Beyond city limits: Working wild in the NZ West Coast

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

Exploring the virtual world of the 2021 ANZCA ASM

ANZCA
Australian and New Zealand College of Anaesthetists & Faculty of Pain Medicine
WINTER 2021
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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 nimble 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. In 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 health strategies, reflected in governments’ health strategies. This has flowed through to the collective raised the importance of good public management and unity of national responses.

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 L exams 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 30). The result was a meeting whose benefits will extend well into the future. Attendees could watch sessions “on demand”. The halls 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.

My thanks go to the chairs of the sessions, the presenters, the Events team, and the IT people for making it happen. Ninety-five hours of continuing professional development, available to the highest calibre is nothing short of amazing. I make special mention to the airway can’t intubate, can’t oxygenate or CICO workshop leaders, who completely reimagined how it could be presented virtually, and succeeded handsomely (see page 58).

ANZCA Council is looking forward to getting our other “big ticket” items under way. 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 longstanding informal relationship between five international colleges of anaesthesiology now has a structure to support joint research and other projects. The Royal College of Anaesthetists (UK), the Royal College of Physicians and Surgeons of Canada, the College of Anaesthetists of Ireland, the Hong Kong College of Anaesthesiologists, and ANZCA have come together as the International Academy of Colleges of Anaesthesiologists - mercilessly shortened to IACA.

IACA’s first project was a virtual conference to consolidate and share the lessons learned from the COVID-19 pandemic, for the future of anaesthesia and critical care. It ran from 15-17 June UK time, and 16-18 June for Australia and New Zealand (see page 11). We were well represented on the conference scientific organising committee by Professor Dave Story and Dr Helen Lindsay. Presentations include a review of the papers that changed practice, ICAU best practice, communication in a pandemic, SARS-Cov-2 sequencing to understand transmission, what we understand about long COVId, and the pandemic’s aftermath.

Speakers included epidemiologist Professor Sir Michael Marmot, Executive Director of the WHO Health Emergencies Programme, microbiologist Associate Professor Stoxurie Wiles ANZCA (New Zealand of the Year), Clinical Associate Professor Nick Coatsworth former Deputy Chief Medical Officer Australia, Professor Kristine Macarney, Director of the National Centre for Immunisation Research and Surveillance Australia and Professor Steve Shayer of Stanford University.

MEETINGS

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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 Bennett FANZCA (NSW)
  For significant service to medical education, and to hyperbaric medicine.
• Dr Nigel Ronald Jones FRACS, FFPMANZCA (SA)
  For meritorious service as a specialist anaesthetist and hyperbaric medicine.
• Colonel Susan Kaye Winter FANZCA CSC
  For meritorious service as a specialist anaesthetist and as a specialist medical advisor to the 2nd General Health Battalion, 3rd Health Support Battalion and Army Health Services.
• Dr Scott Comber Forsey FANZCA (NSW)
  For service to medicine as an anaesthetist.
• Dr John David Paul FANZCA (Tas)
  For service to medicine, and to history.

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Recordