (@ShilpaMashelkar); Dr Tanya Selak (@tonggastrid); Dr Maryann Turner (@MaryannClare); and Associate Professor Leonie Wallsten (@LeonieWallsten).

Cannabis leads media coverage

MEDICINAL CANNABIS, COVID-19 and the ANZCA Annual Scientific Meeting and FPM Symposium featured in recent media requests for expert comment from ANZCA, anaesthetists and specialist pain medicine physicians.

FPM Dean Associate Professor Mick Vagg was interviewed for an exclusive news article on 23 March by the Sydney Morning Herald about the faculty’s joint Choosing Wisely recommendation for medical practitioners not to prescribe medicinal cannabis to patients for chronic non-cancer pain unless the patient is enrolled in a registered clinical trial. The article was syndicated to The Age, the Brisbane Times and WTA Today reaching more than 750,000 readers. The dean authored an article for The Conversation “Medicinal cannabis to manage chronic pain? We don’t have evidence it works” which reached an audience of more than 800,000 people and was syndicated to The New Daily. He was also interviewed on the ABC Radio Sydney breakfast program reaching 90,000 listeners.

The dean was interviewed by the ABC’s World Today program and MIA about cannabis for acute low back pain on 19 April. A study published in the Medical Journal of Australia found the product was no more effective than a placebo for people dealing with acute low back pain.

ANZCA New Zealand National Committee Chair Dr Sally Ure was interviewed for TVNZ on 11 May for a three-minute segment about COVID-19 causing delays in the global supply chain for anaesthetic drugs. The segment reached an audience of 750,000 people.

Queensland FPM Dean Paul Scott was interviewed for a Ten News Brisbane segment on 7 May about his safety shield invention for ventilators, made with boards and retired Melbourne anaesthetist Dr Bob Smith and FPM ANZCA Dr Nicole Sheridan were interviewed for a Nine News Melbourne segment on 21 March about Dr Smith bringing new life into the operating theatre through his art.

ANZCA 2021 ASM and FPM Symposium presentations also featured in the media. Read more on page 55.

Carolyne Jones
Media Manager, ANZCA

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Australian and New Zealand budgets delivered

AUSTRALIA
Aged care reforms and mental health initiatives capture new health spending in 2021-22 budget

Treasurer Josh Frydenberg delivered the 2021-22 federal budget on 11 May. This follows only six months after the last federal budget which was deferred due to COVID-19. The big health ticket items announced in the budget centre on aged care ($17.7 billion to address recommendations from the Royal Commission into Aged Care Quality and Safety), mental health ($2.3 billion) and the COVID-19 vaccination rollout. Some relevant highlights include:

COVID-19 response
- New measures to enable more GPs and community pharmacies to administer vaccines including a specific temporary COVID-19 vaccination MBS item and Practice Incentive Program payment to support vaccination through GPs and a temporary community pharmacy program to leverage community pharmacies to administer both vaccine doses to patients throughout Phase 2 and Phase 3 of the rollout.
- $7.117 billion in new and amended items on the MBS (around 55 per cent of this for mental health services and treatments).
- $204.6 million to extend telehealth services for a further six months (until 31 December) while the long term design is developed in consultation with medical groups and the community.

Medicines and medical devices
(Pharmaceutical Benefits Scheme – PBS)
- An additional $87.8 million in new and amended PBS listings.
- From May 2021, Epidyolex (cannabidiol) has been included on the PBS for use in the treatment of Dravet syndrome.

Digital health
- $301.8 million for continued investments in My Health Record and $87.5 million for the Australian Digital Health Agency.
- $36 million for streamlining reimbursement approvals for health products through the Health Products Portal to allow the sector to digitally manage applications to the Pharmaceutical Benefits Advisory Committee, Medical Services Advisory Committee and the Prostheses List.

Research
- $6 million over four years to continue the Encouraging More Clinical Trials in Australia program which supports collaboration with jurisdictions to grow the number of clinical trials run in Australia.

Aboriginal and Torres Strait Islander Health
- $781 million in new spending across the forward estimates to improve Aboriginal and Torres Strait Islander health outcomes, the vast bulk of this in aged care services ($630 million) and mental health ($78 million).

Hospitals and private health insurance
- No major announcements, with some additional funding for hospitals to ensure capacity through COVID-19.

Rural health
- An additional $65 million for GPs working in rural Australia through an increase in the Rural Bulk Billing Incentive payment from the current $9.80 per consultation to $10.40 for consultations in medium-sized rural towns to $12.35 for those in very remote communities. While the initiative has been labelled a “game-changer” by the Rural Doctors’ Association of Australia, there has been some criticism from remote GPs that the move is a “drop in the ocean” and unlikely to have a significant impact.

$29.5 million for a funding pool for non-GP medical specialist training from 1 January 2022. This will fund activities such as trials of networked training models, supervision models, and transition of junior specialists to practice in rural settings, and continued professional development for rural medical specialists.

NEW ZEALAND
New Zealand Budget 2021: Vote Health a winner on the day

At a glance:
- $200 million over four years for Pharmac, to help 376,000 patients a year.
- $46.7 million more for primary healthcare, such as GPs.
- Almost $500 million for the first stage of the government health reforms.

The health budget sees the first tranche of funding for the health reforms Health Minister Andrew Little is implementing. Allocation of $486 million to move from the district health boards (DHBs) model to a central Health NZ agency. The budget also establishes the Māori Health Authority, which will be set up out of a $243 million allocation for Māori health.

- $2.7 billion over four years for DHBs, $675m more a year.
- $700 million for capital projects, such as hospital buildings.
- $5 16 million to boost the health infrastructure system, such as the patient records system.
- $400 million to support those with long-term impairments.

New Zealand medical colleges have welcomed the wide-ranging health systems reforms announced by the Minister of Health, Hon Andrew Little on 21 April 2021. In a media release, Dr John Bonning, Chair of the Council of Medical Colleges (CMC), said “we commend the government for establishing a Māori Health Authority (MHA) with commissioning powers and a leadership role in developing strategy and policy for the whole sector. This is a necessary step to support equitable health outcomes for Māori and meet obligations under Te Tiriti o Waitangi.”

The reforms include replacing the 20 District Health Boards (DHBs) with a new crown entity, Health New Zealand (HNZ), that will be responsible for the day-to-day running of the health system. The MHA will also have commissioning powers and the authority to work alongside the Ministry of Health on strategy and policy. Also a new public health agency will be established within the Ministry of Health.

Dr Bonning echoed the reaction around the country that the reforms are major. “There’s a lot of work ahead of the sector. We know one of the first pieces of work will be designing a New Zealand health charter to set the culture for the new health system. Te Tiriti o Waitangi and cultural safety will need to be at the heart of the charter, and CMC is looking forward to working closely with government on this.”

Commentators from either end of the spectrum have scrambled to analyse the sweeping changes that went further than the recommendations of the Health and Disability Systems Review. The review had suggested just cutting the number of DHBs not disbursing the system. It had also not given the recommended MHA any commissions responsibilities. Māori health advocate Lance Norman said the budget [for the MHA] now needs to be $5 billion – a quarter of the total health spend – because Māori make up 25 per cent of the those using the health system, despite only making up 16 per cent of the population.

ANZCA New Zealand Executive Director, Kiri Rikihana welcomed the wide-ranging health system reforms announced by the Minister of Health, Hon Andrew Little on 21 April 2021. In a media release, Dr John Bonning, Chair of the Council of Medical Colleges (CMC), said “we commend the government for establishing a Māori Health Authority (MHA) with commissioning powers and a leadership role in developing strategy and policy for the whole sector. This is a necessary step to support equitable health outcomes for Māori and meet obligations under Te Tiriti o Waitangi.”

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Dr Ray Hader Award for Pastoral Care

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

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

Applicants must be an ANZCA fellow or trainee. The award is valued at $4000 to be used for training or educational purposes. Any ANZCA fellow or trainee can be nominated for this award. Individuals must be nominated and seconded by an accredited ANZCA trainee or fellow and supply the details of two additional referees (other than the nominator and seconded). The nomination must consist of a cover letter written by one or both of the nominator explaining the rationale and justification for the nomination and be accompanied by the candidate’s curriculum vitae. The cover letter and CV should include how the candidate has made a significant contribution to the pastoral care of trainees.

ANZCA President Dr Vanessa Beavis and college fellows were key participants in a global virtual COVID-19 conference organised by the International Academy of Colleges of Anaesthesiologists (IACA).

Dr Beavis succeeded Dr Brian Kinirons, President of the College of Anaesthesiologists of Ireland, as the chair of the academy in May this year and was one of several Australian and New Zealand speakers at the “COVID-19: Lessons for the future of anaesthesia and critical care” conference from 15-17 June.

More than 1000 delegates registered for the conference which examined lessons learned from the COVID-19 pandemic and how these could enhance anaesthesia and critical care practice. Speakers included representatives from the World Health Organization, microbiologist Associate Professor Sourcie Wiles MNZM (New Zealand of the Year), Clinical Associate Professor Nick Coatsworth (former Deputy Chief Medical Officer of Australia) and Professor Kristine Macartney, Director of the National Centre for ImmunoSensory Research and Surveillance Australia.

The conference was the first global event by the academy which supports joint research and projects by five international colleges of anaesthesiology including ANZCA – the Royal College of Anaesthetists (UK), the Royal College of Physicians and Surgeons of Canada, the Royal College of Anaesthesiologists of Ireland and the Hong Kong College of Anaesthesiologists. In her opening conference message, the patron of the Royal College of Anaesthetists (UK), HRH The Princess Royal, said the “anaesthetic community has found new ways to meet the demand for care, making vital contributions towards keeping the world safe and for that, I give heartfelt thanks.”

Patron of the Royal College of Anaesthetists (UK), HRH The Princess Royal giving her opening conference message.

...the anaesthetic community has found new ways to meet the demand for care, making vital contributions towards keeping the world safe and for that, I give heartfelt thanks.”

HRH THE PRINCESS ROYAL

ANZCA AND GOVERNMENT – BUILDING RELATIONSHIPS

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.

AUSTRALIA

• Australian Commission on Safety and Quality in Health Care: Draft intravenous catheter clinical care and Quality in Health Care: Peripheral pain clinical care standard.

• Medical Board of Australia; Review of the English language skills registration standards.

• New South Wales Ministry of Health: Amendments to the Private Health Facilities Act 2007 - information sharing for reportable incidents.

• Royal Australian and New Zealand College of Radiologists: Standards of practice for interventional radiology.

• Skills IQ: Consultation on draft diploma of anaesthetic technology and practice qualifications.

• Therapeutic Goods Administration: Repurposing of prescription medicines.

NEW ZEALAND

• Medical Council of New Zealand: Te Kaunihera Rata o Aotearoa: Proposed Council fees and disciplinary levy.

• Medical Council of New Zealand: Te Kaunihera Rata o Aotearoa: Conducting medical assessments for third parties.

• Ministry of Health: Maraiti Hauora: Smokefree Aotearoa 2025 action plan.

• Allen and Clarke: Guidelines for consultation with obstetric and related medical services survey.

• Pharmac/Te Pātaka Whaioranga: Support for reclassification of hyaluronanase as a prescription medicine.

ANZCA PRESIDENT Dr Vanessa Beavis and college fellows were key participants in a global virtual COVID-19 conference organised by the International Academy of Colleges of Anaesthesiologists (IACA).
PERIOPERATIVE MEDICINE

Work towards perioperative diploma continues

RECOGNITION OF PRIOR learning (RPL) in perioperative medicine—either through other recognised qualifications or significant experience—will be an important undertaking in the ongoing development of a diploma in perioperative medicine.

There was significant discussion relating to RPL at the June meeting of the Perioperative Steering Committee and the chair of the Perioperative Medicine Education Working Group Dr Joel Symons will lead the development of a document addressing RPL and grandparenting. The initial draft of this document will be presented to the steering committee later this year.

The education working group has been meeting to develop the curriculum and assessment of the six core modules of the Diploma of Perioperative Medicine:

- Perioperative impact of major disease
- Planning for appropriate care
- Optimisation
- Intraoperative impacts on patient outcomes
- Safe recovery in hospital
- Discharge planning and rehabilitation

This working group includes representation from anaesthesia, pain medicine, general practice, physicians (including rehabilitation and geriatrics), intensive care, surgery and rural and remote medicine. To date, members have approved the structure of the modules and are providing feedback on the content of modules 1, 2 and 4 and developing the curriculum and assessment for modules 3, 5 and 6.

The Perioperative Medicine Care Working Group continues to refine the perioperative care framework, which maps the patient journey from the time surgery is contemplated through to recovery.

The framework document has been circulated for feedback from the:

- Safety and Quality Committee, ANZCA.
- Perioperative Medicine Special Interest Group executive.
- FPM Professional Standards Committee.
- College of Intensive Care Medicine.
- Royal Australasian College of Physicians’ Policy and Advocacy Council.
- Australian and New Zealand Society for Geriatric Medicine.
- Rehabilitation Medicine Society of Australia and New Zealand.
- Royal Australasian College of Surgeons’ Professional Standards and Advocacy Committee.
- Australian College of Rural and Remote Medicine.
- Royal Australian College of General Practitioners and the Royal New Zealand College of General Practitioners.

The framework was also sent to the Indigenous Health Committee to explore aspects such as cultural safety. Another core task of the project is to establish the economic benefits of perioperative medicine through the engagement of a health economist later this year and using evidence from the literature review undertaken on behalf of the college prior to the COVID-19 pandemic.

A vacancy also exists for a representative from the Australian College of Rural and Remote Medicine, following the decision of Dr Eugene Wong who has stepped down from the committee.

Dr Sean McManus
Chair, Perioperative Medicine Steering Committee

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IT HAS BEEN said that growing old is unavoidable but growing up is optional. I have yet to exercise that option! Bearing that in mind I have on occasions asked myself “When is one too old to perform a task, or more importantly, a task at a given level?”

Benchmarks of performance can be considered in terms of physical or mental activities. Insights into observed alterations in performance over time are the realm of physiology of ageing, with which I am most familiar, having lectured on this topic in the ANZCA Part 1 physiology course for over a decade… and now having experienced it firsthand.

Progressive loss of tissue and diminishing ability for gene replication leads to reduced organ function affecting every system in the body. The physical changes tend to be obvious – the mental or cognitive abilities less so.

Much work has been done on elucidating the decline of cognitive function associated with ageing in which there appear to be “swings and roundabouts”. Accompanying deteriorating cognitive function is a diminished ability to rapidly process new challenges and develop new skills. However, there is also the wealth of experience and retention of long-term memory that facilitates maintenance of existing skills. This may explain, in part, the observed narrowing of scope of practice over time.

The following scenario is presented in this context.

You are sitting in the tea room when you overhear a discussion between the head of department and welfare advocate concerning after hours (AH) rostering and whether senior anaesthetists should continue to be required to provide AH services.

The welfare advocate is concerned about increased susceptibility to fatigue with ageing and the consequent impact on patient care. The head of department is concerned about adequacy of workforce to cover AH as well as the potential for departmental conflict.

The welfare advocate notices you and calls you over to canvass your opinion. How would you respond?

WHAT WOULD YOU DO?

Wherever there appears to be a competing need there is the potential for conflict. Conflict resolution 101 (my version) dictates that redirecting perceptions of competition (us and them) towards perceptions of unity (we) reduces attention to finding a common goal. Easier said than done!

In this scenario, one apparent need relates to senior anaesthetists while the perceived opposing need is that of younger colleagues. The common ground, however, is patient care.

Prof docs to the rescue! PS43 Guideline on fatigue risk management to anaesthesia practice recognises and identifies the risks of fatigue. It is a recognised concern for all anaesthetists irrespective of age and PS43 highlights the responsibilities at the individual level as well as the departmental and organisational level in mitigating those risks. The accompanying background paper includes a toolkit of resources.

Of note in the background paper under item 3.5 Fatigue, is the statement that ageing is associated with reduced sleep efficiency as well as the capacity to recover from fatigue. These are supported by articles in the British Medical Journal in 2018 and Sleep in 2003.

In the context of the common goal of patient care it is reasonable to take that into consideration when rostering AH.

Of course, there is the other matter of wellbeing, which is again, applicable to anaesthetists irrespective of age or stage of career. PS49 Guideline on the health of specialists, specialist international medical graduates, and trainees is under review. The value of retaining experienced senior colleagues is understood by inclusion within the professional section of several strategies aimed at promoting wellbeing. For example, recommendations for establishing mentor or buddy systems, and instituting the role of welfare advocate, both of which may be well served by senior colleagues.

Rostering is always a challenge given the limitations on resources in relation to the demand for services. Each location has its specific and local community needs. Rostering in a major university centre accredited for training and staffed by both full-time and visiting staff will be quite different from a remote regional hospital staffed by visiting medical officers and locums, let alone covering AH in private practice.

What would be the impact in a regional centre where services are provided by a small number of FANZCAs (either visiting or locum), specialist international medical graduates (SIMGs) and GP anaesthetists (GPAs) if just one anaesthetist decided to retire due to being forced to provide AH services?

Clearly, there are many considerations. Several options exist including but not limited to:

• All anaesthetists be required to contribute equally to AH in order to retain their appointment.
• Set an age at which anaesthetists are excluded from AH services. What age? 55? 60? 65? We need expert advice on this.
• Set an age at which anaesthetists can opt in.
• Set a base age after which anaesthetists can opt out.

Which, if any, of these would you favour?

Dr Peter Roessler
Director of Professional Affairs, Policy

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Dr Peter Roessler explains ANZCA’s professional documents using practical examples. In this edition he addresses after-hours rostering.

SIMG champion: Dr Michael Steyn retires

MANY READERS WILL know of Michael through his roles on the Specialist International Medical Graduates (SIMG) Committee, the Overseas Trained Anaesthetists Network (OTAN), and past director of anaesthesia at the Royal Brisbane and Women’s Hospital. However, few will be aware of the enormous contribution to the college, the community, and SIMGs that Michael has made as chair of the SIMG Committee.

Michael is regarded by the SIMG team as the “ghostbuster” for SIMGs. Whenever there was a question, especially a cutie one, “who you gonna call?” would ring out, followed by a resounding “Michael”.

Michael started out in general practice in Scotland before “seeing the light” and embarking on his anaesthesia career. Having married Jacqui, an Australian born nurse, Michael made the difficult decision, as do many SIMGs, to uproot himself and his family to emigrate to a new country.

Michael was interviewed after arriving in Australia and has been asked on occasions jokingly stating that he was interviewed by two of the authors of this article while the third was one of his examiners for the ANZCA exam. Our response has always been that it was the “best mistake we ever made!” At the time of his application to become recognised as a specialist in Australia and New Zealand, all SIMGs had to sit the full final examination, which he cleared on his first attempt.

A number of key players were responsible for the establishment of OTSAN. This was an important resource for SIMGs that was run by fellows alongside the college SIMG team with the aim of providing both personal support and practical guidance in preparing for the final examinations. Michael recognised the value of OTSAN and became actively involved in the outset and was one of its drivers.

The decision to settle in Queensland led to a position at the Royal Brisbane and Women’s Hospital and later to appointment as director of the anaesthesia department to which suitable SIMGs were subsequently appointed.

He also championed specific positions for SIMGs in Queensland to help upskill them for practice in Australia.

In his role at the college with the SIMG team, Michael served as an interviewer on the SIMG Interview Panel, as a workplace-based assessment assessor, as a member of the SIMG Committee, and finally as the longest serving chair of the committee.

As a result of his wide and varied experiences he was instrumental and heavily committed to the ongoing evolution of the SIMG process, which has seen significant improvements but also a strategy and plan in place to further this goal.

As chair of the SIMG Committee, Michael was instrumental and heavily committed to the ongoing evolution of the SIMG process, which has seen significant improvements but also a strategy and plan in place to further this goal.

On behalf of the SIMG team and the college we would like to express our sincerest thanks to Michael and wish him and his family the very best for the future.

Dr Peter Roessler FANZCA
Ms Helen Maxwell-Wright FAICD
Dr Leesa Wilson FANZCA

PS49 ([link])

Dr Leona Wilson FANZCA
**Substance abuse: A personal story of recovery and rehabilitation**

**DR COLIN BAIRD**  
**AUCKLAND CITY HOSPITAL**

MY NAME IS Colin and I’m an addict. As I write, I haven’t used in four years and three months. I consider myself incredibly fortunate to have been given the support and opportunity to turn my life around and return to clinical anaesthesia.

I’ve decided to tell my story in order to try and give something back. By doing so, I hope to educate our community about the problem of addiction in anaesthetists, and also to help those among us who may find themselves in a similar situation to mine.

There is a long history of substance use disorder (SUD) in the medical profession, with alcohol the most widely abused substance. Anaesthetists, though, are more likely to abuse anaesthetic agents - most commonly quick acting lipid soluble opioids such as fentanyl.

We are in a unique position among healthcare providers in that we prepare and administer opioids and other drugs of abuse with very little oversight, and there are many opportunities for diversion within this process. The incidence of SUD in anaesthetists is around one to two per 1000 each year and many anaesthesia departments will have experienced SUD within their ranks.

The mortality among anaesthetists with addiction is high, and the death of a colleague has devastating repercussions for all affected, with some wondering whether they could have intervened sooner. SUD can also result in suboptimal patient care and even direct patient harm in some cases.

I became addicted to fentanyl during a difficult and stressful time in my life, when I was susceptible to temptation and risk-taking behaviour.

What began as experimentation in pursuit of comfort, rapidly escalated into an addictive behaviour which dominated every facet of my life.

My entire professional identity was subsumed by the overarching need to maintain and conceal the addiction. It became a continuous cycle of anxiety, anticipation, consumption and remorse, and I could see no way out of the hole I found myself in. I knew I had a serious problem but feared losing everything were I to admit this and ask for help. I tried repeatedly to stop, but whenever the opportunity arose to divert and use, all my willpower melted away and I was back on the addiction merry-go-round.

It took an intervention to break the cycle. My increasingly erratic behaviour aroused the suspicion of colleagues who reported their concerns to the clinical director. I am forever indebted to them for doing this as a tragic outcome may otherwise have ensued. I was presented with the evidence and in that moment felt an overwhelming sense of relief.

Life couldn’t continue in this way, I needed help and was ready to accept whatever had to happen. I was also given hope. A route back to medicine would be possible if I was ready to accept the severity of my addiction.

I was ready to accept that I had a problem and was willing to do whatever it took to get the help that I needed. I knew that I was not alone and that others had been through similar experiences.

I knew I had a serious problem but feared losing everything were I to admit this and ask for help.

The mortality among anaesthetists with addiction is high, and the death of a colleague has devastating repercussions for all affected, with some wondering whether they could have intervened sooner. SUD can also result in suboptimal patient care and even direct patient harm in some cases.

“M Y N A M E I S C o i n a n d I’ m a n a d d i c t. A s I w r i t e , I h a v e n ’ t u s e d i n f o u r y e a r s a n d t h r e e m o n t h s . I c o n s i d e r m y s e l f i n c r e d i b l y f o r t u n a t e t o h a v e b e e n g i v e n t h e s u p p o r t a n d o p p o r t u n i t y t o t u r n m y l i f e a r o u n d a n d r e t u r n t o c l i n i c a l a n a e s t h e t i a . ”

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**Free ANZCA Doctors’ Support Program**

**How to make an appointment:**

- To speak with a counsellor over the phone or make an appointment to see a counsellor for a face-to-face session:
  - Telephone 1300 687 327 in Australia or 0800 666 367 in New Zealand.
  - Email eap@convergeintl.com.au.
  - Identify yourself as an ANZCA fellow, trainee or SMAG (or a family member).
  - Appointments are available from 8am to 6pm Monday-Friday (excluding public holidays).
  - 24/7 emergency telephone counselling is available.

**HELP IS ALSO AVAILABLE VIA THE**

**Doctors’ Health Advisory Service:**

- **NSW and ACT** 02 9437 6552
- **NT and SA** 08 8366 0250
- **Queensland** 07 3833 4352
- **Tasmania and Victoria** 03 9495 6011
- **WA** 08 9321 3098
- **New Zealand** 0800 471 2654
- **LifeLine** 13 11 14
- **beyondblue** 1300 224 636
Opioid regulatory changes in Australia and their impact on fellows and patients

OPIOID REGULATORY REFORM In Australia resulted in significant changes to the listed indications and Pharmaceutical Benefits Scheme (PBS) approval process in 2019. A detailed timeline of the changes and the rationale behind them was laid out by Therapeutic Goods Administration (TGA) Chair Professor John Skerritt in a talk at the recent annual symposium. These changes also coincided with alterations to the PBS prescribing rules. Doctors, especially GPs, were partly aware of the TGA changes, but were largely caught unawares by the PBS changes, especially when their non-updated practice management software led to phone authority prescriptions being declined.

The impacts on both consumers and frontline health professionals have been very significant. Few specialist pain medicine physicians have not had patients who were well maintained on low or moderate doses of opioids as part of their management plan but who were suddenly confronted with a GP who wanted to unilaterally impose a forced taper or who simply abandoned prescribing.

FPM has been in regular liaison with Painaustralia, which has been overwhelmed with negative feedback about these changes and has been leading the response on behalf of consumers. It was predicted that anger from patients might lead to an increase in reporting to the Australian Health Practitioner Regulation Agency (AHPRA) of GPs or specialist pain medicine physicians who refuse to authorise increased or continuing doses of opioids. Although they were mostly well-considered and supported by expert groups such as the faculty and the Australian Pain Society, these changes have caused such a backlash from consumers, GPs and our fellows that a few lessons seem apparent at this stage.

• There was very little lead-in time given to prepare. The up scheduling of codeine was flagged many months in advance and proceeded smoothly. The result was an almost seamless achievement of the policy goal of reducing codeine use while not impacting the management of patients who may need it. By contrast, the TGA reforms were pushed ahead for a pre-determined implementation date without the benefit of adequate time or attention being given to impact predictions from stakeholders. The PBS changes, which had significant practical effects, were very poorly flagged to GPs who then had to scramble to solve the problem without enough background to understand it.

• There was no meaningful practical support given to prescribers or pain services. While TGA funded a number of educational initiatives, no additional resources in the form of new Medicare item numbers, funding for pain clinics or addiction treatment centres, helplines or other decision support tools were provided. Existing pain services, congested at the best of times due to chronic under-resourcing, became caught up in a culture of long waiting times and service rationing.

• As a result of both the above factors, many GPs clearly began to feel that opioids were simply too much of a problem and they appear to have become much more reluctant to offer opioids, even when they may be appropriate for a period of time. Far too little consideration was given to consumers who had long been maintained on a stable dose of medication in the absence of any other effective therapy. This large group of “legacy” patients may still benefit significantly from a properly conducted, consensual dose reduction, but many of them have been forced onto a lower dose abruptly, with compromised quality of life and the risk of suicide. Not only is it unethical and seriously harmful to the patient to abruptly cease moderate or high-dose opioids without adequate support, due to severe erosion of quality of life and the risk of suicide, but also the health system itself is brought into disrepute. The TGA was made aware of the needs of this group in strenuous terms by the faculty in the short period we had to advocate and comment on the proposed changes.
The recent Therapeutic Goods Administration (TGA) changes to opioid prescribing (see www.tga.gov.au/hubs/prescription-opioids) prompted a review of FPM’s statement on the use of opioid analgesics for chronic pain as well as college statements on slow-release opioids for acute pain and opioid-induced ventilatory impairment (OIVI).

**PS01 (PM) REVIEWED**

The former title of PS01 Recommendations regarding the use of Opioid Analgesics in patients with Chronic Non-Cancer Pain became immediately untenable, as the document was, in fact, a guideline.

An urgent revision in content and tone was undertaken to articulate the college’s stance on opioid use in this context. Consequently, PS01 was transmuted into PS01 (PM) Statement regarding the use of opioid analgesics in patients with chronic non-cancer pain (footnote paper) which is a formal position statement describing the current position of FPM regarding the prescription of opioids in chronic non-cancer pain, presented as a series of principles:

- General principles informing the management of patients with chronic non-cancer pain.
- Principles informing the prescription of opioids to patients with chronic non-cancer pain.
- Additional principles underpinning management of the patient already established on opioids the “unhindered” or “ legacy” patient.
- Additional principles underpinning initiating a trial in an opioid-naive patient.
- Response to difficulty achieving or maintaining therapeutic goals in an opioid trial.

The document also offers the only interpretation of the “exceptional circumstances” promulgated but not defined by the TGA.

**STATEMENTS ON SLOW-RELEASE OPIOIDS AND OIVI**

The college statements on slow-release opioids for acute pain and opioid-induced ventilatory impairment (OIVI) are also being reviewed.

The two statements — Position statement on the use of slow-release opioid preparations in the treatment of acute pain and Statement on principles for identifying and preventing opioid-induced ventilatory impairment (OIVI) — will be incorporated into an updated PS41 Guideline on acute pain management, which is under review.

Professional document PS41 Statement on patients’ rights to pain management and associated responsibilities, is also under review.

The diagram shows an overview of the risk factors anticipated and methods to trap these potential hazards, summarised in a qualitative bowtie diagram. It is also possible to have quantitative diagrams with a single pathway from the hazards to the top event, but these are more difficult to construct in complex situations, such as anaesthesia. Using the diagram above as an overview, it is possible to expand each section with more detail. The detail can be as complex as required. There are five columns in this version of the diagram under the five headings: avoidance, trap, top event, rescue, and learn. The hazards are split into five categories as shown in the green boxes. The results of the interim hazard analysis are shown below with the percentages rounded to one decimal place.
**LEARNING FROM OUTCOMES**

<table>
<thead>
<tr>
<th>Immediate outcomes</th>
<th>Per cent</th>
</tr>
</thead>
<tbody>
<tr>
<td>No effects</td>
<td>40%</td>
</tr>
<tr>
<td>Minor effects</td>
<td>20%</td>
</tr>
<tr>
<td>Case cancelled</td>
<td>8%</td>
</tr>
<tr>
<td>Prolonged length of stay</td>
<td>6%</td>
</tr>
<tr>
<td>Unplanned ICU/HDU admission</td>
<td>11%</td>
</tr>
<tr>
<td>Death</td>
<td>3%</td>
</tr>
<tr>
<td>Not specified</td>
<td>6%</td>
</tr>
<tr>
<td>Total</td>
<td>100%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Final outcomes</th>
<th>Per cent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not affected by incident</td>
<td>64%</td>
</tr>
<tr>
<td>Temporary disability</td>
<td>21%</td>
</tr>
<tr>
<td>Permanent disability</td>
<td>2%</td>
</tr>
<tr>
<td>Death</td>
<td>6%</td>
</tr>
<tr>
<td>Not specified</td>
<td>7%</td>
</tr>
<tr>
<td>Total</td>
<td>100%</td>
</tr>
</tbody>
</table>

The immediate outcomes and the final outcomes are shown in the tables above. The majority of patients (54%) had some degree of harm or inconvenience in the immediate outcome of the episode of care. There were no immediate effects in 40% and the immediate outcome was not specified or not known in 6%.

**AVOID HAZARDS**

- Patient factors: Low BMI, age, history of patients of all ages, ASA PS, Sex and BMI.
- Task factors: Unfamiliar procedure technique 3.6%.
- Caregiver factors: Anaesthetist unavailable 0.5%.
- Communication (3.3%)
- Distraction/fatigue base 6.5%.
- Pressure to proceed 4.9%.

**TRAP ANOMOLIES**

Setting up barriers to prevent infrastructure and system problems typically takes a long time. For example, the Safe Surgery Checklist, which was an improvement to the existing checklist procedures, took several years to design, agree on a standard operating procedure (SOP), and implement in the participating countries, which included Australia and New Zealand. In general, providing the right equipment and environment requires a detailed planning and ANZCA Professional documents may assist. While the incidents reported to webAIRS might involve a wide range of errors, selected patients may require particularly complex equipment or facilities such as ICU and ICU.

Management of the listed caregiver factors might include efforts to improve workplace culture, to reduce working while distracted, fatigued, or unwell, or faced with inappropriate pressure to proceed. Working while unwell or coercive behaviours such as pressure to proceed might also contravene the Australian Workplace Health and Safety legislation. Communication problems might be mitigated by improved use of the Safe Surgery Checklist and by targeting training and ongoing education, such as that provided by EMAC courses, or the NetworkZ program in New Zealand (www.networkZ.nz). Prevention strategies may include greater emphasis on balancing the risk versus benefit to the patient when making decisions regarding the safety and wisdom of proceeding.

**SAFETY AND QUALITY**

- An inconsistency in harm and system errors was associated with subsequent death in 5% of the reports and unplanned and unannounced admission to ICU/HDU in 11% of the reports. Case cancellation (8%), prolonged length of stay (6%), minor effects (24%) occurred in 48% of the reports. The final outcomes were also concerning with some degree of harm in 29% of reports, ranging from temporary disability in 21%, permanent disability in 2%, and death in 6%. The latter was a further 3% increase from 5% observed in the immediate outcome.

- Infrastructure, including staff, facilities, and environment were also frequently reported in a study of 12,686 reports. The UK National Reporting and Learning System2, with essentially similar contributing factors1.

A full analysis is under way to determine the relationships between the outcomes of the various risk factors in the hazards section of the bovive. This will allow a more detailed description of the analysis of each item in the hazards section and more detailed diagrams depicting each in more detail.

**ANZTADC Case Report Writing Group ANZTADC thanks all webAIRS users for their contributions to the webAIRS database**

**REFERENCES**

3. Gander PH, Merry A, Millar MM, Weller J. Hours of work and Fatigue—urgent of providing emergency care if undue haste should be avoided and balanced with the urgency of providing emergency care if required.

**RESCUE FROM HARM**

Management will depend on the stage at which the Top Event occurs. If the procedure has not begun, a risk versus benefit decision will be still a possibility, ideally in consultation with the patient, particularly if the environment or equipment is not available or unsatisfactory. In situations where a caregiver is unwell, distracted, tired, hungry, or late, it might be possible to relieve that member of staff for a break or for the rest of the day. Undue haste should be avoided and balanced with the urgency of providing emergency care if required.

**THE COLLEGE FELLOWSHIP survey in 2021 will be emailed to all ANZCA and FPM fellows in mid-August. The survey development has been led by a working party of fellows including myself, Dr Bridget Effleny, Dr Chris Hayes, Dr Leesa Moreton, and the college membership services team. As in previous years the survey will be managed by an independent, qualified and professional agency, RPMG, who will facilitate distributing the online survey, send reminders and provide a detailed analysis back to the college. Importantly RPMG will retain the primary data and individual responses from the survey will remain confidential. After analysing responses from fellows, RPMG will de-identify responses from fellows and provide a report including descriptive analysis and high-level themes.

You will notice a distinct difference in the 2021 fellowship survey from previous surveys. The 2021 Fellowship survey has one aim which is to gauge the thoughts and opinions of the fellowship on the future direction of the college. This vital information will help ANZCA Council develop the 2022-2027 ANZCA Strategic Plan. The survey does not focus on past experience nor it is a satisfaction survey. Most of the questions will ask about how much fellows value aspects of college activity.

**We need you to tell us what you think about the future for ANZCA**

As a company partner of The Research Society, Australia, a peak body for market research professionals, RPMG is bound by the Code of Professional Behaviour which is consistent with the Australian Privacy Principles in the Privacy Act 1988 (Cth) (Privacy Act).

As a further commitment to quality, RPMG is currently in the process of achieving AS ISO 20252-2:19 accreditation, the quality standard for market, opinion and social research.

KPMG uses secure, encrypted systems to manage fellow’s details with this information only be used for the purpose of distributing the survey. At the conclusion of the survey the lists will be permanently removed from KPMG’s servers. Identifiable information will be removed from the survey database.

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I am proud to be involved with this important initiative and have, with the working group, developed a survey that I believe meets the standards expected by you in terms of rigour and best practice. It is only by your participation in the survey that the strategic direction of the college in the coming years will satisfy and meet your expectations.

Results of the 2021 Fellowship Survey will be reported back to fellowship via the ANZCA Bulletin and the college newsletter. website before the end of 2021, and at the 2022 AGM. We encourage you all to proactively respond when you receive your online fellowship survey. We want to know what you truly think.

Professor David Story
ANZCA Councillor and Chair of Safety and Quality Committee
Mr Ross McClelland
Director, Co-Lead RPMG Customer Intelligence

**ANZCA Bulletin**

Winter 2021
The wild and wonderful West Coast

When Dr Andrea Hages found an advertisement for a senior anaesthetist position at Grey Hospital on the West Coast of New Zealand, it seemed a world away from her northern Californian life. However, it was one she and her husband, both ex-US military, were ready to try. They packed up their three children in the middle of the first year of COVID-19 last year and headed to Greymouth in the South Island. What they are discovering is just one big West Coast adventure.

YOU MIGHT THINK a 40-bed brand new hospital with just three theatres doing mainly day surgery and endoscopy might be too quiet for this intrepid doctor who has been on emergency retrieval teams into parts of Africa and worked out of the biggest US base in Germany. Dr Hages, however, says it is surprisingly stimulating and rewarding.

What makes this a unique position is Greymouth’s setting. With the Southern Alps on one side boasting the country’s highest mountains, glaciers, mirror lakes and primeval rainforest, and the wild Tasman Sea on the other, it is remote. This means transporting anyone who is in need of high-level care across the mountains or through mountain passes to Christchurch Hospital. The West Coast is vulnerable to bad weather and it closes in fast. Anticipating that a patient may deteriorate and may need to be moved sooner rather than later, means knowing your patients and their prognosis intimately.

“Doctors may think that this is not a challenging practice. However, one of the more challenging things about working here is knowing what you can safely do and what complications you might run into. At the back of your mind is, if there is bad weather or the retrieval team are on another job, you cannot always fly your patient out to Christchurch. So being a true perioperative physician and doing perioperative screening really is paramount in a setting like this.” Dr Hages says that despite not doing the big heads and hearts [operations], in all cases, you really need to know your patients.

Te Nikau (the new Grey Hospital) is transporting up to three patients to Christchurch daily by ambulance through the magnificent Arthur’s Pass. The return journey brings coasts back following their treatment. Up to two or three times a week there are emergency transfers by fixed-wing or helicopter. At night, there is a dash 40 minutes down the road to Hokitika Airport to add to the computations. Greymouth Airport, directly opposite the hospital, is not equipped with lights for night landings of fixed wing aircraft.

The area of capture for this small hospital is from Haast down south to Karamea up north – more than 500 kilometres of windy road along the coastline. The population is just 32,000 spread widely along that route with many elderly people and a high proportion with co-morbidities.

Chief medical officer for the West Coast District Health Board (WCDHB) and clinical director for the anaesthesia department is ANZCA fellow Dr Graham Roper. He comes from Christchurch where he worked at the public hospital including six years as the clinical director. Dr Roper started working part-time in Greymouth eight years ago and made the move permanently just 18 months ago.

Dr Roper loves the coast. He loves the lifestyle but he loves his work as well. “It’s the smaller team environment and the leadership opportunities. In such an environment, you are more likely to make a difference.” Like Andrea, he says, it is the challenge.
The deputy chair of the ANZCA New Zealand National Committee, and a cardiovascular specialist anaesthetist, Dr Roper has been pivotal in a couple of major emergencies at Te Nīkau just recently that are a good reminder of the isolation. The first was an unusual presentation of a toddler with epiglottitis, which thankfully was recognised early. She was put on to a ventilator overnight before being flown to Christchurch. Dr Hages has also dealt with an older child with a similar condition from the same local community. Then there was also a seemingly innocuous weed eater incident, which had the patient bleeding out on the table. A flicked piece of metal had damaged the lung of the patient. In all these cases, the presence of senior anaesthetists has been the difference of life and death.

So, call the caseload unchallenging if you like but you will get a wry smile from any anaesthetist who has worked on the wild and wonderful West Coast.

Adele Broadbent
Communications Manager NZ, ANZCA

“So being a true perioperative physician and doing perioperative screening really is paramount in a setting like this.”

DR ANDREW WOODHEAD, formerly of St Vincent’s in Melbourne, was coming to the end of a three-week locum on the West Coast at Te Nīkau Grey Hospital when the Bulletin visited. He loved it. “It’s an excellent work-life balance. A brand new hospital with friendly welcoming staff who provide great care. It’s a really enjoyable workplace.” Dr Woodhead did not waste a minute of his stint, getting off shift and on his bike to explore the whole of the famous West Coast Wilderness Trail. This is a series of tracks carved by pioneering gold rush miners, together with extensive water races, logging tramways and short length railway lines. Dr Woodhead did parts of the 120 kilometre trail in all weathers over the time he was locuming. When he could not do one week down south, his colleague, Dr David Choi of Middlemore filled in. He also fell for the wild and wonderful West Coast exploring some of the many outdoor adventures it has to offer.

“Team-focussed” training

SUMMER PIZZATO WAS taking a gap year after leaving Grey High School when she spotted an advertisement for a trainee anaesthetic technician (AT). Te Nīkau Hospital has just received accreditation to train ATs after many years’ hiatus. For this 19-year-old, it was an opportunity of a lifetime. Ms Pizzato is halfway through training and loves her job. She does six months at Grey and six months at Christchurch where she gets to experience and learn from the bigger cases, but it is here on the coast that she is most at home. “It’s more team focused and supportive. You know everyone. Christchurch has hundreds of nurses, surgeons and anaesthetists and it is not as personal. I love my team and my patients. It’s a special place.”

Anaesthetic technician Summer Pizzato and Dr Graham Roper.

Making the most of the wilderness

Dr Andrew Woodhead on the West Coast Wilderness Trail.

Dr David Choi also locumed and took advantage of the great outdoors.

One of the West Coast’s drawscards, Fox Glacier, descends from the Southern Alps down into temperate rainforest just 300 metres above sea level.

Dr Hages with son Blake (3), daughter Victoria (10), husband Lee and son Colby (13); the Haast UNESCO World Heritage area.
THE HUMAN MIND has an amazing ability to rapidly forget the bad times, and remember only the good times. Such is how I now feel, some months after returning to normality in Auckland. At the time I was in South Africa, the situation felt remarkably similar to what we have experienced in India in recent weeks, under despair, death everywhere, hospitals completely swamped, and healthcare systems overridden.

I host a younger brother, had many flights home cancelled, contracted COVID-19, was refused permission to return into Managed Isolation and Quarantine (MIQ) in New Zealand. I faced spending three months locked in South Africa, and then watched the America’s Cup races on my laptop, while isolating, recovering in my beachfront hotel. All very surreal at the time.

As I lay on my bed, feeling quite ill, in my “isolation hotel” in Durban, I would chat to my wife, Trish, by FaceTime several times a day, 12,000km away in Auckland. Reflecting now, it must have been so stressful for her, as she truly worried whether, at 69, I was ever going to get better, or not. Again, quite surreal.

I am now well back at work, fully recovered and fit, and fortunately suffering no long COVID symptoms. I watched live on the water as Team NZ successfully defended the last races of the 36th America’s Cup. I reflected on the experiences learnt while racing around the world on the Whitbread Race, with fellow crewmate, Grant Dalton who was now fronting the America’s Cup campaign. The resilience and glass half-full attitude learnt then stood me in good stead as I faced possibly the biggest challenge of my life in South Africa.

As on long ocean passages, I have still not shaved since fleeing from South Africa in late January, just trimming now and then, so whiskers remain, as a visible reminder of hard times.

As I touched down, in Durban, on 19 December, daily cases had risen to 8500, with a further 8500 in hospital, most those 1000 in ICU, and 450 ventilated. The day that I became symptomatic, on 6 January 2021, the numbers were extremely grim, with 16,000 new daily cases, 13,400 hospital admissions, nearly 2000 in ICU and nearly 700 ventilated. By the time I flew out 15 days later, daily cases had just peaked at 20,000, with 17,000 admitted, 2500 in ICU and 1400 ventilated.

I guess it was almost inevitable that I would get the virus, although I took all the usual precautions, including mask-wearing, hand sanitising, and distancing. I rarely “went out” apart from visiting my sick brother at his home every day.

Prior to becoming sick, I had end up having 10 wonderful, quality days with my brother, before he passed on 29 December 2020.

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Pandemic challenges in PNG

AS COVID-19 sweeps through PNG, ANZCA Global Development Committee member Dr Arvin Karu explains how he and his colleagues are trying to cope.

AT THE HEIGHT of the second wave of COVID-19 infections in Papua New Guinea (PNG) in March this year Port Moresby General Hospital anaesthetist Dr Arvin Karu became aware of just how dire the situation had become.

As co-ordinator of the hospital’s anaesthesia and ICU department, Dr Karu knew that he and his colleagues – 10 senior medical officers (SMOs) and 12 registrars – were fighting a battle on several fronts.

Apart from a shortage of much-needed ventilators for patients in their dedicated COVID ward there were not enough trained intensive care staff who knew how to operate the ventilators. And enforced absences of staff who had either tested positive for COVID-19 or who were sent home to isolate for 14 days made the staffing issues even more challenging.

“We had six patients on ventilators in a dedicated COVID ward of 201 patients and it was very busy,” Dr Karu told the Bulletin from Port Moresby.

“Those two days in mid-March when we had six ventilated patients were hard because we didn’t have enough nursing staff who knew how to manage patients on ventilators. It was very difficult to monitor the six patients and to watch them properly. We ran out of syringe pumps so that was challenging and we were dealing with two or three people at the same time but without the staff to look after them.”

“From July 2020 to April this year we have had 602 patients admitted to isolation and of these 140 recovered and 62 died. Of the 54 patients we ventilated, about 95 per cent died with only about five surviving.

“From the first wave last year we didn’t have enough ventilators. We only had four. Now we have 20 located throughout the hospital and in our COVID ward we have an eight-bed ICU.”

As president of the Society of Anaesthetists of PNG (SAPNG), Dr Karu is in regular contact with government health department officials and other medical specialists as the country deals with the pandemic crisis. A flood of offers of ventilators, personal protective equipment and oxygen from countries including Australia and the US has helped PNG to manage the pandemic’s second wave.

“The temporary hospitals have now closed but of course we are on standby just in case. Our COVID isolation ward is closed but of course we are on standby waiting in case there is another wave,” Dr Karu said.

Dr Karu is a member of ANZCA’s Global Development Committee and his frontline experience has been crucial in giving the college a better understanding of the situation on the ground in PNG.

“More than 15 COVID positive cases in the hospital’s dedicated COVID theatre – from July last year through to May this year – but there were also some cases that we didn’t know were positive until after their surgery.”

The SAPNG has been proactive and has organised a series of UNICEF-funded workshops of ventilator and basic ICU training for healthcare workers, anaesthetists and anaesthetic service officers (ASOs).

“When the extra ventilators arrived we received calls from doctors asking us how to use them so we decided to come up with a two to three day ventilator workshop. We have now done three of these and we have brought in health workers from different provinces and they have gone very well. We know we will need to offer more of these over the next few months,” Dr Karu explained.

“Many staff from the anaesthetic and ICU departments contracted COVID. Nine of our staff were diagnosed as positive but all had mild symptoms. A couple of doctors with moderate symptoms were admitted to an isolation ward and a few registrants and resident doctors also had mild symptoms but recovered well.

“We have had about 15 COVID positive cases in the hospital’s dedicated COVID theatre – from July last year through to May this year – but there were also some cases that we didn’t know were positive until after their surgery.”

With the pandemic having hit PNG very hard and with most of the patients being young adults who were recovering well, the hospital had focused on providing oxygen and dedicated critical care beds.

“In the hospital almost impossible if those scenarios were realised. Dr Karu told the committee that coronavirus testing rates were extremely low and it had been predicted that between five to 10 per cent of the population (400,000-800,000 people) would contact the coronavirus.

“At the same time the hospital had tested positive for COVID-19 and there were projected staff deficiencies of 50-60 per cent which would make running the hospital almost impossible if those scenarios were realised. Dr Karu told the committee that coronavirus testing rates were extremely low and it had been predicted that between five to 10 per cent of the population (400,000-800,000 people) would contact the coronavirus.

Most of PNG’s 21 provinces were reporting several hundred cases and there were frequent requests for advice on oxygen therapy and ventilation from the provincial capitals which had much more limited resources than Port Moresby.

As of 8 June the country had officially recorded 16,300 cases and 164 deaths according to the Johns Hopkins coronavirus resource centre. However, these figures are believed to be much higher because the country’s low rate of testing is masking the true number of cases.

Nearly 200 staff at the hospital had tested positive. While vaccination rates are severely tested the country’s health services. While vaccination rates are likely to be low, the country’s low rate of testing is masking the true number of cases.

With a population who speak more than 800 languages and mostly live in traditional villages the pandemic has severely tested the country’s health services. While vaccination rates are likely to be low, the country’s low rate of testing is masking the true number of cases.

Dr Karu says while the rate of infections appears to have slowed with local cases getting used to a “new normal” approach to living with the virus, the next few months will be crucial in helping to prevent a potential third wave. He is hoping the recent decline in COVID-19 hospital admissions will give his colleagues time to organise more training workshops for healthcare workers and anaesthetic service officers.

“The temporary hospitals have now closed but of course we are on standby just in case. Our COVID isolation ward is one third full at the moment and these are mild, moderate cases.”

Carolyn Jones
Media Manager, ANZCA

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Pacific boost for online anaesthesia learning

ANZCA’s Global Development Committee makes a real difference to people living in Australia and New Zealand’s nearest neighbours in the Asia-Pacific. As an educational college, teaching and vocational training is at the core of the committee’s activities – fostering and developing a sustainable, local health workforce. The ongoing COVID-19 pandemic and the resulting travel restrictions have affected how we can provide ongoing educational support to our anaesthesia colleagues throughout the Pacific.

Our first online education sessions started in February when Dr Anna Loughlan provided obstetric anaesthesia sessions on two consecutive Saturdays. A total of 58 participants from Papua New Guinea, Timor Leste, Solomon Islands, Samoa and Fiji attended. Dr Loughlan has a specific interest in obstetric anaesthesia and has made many visits to low resource countries. Hence, she was the perfect candidate to kick off the POLE learning sessions.

In Papua New Guinea, anaesthetic scientific officers (ASOs) provide the majority of anaesthesia in the country. ASOs are mainly nurses who have received about a year of anaesthesia training before working primarily independently in provincial and rural areas of the country. POLE supported the yearly ASO education in March with online sessions covering topics in paediatric anaesthesia over one week. Also during March, other online education sessions continued with Dr Rim Fuller providing an update on paediatric anaesthesia for trainees and Dr Jess Irm covering basic and advanced life support for anaesthesiology and scientific officers. The popularity of the sessions continued to grow with participants joining from Micronesia, Tonga, and Tokelau in addition to those Pacific nations already mentioned.

In April, the focus of the training sessions was on pain management. Dr Roger Goucke donated his time over three consecutive Saturday mornings to facilitate education sessions for ASOs, trainees and the first consultant continuing medical education session. Dr Goucke is the co-founder of the Essential Pain Management course (with Dr Wayne Mortimer), a program designed to address pain issues in low resource countries. Sessions in May covered regional anaesthesia for ASOs and junior doctors, presented by Dr Mark Trembath.

In addition to the online sessions, the POLE working group has organised other education events for anaesthesia and pain medicine professionals in the Pacific, such as facilitating attendance at the medical viva preparation course, as well as sponsoring 31 registrations for the ANZCA Annual Scientific Meeting (ASM) and, through the Society for Paediatric Anaesthesia in New Zealand and Australia (SPANZA), 24 registrations for the virtual component of their conference in October.

Feedback from the Pacific has been overwhelmingly positive. The regular meeting sessions are an opportunity to stay in contact, continue medical education and exchange experiences while further developing and strengthening the anaesthesia and pain medicine network in the Pacific. The sessions provide collaborative two-way learning with facilitator learning from our Pacific colleagues, as they do from us. In a May talk on regional anaesthesia, participant Mrs Martha Nisula, from Chuuk in the Federated States of Micronesia, talked about how they use spinals for open appendectomies with excellent anaesthesia. This was a delightful moment in which we learnt about how our colleagues in the Pacific use regional anaesthesia to provide safe anaesthesia care in a resource limited setting.

In May, POLE working group sessions covered regional anaesthesia for ASOs in low resource countries. In low resource countries, ASOs do the majority of the anaesthesia. Goliath Leonard, one of our POLE working group members, has been taking sessions on what needs to be known about pain.

A project like this is only possible with the help of a team of enthusiastic colleagues who are donating their time to share their expertise. A huge thank you to everyone involved! Special thanks go to Dr Nilho Vitharana and Dr Jessica Lim who facilitate the regular ASO and nurse anaesthetics education sessions, to Dr Mark Trembath who is organising the regular trainee sessions and Dr Indu Kapoor and Dr Meg Walmsey for their ongoing support for the consultant continuing medical education sessions. Thanks also go to college staff for ongoing administration and technical support.

Dr Yasmin Endlich, FANZCA Chair, POLE Working Group

Feedback from the Pacific

“...It was a wonderful session, very interactive and curtailled to our needs, Very happy with the session, looking forward to more.”

Goliath Leonard (PNG)

“I think it’s perfect!”

Goliath Leonard (PNG)

“It personally feel these have been very useful and delivered in a manner very applicable to our settings. The feedback I received from the trainees has been similar.”

Dr Sherene Prasad (Fiji)

“How you can get involved

Feel free to share the timetable, including the Zoom link, with your colleagues and friends in the Pacific: www.anzca.org.au/safety-advocacy/global-health-connection/asia-pacific-resources

Colleagues who have anaesthesia experience in lower- and middle-income countries and who would like to get involved and share their knowledge are invited to contact the chair of the POLE working group, Dr Yasmin Endlich, at globaldevelopment@anzca.org.au

Feeling inspired? You can get involved too, please contact the POLE Chair: Dr Yasmin Endlich, Chair, POLE Working Group, yasmin.endlich@anzca.org.au

The POLE Learning and Education Working Group consists of representatives from:
- The Australian Society of Anaesthetists (ASA)
- The New Zealand Society of Anaesthetists (NZSA)
- The Society for Paediatric Anaesthesia in New Zealand and Australia (SPANZA)
- The Society of Anaesthetists of Papua New Guinea (SPANZA)
- The University of Papua New Guinea (SPU)
- Fiji National University College of Medicine
- The Pacific Society of Anaesthetists
- The Micronesia Society of Anaesthetists
- Timor Leste (Hospital Nacional Dili)
- The Samoa Ministry of Health
- An Australian junior consultant.

The first online meeting between all representatives was held in November 2020 with some of us meeting virtually for the first time. The first step was to undertake a needs assessment and develop an education plan for 2021. This plan included:
- Monthly Saturday morning education sessions for anaesthesia trainees and junior doctors.
- Monthly Saturday morning education sessions for anaesthetic scientific officers (in PNG) and other nurse anaesthetists.
- Four continuing medical education sessions for consultant anaesthetists spread over the year.
- A Pacific whole-day conference.

The Pacific representatives provided topic choices for these education sessions over December and January. The collaboration between all of our societies also helped to expand our network and opportunities.

In January, 25 anaesthesia trainees from around the Pacific attended a one-day medical viva preparation course. Dr Nilho Vitharana, the junior consultant representative in the POLE working group, is also the convener of the course and with the support of the ASA was able to organise complimentary registration for these registrants. In the Pacific, they are particularly reliant on their clinical skills when they may not have access to investigations that are routinely available in Australia and New Zealand, so the medical viva remains a core component of their exams. The Pacific trainees all enjoyed the day and welcomed the opportunity to join their Australian colleagues preparing for their exams.

In February, 58 participants from Papua New Guinea, Timor Leste, Solomon Islands, Samoa and Fiji attended. Dr Loughlan has a specific interest in obstetric anaesthesia and has made many visits to low resource countries. Hence, she was the perfect candidate to kick off the POLE learning sessions.

In March, other online education sessions continued with Dr Rim Fuller providing an update on paediatric anaesthesia for trainees and Dr Jess Irm covering basic and advanced life support for anaesthesiology and scientific officers. The popularity of the sessions continued to grow with participants joining from Micronesia, Tonga, and Tokelau in addition to those Pacific nations already mentioned.

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Tracking ANZCA’s reconciliation journey

ANZCA’s Indigenous Health Committee launched a college-wide Indigenous Health Strategy in 2018 following 12 months of development and consultation with Indigenous health organisations, internal committees, Indigenous members and other relevant stakeholders. As a bational college, ANZCA’s Indigenous Health Strategy targets health inequity between Indigenous and non-Indigenous peoples in both Australia and Aotearoa New Zealand.

ADDRESSING INEQUITY is at the core of the strategy along with the principles of Australia’s commitment to ‘Closing the Gap’ and Aotearoa New Zealand’s Te Tiriti o Waitangi (Treaty of Waitangi). Since the launch of the strategy the college and the Indigenous Health Committee have worked to implement dozens of initiatives and programs that serve to increase the number of participants including the activity as part of their CPD portfolio over the past 12 months.

WHY IS A RAP IMPORTANT?

Today, the health and wellbeing of Indigenous peoples in Australia and Aotearoa New Zealand is an urgent priority due to significant disparities across a wide range of measures. In Australia, Aboriginal and Torres Strait Islander people have a significantly shorter life expectancy compared to Indigenous Australians (median age at death 60.4 years compared with 81.9 years). Statistics on surgery, hospitalisation and waiting times also highlight significant differences in access to care for Aboriginal and Torres Strait Islander people.

ANZCA’s indigenous health strategy includes the development of the ANZCA’s Indigenous Health Committee’s RAP, a formal, strategic document that provides a framework for organisations to support national reconciliation. It provides a detailed list of initiatives the college will undertake to play our part in reconciliation with Australia’s First Nations Peoples. Reconciliation action plans are submitted to, and must be approved by, Reconciliation Australia – a national, independent not-for-profit organisation leading the nation’s reconciliation journey.

There are four different types of RAP that an organisation can develop: Reflect, Innovate, Stochastic and Hervis. Each type of RAP is designed to suit an organisation at different stages of their reconciliation journey. Given ANZCA’s work to date under our Indigenous Health strategy, the college will commence with an Innovative RAP.

The colonisation of Australia and Aotearoa New Zealand has had a devastating impact on the First Nations Peoples of both countries. The survival and flourishing of First Nations’ knowledges and culture are testament to their resilience and resistance. Nevertheless, the cultural trauma caused by the loss of lives, lands, languages, culture and freedoms, entrenched by government policies and interventions, and by racism, has left a growing and immeasurable amount of health and wellbeing issues.

Today, the health and wellbeing of Indigenous peoples in Australia and Aotearoa New Zealand is an urgent priority due to significant disparities across a wide range of measures. In Australia, Aboriginal and Torres Strait Islander people have a significantly shorter life expectancy compared to Indigenous Australians (median age at death 60.4 years compared with 81.9 years). Statistics on surgery, hospitalisation and waiting times also highlight significant differences in access to care for Aboriginal and Torres Strait Islander people.

Opportunities for First Nations peoples to pursue careers in health are increasing, however, Indigenous health practitioners remain significantly under-represented in the specialist workforce. For example, about 3.5 per cent of the Australian population identifies as Aboriginal and Torres Strait Islander yet First Nations People comprise only 0.15 per cent of Australia’s 71,700 medical specialists. At ANZCA, 0.4 per cent of our trainees and 0.2 per cent of our fellows identify as Aboriginal and/or Torres Strait Islander people (as at 31 December 2020). In Aotearoa, 4.4 per cent of college fellows and trainees identify as Māori (versus 14.9 per cent of the population).

There are many systemic barriers to entering the health workforce, including educational disadvantage, reduced access to secondary and tertiary education, lack of access to information about higher education and specialisation, and policies that focus on enrolment quotas rather than graduation outcomes. Overcoming these barriers, there is an ever-growing number of Aboriginal and Torres Strait Islander doctors and fellows who now provide First Nations’ youth with culturally aligned role models – a necessary foundation for imagined futures in medicine and its specialties.

ANZCA RAP WORKING GROUP

• Dr Susie Lord, FFFPMANZCA
• Dr Dash Newton, FANZCA
• Dr Angus McNally, trainee
• Dr Sharon MacGregor, FANZCA
• Dr Paul Mills, FANZCA
• Dr Matt Bryant, FFFPMANZCA, FANZCA
• Mr Nigel Edgerton, Chief Executive Officer
• Ms Elion Webber, Learning and Innovation Manager
• Ms Kate Davis, Policy Officer
• Ms Laura Foley, Operations Manager, Knowledge Resources
• Ms Leith Keen, Queensland Committees and QARTS Coordinator
• Ms Kiri Rikihana, Executive Director New Zealand
• Ms Marayah Taylor

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A silicon device developed by FANZCA Dr Paul Scott to make it easier to bag-mask bearded patients has been awarded a $100,000 innovations grant by the Queensland government.

**INNOVATION**

**BAG-MASKING** a patient with a beard has long been a challenge for anaesthetists who often resort to cling wrap, plastic dressings or a lubricating jelly to try and secure the seal.

For Brisbane fellow Dr Paul Scott developing a solution to the problem became such a priority that in September 2018 he sketched a prototype of a device on a cafe napkin and his SAM Safety Shield was born.

Since drafting that first sketch he has received a prestigious Australian Good Design Award and a $100,000 grant from the Queensland government’s Advance Queensland Ignite Ideas Fund which helps small-to-medium businesses to scale up ready, innovative products or services to national and global markets.

Dr Scott’s silicon shield is now being used by a Queensland private hospital group and is under evaluation in the state’s public health system. The device is now made in China but Dr Scott is hoping he can manufacture the device in Australia.

“The $100,000 grant will enable us to produce on a mass scale and create jobs and we’re currently evaluating the possibility of producing the product here in Australia. It has been wholly Australian designed and developed and we would love to see it being manufactured in Australia,” he explains.

When patients can’t breathe anaesthetists apply bag-mask ventilation (BMV) to push oxygen into the patient’s lungs. BMV relies on a tight face seal and having a beard or a misshaped face can make it difficult.

“I had a couple of these patients on the same day and not long after I was at the Royal Brisbane and Women’s Hospital and watched an anaesthatist trying to overcome the problem using small plastic dressings which is one of the proscribed techniques. It was time consuming, fiddly and ultimately ineffective and it has been a problem since anaesthetists started bag mask ventilating 70-80 years ago. It can be stressful for the anaesthetist and clinical staff and dangerous for the patient,” Dr Scott recalls.

His “aha” moment came later the next day: “I was at a cafe and I noticed there were all these hipsters there with beards and my prototype sketch developed from there.”

Dr Scott applied for a patent and then started some basic trials with a dental dam before employing an industrial designer to build the first silicone prototype. After trialling 10 different prototypes produced in China the safety shield is now in market.

While the device was first developed to make it easier for anaesthetists and emergency responders working with bearded patients the onset of the COVID-19 pandemic early last year fuelled further interest in the device from hospitals and clinical staff concerned about aerosol generating procedures.

“When you’re doing our job you can’t avoid these risks. We can’t stay away from the patient or socially distance and the patient can’t wear a mask. So it became clear at that point that this device could help reduce aerosol airway secretions by improving the seal and capturing any aerosol secretions,” Dr Scott explains.

“Until COVID and this device everyone was happy to wear a mask but no one was thinking about what the patient actually emits. This is the first device that helps to protect against those emissions.”

“While one option is to shave the patient’s beard off many patients will refuse that either for aesthetic or religious reasons. I recently spoke to a patient who remembers 15 years ago that he was asked to shave off his beard that he had had for 40 years. To this day he is still angry that he was forced to shave it off.”

In recognising the SAM Safety Shield with a Good Design Award accolade in the product design medical and scientific category for outstanding design and innovation the judges noted: “The protective aspect of the device is critical, particularly at the time of global pandemic.”

The device has been registered with the Therapeutic Goods Administration in Australia and Dr Scott is working towards receiving approval from regulatory bodies in the US and Europe.

For more information visit www.scottans.com.au

Carolyn Jones
Media Manager, ANZCA

*Publication does not imply ANZCA endorsement of the above product or other similar devices.*

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**Strait Islander, Māori or Pacific Islander; and alert us if you are receiving important information!**

If you have multiple addresses you can select a primary address.

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2. Click “Update my contact details”
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So please take a few minutes to check your personal details. It’s easy to do, and ensures you won’t miss out on important information.

With all the uncertainties that COVID-19 continues to cause, it’s more important than ever to keep in contact. We use the information on your MyANZCA profile for all of our official communications, including:

- Exam updates
- Events and courses
- Committee vacancies
- Safety alerts
- Hospital rotations
- Research opportunities

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**ANZCA Bulletin**

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**Australian and New Zealand College of Anaesthetists** 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.**
New “Wellbeing CPD education sessions” activity

WE HAVE APPROVED a new “Wellbeing CPD education sessions” activity for the Knowledge and skills category at one credit per hour, capped at 10 per year. The new activity acknowledges the importance of our members’ development in this area and ensures we maintain a sustainable workforce with healthy doctors who can provide the best in patient care. This need was heightened by the demands of the COVID-19 pandemic, requiring specific attention from our members and all healthcare personnel.

The activity is supported by a new CPD Handbook – Appendix 2 Guidelines for Wellbeing CPD education sessions. Full details are available on the college website.

INNOVATIVE CPD AT 2021 ANZCA ASM

Our first virtual annual scientific meeting (ASM) from 27 April – 4 May 2021 was a huge success and captured our innovative approach to professional development. With virtual Emergency response workshops for CICO, Cardiac Arrest and Acute Severe Behavioural Disturbance (ASBD), to a Practice evaluation Clinical audit on preoperative fasting, to our new Knowledge and skills activity “Wellbeing CPD education sessions” - our approach offered many opportunities for participants to participate in a diverse range of professional development – all while remaining virtual.

We recommend you check out the ASM highlights on the college website and continue to access the post-meeting recordings.

Importantly, CPD participants who attended the ASM now have their CPD credits auto-populated to their CPD portfolio, awaiting confirmation in your “pending folder”. All post-meeting content viewing will need to be manually updated to your CPD portfolio.

2021 COLLEGE CPD OPERATIONS

After careful consideration the ANZCA and FPM CPD Committee will proceed as per normal with its 2021 verification of CPD activities (audit) notifying those randomly selected in September. We recommend all participants to regularly update their CPD portfolio with completed activities and supporting documentation/evidence. Full details are available at www.anzca.edu.au/news/cpd-news/cpd-update.

2018-2020 CPD END OF TRIENNIUM RESULTS

Congratulations to all 1687 participants in the 2018-2020 CPD triennium for achieving 100 per cent completion, and for their dedication to updating their CPD portfolios. Professional development has never been more important, with the need to upskill to support your patients, yourselves and to deal with this highly infectious disease. This result shows the resilience, innovation and dedication you have to your professional development amidst a pandemic and its ongoing restrictions. Full details are available on the college website.

CPD FOR DHM PRACTITIONERS

The ANZCA and FPM CPD Program is open to all DHM practitioners. Those who do not hold a FANZCA or FFPMANZCA may choose to do the CPD program of their primary college or choose to join our program through our non-fellow pathway. There is no separate CPD program for DHM practitioners or additional DHM CPD requirements for verification (audit). In addition to the new CNS-OT emergency response activity, to support DHM practitioners completing CPD activities the college has:

- Tailored Practice evaluation appendices

In June 2019, nine tailored CPD handbook appendices were made available to support DHM practitioners completing Practice evaluation activities. This includes forms and guidelines relating to the Patient experience survey, Multi-source Feedback (MsF) and Peer review of practice activities. These are available via the CPD handbook.

- DHM specific clinical audit sample

A new DHM specific Clinical audit sample on Prevention of Middle Ear Barotrauma (MEBT) during compression for hyperbaric oxygen therapy (HBO) was made available in September 2019. This Clinical audit sample includes a clinical audit guide, date collection form and summary of results form for participants to use for the Practice evaluation Clinical audit activity (valued at 20 credits). These are available for members through Networks.

NEW EMERGENCY RESPONSE ACTIVITY CNS-OT, DESIGNED FOR DHM PRACTITIONERS

A new Continuing Professional Development (CPD) emergency response activity for “Central nervous system oxygen toxicity (CNS-OT)” has been introduced from April 2021 designed specifically for diving and hyperbaric medicine (DHM) practitioners. This is the first DHM-specific emergency response activity, and has been developed by Dr Susannah Sherlock (FANZCA, ANZCA Dip Adv DHA, pictured in liaison with the ANZCA and FPM CPD Committee and the Diving and Hyperbaric Medicine Sub-Committee (DHMSC).

Dr Sherlock reflects “As many hyperbaric physicians are also anaesthetists, they participate in the ANZCA and FPM CPD program and split their learning between the two areas of interest. It made sense to formalise an emergency response which most units regularly practice to enable recognition. Hopefully colleagues may consider contributing other responses.”

There are no changes to annual or triennial CPD requirements, the CNS-OT inclusion is the eighth activity to the emergency response category. The inclusion of a DHM-specific emergency response activity provides the opportunity for all to participate in components of the CPD program relevant to their scope of practice.

The emergency response category has doubled in the past few years, with FPM specific activities Acute Severe Behavioural Disturbance (ASBD) introduced in 2019, and Cardiac Arrest – Special Pain Medicine Physicians (SPPM) introduced in 2020. With the seventh, COVID-19 airway management policy introduced in April 2020 in response to the pandemic’s essential training. The ANZCA and FPM CPD Committee continue to evaluate and encourage the development of this category and members key learnings.

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Calling future ANZCA educator facilitators

Looking for a new opportunity to get involved with college work?

The ANZCA Educators Sub-Committee are seeking new facilitators to deliver modules from the ANZCA Educators Program (AEP) across Australia and New Zealand.

The AEP consists of a series of teaching and feedback modules designed to help facilitate positive learning.

ANZCA EDUCATORS PROGRAM LEARNING TO TEACH

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Share your passion and experience, network with peers and be a part of a rewarding and engaging teaching program while learning CPD credits.

Email AEP@anzca.edu.au for the selection criteria, terms of reference and to register.
NSW health district drives change to reduce healthcare waste

**CLIMATE CHANGE IS** the greatest global health threat of the 21st century. It directly increases pressure on existing healthcare systems and undermines public health achievements. This is evident in the increased cardiovascular and respiratory admissions following catastrophic Australian bushfires1-3 and the redistribution and resurgence of infectious diseases like malaria14-15. Healthcare itself also fuels climate change with Australian hospital CO₂ emissions comprising 7 per cent of national emissions.4

Healthcare locals also fuel climate change with Australian hospital CO₂ emissions comprising 7 per cent of national emissions. Healthcare itself also fuels climate change with Australian hospital CO₂ emissions comprising 7 per cent of national emissions. For example, perioperative nurse Vicky Sandy contributed to a recycling stream in 2020; with anaesthetists acting as leaders of change and sustainability. Collaboration between anaesthetics and the infrastructure and planning department led to the formation of an Environmental Sustainability Committee to drive initiatives in theatres and perioperative areas. New Sustainability Project Manager Elissa Klinkenberg further enhances network-wide sustainability via advocacy for HD-EU14 sustainability representatives and facilitating communication between clinicians and executives. Interdisciplinary collaboration enables a united transition towards sustainable healthcare. At John Hunter Hospital (JHH), collaboration between anaesthetists and perioperative staff established reliable recycling streams. For example, perioperative nurse Vicky Sandy contributes to a Kipmarg recycling setup. Post-anaesthetic recovery unit (PARI) nurses Amy Remotus and Nick McKeown assist in intravenous bag recycling and auditing soft plastic production. Copper wire recycling established by anaesthesiology senior resident medical officer (SRMO) Dr Timothy Wong reduces waste, abates CO₂ emissions from new material production and raises funds for future sustainability projects. Setbacks, however, are inevitable, with ongoing difficulty in constructing a company for soft plastic collection and recycling within the Hunter region. The anaesthesia department is raising funds for a baler machine to partially overcome this. Pharmacological and disposable equipment all affect the JHH’s sustainability. They contribute to healthcare being one of the highest carbon footprint areas in healthcare.4 The direct involvement of anaesthetists in medication administration and handling of waste and equipment, provides an opportunity to examine theatre resource use and waste production.

Modification of daily routines by anaesthetists can impact general waste output. Many HD-EU14 anaesthetists have committed to minimizing use of environmentally damaging equipment. For example, replacing “blueys”, used to collect removed supraglottic devices in PACU, with patients’ disposables has (with thanks to Dr Tristan Bruce, staff specialist anaesthetist, and dissemination via Twitter) on collecting uncontaminated soft plastic theatre waste by staff specialist anaesthetist Dr Candice Peters’ team for disposal in REDcycle bins. These simple practices reduce landfill and abate CO₂ emission associated with new material production.

Inhalational anaesthetic agents contribute to climate change via atmospheric pollution.5 Anaesthetists are encouraged to examine their individual practices and preference environmentally friendly techniques, like TIVA and regional techniques.6 A staff specialist anaesthetist Dr Gavin Sullivan, for example, has stopped using desflurane due to its known high global warming potential and runs departmental education on its deleterious effects.7 Consequently, all JHH desflurane canisters were relocated to satellite storage, effectively deterring desflurane use. Dr Michael Law, staff specialist anaesthetist has also long promoted a volatile sparing induction (VSI) technique which he will present at the Newcastle anaesthesia conference on 6-7 August 2021. Personal anaesthesia carbon footprints can be estimated via free tools, like the Yale Gassing Green and the Association of Anaesthetists Anaesthetists’ Carbon Calculator8. In summary, anaesthetists are well positioned drivers of environmentally sustainable healthcare. Given the urgency of climate change and its close relationship with human health and healthcare, they have the responsibility to strive for sustainability, raise awareness and minimise the negative environmental impacts of healthcare.

**References:**


Operation Clean-Up: Raising awareness in healthcare

For the second year running, TRA2SH (Trainee-led Research in Anaesthesia and Sustainability in Healthcare) hosted its annual Operation Clean-Up on 22 April. The four-bundle theme included "refuse desflurane, reduce bluey use, reuse drug trays, and recycle".

AUSTRALIAN HEALTHCARE PRODUCES an overwhelming amount of waste, contributing 7 per cent of the country’s carbon footprint. This is compounded by increasing use of single-use items and complex recycling programs which are dependent on waste companies. Infection control restrictions, time, space, and lack of knowledge are barriers that can be overcome by an organised effort to practice sustainably. Operating theatres produce 30 per cent of total hospital waste. Of this, 25 per cent is due to anaesthesia, 60 per cent of which is recyclable (PS64: Statement on Environmental Sustainability in Anaesthesia and Pain Medicine Practice).

Trainees tackled these challenges with the use of evidence-based information provided in TRA2SH resource packs. Trainees had the opportunity to take on a scholarly role by collecting data for procurement audits that were in line with this year’s theme (desflurane index audit, bluey audit, drug tray audit), in which data over a period of 12 months was entered into a centralised database. During this process staff received feedback and reflected on their current practices and were free to come up with solutions and implement a change that suited individual departments.

Educational posters, PowerPoint presentations, and journal articles were available for bulletin boards, departmental talks, and journal clubs. Many hosted an afternoon tea to engage the perioperative team, fostering an inclusive and interactive forum to start the conversation and trial creative ways to reduce, reuse, and recycle. Green Champions were also identified and Green Theatre Groups were helped implement change and monitor activity.

Many hospitals have an underdeveloped recycling program. Therefore, focusing efforts on reducing and reusing will mitigate the barriers of recycling. At Ipswich Hospital, Kingguard (sterile wrap) is one such item that can be repurposed for many tasks for which blueys are used including use as a table liner for the endoscopy trolley, placing on the operating table while applying surgical drapes, and placing under the wrist for arterial line insertion, and for covering up laryngeal mask airways that are removed from patients in the post anaesthetic care unit.

At the same time, waste from bluey use is reduced. Reducing use is one of the most effective ways to decrease the environmental impact of items because it not only reduces landfill but also reduces the impact of manufacturing, sourcing, transporting, and processing raw materials. One can envisage these efforts spilling over into other clinical areas including the emergency department, the intensive care unit and medical/surgical wards.

Provisional fellowship trainees (PFTs) are required to have a portfolio which focuses on non-clinical aspects of training. A passion for the environment, a gap in sustainable practice in anaesthesia and the support from TRA2SH provides many PFTs the opportunity to value-add to the department and focus their energy on making key changes by educating and leading the registrar group to undertake audits or to produce educational material for submission to TRA2SH. More departments should be encouraged to provide a provisional fellowship year in environmental sustainability. This will also allow the momentum of sustainable practice to continue beyond Operation Clean-Up.

Since its inception in 2020, TRA2SH has grown to include more than 200 participants on its mailing list across Australia and New Zealand as well as a Twitter following of more than 400 and growing! TRA2SH also collaborates with the ANZCA environmental sustainability working group and presents at numerous scientific meetings including the ANZCA Annual Scientific Meeting. Trainees are well positioned to share ideas and lead by example to make changes at a grassroots level. As the network expands, TRA2SH aims to remain trainee-led and collaborative to help achieve a common goal. If you are interested in joining the TRA2SH team email tra2shgroup@gmail. For more information visit our website at www.tra2sh.org and follow us on Twitter @tra2sh.

Many thanks to the 80 participants who signed up this year representing 34 hospitals in Australia and five each in New Zealand and the UK.

Dr Rajesh Pachchigar
Provisional fellow, Anaesthesia
Ipswich Hospital, Queensland

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Research

The evolution of CTN

The publication of The Perioperative Administration of Dexamethasone and Infection (PADDI) trial results in the New England Journal of Medicine on 6 May builds on the brilliant track record of the ANZCA Clinical Trials Network as a world-leading clinical trials network to deliver trials that improve the evidence base in anaesthesia, perioperative and pain medicine. The results were announced at a worldwide webinar by chief principal investigator, Professor Tomás Corcoran, Director of Research in the Department of Anaesthesia and Pain Medicine, Royal Perth Hospital and Adjunct Clinical Professor in the Central Clinical School at Monash University.

The PADDI trial received $A4.6 million from the National Health and Medical Research Council (NHMRC) project grant, which was the highest value grant in that year of the scheme. The pilot study (PADDAG) was funded by the Royal Perth Hospital Research Foundation, with $A143,000 being provided to support that trial. The PADDI trial recruited 8880 patients from March 2016 to July 2019 from 55 hospitals across Australia, New Zealand, Hong Kong and South Africa. We thank all our PADDI trial committee members, site investigators, fellows, trainees, research co-ordinators and the thousands of patients who were involved in the trial. Their efforts ultimately improve safety and care in the perioperative setting. The PADDI trial has debunked myths about the use of the dexamethasone in the perioperative settings, especially in patients with diabetes.

Since PADDI started recruitment in 2016, CTN has experienced 50 per cent growth in new sites in Australia and New Zealand coming onboard our trials. We believe that PADDI was important in the evolution of CTN as the trial was relatively easy for hospitals to get a handle of clinical trial research for the first time. Contributory factors included the ease of delivery of the trial intervention (single 8mg bolus of dexamethasone intraoperatively), the user friendly clinical trial management system, the accessible patient population and the support by the CTN office and the PADDI project teams.

We invite you to be part of the next success story. We have 12 clinical trials under way that you can become involved in. Each of these trials will answer important questions in perioperative medicine over the next five years. We encourage you to get in contact with the CTN office to learn more about these trials and the support available to your site.

Contact Karen Goulding for further information – ctn@anzca.edu.au. For links to the PADDI webinar recording and publication and for more information on our clinical trials, visit www.anzca.edu.au/ctn or follow us on Twitter @PADDI_Trial.

2021 ANZCA Clinical Trials Network Strategic Research Workshop 13TH ANNUAL MEETING

5-8 August 2021 | Pullman Brisbane
For further information on the workshop, please contact events@anzca.edu.au.
The PADDI trial was the first large randomised trial to evaluate the safety of dexamethasone in terms of its influence on surgical site infection and was the culmination of 10 years of investigation from concept development and preliminary research through to trial completion.

Dexamethasone is widely used by anaesthetists in the perioperative period, particularly as an effective antiemetic to prevent postoperative nausea and vomiting (PONV), but there are a number of other indications for its perioperative use, including to improve post-operative analgesia, improve the quality of recovery and decrease facial swelling and sore throat in mastoidectomy and to reduce the risk of respiratory complications during cardiac surgery. Because it is a potent glucocorticoid, it has immunosuppressive and anti-inflammatory effects, and the investigators hypothesised that these actions may increase the risk of perioperative infections, particularly in patients with diabetes mellitus, who are already at increased risk of complications. This is an important health priority as in each year in Australia alone, there are at least 200,000 healthcare-associated infections including surgical site infections that are diagnosed in hospital at a cost of approximately $1 billion a year.

The PADDI trial was a pragmatic, multicentre, randomised, noninferiority trial conducted in 55 hospitals across four countries. A total of 8888 adult patients were enrolled and randomly assigned to 8mg dexamethasone or matched placebo shortly after the induction of anaesthesia and before incision, and randomisation was stratified according to diabetes status. The study population consisted of adult patients undergoing elective or expedited noncardiac, nonobstetric surgery with an expected operative duration of at least two hours. The primary endpoint was the onset of surgical site infection within 30 days of surgery. Secondary outcomes included other infections as deep and organ space infections at 90 days and quality of recovery on Day 1 and Day 20 as well as onset of chronic postsurgical pain, death on new onset of disability at six months.

The findings showed that 8.1 per cent of patients who received dexamethasone experienced a surgical site infection at 30 days after surgery, compared to 9.1 per cent in the placebo group. The p value for non-inferiority was highly statistically significant (p < 0.001) and therefore the conclusion is that dexamethasone does not increase the risk of surgical site infection. This is particularly reassuring in patients with diabetes and in those with prosthetic material implanted as they are believed to be at a higher risk of infection. The trial also confirmed the antirenic effectiveness of dexamethasone, but there did appear to be a small increase in the incidence of chronic postsurgical pain in those patients treated with dexamethasone (8.7% versus 7.1%), a finding which may be spurious and which is under further investigation. The authors have recommended that dexamethasone is safe to use as clinically indicated.

The theme for this year is “Anaesthesia and having a baby”

A new ANZCA patient information video will also be launched in time for #NAD21 so you can start thinking about your displays now. ANZCA National Anaesthesia Day is held each year to raise awareness of the crucial role anaesthetists play in healthcare. The aim of the 2021 theme is to help the community understand how anaesthetists keep women and their babies safe if they need an anaesthetic before, during or after the birth.

An ANZCA initiative, National Anaesthesia Day is usually held each year on 16 October to mark the anniversary of the day in 1846 that ether anaesthesia was first demonstrated publicly. Due to 16 October falling over the weekend we will instead celebrate on Monday 18 October.

ANZCA will send posters and other material to hospitals in late September. Visit www.anzca.edu.au/NAD for more information or email communications@anzca.edu.au. ANZCA will send posters and other material to hospitals in late September. ANZCA will send posters and other material to hospitals in late September.

The ANZCA Provisional New Fellow Research Award, is provided every two years to an emerging investigator to assist during the difficult early stages of embarking on a career in research. The ANZCA Research Committee provides matching funding, allowing a grant equivalent to an ANZCA Novice Investigator Grant. In alternating years, the earnings provide the ANZCA Joan Shales Staff Education Award.

Robin Smallwood Request
A visionary philanthropic gift from Miss Rosalind Smallwood, inflating funds bequeathed by the late Dr Robin Smallwood, a past Dean of the Faculty of Anaesthetists at the Royal Australian College of Surgeons, provides ANZCA’s Robin Smallwood Research Request, an annual grant for medical research led by an ANZCA, or FFP, or FPM fellow or trainee. This substantial bequest has made possible the completion of a diverse range of high-quality studies adding significant new knowledge in important sub-specialties within anaesthesia, pain and perioperative medicine.

Elaine Lilian Klaver Request
Another very generous bequest was left to the foundation by Dr Elaine Lilian Klaver. With a quantum that through the investment earnings produced has been able to also support the annual provision of a significant ANZCA Project Grant through the research committee.

Darcy Price ANZCA Regional Research Award
The foundation, Dr Michel Klages and his colleagues at Auckland’s North Shore Hospital established this annual grant in 2019 to honour the memory of Dr Darcy Price, and his passion for education in regional anaesthesia. This new award is annually funded through the Waitemata District Health Board. The foundation is again honoured to be able to join the team at North Shore Hospital in honouring the memory and legacy of Dr Darcy Price.

Empowering Quality and Safety
Several ANZCA Research Committee initiatives recommenced this year with funds bequeathed by the late Dr Robin Smallwood, a past Dean of the Faculty of Anaesthetists at the Royal Australian College of Surgeons, provides ANZCA’s Robin Smallwood Research Request, an annual grant for medical research led by an ANZCA, or FFP, or FPM fellow or trainee. This substantial bequest has made possible the completion of a diverse range of high-quality studies adding significant new knowledge in important sub-specialties within anaesthesia, pain and perioperative medicine.

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Initialising the annual ANZCA Melbourne Emerging Anaesthesia Award, Peter then added the ANZCA Melbourne Emerging Researcher Scholarship. Peter extended his initial five-year support commitment to ongoing provision of both grants, recognising their track record of recipients successfully delving high-quality studies, establishing their careers and more recently completing PhD degrees in anaesthesia research.

Professor Barry Baker
Professor Barry Baker, a past ANZCA Dean of Education and current ANZCA Honorary Historian, made generous gifts in 2014 and 2015, the investment of which has become capable of funding two high-quality, dedicating grants. The first, the ANZCA Provisional New Fellow Research Award, is provided every two years to an emerging investigator to assist during the difficult early stages of embarking on a career in research. The ANZCA Research Committee provides matching funding, allowing a grant equivalent to an ANZCA Novice Investigator Grant. In alternating years, the earnings provide the ANZCA Joan Shales Staff Education Award.

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Two years ago, the Regional Organising Committee for the 2021 ASM decided the theme for the meeting should be “Leaps and Bounds”, based on the Paul Kelly song about Melbourne in May. As it happened, it also turned out to be an appropriate theme song for running a meeting during a pandemic, something none of us expected we would ever have to do.

The switch to virtual happened in August last year, when Melbourne was in the grips of a long winter lockdown. The decision was not made easily but once it was made, the certainty was helpful – finally we could make plans. We engaged the excellent audiovisual team, Wallfly, pooled all our collective knowledge of virtual meetings and put our imaginations to work.

The result was an extraordinary virtual meeting with almost 2500 registered delegates and 75 online workshops. Fortunately Melbourne remained Covid-free long enough to allow ANZCA President Dr Vanessa Beavis to fly into Melbourne and for us to host many of the sessions from the Melbourne Convention Centre. The rooms were repurposed like small television studios with chairs and panels presenting to camera, often after watching pre-recorded content. It was a strange experience for everyone but it was great to see how willing everyone was to engage with this new format.

For the first time we had a Welcome to Country and smoking ceremony by the Boon Wurrung people and we were fortunate that the convention centre allowed us to stage this inside the largely empty building. The smell of the eucalyptus lingered for days, adding even more poignancy to those of us who were there each day, guiding people through the maze of technology.

In order to provide at least some in-person experience, and to enable our new fellows to graduate, we instituted a series of hubs around Australia and New Zealand for Super Saturday. Apart from the late withdrawal of Perth due to a brief lockdown, this was a really successful and emotional day. Many people took advantage of the hubs to meet with their colleagues and watch the online content during the day. And then in the evening, attendance increased even more for the College Ceremony. The College Ceremony proceeded as normal in Melbourne with the stage party and our wonderful guest orator, Professor Sharon Lewin, Director of the Doherty Institute. She had many interesting insights for our fellows and was quick to acknowledge the great contributions that anaesthetists have made during the current pandemic. The hubs were all visible on the large screen and it felt really surreal to see everyone waving and cheering as their cities were announced.

Scientific program

While presenting a daunting challenge, the decision to convert the meeting from in-person to virtual eight months before it was due to start presented some unique opportunities for the scientific program, convened by Dr Lachlan Miles, Associate Professor Lis Evered and Dr Tuong Phan. Normally, the attendance of an international speaker is associated with appropriate reimbursement of travel costs. However, due to the introduction of pre-recorded presentations and virtual attendance, costs were minimised and access to international speakers was increased. In addition to keynote speakers Professor Hugh Hemmings, Professor Cor Kalkman, Professor Alicia Dennis and Associate Professor Meghan Lane Fall, the scientific committee was able to secure Professor Donal Buggy, Dr Kariem El-Boghdadly, Professor Paul Wischmeyer, Dr Florian Falter and Associate Professor Laura Duggan.

First virtual meeting a great success

Reflecting on an extraordinary meeting

ASM SNAPSHOT

<table>
<thead>
<tr>
<th>Delegates</th>
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<tbody>
<tr>
<td>Speakers and facilitators</td>
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<td>Plenary sessions</td>
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<td>ENGAGE hubs in nine locations, around Australia, New Zealand, and Hong Kong</td>
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<td>Number of virtual platform logins</td>
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<td>Most watched session “Pandemic” plenary session</td>
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Leaps and Bounds

First virtual meeting a great success

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FANZCA Dr Kara Akin prepares to host a virtual program session in one of the ASM studios at the Melbourne Convention and Exhibition Centre.

ASM Convener Associate Professor Chris Bell with Scientific Convener Dr Lachlan Miles.

David Tourner a Boonwurrung Senior Cultural Officer and his daughter Tahlia Tourner.
Further innovations were built into the program upon recognizing the altered attendance patterns associated with virtual conferences, and to consider “domestic” delegates attending from across multiple timezones, stretching from Perth in Western Australia to Gisborne in New Zealand. It was anticipated that delegates were less likely to forego income to attend a virtual meeting; consequently, evening sessions (branded “ASM@Night”) were introduced on normal business days to allow delegates attend both the meeting and work if they chose. Start times on weekends were delayed, allowing delegates to spend time with their families in the mornings should the timezone allow. The addition of pre-recorded sessions added further flexibility: No longer were delegates restricted to attend a single session where concurrent sessions were running. Rather delegates could move seamlessly between sessions, or alternatively, watch the recorded session later. These recorded sessions – totaling more than 95 hours of curated content – will be available to watch to those who registered before, during or after the meeting for the next 12 months.

Despite our confidence in the program (helped immeasurably by the constant and unwavering support of Kate Chappell and Fran Lalor from the ANZCA Events team), the experience of executing the program at the meeting itself was rather discombobulating, as the remote experience of the delegate was reflected on us as convenors. We did not have access to the immediate feedback that an in-person meeting affords, and the entire experience was a little like shouting into the void for eight days. Nevertheless, the echoes returned eventually, and the feedback submitted thus far suggests the scientific program has been generally well received by the fellowship. Given the circumstances under which it was established, the experience of the 2021 ANZCA ASM will hopefully never be repeated. However, we shall be interested to see which virtual elements of this extraordinary meeting can be incorporated into future ANZCA events.

Workshops

The workshop programs for the ASM needed to be completely reimagined following the decision to go fully “virtual”. After the shared experience of several months of videoconferencing it was clear that the main challenge would be to ensure adequate engagement with the material in a workshop format, rather than just providing lectures with minimal interaction via a virtual platform. Early after the decision to go virtual was made the workshop convenors and Events staff worked closely with the facilitators of more than 70 workshops to confirm the learning objectives and interactivity of the sessions could be maintained in the “in-silico” delivery method. The use of polls, breakout rooms and practical “at-home” demonstrations was planned in detail. Online education sessions for the facilitators about the capabilities of the platform were run and a “resource portal” webpage was created with ideas, tips and tricks to improve the effectiveness of the learning methods chosen.

The Events staff contacted all of the workshop facilitators multiple times to troubleshoot any problems they may have had, or answer questions. Not all of the workshop facilitators were experts at the technology as well as being a skilled educator on their expert topic! As a result, some needed additional coaching as well as the “ANZCA host” available online for every workshop to troubleshoot any issues that arose.

There’s still time to access ASM content

You can still catch up on more than 95 hours of onDemand content, whenever and wherever suits you until May 2022, just by registering for the ANZCA ASM by Saturday 31 July. Visit www.asm.anzca.edu.au.
Apart from engagement, the other substantial problem was to maintain the high quality of education for the workshops such that the stringent ANZCA continuing professional development (CPD) standards were met and were therefore eligible to attract CPD credits.

The workshop convenors and Events team liaised closely with the CPD Committee to not only make sure that these standards were met but to develop new ways of delivering content that could be used in the future. Of particular significance were the emergency response activities. The new Acute Severe Behavioural Disturbance (ASBD) and the Can’t Inhale, Can’t Oxygenate (CICO) activities both have substantial practical components. Videos were created for the ASBD workshops with attendees pairing up with friends or family members at home to practice defensive manoeuvres. The virtual CICO workshops required even more preparation, with 3D printed laryngeal models and CICO rescue kits mailed to the participants several weeks before the sessions. Furthermore, a set up at the convention centre with overhead high definition cameras a full mixing desk and audiovisual technicians provided a television quality experience for more than 30 cameras a full mixing desk and audiovisual technicians provided a television quality experience for more than 30 attendees in the workshops run over the course of the day. Overall a total of more than 2700 workshop places were provided with nearly all sold out.

Each year the ASM Regional Organising Committee chooses a preferred charity to donate $10,000 in lieu of speaker gifts. We chose FareShare – born in Melbourne and the brainchild of a pastry chef, FareShare has grown to be Australia’s largest charity kitchen with its executive team of six professional chefs cooking over 120 healthy and delicious meals provided free of charge. FareShare has grown to be Australia’s largest charity kitchen with its executive team of six professional chefs cooking over 1200 healthy and delicious meals provided free of charge to soup vans, homeless shelters, women’s refuges and community food banks.

It remains only for us to thank everyone involved in this extraordinary meeting. The rest of the Regional Organising Committee, the hard working and extremely professional Events team, Waivy, and all the presenters, chairs and workshop coordinators. The ASM only happens every year because so many give so generously of their time and expertise. On this occasion people were also generous with their understanding – and we are really grateful. The content is still there – make sure you continue to watch it over the next 12 months and get the maximum benefit from this highly unusual meeting.

Associate Professor Chris Ball
Convener
Dr Lachlan Miles
Scientific Convener
Associate Professor Stuart Marshall
Workshops Co-Convener

FPM Symposium

On Friday 30 April we had our annual FPM symposium day held virtually for the first time. It was a great event, which saw our international invited speakers Professor Matthew Smuck and Professor Eva Kosek give us insight for how they treat back pain in the US and Sweden and we had an Australian perspective provided by Professor Flavia Cicuttini.

Other highlights included reframing the ideas about pain through adversity and better ways to enhance communication with First Nations Peoples and other marginalised patient groups. We had the latest updates in opioids and Therapeutic Goods Administration and Pharmaceutical Benefits Scheme changes, which invariably led to a discussion on cannabis and finally rounded out the day, with an overview of the third-party system and better ways to enhance collaboration between doctors and insurers, ultimately leading to better outcomes for our patients.

These recordings will be available for 12 months after the meeting, so if you missed out there’s still a chance to watch and learn. Register before Saturday 31 July to gain access! Visit asm.anzca.edu.au.

A big thank you to all invited speakers, Deputy Convener Dr Guy Buchanan and the Events team for putting on a memorable virtual meeting!

Dr Noam Winter
FPM Symposium Convener

Raising our profile

Social media

Social media played a more important part than ever at this year’s ASM, by providing places for you to connect, collaborate, and share an ASM experience even though we couldn’t come together in person.

The conversation on Twitter didn’t disappoint. 640 people posted almost 6000 tweets using the #ASM21MEL hashtag. This resulted in a tremendous 30 million impressions, smashing our previous record at KL’s ASM by almost 10 million.

Although we’ve been on Instagram since October 2020, this was our first real wave. We shared casual, behind-the-scenes interviews with the Melbourne Regional Organising Committee and workshop facilitators. These videos were a hit and received over 2000 views in scenes interviews with the Melbourne Regional Organising Committee and workshop facilitators. These videos were a hit and received over 2000 views on our profile. We also did our inaugural Instagram Livestream. We streamed the cleansing smoking ceremony, performed by representatives of the Boon Wurrung People before the Opening Plenary.

Social media

The Numbers

31.010M
5,946
36
35
9
642
3
5
1
5

We livestreamed the Melbourne College Ceremony to Facebook which received over 1000 views and reached nearly 5000 people. As it was the first time new fellows weren’t all presenting in the one place, we set up Zoom links for the families of those in the regions so they could catch a glimpse of their loved ones too. We received a lot of positive feedback that people were grateful for the chance to join in and watch the ceremony virtually.

Dr Allen’s presentation was featured in an ANZCA media release and the article reached 310,000 readers.

FPM guest speaker Associate Professor Flavia Cicuttini’s presentation on back pain image screening and the ANZCA media release “Back pain imaging on rise despite calls to limit use” led to a news broadcast interview on Radio 2SM in Sydney on 30 April that was syndicated to several regional NSW radio stations.

Another guest speaker, Deakin University epidemiologist Professor Anna Peeters, was interviewed by the Herald Sun medical editor Grant McArthur for an article on 30 April “Call to ensure obesity fight stays a priority”. Professor Peeters’ presentation was the topic of an ANZCA media release and the article reached 310,000 readers.

Media coverage

ANZCA 2021 ASM and FPM Symposium presentations featured in the media.

ANZCA New Fellow Announcement Dr Meg Peeters’ presentation was the topic of an ANZCA media release and the article reached 310,000 readers. ANZCA New Fellow Announcement Dr Meg Peeters’ presentation was the topic of an ANZCA media release and the article reached 310,000 readers.
Ground control to ANZCA ASM

At first glance it looks like a fancy computer set-up: a serious gamer might use it but ensconced in an area of about one metre square is the beating heart of the 2021 ANZCA Virtual Annual Scientific Meeting (ASM) in Melbourne. It has the technical capacity of an outside live broadcast (OB) van — similar to those you see lined up outside large sports events.

Here, at the Melbourne Convention and Exhibition Centre (MCEC), technician John McCartney is operating one of the ASM’s “mission control” — the room at the MCEC that serves as the command centre for delivering more than 35 hours of live and pre-recorded core meeting content across the scientific program including plenaries, panel discussions, workshops and panel presentations. Mr McCartney is essentially performing the equivalent of multiple OB roles — he’s a vision operator, a broadcast switcher and content manager all rolled into one.

Each ASM studio room at the MCEC has the same rock set-up — with identical cabling, computer equipment and software ensuring that the delivery of each streamed session completes with multi-channel Zoom rooms, is seamless. In one studio on the day the Bulletin shadowed the Wallfy team, Melbourne anaesthetist Dr Kara Allen was sitting in front of a green screen presenting a Virtual CRASH workshop. (The virtual course is designed to help participants revisit skills and knowledge in preparation for returning to work, including accreditation for ANZCA emergency response for cardiac arrest.)

Over eight days on site and eight months leading up to the event a team from Adelaide-based conference technology management specialists Wallfy and their technology partner Novatech developed and ran a bespoke virtual platform — including the world’s first virtual CICO (Can’t Intubate, Can’t Oxygenate) workshop — that was delivered globally to 2500 delegates. More than 300 speakers, presenters, contributors and facilitators were involved with the program that also included 75 virtual workshops, plenaries (pre-records and live sessions) panel discussions, workshops and poster presentations.

Wallfy’s managing director Grant Yarwood and chief technical officer Grant Whitehead worked with ANZCA’s Events team from June 2020 on the new meeting plans. Most of the planning was carried out by the Melbourne-based ANZCA team from their homes as many of the city’s offices were shut down by COVID-19 until earlier this year.

“It’s really just like a military operation,” Mr Yarwood told the Bulletin.

"Until you actually see how we pull everything together there’s this perception that all we’re doing is setting up Zoom meetings. Zoom is one of the tools we use but how you use it and the showcase you apply to it is what makes the difference. It was a massive effort to set this up in six months with the ANZCA Events team as the college hadn’t done anything on this virtual scale before. It really was an intense level of systemisation so we had to rely on everyone playing their part!”

Mr Yarwood and colleague Andrew Ely have worked for ANZCA on several consecutive ASMs and Wallfy has been managing and running virtual events and live streams for the last decade.

“We understand the fabric of what makes a successful event so when we had the pivot to go online it was quite easy for us to transition,” Mr Yarwood explained.

“Very quickly we found a solution to make it work. It’s not just about the technology, it’s about how you continue to create community engagement to keep your virtual and in-person delegates connected. Our gold standard is to make sure that whether you are sitting in the conference centre ballroom, one of the ASM hubs or at home or in your office that you are an equal part in the event.”

"We try to use technologies to strike a balance between the software and the human interface. It’s easy enough for people to do it and they become familiar because there’s a steep learning curve when you jump online and start doing these things. It’s about finding the right software that’s easy enough to learn for the broader audience but that also gives us the technology and tricky bits we need to live up on.”

“There’s always a bit of a trade-off. It’s not like a TV production where you can throw keeping lots of resources at it. We have to work within a budget and find the right formula to promote that engagement for the online community so that people don’t feel like they’re sitting in the cheap seats or the back seats and that’s often what can happen in a virtual event. So we are really mindful of making sure everyone feels they are getting an equal part of the event.”

One of the challenges in developing customised equipment such as the one system constellation racks was having to deal with global supply chain delivery delays caused by the coronavirus pandemic. The Wallfy and Novatech teams had to find computer equipment from a range of disparate international suppliers and relied on the goodwill of their contacts in the UK and US to air freight essential equipment to Adelaide in time for the ASM pre-recording sessions.

Much of the success of the delivery of the ASM’s virtual focus lay with the booking and pre-recording of dozens of sessions for the scientific program, the FPM Symposium and special interest group sessions by the Wallfy team at their Adelaide studios from 8-14 April. Technicians worked across two time zones from 7am to 9pm and then 6pm to 10pm to ensure that presenters in Australia, New Zealand, Canada, the US, the UK and Sweden could pre-record their sessions at their preferred local times. Hundreds of recodings were made and then edited using customised software. Each presenter was given access to an online briefing session which was then downloaded to a specially created resource hub “how to” website.

Once the ASM was under way the recordings were then matched to a program run-sheet for streaming.

“The technology can be quite overwhelming for some presenters and trainers,” Mr Yarwood explained.

“But by doing the pre-recording we were able to maintain a level of quality control which meant that on the actual day of their session or event they were able to connect, see back and listen and watch and they could hear their presentation played back and then hear the others in the session. The pre-recording takes a lot of pressure off those speakers on the day if say, they’re wondering about their camera not working. We had a few people who had problems connecting from home so we had time to manoeuvre during the pre-recording sessions. It gave us a lot more flexibility and we had a pretty good success rate.”

Once on site at the MCEC the nine Wallfy and Novatech staff worked with five local technicians and MCEC staff across four studio rooms. Another four Wallfy staff in Adelaide and Brisbane worked as online tech support crews from 7am-9pm each day.

The face-to-face interaction model of traditional ASMs was modified for 2021 in Melbourne. All virtual presenters had a dedicated ANZCA host for their sessions and a virtual “green room” was also available before the presenters or speakers were moved into their virtual stage.”

“The presenters and speakers were constantly managed,” Mr Yarwood said. “That’s a significant part of the success of this virtual model. Often people are left to fend for themselves but that’s not how the college or Wallfy approached it.”

Back at the MCEC inside the mission control centre Mr Yarwood and his team directed the proceedings through a series of computers and giant screens that not only stream real-time sessions but also display key graphics including a giant map of the world showing how many delegates are logged in at any one time across the globe. Over the opening plenary the global heat map revealed that more than 600 people were watching the live stream of the event. Interest in individual presentations and workshops was also captured in a series of bar graphs to make it easy to see at a glance how many delegates were watching.

While the Wallfy crew knew the on-demand content for the STAT sessions would be popular they had to move quickly to ensure the content was available as soon as possible even though registration gave delegates up to 12 months to view the content at their leisure. The demand was so strong that Wallfy’s initial goal of having content online within 24 hours had to be stretched to 48 hours.

Mr Yarwood regards the 2021 Melbourne ASM as a watershed in terms of the hybrid model approach that could be the future of scientific meetings such as ANZCA’s.

“COVID-19 has forced our hand five to 10 years forward in the space of just a few months. We and ANZCA have already been doing some virtual events on a much smaller scale and you might have had one or two keynotes in past ASMs that were virtual.

“Virtual events will never go back to what they were. In person events will return but there will always be a virtual expectation. People are no longer restricted by time. They can get online and consume all this great information at their own leisure. What Melbourne showed is there’s no more bookends on an event any more.

“The whole virtual aspect means we now have a bigger audience, a global audience. We’re not restricted by time or space. It’s a natural progression but of course I can’t wait for the face-to-face events to return.”

Carolyn Jones
Media Manager, ANZCA
ASM hosts world-first virtual CICO workshop

Dr Luke O’Halloran and his anaesthesia team at Monash Health have spent the past few years finessing their face-to-face delivery of the-bedrock CICO (Can’t Intubate, Can’t Oxygenate) continuing professional development (CPD) sessions for anaesthetists and critical care doctors.

So when planning began for the 2021 ANZCA Annual Scientific Meeting (ASM) back in 2019 and his CICO workshop was added to the program he expected that participants would most likely be bussed from the Melbourne Convention and Exhibition Centre (MCEC) to Monash Medical Centre in Clayton for several high fidelity simulation sessions (The sessions meet requirement for ANZCA’s CPD).

When COVID-19 forced the transformation of the 2021 Melbourne ASM into a mostly virtual meeting Dr O’Halloran and his team had to make a decision – could they deliver the CICO workshop to 60 participants across these 90 minute sessions as an online presentation, complete with real-time hands-on tasks and equipment?

“We were optimistic that this was something we could do even though the workshop had never been attempted virtually before,” Dr O’Halloran, Deputy Director, Department of Anaesthesia and Perioperative Medicine at Monash Health, explained.

“Given this was a virtual workshop the big issue we needed to cover off quickly were the workshop resources. In our face-to-face workshop model the equipment is all there ready for the participants when they arrive on site and then they sit at a bench and are ready to go. For the virtual workshop we had to provide all the course materials to the participants at home so they could set everything up themselves and have everything ready. You can imagine the logistics involved as we had to ensure we had all the equipment ready for the mid-out well in advance of the workshop date.”

Dr O’Halloran and his workshop facilitators worked with ANZCA Councillor Associate Professor Stu Marshall to build and prepare the CICO kits so they could be posted to all workshop participants in Australia, New Zealand and other countries by mid-March.

The clinical procedural equipment section of the CICO kits used by the Monash Health anaesthesia team were easily reproduced as these included cannulas, syringes, scalpels and oxygen delivery devices. The second part of the kit, the Cric (cricothyrotomy) Trainer that replicates the anatomy of a patient’s neck, was more challenging as 60 of these had to be built from scratch using a 3D model template from Canada complete with artificial “skin”, cable ties and staple guns.

With the help of the ANZCA Events team the kits were mailed out to the workshop participants well ahead of the sessions to allow for postage delays. A week before the workshop the team from virtual conference company Wallfly organised a tech information session so all participants could check in and see if their camera and audio set-ups worked. The workshops require focused close-ups of each participant’s hands so this preparation was crucial to ensure nothing was left to chance on the day.

On the day of the workshop Dr O’Halloran, as lead facilitator, was on site at an MCEC studio with two other facilitators. He started the presentation by demonstrating the drills and procedures that would be practised during each 90 minute session. Four home-based facilitators then led virtual breakout sessions so participants’ skills and techniques could be monitored and feedback provided.

“We had a checklist of all the skills required of each participant and we made sure that all of them completed every task to our satisfaction. Also, the MCEC studio had multiple camera angles set up so we could get close-ups of our hands and the CICO procedures. The feedback from the participants was so positive. Many of them said they had never seen such high resolution presentations or close-ups – even in the face-to-face live sessions – so these were really useful for them,” Dr O’Halloran said.

“It was crucial for us to have a clear view of what the participants were doing with their hands and also we had to make sure we could hear them. Preparation was critical and the expert audio visual support was essential. Everyone collaborated exceptionally, and the delivery of the course really did exceed our expectations.”

Dr O’Halloran said the success of the virtual CICO workshop proved that ASM or CPD presentations need no longer be confined to just one traditional face-to-face model.

“It’s pretty likely that a virtual approach will be part of our future CICO workshops. It might be that some participants can’t attend face-to-face as they may be overseas or interstate but we know that we can still have a large group on site as well. We proved that it was possible to have either virtual, face-to-face or a combination of both.”

Carolyn Jones
Media Manager, ANZCA

Preparing one of the 3D printed Cric (cricothyrotomy) CICO kits complete with artificial “skin”, cable ties and staple guns.

Below: A screenshot of one of the CICO workshop sessions complete with the CICO tools of trade.

Right: Pre-packed kit equipment bagged ready to send to CICO workshop participants.
### Keynote presentations

**ANZCA ASM Visitor Ellis Gillespie Lecture**
Professor Hugh Hamings, “Why anaesthetists should care about basic science”.

**Organising Committee Visitor Lecture**
Associate Professor Meghan Lane-Fall, “A failure to communicate: Interpersonal interactions and detection of the deteriorating patient”.

**FPM ASM Visitor Michael Cousins Lecture**
Professor Matthew Smuck, “Physical performance monitoring and the future of precision pain medicine”.

**ANZCA Australasian Visitor Mary Burnell Lecture**
Professor Alicia Dennis, “Doctors, Disasters and Destiny”.

**Victorian Regional Visitor Lecture**
Professor Cor Kalkman, “Wearable patient monitoring and the Nightingale Project”.

**FPM Regional Visitor Edward Shipton Lecture**
Professor Eva Kosek, “Nieplastic pain – why should anaesthetists care?”.

### Prizes

**Gilbert Brown Prize**
2020
Dr Lashkan Myles for “Pharmacokinetic algorithm-driven versus fixed dose ratio dosing of protamine following cardiopulmonary bypass: the PRODOSE phase II randomised controlled trial”.

2021
Dr Patrick Tan for “High flow humidified nasal oxygen (HFNO) versus face mask oxygen for preoxygenation of pregnant women – a prospective randomised controlled crossover study (HFNOPI2)”.

**ANZCA Trainee Academic Prize**
2020
Dr Nathaniel Hiscock for “Regional anaesthesia and its association with Victorian inpatient arteriovenous fistula complication rates”.

**ANZCA Trainee Research Prize**
2021
Dr Jason Denny for “Incidence of ketone elevation amongst patients with diabetes on day of surgery”.

**ANZCA Trainee Quality Improvement Prize**
2021
Dr Joanna Yu for “Surgical day care unit (SDCU) fasting clock – an initiative to reduce prolonged preoperative fasting times in patients undergoing elective colorectal and bariatric surgery”.

**Open ePoster Prize**
2021
Associate Professor Victoria Eley for “A comparison of the ClearSight™ finger cuff with invasive arterial pressure measurements in patients with Class III obesity: A Pilot Study”.

**Trainee ePoster Prize**
2021
Dr James Cheng Jang for “Postoperative recommencement advice for antithrombotic agents”.

**FPM Dean’s Prize**
2020
Dr Rupesh Gawankar for “Targeting two birds with one stone: Efficacy of Ketamine in pain and opioid reduction”.

**FPM Best Free Paper Award**
2021
Dr Megan Allen for “Opioid stewardship assessment: a multicentre study of post discharge opioid use and handling in surgical patients”.

**Robert Orton Medal**

**PROFESSOR MILTON L COHEN AM**

**2020 RECIPIENT**

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

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

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

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

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

Dr Meredith Craigie
FPM Immediate Past Dean

**Dr Ray Hader Award for Pastoral Care**

**DR CHRISTOPHER J SPARKS**

**2020 RECIPIENT**

The Dr Ray Hader Award for Pastoral Care promotes compassion and has a focus on the welfare of anaesthetists, other colleagues, patients and the community. The award was established by Dr Brandon Carp in memory of his friend Dr Ray Hader, a Victorian trainee who passed away in 1998 due to an accidental drug overdose.

Dr Christopher Sparks, FANZCA, is the recipient of the 2020 Ray Hader Award based on his significant contribution to the pastoral care of trainees as a mentor as well as providing welfare and wellbeing support especially for the young trainees in the Pacific Island.

Dr Ray Hader Award

Dr Christopher Sparks receiving the Dr Ray Hader Award at the College Ceremony; Dr Christopher J Sparks receiving the Dr Ray Hader Award for Pastoral Care at the College Ceremony; From top: Professor Milton L Cohen AM receiving the Robert Orton Medal at the College Ceremony.
Steuart Henderson Award

The Steuart Henderson Award is awarded to a fellow who has demonstrated excellence and provided outstanding contribution, scholarship, and mentorship to medical education in the field of anaesthesia and/or pain medicine.

Dr Adam H Rehak
2021 Recipient

Dr Adam Rehak commenced his anaesthetic registrar training with Southern Health at Monash Medical Centre in 2002. During his training he also spent a year at Guy’s and St Thomas’ Hospital in London. In 2006 Adam moved to Sydney for his provisional fellowship at Royal North Shore Hospital where he was given the simulation fellow portfolio.

From this time Adam has been strongly involved in clinical simulation and education. He has been a staff specialist at Sydney Clinical Skills and Simulation Centre (SCSSC) since obtaining his FANZCA in 2007 and the lead for the anaesthesia stream of courses. Adam was the centre’s supervisor of EMAC from 2007-2018, and continues to instruct there as one of SCSSC’s most experienced instructors. He has also played a significant role in the evolution of the EMAC curriculum as a co-author in the revision of both the airway and trauma modules.

Adam has also developed and run numerous other anaesthesia courses including a difficult airway course which focuses on human factors and decision-making in difficult airway management, a suite of emergency response unit courses, and a neuroanaesthesia course. The creation of new educational programs is an aspect of simulation and education that Adam finds particularly rewarding, and one that he continues to be heavily involved in.

Adam has also made a significant contribution in shaping our current understanding of best practice in airway management. He co-authored the 2014 ANZCA report Transition from supraglottic to infraglottic rescue in “can’t intubate can’t oxygenate” (CICO) scenario which subsequently formed the basis for the ANZCA professional document P161-BP. He was a key member of the Safe Airway Society working group which published the widely endorsed statement on airway management and intubation in Covid-19 patients. He has also co-authored multiple publications in the British Journal of Anaesthesia and Anaesthesia which have largely been related to the role of human factors in promoting effective airway management.

Adam’s engaging presentation manner combined with an expertise in human factors and airway management has led to regular invitations as a speaker and workshop convenor at national and international conferences. This included his involvement in the 2019 World Airway Management conference in Amsterdam. He has been a member of the EMAC sub-committee since 2014, and is also a co-opted member of the ANZCA Airway SIG. Adam has previously been a member of the Education and Simulation SIG executives. Adam is also one of the founding members of the Safe Airway Society.

Despite his busy non-clinical and clinical schedule, Adam has always been generous with his time in providing support to colleagues. He is viewed in extremely high regard by both anaesthetic and non-anaesthetic colleagues and this is reflected in his guidance being regularly sought on challenging clinical cases as well as issues relating to human factors and communication. Adam has a reputation for treating people with honesty and integrity, and for his ability to offer insightful observations and pragmatic advice.

Adam is the type of anaesthetist you want there before the crisis, during the crisis and after the crisis. The respect he garners is not only related to his high level of technical skills and knowledge in education, debriefing, human factors and trauma management but also the humility and respect in his communication with others. He is an inspirational mentor and role model to trainees and consultants alike. It is for these reasons that Adam embodies the values of the Steuart Henderson Award.

Dr Gerri Khong

Dr Damian J Castanelli
2020 Recipient

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

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

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

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

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

Dr Jennifer Woods
Faculty's advocacy crucial for bi-national approach

“The biggest barrier to expanding high-quality multidisciplinary care into the subacute and community sector is the lack of Medicare item number support.”

Pain management health practitioner education strategy project update

The faculty-led, federally-funded project to develop a national pain management education strategy for Australian health practitioners is progressing well towards completion in December 2021. The strategy will utilise current evidence-based information to guide and promote pain management education for a broad range of Australian health practitioners, across the span of their career.

The Australian Department of Health awarded two further grants in 2020 for pain management education. The first, focusing on the development of pain management education and training programs and resources for health professionals, is being undertaken by a consortium led by the Pain Management Research Institute. The second project, led by Painaustralia, is consumer-facing and focuses on increasing the availability of evidence-based information about chronic pain for consumers. The faculty is engaged with representatives from both projects through our governance advisory group to ensure that the work is clearly aligned.

In the last Bulletin we reported on a successful roadshow comprising seven consultation workshops conducted face-to-face and via Zoom for stakeholders across Australia. The workshops were an excellent opportunity to engage with stakeholders from across the spectrum of pain care and health practitioner education. The 120 workshop participants represented a diverse range of sectors, including clinicians, educators, consumers and students, as shown below. During the sessions, participants worked in multi-disciplinary groups, brainstorming ideas to inform the strategy’s values, principles, and goals, as well as implementation considerations and recommendations.

Feedback from workshop participants illustrated that people valued the opportunity to engage with the project and with a multi-disciplinary group. While participants recognised the challenges of creating a nationally consistent approach to pain management education, they felt positive about the passion and commitment of stakeholders across Australia who are willing to work together to make it happen.

The project team are currently in the process of validating and thematically analysing the workshop data. The analysed data, along with findings from the comprehensive literature review and end-of-meninal scan completed last year, will inform the strategy writing process over the coming months. Ongoing input from a smaller, representative group of stakeholders will assist with data validation and implementation design. There will be an opportunity for stakeholders to provide input on the draft strategy more broadly when it is distributed for consultation later this year.
ASSOCIATE PROFESSOR MEREDITH CRAIGIE

Dr Craigie was elected as a new fellow board member in 2018, and took office in May that year. She has served for many years as an active service medical officer in the RAAF and has attained the rank of Wing Commander with several tours on active service. As a board member, she has brought the perspective of not just trainees and new fellows but also that of the Queensland fellowship as well as a perspective of caring for current and former serving members of the ADF. She provided open and frank opinions to the board, and was a valuable contributor to many challenging discussions. We look forward to further contributions from her as she continues her professional relationship with the faculty.

DR MELISSA VINEY

She formed a crucial part of the Curriculum Development Working Group which produced the 2015 curriculum document. This world-leading document is a specialist pain physician and trained in psychiatry as well. He is senior lead clinician at The Auckland Regional Pain Services. He is the chair of the FPM New Zealand National Committee, a member of the Learning and Development Committee, an examiner, an accreditation reviewer and a previous supervisor of training. His interests include continuing the education of new specialists to ensure the vitality of our specialty and increasing awareness and recognition for this valuable field of medicine in the eyes of rest of medical profession and public. He has two children and enjoys outdoor pursuits which include cycling, tramping and kayaking.

DR GRETEL DAVIDSON

Graduated in medicine from the University of Sydney, and completed training in anaesthesia at the Prince of Wales Hospital in Sydney, with a fellowship at Children’s Hospital Westmead. After several years as a consultant anaesthetist at both Sydney Children’s Hospital and Children’s Hospital Westmead, and completing postgraduate studies in pain management, the opportunity to complete formal training in pain medicine arose. She is currently working in both anaesthesia and pain medicine (acute and chronic) for children and adults, in public and private facilities. Her main clinical interest is chronic pain management in children, adolescents and young adults.

DR STEPHANIE OAK

She is a specialist pain physician and trained in psychiatry as well. He is senior lead clinician at The Auckland Regional Pain Services. He is the chair of the FPM New Zealand National Committee, a member of the Learning and Development Committee, an examiner, an accreditation reviewer and a previous supervisor of training. His interests include continuing the education of new specialists to ensure the vitality of our specialty and increasing awareness and recognition for this valuable field of medicine in the eyes of rest of medical profession and public. He has two children and enjoys outdoor pursuits which include cycling, tramping and kayaking.

New members co-opted to board under new process

As part of the board reforms introduced last year, a formal process of co-option was used to replace retiring board members. The departures of Associate Professor Meredith Craigie and Dr Melissa Viney opened the option for the board to co-opt up to two replacements.

Under the new process, the faculty executive developed a skills and attributes matrix for the board to guide the choice of co-opted members. The aim of adding co-option to election in the new process was to ensure that the board was adequately representative of the fellowship, and also displayed a diversity of gender, regional representation, governance skills, faculty knowledge and cognitive styles. This is in keeping with research suggesting that leadership groups which are multiply diverse make better decisions and produce more effective strategic planning.

Once the results of the board election in February were known, the nominees who were not elected from that election were automatically considered for co-option. The board then considered the diversity matrix and invited a small number of fellows to nominate for co-option. This process was conducted with high regard for confidentiality and ensured that at the April board meeting there was an exceptional shortfall of five candidates for the two co-opted positions available. Following a secret ballot, the new board members chosen were Dr Tipu Aamir (NSW) and Dr Stephanie Oak (NSW). On behalf of the board, I would like to congratulate our two new members, and thank all our nominees for providing a very high-quality field.

DR AAMIR AND DR OAK WILL JOIN THE INCOMING NEW FELLOW BOARD MEMBERS, DR GRETEL DAVIDSON (NSW) FOR INDUCTION WORKSHOPS AHEAD OF THE FIRST FULL MEETING OF THE NEW BOARD IN JUNE. EARLY FEEDBACK FROM BOARD MEMBERS WAS POSITIVE ABOUT THE PROCESS AND FURTHER IMPLEMENTATION OF THE REFORMS TO BOARD MEMBERSHIP WILL CONTINUE FOR THE NEXT ROUND OF ELECTIONS.

Meet our new board members

The board has received the resignations of two members for personal reasons. We thank them both for their service and wish them well.

DR RENATA BAZINA

Dr Bazina joined the board in 2020 and is chair of the FPM New South Wales Regional Committee, a member of the Examinations Committee and a contributor to the Procedures in Pain Medicine project. She is an examiner and supervised pain medicine trainees.

DR GEOFFREY SPELDEWINDE

He is a consultant psychiatrist and specialist pain medicine physician who is based in Newcastle, NSW. She studied medicine at the University of Newcastle, completed psychiatry training in 1998 and was elected to fellowship of the FPM in 2009 while working with the Hunter Integrated Pain Service. Since 2012 she has been actively involved with the Continuing Professional Development and Professional Standards committees of FPM and ANZCA, and designed the first emergency response module specifically targeting pain specialists in the ANZCA and FPM CPE program. Her clinical interests include pain management for people with co-morbid mental illness, improving service provision for those who live in rural and remote communities, and dizziness and wellbeing.

DR TIPU AAMIR

Associate Professor Michael Vagg

Dean, Faculty of Pain Medicine
Hitting the 10,000 target – high demand for faculty education modules

The TGA has congratulated the faculty for not only producing an e-learning package that has remained consistent with their opioid regulatory opioid reform objectives, but also for our performance in successfully reaching and influencing agreed target prescriber audiences. We are sincerely grateful to our fellowship for their professional networking efforts and “word of mouth” support, and our sincere thanks go to all those who have helped drive this educational program across their respective hospitals, clinics and university locations.

The TGA grant has provided development revenue for the faculty, enabling us to further position ourselves as a reliable and authoritative source of advice for health professionals, regulators and government. The faculty looks forward to continuing its engagement with key pain medicine groups, prescribers, allied health associations and educational institutions, to further extend the reach of the BPM education offer.

WHAT’S NEW IN BETTER OPIOID MANAGEMENT?

BPM learning product options have recently been extended to enable the creation of personalised study packages. Users can choose a selection of three or six learning modules from the BPM library and they can be bundled in a single discounted package.

Midyear the faculty is commencing work on reviewing and revising a number of key BPM modules.

Thirty-six per cent were general practitioners.

More than 60 per cent of course enrolments from prescribers and other key pain management influencers.

Seventy per cent individual course completion across all Australian states.

Thirty-six per cent were general practitioners.

Course inclusion within medical school pain management curriculums.

New user page-views on BPM website tripled to 100,000 since project commencement.

Expert Advisory Group starts work on chronic pain model of care

The Ministry of Health/Faculty of Pain Medicine Expert Advisory Group (EAG) had its first meeting in Wellington on 2 June setting the groundwork for a national model of care to cover chronic pain.

The group of 12 is made up of representatives from across the pain management spectrum. The group is investigating overseas models of care and designing a New Zealand specific system that can be used across the country.

The timing fits well with the new Health and Disability System reforms that come into place in July next year. This is when all the 20 district health boards are disbanded and Health New Zealand and the MoH Health Authority take up leadership of a national health system.

The FPM New Zealand National Committee (NZNC) chair Dr Tipu Aamir, deputy chair Dr Duncan Wood, vice FPM dean Dr Karen Park and committee member Dr Leenah Atoor attended the meeting after the FPM/NZNC, to help set up the membership of the advisory group.

Dr Aamir says the two-hour meeting made more progress than expected with the hub and spoke framework (as outlined in FPM’s Safer Pain Report on chronic pain) being seen as the best model to remedy what he says they all agreed is, “the current diabolical inequitable services that not only produce an overload of pain practitioners. The project has now been under way for almost 12 months and is due to be completed at the end of this year.

As part of the $2.5 million two other priority areas were funded, Painaustralia was awarded $1 million to support consumer education and awareness and, at the Parliamentary Friends of Pain event, launched its improved National Pain Services Directory. The revamped directory is aimed at making it easier for pain sufferers, carers and health professionals to search for appropriate pain services by location. In addition, the University of Sydney – Pain Management Research Institute is leading a $1 million project to develop pain management education and Painaustralia.

It is hoped that this launch will add more weight to the push to have chronic pain recognised as a national health priority and assist the faculty as it continues to work with governments and fellows at a national and local level to grow and improve services for Australians living with pain.

The visit to Canberra was a great opportunity for the dean and to catch up face-to-face with Painaustralia CEO Carol Bennett, local politicians, pain advocates and fellows, including Dr Chris Hayes, who made the trip down from Newcastle.

Leone English

Executive Director, FPM

On 18 May FPM Dean Associate Professor Michael Vagg and FPM Executive Director Leone English travelled to Canberra to attend Painaustralia’s annual general meeting (AGM) and the launch of the National Pain Services Directory at a Parliamentary Friends of Pain Management event.

The Painaustralia AGM heralded a change in board leadership with Major General Duncan Lewis set to take over as chair of the board from Emeritus Professor Ian Chubb AC. The meeting also saw the approval of proposed constitutional changes which will mean that ANZCA and the faculty will cease to be “category A members”, as this classification will no longer exist, and as of 1 July 2021 will be “members”.

While this change signals another phase in the evolution of Painaustralia, and brings its board processes in line with current governance practice, it also means that ANZCA and the faculty no longer have guaranteed seats at the board table. For now, faculty fellows Dr Chris Hayes and Associate Professor Meredith Craige will remain on the board as individual directors to serve their terms of office.

ANZCA and the faculty remain committed to working collaboratively with Painaustralia to promote the pain agenda at a federal and state level.

In a positive move at the Parliamentary Friends of Pain Management event that followed the AGM, Minister Greg Hunt formally launched the National Strategic Action Plan for Pain Management.

The plan outlines eight key priority areas to help address the growing burden of chronic pain in Australia. Since its publication in 2019 the plan has gained national support and the minister reported that it has now been endorsed by all Australian jurisdictions.

In 2020 the government provided $2.5 million towards the early implementation of the plan with the Faculty of Pain Medicine receiving $580,000 to develop a national strategy for pain management education for Australian health practitioners. The project has now been under way for almost 12 months and is due to be completed at the end of this year.

National Strategic Action Plan for Pain Management launch
The FPM Symposium and annual scientific meeting (ASM) programs were a great success and a tribute to the hard work of the faculty’s FPM Symposium Convenor, Dr Noam Winter. See page 55 for Dr Winter’s wrap up of the event.

COLLEGE CEREMONY
The faculty would like to congratulate its new fellows who were presented at the College Ceremony on Saturday 1 May 2021.

BEST FREE PAPER AND DEAN’S PRIZE
The faculty would like to congratulate Dr Roopa Gawarikar and Dr Megan Allen on being awarded the 2020 FPM Dean’s Prize and 2021 Best Free Paper Award.

Dr Roopa Gawarikar was awarded 2020 Dean’s Prize for her paper, “Targeting two birds with one stone: Efficacy of ketamine in pain and opioid reduction”.

Dr Megan Allen was awarded the 2021 Best Free Paper for “Opioid stewardship assessment a multicentre study of post discharge opioid use and handling in surgical patients”.

THE BARBARA WALKER PRIZE
The 2021 Barbara Walker Prize was presented to Dr Hannah Bennett by Associate Professor Newman Harris at the Queensland remote hub at the ASM. Dr Bennett was awarded the prize for achieving the highest mark in the 2020 fellowship exam.
Self matters

This edition’s column is by Dr Joanna Sinclair, anesthetist at Counties Manukau Health, Wellbeing SIG executive member, and chair of the Long Lives Healthy Workplaces Toolkit Implementation Committee. One of the biggest challenges we face is creating effective and sustainable changes within our hospitals.

As you will read, Jo has tackled this by developing relationships outside her department, particularly through executive sponsorship for her new hospital-wide wellbeing role. I’m sure that many wellbeing advocates and others will find her insights both inspirational and instructive.

As always, I welcome ideas for future columns to lroberts@anza.edu.au.

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

EVERY WORKPLACE HAS a responsibility to protect the mental health and wellbeing of its workers and reduce risks associated with mental ill-health. The global pandemic has thrown a spotlight on some of the unique stressors healthcare workers face. Despite ample evidence of the benefits of investing in workforce wellbeing, we had not made it part of “business as usual” in healthcare. When the pandemic arrived, we scrambled to put support structures in place as we recognised the added stress our healthcare workers were facing.

The Long Lives Healthy Workplaces (LLHW) toolkit, recently relaunched with new resources to assist implementation, is designed to support anaesthetists and departments to operationalise an evidence-based framework for a workplace wellbeing programme that would be business as usual. Through the LLHW implementation group I met some amazing mentors who advanced my understanding that true systems changes require executive level buy-in.

Unfortunately, many departmental wellbeing advocates still struggle to get support for wellbeing initiatives in their workplaces.

My own journey in wellbeing advocacy arose from similar frustrations. Using the Wellbeing Index, a simple tool to identify doctors in distress which has undergone rigorous multi-step validation, I surveyed senior medical officers (SMOs) at my hospital and found really high distress levels. I presented these results with the evidence on the cost of not attending to staff wellbeing, to our chief medical officer (CMO), human resources (HR) director and chief executive officer. I proposed a new role, SME wellbeing officer, with full-time equivalent (FTE) attached, to work on wellbeing issues and keep them on the executive leadership team and board agendas. The HR director and CMO became my executive sponsors and after 18 months the new role was established. I am now our hospital lead for the Health Roundtable Workforce Wellbeing Improvement Group, Schwartz Round 4, and a Stress First Aid (Peer Support) program which is in development. I work with colleagues from nursing, allied health and psychological medicine on these projects.

I also work closely with our organisational development and HR teams. I have observed that staff working in these areas have both an in-depth understanding of the organisation’s obligations to their employees’ wellbeing at work and a genuine desire to look after our staff. Most have experience predominantly outside of healthcare and so do not fully understand the unique features and stressors of working on the frontlines of healthcare. They are very worried about things like fatigue and burnout, but unpacking these issues without some context from front line staff is a challenge. On the other side, doctors and nurses are often suspicious of HR and have little interest in bridging that gap. The HR staff I work with are grateful to have a doctor’s voice at the table when planning workplace initiatives for staff.

I do not believe the “organisation” is the only problem though. Medicine also needs cultural change and that needs to come from those in practice. We have problems with gender bias, racism, incivility, bullying and a hierarchical system that still encourages and rewards self-sacrifice. Added to this, doctors are typically not great at self-compassion. If we ignore compassion for ourselves, in the end that erodes our compassion for others – our colleagues and our patients. There is overwhelming evidence that this will cost our health system dearly, through poor patient compliance with treatment plans, increased medical errors, high staff turnover or reduced FTE, increased sick leave and so on. Unfortunately, reversing this requires more effort than many of us think we can currently give.

Individuals, leaders and organisations share a mutual interest and responsibility for creating an optimal work environment and addressing high rates of burnout and job dissatisfaction in our medical workforce. In 2020, Dr Tait Shanafelt and Dr Stephen Swensen, two of the world’s foremost authorities on burnout in healthcare, published a blueprint for creating the ideal workplace. They propose eight ideal work elements for organisational resilience (Figure 1).

The Pandemic Kindness Movement in Australia’s presents for organisations who make work for their staff one of the highest priorities in their organisation.

ANZCA’s Doctors’ Health and Wellbeing Resources

ANZCA has confidential and free health and wellbeing resources for fellows, trainees, specialist international medical graduates and immediate family members including the 24-hour ANZCA Doctors’ Support Program.

This is an independent counselling and coaching service available via the helpline, online chat, app and face-to-face meetings. It provides support for a variety of work-related and personal problems that may be affecting work or home life. The Aboriginal and Torres Strait Islander People’s Helpline is also available on 1800 287 432


ANZCA’s Doctors’ Support Program (see above)

Emergency contacts

• Your GP
• Doctors Health Advisory Service
• Lifeline 13 11 14
• ANZCA Doctors’ Support Program (see above)

ANZCA ASM with a new suite of resources to assist – www.asa.org.au/llhw - recently relaunched at the ANZCA ASM with a new suite of resources to assist implementation.

References:

2. https://www.mywellbeingindex.org/product/validation
7. The Pandemic Kindness Movement, At https://sci.health, newpage/australia (Kindness accessed 31 May 2021)
What’s new in the library?

NEW RESEARCH CONSULTATION SERVICE
ANZCA Knowledge Resources has begun
a pilot for a new Research Consultation Service until the end of 2021, which aims to
develop and deliver research services to fellows, trainees, college staff and other
key college stakeholders.

A key goal of the research consultation service is to facilitate the translation of
research-based evidence about anaesthesia, pain medicine and perioperative medicine into policy and
practice.

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

The new research librarian is Kathryn Rough, who is available on Tuesdays and
Fridays.

Research related literature searches should be submitted using the Request a
Literature Search form on the library website (and selecting Purpose =
‘Research’). Kathryn can be contacted directly via email krough@anzca.edu.au.

LATEST TRIALS
ANZCA library has recently begun two
 Trials:
• Covidence is a web-based tool that improves healthcare evidence synthesis by improving the efficiency
and experience of creating and maintaining Systematic Reviews. The
Trials ends 30 June 2021.
• AccessEmergency Medicine is a comprehensive online resource covering the fundamentals of
emergency medicine. Includes leading medical e-books like Tintinalli’s Emergency Medicine, multimedia,
interactive self-assessment Q&As, an integrated drugs database and patient education. The Access EM trial ends 20
July 2021.

Google “ANZCA library trials” to access further information and provide feedback.

NEW MEDICINAL CANNABIS LIBRARY GUIDE
The library recently launched a new
medicinal cannabis library guide. The
guide has been designed for anaesthetists and pain specialists seeking more
information on how medicinal cannabis impacts anaesthesia, perioperative
medicine, and pain management. The
guide brings together a wide variety of resources, including PubMed. Statement
on “medicinal cannabis” with particular
reference to its use in the management of
patients with chronic non-cancer pain and
therapeutic guidelines. Other resources include relevant articles from clinical
journals, articles from the ANZCA bulletin, podcasts, e-books, and links to legislation
and policy regarding prescribing and
using medicinal cannabis.

Google “ANZCA library cannabis” to access the guide.

Note: The guide is not intended to endorse or support the use of medicinal cannabis,
but provide medical professionals with an introduction to the topic.

KEEPING CURRENT USING READ BY OXMD
Read by QxMD is a mobile app for
tablets and smart phones that allows you
To create a custom profile that alerts you to – and summaries – newly
published content based on your
selection of favourite journals, favourite
topics, followed collections and specific
keyword matches.

It is easy to set-up, employs an alerts-based approach to notifications,
and displays content in the style of a
personalised digital journal with full PDF
access.

You have the choice of receiving your notifications as either an email or SMS
style alert, and can connect through to
the ANZCA full-text (where available)
or submit an ILL request (where not available).

Google “ANZCA apps” to access our apps
guide for further details, including full set-
up instructions.

Recommendations: This app is ideal for tracking newly published content and for
bookmarking articles for CFD purposes.

NEW BOOKS FOR LOAN
Books can be borrowed via the ANZCA Library catalogue:
www.anzca.edu.au/resources/library/borrowing

ANZCA Bulletin
Winter 2021

New exam books
A number of new primary and exam
prep titles are now available online:
libguides.anzca.edu.au/training-hub

Covidence trial ends 30 June 2021.
The perioperative administration of
dexamethasone and infection (PADDI)
trial protocol: rationale and design of a
pragmatic multicentre non-inferiority

van Rynen Y, Sadik M, Blunt I, et al. The perioperative administration of
dexamethasone and infection (PADDI)
trial protocol: rationale and design of a
pragmatic multicentre non-inferiority


Craig A, Hatfield A, Oxford: Oxford


CRQs for the final FRCA
The Fourth ANZCA Trainee Survey confirms a high level of trainee satisfaction with the anaesthesia training program while identifying some areas for improvement. Not surprisingly, working conditions in 2020 and the need to delay examinations during the COVID-19 pandemic impacted trainee wellbeing, which was demonstrated in the survey results.

During the survey period the coronavirus pandemic significantly impacted Australia and New Zealand, with varying levels of lockdown and border restrictions across different regions. There were significant effects on trainees, both in their training through ANZCA, and also in the general wellbeing of trainees and their families.

The 2020 online survey was conducted from 12 October to 8 November 2020 and invited 1591 trainees to participate by asking trainees to comment on the preceding 12 months of training. The survey attracted 662 responses (42 per cent) and trainees were asked about the impact that COVID-19 has had on their wellbeing, their training, and their exams.

In the hospital environment, trainees experienced redeployment to other hospital units, difficulty accessing training lists, inability to access leave, a heightened requirement for personal protective equipment (PPE), and the risk of encountering COVID-19 patients.

In the training program, trainees were affected by access to specialised study units and in-person teaching, significantly delayed examinations, and delayed progression through the training program.

Due to the negative impacts of the COVID-19 pandemic, there are some elements of the survey in which declines, or increases have occurred year on year. These may not be a reflection of the ANZCA training program year on year, but are rather a reflection of measures implemented as consequences of the pandemic.

Some of the changes driven by COVID-19 have resulted in positive impacts on trainees, for example, access to more accessible digital learning. However, many of the trainees said they would have preferred more regular communication about the disruptions to the exam process caused by COVID-19.

Impact of COVID-19

- The majority of trainees have been impacted by COVID-19, particularly through delayed examinations. Of those who intended to sit exams in 2020 the majority (95 per cent) felt COVID-19 had impacted their ability to prepare for exams, and one quarter (25 per cent) have had to delay their exams due to COVID-19.
- One in two trainees (54 per cent) planned to sit exams in 2020.1 or 2020.2, and of those, only one quarter (25 per cent) agree strongly agree decided to delay their exams due to COVID-19.
- Changes to exam plans (61 per cent) had the greatest impact on their wellbeing, followed by life impacts such as cancellation of travel plans (58 per cent) and worrying about family members (52 per cent).
- Overall, trainees felt that they were adequately trained in the use of PPE (88 per cent agree/strongly agree) and had adequate access to PPE (86 per cent agree/strongly agree). However, two thirds of trainees believe that COVID-19 has impacted their volume of practice (68 per cent agree/strongly agree), and one half that COVID-19 has impacted their training time (51 per cent agree/strongly agree).

Flexible Working and Training Options

Two thirds of trainees (60 per cent) say they believe having access to flexible part-time training options is important, and of these, one in five (19 per cent) had tried to access these options.

Of those trainees who tried to access flexible working, 86 per cent were successful, agreeing that their hospital departments were supportive.

Among the trainees who had not tried to access flexible or part-time options, the increased length of training time, or being unsure what impact this would have on their training, were identified as barriers.
BULLYING, DISCRIMINATION OR SEXUAL HARASSMENT (BDSH)

The optional BDSH section of the survey was completed by 578 trainees, a response rate of 87 per cent, down slightly from 2018 and 2017. Trainees were asked whether they had been personally subjected to any BDSH in the workplace in the past 12 months.

Workplace bullying

The number of trainees who had witnessed bullying is trending downwards, with 40 per cent saying they had witnessed bullying (44 per cent in 2018, 47 per cent in 2017, 54 per cent in 2016).

Two thirds of trainees felt adequately supported to deal with bullying, discrimination or sexual harassment, but fewer had received formal education in these areas.

One third of trainees reported they had received formal education and training in identifying, managing or preventing workplace bullying, discrimination or sexual harassment.

Workplace discrimination

Claimed experiences of workplace discrimination have significantly increased since 2018, with significantly more trainees reporting they have experienced discrimination in the workplace compared to 2018 (15 per cent up from 11 per cent). The overall increase in experiencing discrimination among trainees has been driven particularly by South Australia and the Northern Territory where the proportion of trainees personally experiencing discrimination has increased to 26 per cent – the highest of all regions.

Similar to 2018 and results on workplace bullying, trainees were far more likely to know how to report or seek help regarding discrimination in their hospital department (84 per cent) and hospital (58 per cent), than through their college(s) (44 per cent) or outside bodies (50 per cent).

Workplace sexual harassment

In line with 2017 and 2018, those reporting experiencing and witnessing workplace sexual harassment are low, with very few trainees reported having experienced (5 per cent) or witnessed (7 per cent) workplace sexual harassment and no significant differences between hospital locations.

Consistent with 2018, two thirds (67 per cent) of trainees feel prepared and supported to deal with sexual harassment in the workplace. However, the number of trainees who reported having received formal training on identifying, managing or preventing sexual harassment has slightly decreased this year from 36 per cent in 2018 to 27 per cent, with all hospital locations experiencing a slight decrease.

ANZCA TRAINING PROGRAM

The majority of trainees (79 per cent agree/strongly agree) were overall satisfied with the ANZCA trainee program.

Trainees are significantly more satisfied in 2020 with:

• The overall usefulness of the training portfolio system (85% agree/strongly agree).
• The overall satisfaction with the ANZCA trainee program.
• The consultant in the department had been fair in their assessment of performance (97 per cent agree/strongly agree).
• They had been able to take leave when required (92 per cent agree/strongly agree).
• The supervisor of training had been supportive in helping to meet training goals (94 per cent agree/strongly agree).
• The consultants in the department had been fair in their assessment of performance (97 per cent agree/strongly agree).

RURAL, PROVINCIAL AND REMOTE WORK

Nearly three in four trainees have lived in a regional or rural area, with almost one in two (44 per cent) having trained for 12 months or more in these areas. While only 31 per cent plan to work in a regional or remote area after training, 70 per cent would consider working in these areas in future.

WHAT HAPPENS NOW?

The ANZCA Trainee Committee thanks all trainees for taking the time to share feedback on their training experience.

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

The survey was managed by an external consultant and a state of reports has been prepared for ANZCA to disseminate results to key stakeholders, including ANZCA training sites. Training sites have received de-identified results of the survey relevant to that site. Results have also been shared with ANZCA executive committees and committees that support trainees and the training program.
Successful candidates

Primary fellowship examination

2021.1 Exam

One hundred seventy-two candidates successfully completed the primary fellowship examination:

AUSTRALIA

Australian Capital Territory

James Marcus McCredie

Queensland

Stuart Anthony Arnold

New South Wales

Catherine Rose Epstein

Victoria

Andrew James Simpson

South Australia

Andrew Benjamin Pons

Western Australia

Daniel Joseph Pearce

Darling Anthony Melling

Northern Territory

Daniel Thomas Robertson

Australian Capital Territory

Michelle Dohah Waataki

South Australia

Rafael Weidenfeld

Victoria

Natalie Elizabeth Smith

New South Wales

Richard John Huson

Queensland

Archie Cameron Hughes

Northern Territory

Sasiree Rachel Kelly

Darling Anthony Melling

Natalie Sarah Elizabeth Smith

James Marcus McCredie

Rafael Weidenfeld

Natalie Elizabeth Smith

Michelle Dohah Waataki

Rafael Weidenfeld

Andrew James Simpson

Daniel Joseph Pearce

Sasiree Rachel Kelly

Archie Cameron Hughes

Richard John Huson

James Marcus McCredie

ANZCA PRIMARY EXAMINERS

Clockwise from left: Primary Exam examiners in New Zealand, Victoria and New South Wales, clockwise from left: Primary Exam examiners in New Zealand, Victoria and New South Wales

RENTON PRIZE

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

Natalie Sarah Elizabeth Smith, WA

MERIT CERTIFICATE

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

Neeban Balayasoderan, QLD

Louise Marie Rafter, QLD

Kieran Patrick Robinson, WA

Joseph WilliamCollinson, NZ
2020.2 Exam
Seventy-six candidates successfully completed the final fellowship examination:

AUSTRALIA

Australian Capital Territory
Amedee Kerr
Kurtis Tadeusz Zapański

New South Wales
Benjamin James Bartlett
Mark Chemali
Tejas Chikkerur

Victoria
James William Charles Ballantyne
Katherine Amelia Carroll
Maryam Khalid Cassim
Joanne Linzi Court

Tasmania
Charles Paul Noonan

2021.1 Exam
One hundred and sixty-six candidates successfully completed the final fellowship examination:

AUSTRALIA

Australian Capital Territory

New South Wales

New Zealand

2021 SIMG examination

Two candidates successfully completed the specialist international medical graduate examination:

Queensland

SIMG examination

Seven candidates successfully completed the specialist international medical graduate examination:

New Zealand

CECIL GRAY PRIZE

No candidates were awarded the Cecil Gray Prize for the 2021.1 examinaion.

MERIT CERTIFICATES

Merit certificates were awarded to:

Devin John De Groot, NZ
Walston Reginald Martis, NZ
Michael John Russer, Queensland

Natalie Hazel Paterson
Anna Julia Pozaroszczyk
Tim Nguyen
Sandeep Singh Rakhra
Nicole Paterson

Cecil Gray Prize

No candidates were awarded the Cecil Gray Prize for the 2020.2 final examination.

Merit certificates were awarded to:

Trent George Cutts, NZ
Michael Craig Waterhouse, NZ

Michael John Russer

Cecil Gray Prize

No candidates were awarded the Cecil Gray Prize for the 2020.2 final examination.

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Michael Craig Waterhouse, NZ

Michael John Russer

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Michael Craig Waterhouse, NZ

Michael John Russer

Cecil Gray Prize

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Foundations of clinical anaesthesia course for WA trainees

THE FIRST THREE-DAY Readiness for the Initial Assessment of Anaesthetic Competencies Training (RIACCT) course was held recently for WA trainees. The course aims to provide a solid foundation for introductory trainees’ (ITs) clinical practice. Adapted for the ANZCA curriculum and WA’s training needs, the RIACCT course is based upon the well-established RIACT course run for the UK’s Oxford Deanery trainees.

RATIONALE
Introductory trainees begin training with varying levels of experience. With no centralised, clinical education on the IT syllabus plus an “intimidation factor” created around the primary examination, ITs focus much of their early enthusiasm and effort on exam preparation rather than developing clinically safe anaesthetic practice. RIACCT shifts this focus back to the theatre and contributes towards the primary purpose of the IAAC—to ensure ITs can “safely work beyond Level 1 supervision for suitable cases”.

COURSE STRUCTURE
The objectives of RIACCT are:
- To provide a structured overview of core topics for ITs to “pin” their daily experiences on.
- To provide a safe environment to encourage open discussion and facilitate applying new skills, knowledge and experience to clinical situations in both case-based discussions and simulation scenarios.

Held over three days in the first three months of introductory training, each day escalates in complexity. Following a set of short lectures, trainees rotate through sets of three concurrently running sessions with four to five trainees per group. We used a combination of learning techniques including hands-on skills stations, immersive simulation and interactive tutorials to promote active learning and reflection.

MOVING FORWARD
The course ran well with very positive feedback from both faculty and trainees and we are hugely grateful for the ongoing time and effort given by the faculty at all of our hospitals. Special thanks go to Dr Archana Shrivathsa in her role as medical lead and running the Fiona Stanley Hospital component and to Dr Tania Robertson and Dr Ryan Jumper for running the Sir Charles Gairdner and Royal Perth Hospital components.
RIACCT will continue to run every six months in WA. As expected, a few minor aspects can be improved over subsequent courses, however no changes to course structure, content or methods are needed.

We are happy to share our resources and experience with anyone who is interested in extending the RIACCT course to their area so please contact us if you require more information.

Dr Michael Robbins,
Advanced Anaesthesia Trainee, Fiona Stanley Hospital
RIACCT Co-ordinator
Michael.robins@health.wa.gov.au

Dr Archana Shrivathsa, FANZCA
Medical Lead, Fiona Stanley Hospital
Archana.shrivathsa@health.wa.gov.au

www.nzanaesthesia.com #NZASM21
A coffee break with a difference

Two Melbourne anaesthetists have created a podcast that is aimed at trainees preparing for their ANZCA primary exam.

ANAESTHESIA COFFEE BREAK was developed by Dr Lahira Amaratunge and Dr Stanley Tay, both consultant anaesthetists from Western Health and honorary lecturers at the University of Melbourne. The podcast centres on the ANZCA primary exam and explores the important basic science concepts as well as tips and tricks to passing the exam.

The podcast launched in November 2020 and episodes include short answer question and multiple choice question tips, the effect of morbid obesity on the washout of volatile anaesthetics, and practice viva simulations with primary exam candidates.

Dr Amaratunge and Dr Tay describe themselves as passionate educators who are “part of the evolutionary changes in education, using digital technology to support trainee-centred constructivist learning.”

“We recognised early during the pandemic last year that online learning and social interaction through video conferencing apps had rapidly become the substitute for traditional face-to-face classes and study groups. We wanted to support this method of learning and after seeing the success of the Deep Breaths podcast by Dr Katherine Steele and Dr Kate McCrossin for the final exam, starting a podcast for the primary exam seemed like the natural thing to do,” says Dr Tay.

Dr Amaratunge who already runs a Viva Boot Camp for final exam candidates as well as a YouTube channel (ABCs of Anaesthesia), was excited at the opportunity to share his knowledge and experience in assisting trainees to pass the exam.

“The ANZCA primary exam is one of the most difficult exams in the medical system. For most of us it is our first specialty exam and the first exam that requires us to memorise a vast and potentially overwhelming quantity of information,” said Dr Amaratunge.

“Our aims for this podcast are to cover the core components of the syllabus, discuss exam techniques and interview interesting guests such as examiners and anaesthetists who have excelled in this exam. We want trainees to pass this exam on their first attempt and to do this, we want to rapidly enhance their learning curve, avoid crucial learning errors and unproductive study patterns and most importantly be motivated, productive and efficient in their study.”

The podcast is available on all platforms including iTunes, Spotify, Google and Amazon.

With more than 15,000 downloads and a global audience, Dr Amaratunge and Dr Tay believe the content they are producing is making a difference, allowing trainees to learn when it suits them.

“We have a lot to be thankful for, and we are grateful for the support of our listeners, because to know that we are making a positive difference, allowing trainees to learn when it suits them.

“We have a lot to be thankful for, and we are grateful for the support of our listeners, because to know that we are making a positive difference means the absolute world to us,” reflects Dr Tay.

Search for “Anaesthesia Coffee Break” on all major podcast sites. We invite those who share the same passion and vision as us to contribute to our podcast by contacting us at lahiraandstan@gmail.com.
Aotearoa NZASM this October

The theme of the Aotearoa New Zealand Anaesthesia Scientific Meeting (ANZASM) is ‘Ourselves, Our City, Our Planet’. The Anaesthesia Scientific Meeting (ANZASM) is hosting an anaesthesia conference that you do not want to miss.

The city is back and more revitalised city in the heart of New Zealand. Healing has been big on the agenda here, at this whanau (family) friendly conference from 27-30 October, Whakaora guides everything the organising committee are doing and everything you will experience.

“Whakaora – to heal is not just a theme,” says organiser Dr Ross-Scott Weekly. “It underpins every decision and plan we have made for this conference. There is a sense of healing that is happening for the people of Otautahi after a tumultuous decade. Hosting an exciting, innovative conference is part of that healing.”

One of the keynote speakers, Professor Carol Peden is well known for her role co-ordinating the National Emergency Laparotomy Audit (NELA) in the UK. Earlier this year, her team published the first consensus guidelines for optimal care of these patients using an Enhanced Recovery After Surgery (ERAS) approach. ERAS protocols reduce length of stay, complications and costs for a large number of elective surgical procedures. A similar, structured approach appears to improve outcomes, including mortality, for patients undergoing high-risk emergency general surgery. Dr Peden is also the chair of the American Society of Anesthesiologists’ Perioperative Brain Health Initiative.

Another keynote is Professor Daniel Sessler from Ohio who founded and directs the Outcomes Research and Education (FAER). He is an editor for the world’s largest clinical anaesthesia journal, the Anesthesia 

Dr Ben van der Griend, convenor of the 2021 ANZASM in Christchurch says this conference will be one you will always remember. “We are very fortunate and excited to be able to host this conference. We are hoping that many of you will come to Christchurch to take the opportunity to reconnect face-to-face with the broader anaesthetic community. With the trans-Tasman travel bubble established, we may even get to welcome some of our colleagues from across the ditch.”

Early bird registrations are open, closing on 26 September (https://www.nzanaesthetics.com/register). Paper or poster submissions are welcome from all delegates attending the meeting. There are three ANZCA and New Zealand Society of Anaesthetists (NZSA) prizes on offer.

Tamarki attending the ASM? Back by popular demand, on-site childcare facilities will be available for all “junior delegates” who will be accompanying you on your trip to Christchurch, but may find the scientific content of the plenary sessions a little beyond their current attention span. If your pēpi needs to be with you, you are of course welcome to bring them to all of the sessions.

Christchurch Hyperbaric Medicine unit certified for training

TE WHARE HAU o Te Hau Ota (the Christchurch Hyperbaric Medicine Unit) recently received approval for advanced training in Diving and Hyperbaric Medicine (DHM) from ANZCA’s DHM subcommittee. The Canterbury unit is one of only two in New Zealand, which, alongside the Mark Hyperbaric Medicine Unit at Waitemata District Health Board, provide hyperbaric oxygen therapy services for both acute and elective conditions for all of New Zealand. Christchurch now joins the five Australian Hyperbaric Units accredited for training by ANZCA.

The subspecialty of Diving and Hyperbaric Medicine (DHM) has two main areas. These are diving medicine, which is primarily involved in the prevention and treatment of diving-related injury, and hyperbaric medicine, the treatment of specific medical conditions with hyperbaric oxygen.

DHM in the South Island of New Zealand began in Christchurch in 1973 with a trial of hyperbaric oxygen (HBO2) to enhance radiotherapy for patients with head and neck cancers. It was also used to treat acute problems such as decompression sickness, gas gangrene and carbon monoxide poisoning.

In the late 1970s, the local diving community raised the money for a dual lock chamber, which they donated to the North Canterbury Hospital Board. The chamber operated at the Princess Margaret Hospital for 15 years. In 1995, the chamber and associated plant moved to Christchurch Hospital, allowing better access to core services such as radiology and intensive care. In 2000, permanent staff were appointed and a new rectangular, walk-in chamber replaced the old one. This achieved the goal, set back in the early 1980s, to establish the Christchurch unit as a comprehensive hospital based hyperbaric facility.

Over the years, permanent medical, nursing and technical staff were recruited incrementarily, but there has been no recognised training positions in DHM for medical, nursing or technical trainees in New Zealand. Without the ability to train the next generation of diving and hyperbaric physicians, technicians and nurses, small subspecialised areas like this tend to furl from one staffing crisis to the next.

ANZCA’s Diving and Hyperbaric (DHM) Sub-Committee put significant time and effort into developing the Diploma of Advanced Diving and Hyperbaric Medicine that became available in its current form in 2017. While this post-specialisation qualification for medical practitioners does not lead to specialist registration in DHM, it is the only one of its kind in Australasia. The Christchurch Hyperbaric Medicine Unit is also in the final stages of developing a training position for a hyperbaric technician.

The current hyperbaric fellow in Christchurch is Dr Kenneth Lo, FACEM. The Christchurch Emergency Medicine Department recently developed subspecialisation fellowship positions, one of which is in DHM. Fellows are appointed for two years with a 75 per cent/25 per cent split between emergency medicine and DHM. The benefits of having a fellow join the Hyperbaric Unit team are already apparent with a sharing of knowledge from different primary subspecialty backgrounds bringing an injection of enthusiasm and new ideas for research.

Dr Greg van der Hulst, FRNZCOG, FFRH(MNZ), DipAD(HM ANZCA)
ART OF ANAESTHESIA

The 2021 Art of Anaesthesia CME will be held on September 11 and 12 at the Hotel Realm, Barton ACT. The theme of the meeting is “The Occasional Anaesthetist” and the focus for much of the lectures will be refreshers in the main anaesthesia disciplines. We have an exciting line up of speakers on offer this year including Dr Joanne Brots (RFPA, Sydney), Professor Bernhard Riedel (Peter Mac, Melbourne), Associate Professor Forbes McGain (Western Health, Melbourne), Dr Peter Hebbard (Northeast Health, Wangaratta), and plenty of our local speakers. On Sunday morning, delegates will also be able to register to participate in ALS and CICO emergency response workshops. We have timed the meeting to coincide with the Floriade flower festival, Australia’s largest celebration of spring which showcases one million flowers in bloom throughout Commonwealth Park. Why not bring the family, stay for the weekend and enjoy a unique experience in the nation’s capital.

The course is specifically aimed at basic trainees in their first year of training or doctors about to take up training positions in 2022. The course covers many topics, from how to deal with clinical errors, to what to expect in anaesthesia training and how to look after your own welfare, all delivered in a short and informal format. The session has been such a success in previous years that many departments have made it compulsory for new trainees. Look for the flyers soon to be sent to anaesthesia departments. The course is free. Register your interest by emailing nswcourses@anzca.edu.au or phone +61 2 9966 9085.

Dr Rebecca Lewis
Convener
Dr Natalie Kent
Convener

PRIMARY EXAM REFRESHER COURSE

This is a full-time revision course, run on a lecture/interactive tutorial basis and is most suitable for candidates presenting for their primary examination in the first part of 2022.

- Monday 29 November – Friday 3 December 2021
- Northside Conference Centre, Corner Ordey Street and Pole Lane, Crows Nest NSW 2065
- $4465

Applications close on Monday 15 November 2021, if not already filled. The number of participants for the course will be limited. Preference will be given to those candidates who will be sitting the primary examination in the first part of 2022. Late applications will be considered only if vacancies exist. For further information please email nswcourses@anzca.edu.au or phone +61 2 9966 9085.

Dr Hannah Bennett
Convener

FINAL EXAM REFRESHER

The course is a fulltime revision course, run on a lecture/interactive tutorial basis and is open to candidates presenting for their final fellowship examination in 2022.

- Monday 6 December – Friday 10 December 2021
- Northside Conference Centre, Corner Ordey Street and Pole Lane, Crows Nest NSW 2065
- $825

Applications close on Monday 22 November 2021, if not already filled. The number of participants for the course will be limited. Preference will be given to those candidates who will be sitting for their final fellowship examination in the first part of 2022. Late applications will be considered only if vacancies exist. For further information please email nswcourses@anzca.edu.au or phone +61 2 9966 9085.

Dr Hannah Bennett
Convener

UPCOMING MEETINGS

NSW Spring Meeting Laura – 20 and 21 November 2021
NSW Anatomy Workshop – 21 November 2021

QUEENSLAND REGIONS

2021 ANZCA ASM – BRISBANE ENGAGE HUB AND COLLEGE CEREMONY

The ANZCA annual scientific meeting (ASM) came to Brisbane on Saturday 1 May as part of this year’s virtual ENGAGE hubs “Super Saturday”. Delegates had the opportunity to come together and network at the Pullman King George Square, with morning and afternoon sessions being broadcast on the big screen. In the evening the hub transformed into the College Ceremony. Congratulations to the 39 new fellows of the college, and the three new fellows of the Faculty of Pain Medicine who were presented in Brisbane. Well done also to Dr Hannah Bennett who was awarded the Barbara Walker Prize for achieving the highest mark in the 2020 pain medicine fellowship exam. The evening concluded with light refreshments and a chance for family, friends and colleagues to celebrate this tremendous achievement.

Many thanks to Dr Sean McM anus, Dr Christopher Stornell, and Dr Paul Lee-Archer for hosting the ENGAGE hub, and also to Dr Sean McM anus, Associate Professor Newman Harris, and past president Dr Genevieve Goulding for presenting at the College Ceremony.

PRIMARY EXAM REFRESHER COURSE

The primary exam refresher course was held from 31 May to 4 June at the Souths Leagues Club, West End, attended by 34 trainees. This week-long interactive course was designed to help candidates prepare for the primary exam in August, and included practise short answer questions. Special thanks to course convenor Dr Bronwyn Thomas, and to all presenters for contributing their time and expertise to this course.

About Course convenor Dr Bronwyn Thomas presenting to Queensland trainees.

Photo credits: Scene to Believe

Dr Bronwyn Thomas presenting The Barbara Walker Prize to Dr Hannah Bennett.
South Australia and Northern Territory

BIENNIAL NORTHERN TERRITORY ACE CONFERENCE

The 2021 NT Anaesthetists Continuing Education Conference “Clever Clever in the Never Never – Improving perioperative outcomes” was held at the Darwin Convention Centre on 5 June 2021. Delegates took the opportunity to network, share ideas and face to face to examine the themes of perioperative optimisation and improving perioperative outcomes.

Keynote speaker Professor Gray Ludbrook presented “The hidden pandemic” discussing current and emerging initiatives in the field of early postoperative care and strategies to improve outcomes and value in healthcare. Professor Ludbrook also spoke on “Back to the future” outlining the processes of developing therapeutic goods, some perspectives of what it takes to develop these and how clinicians and jurisdictions consider new drugs and devices when planning their care delivery.

During the afternoon, delegates had the opportunity to choose from two emergency response workshops – Advanced Life Support and Can’t Intubate, Can’t Oxygenate. Dr Allan Cyna also presented a workshop “Wizard ways with words – the hitchhiker’s guide to hypnotic communication in anaesthesia” which provided a “how to” guide to therapeutic communication for anaesthetists when the usual strategies aren’t working. Challenges addressed included severe needle phobia, communicating calmly to the extremely anxious, soothing words in acute and chronic pain management and adjunctive communication techniques in paediatric burns and obstetric anaesthesia.

Delegates and partners enjoyed some Top End hospitality at the end of the day at the alfresco conference dinner, watching the glorious sunset.

Delegates and partners enjoyed some Top End hospitality at the end of the day at the alfresco conference dinner, watching the glorious sunset.

COLLEGE CEREMONY

The SA/NT College Ceremony held at the Adelaide Intercontinental Hotel on 29 April 2021 was a special occasion for our new fellows and a wonderful opportunity to celebrate together with family and colleagues.

COLLEGE CEREMONY

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The ceremony held simultaneously around the country (except for WA due to a last minute outbreak). The ceremony in Hobart was held on Saturday 1 May at The Hobart Function and Conference Centre on Elizabeth Pier. This provided a sparkling waterfront outlook for the three new fellows presenting: Dr Nathanial Jackson, Dr Nicola Delaney and Dr Shrin Jamshidi with Dr Lia Freestone, Chair, Tasmanian Regional Committee hosting the event.

Dr Nicola Delaney was thrilled that her parents in Christchurch were able to watch the ceremony live from Melbourne as well as the ceremony in Hobart. The event was a special occasion for our new fellows and a wonderful opportunity to celebrate together with family and colleagues.

TASMANIAN REGIONAL COMMITTEE (TRC)

The committee last met on 29 April 2021 via Zoom, which has become the standard mode of meeting. For the first time in three years, the Tasmanian ASA Committee of Management also held their meeting on the same night. Both committees plan ACE meetings together and share the CME officers and welfare officer positions. Dr Lia Freestone, Chair of the Tasmanian Regional Committee outlined that as both committees have a strong history of working collaboratively together, holding the meetings on the same night, five times a year makes a lot of sense and ensures continued close collaboration.

The TRC has had quite a few recent changes with Dr Andrew Messiner stepping down as safety and quality officer which he has undertaken since 2013. Dr Pravin Dahal has recently taken over this role. Dr Joanne Samuel has stepped down from the CME role and has been replaced by Dr Sam Walker. Dr Margo Pear is no longer working at the North West Regional Hospital and is currently working at the Royal Hobart Hospital. Although ANZCA councillor and Committee of Management member Dr Lia Freestone provided strong representation for north west Tasmania, the TRC is seeking a new west representative and welcome anyone from the north west who would like to join. Strong regional representation is a priority for the TRC to ensure equitable and accessible representation throughout Tasmania.

On behalf of members of the Tasmanian Regional Committee I thank those leaving the committee for their valuable time and support over the years. I also thank new members joining the committee for their time and support and outlined how important it is, especially in smaller regions to have dedicated passionate members to contribute to the work of the committee.

Dr Lia Freestone
Chair, Tasmanian Regional Committee

WINTER MEETING IS COMING UP

Check out the Tasmanian Winter Meeting that is coming up on Saturday 21 August 2021 at Barnbougle. This will be the third time the meeting has been held there and has proven to be a popular destination. The theme “Links to the future” explores topics and examines challenges that the future holds in relation to pediatrics, the environment and sustainability, both on a personal and professional level.

This is being held in a stunning location in north east Tasmania, where you will have the opportunity to relax with colleagues, enjoy the sunset over the Bass Strait and either golf or explore the local award winning wineries nearby on the Sunday.

Check the 2021 Tasmanian Winter Meeting webpage on the college website for details and registrations. If the meeting is full please e-mail tas@anzca.edu.au to add your name to the waiting list. With changeable restrictions, you may be able to come.

TASMANIAN ASM

After the success of this year’s meeting, planning for the Tasmanian ASM 2022 is well under way. Convener Dr Jana Vitenkovska and Dr Stephanie Cruice are planning another dynamic meeting on “Making connections” that will run the weekend of 26-27 February 2022. Mark it in your calendars with registrations expected to open November 2021.

Dr Sam Walker
CME Officer, Tasmanian Regional Committee

Tasmania

COLLEGE CEREMONY

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TRAINEE COMMITTEE

The Tasmanian Trainee Committee would like to congratulate candidates Dr Lisa Allan and Dr Birin Chan in the most recent primary exam. The 100 per cent success rate continues Tasmania’s strong academic performance over recent years and reflects well on both trainees and supervisors. Successful candidates who sat the exam, all candidates have achieved an invitation to the viva and we wish those sitting all the best. The new medical viva format has been well received by candidates and it’s pleasing to see the adoption that departments have shown in preparing practice exams for those sitting. Exam preparation in general continues to impress in Tasmania with organised viva practice sessions being successfully run for both examinations – thank you to all those involved.

The committee was pleased to see the interest shown in the TRASK environmental stall hosted at the Launceston General Hospital in April and hope to run similar events around the state in the future.

Dr Dylan Skjeka
Deputy Chair, Tasmanian Trainee Committee

FPM UPDATE

Tasmanian anaesthetists should be aware that there are plans to transition from the current Tasmanian Real Time Prescription Monitoring System (RTPM) DORA to a national system. The new system is due to be rolled out later this year.

FPM is leading a project to develop a pain management education strategy for Australian health practitioners, funded by the Department of Health’s Public Health and Chronic Disease Program. Tasmania was well represented in a recent stakeholder consultation forums and some representatives will continue their representation into the future.

March saw the annual state-wide Acute Pain Day being held for anaesthesia registrars in the north and north west of the state.

Dr Nina Loughman
FPM representative, Tasmanian Regional Committee

ANZCA Bulletin

Winter 2021

From top: Dr Lia Freestone; Dr Andy Burch and the 16 new fellows, including Scott Ma and ANZCA staff were delighted to congratulate and celebrate the SA/NT College Ceremony held at the Adelaide Intercontinental Hotel.
UPCOMING COURSES AND EVENTS

Melbourne Winter Anaesthetic Meeting
Plans are progressing for this year’s meeting to be held on the last weekend in August: Saturday 28 August (an online scientific meeting during the day, followed by a face-to-face dinner in the evening at the Sofitel Melbourne on Collins) and Sunday 29 August (Emergency Response Workshops to be held face-to-face at the Sofitel). Further details to come. Save the date in your calendars!

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

Exam prep course dates
• Final Refresher Course (Monday 19 to Friday 23 July)
• Final Anatomy Course (Monday 26 July)
• Final viva practice nights (Monday 4, Wednesday 6, Monday 11, Wednesday 13, Monday 18, Wednesday 20, Monday 25, Wednesday 27, Monday 31 July, Tuesday 2 August)
• Final Refresher Course (Monday 13 to Friday 26 August)

We plan to offer our refresher courses face-to-face at the college with the option to also dial in for those that are unable to come in person. Should lockdowns restrictions prevent us holding face-to-face we will move to a full online delivery. Please contact us should you wish to express interest in attending either of our courses events by emailing vic@anzca.edu.au or phone +61 3 8517 5313.

Attention trainees!
You can contact the members of Victorian Trainee Committee confidentially if you have any queries or concerns that you would like to discuss with a member of the Victorian Trainee Committee. You are welcome to contact them direct via their private email, viaanaestheticstrainers@gmail.com.

PPE IN THE OPERATING THEATRE

2020 was the year of the rat and it was also the year that COVID caused a hole in our comfortable approach to PPE in the operating theatre. Like the rest of the anaesthesia community, early on we saw the slowly moving tsunami of destruction moving towards Australia. Colleagues around the world getting sick, unable to protect themselves due to the world-wide shortage of N95 masks and adequate PPE. At St Charles Gardiner Hospital, we took a slightly novel approach researching viable reusable N95 options. We landed on the Australian-made Clean Space Halo PAPR and haven’t looked back.

These PAPRs were potentially provided essentially an unimpeachable, high level (99.9 per cent) protection to wearers. We quickly moved to secure units in the department and set about getting them accredited for use in the hospital. This involved a number of departments including OSH, infection control and CSSD. Eventually a guideline was developed and signed-off on. This has paved the way for a roll out of these devices in other departments and WA hospitals.

In addition, we had to learn and train staff in the correct donning and doffing technique. There is a steeper learning curve to using this device than with most N95 masks but the benefits (comfort for use when worn for long periods, high level of protection, reusable) certainly made it worthwhile.

The health department has now purchased additional units and these are being made available to other hospitals around the state. We are proud of our foresight in securing these devices and despite the work required in developing an approved guideline, can see the future benefit in providing higher grade protection of staff.

Dr David Kingsbury, Dr Scott Sargent, Dr Bridget Hogan, Dr Cat Goddard and Dr Tania Rogerson
St Charles Gardiner Hospital

WA ACE CONFERENCES

The WA ACE Country Conference 2021 “All the small things” will be held from 29-31 October at the Pullman Resort in Bunker Bay and is convened by Dr Chris Gibson and Dr Paddy Cowie from the Perth Children’s Hospital with the WA office.

Dr Benjamin Halkit will be speaking on TIVA for kids, Dr Priya Thalayasingam will present on scarred kids and anxious parents and Dr Chris Gibson, Dr Marlene Johnson and Dr Ian Forsyth will present an airway case-based discussion. Jon Mould will provide a paediatric advanced life support workshop and Dr Tom Fleet will provide an airway workshop.

The social calendar includes a welcome dinner at the Pullman Resort and an evening at Bunkers Beach House. A mini-conference for children will be held on the Saturday afternoon with more details to come!

FINAL EXAMS

Trainees from the 20.2 and 21.1 sitting set their final examinations at the Perth Convention Centre from 28-29 May. It was an immense week for all involved and would not have been possible without the tireless efforts from the examiners and the WA office. Congratulations to all of the trainees!

FINAL EXAM PREPARATION COURSE

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

RECENT COURSES AND EVENTS

A series of evening sessions were hosted for our trainees to attend viva practice nights over 12 nights in April and May. One was held onsite at Western Health and others were held online via Zoom. The breakout room function was used to run sets of viva practice over the duration, typically with two-to-three candidates to one examiner in each room and groups would rotate to have a different examiner each set. Each set would give a trainee a chance to have a go at a viva while others observed. Thanks to all the hospitals and staff that contributed to these nights.

We were thrilled to be able to hold our first face-to-face course at the college after COVID lockdowns and restrictions. The Primary Refresher Course was held in May and we had a hybrid set up where trainees were able to come onsite and/or join online via Zoom to watch the presentations. Unusually COVID-19 restrictions resulted in the last few days of the course being fully online. Over the two weeks there were 28 presentations that were tailored to assist with preparation for the primary exam. Each one was recorded giving trainees the option to continually review in the lead up to their exams. Many thanks to the trainees that joined, and special thanks to all the presenters, the viva examiners and convenor Dr Adam Skinner for their time and commitment to this course.

The Victorian Anaesthetic Training Committee held an information evening meeting at the college on Monday 24 May. Presentations were given on the selection process and from each of the four rotations (Eastern, Monash, North Western and Regional) that form our rotation scheme to give an overview of their hospitals and facilities they can offer. More than 140 attended either face-to-face or online via Zoom. Many thanks to the committee chair Dr Tamir Ward, the presenters, rotation supervisors and supervisors of training that contributed to the evening.

A supervisors of training meeting was held in early June. The group was welcomed by our education officer team – Dr Alex Henry, Dr Tim McIver and Dr Dina Rouxerus. The program included two educators workshops “Feedback to enhance learning” and “Planning effective teaching and learning”, updates from the Education unit and competencies based medical education project group, a talk on “Helping the previously unsuccessful candidate to re-sit the (final) exam” by Dr Craig Noonan and an opportunity to ask the DPA questions with Dr Maggie Wong. The next meeting is scheduled for Tuesday 9 November. It will be another full day meeting with two educator workshops modules and the plan to hold a dinner in the evening (should restrictions permit).
Joint SIG success

For the first time the Airway Management, Obstetric Anaesthesia and Perioperative Medicine Special Interest Groups held a one-day virtual meeting on Thursday 29 April. The meeting included well known international speakers Professor Monty Mythen (UK), Professor Ranami Moonesinghe (UK), Associate Professor David Healy (USA), Associate Professor Lisa Lefert (USA), Dr Louise O’Brien (USA) and Dr Imran Ahmad (USA) and plenty of outstanding local speakers. With more than 370 registrations the meeting was a great success and we look forward to working together in the future.

We’re excited to announce these upcoming events

For further information on the meetings, please contact events@anzca.edu.au.

We're excited to announce these upcoming events
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Significant Reduction in Post-surgical Mortality

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<thead>
<tr>
<th>Year</th>
<th>Control Group</th>
<th>Experimental Group</th>
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<tr>
<td>2013</td>
<td>Retrospective Control (n = 9,285)</td>
<td>No GDT algorithm or Masimo technology implemented</td>
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<tr>
<td>2014</td>
<td>Prospective Control (n = 5,856)</td>
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<tr>
<td>2014</td>
<td>Prospective Experimental (n = 3,575)</td>
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<td></td>
<td>&gt; Post-surgical mortality was 33% lower at 30 days and 29% lower at 90 days</td>
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<tr>
<td>2015</td>
<td>Post-Study Observational</td>
<td>GDT algorithm implemented without Masimo technology</td>
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<td></td>
<td>&gt; Mortality rates rebounded to pre-study levels</td>
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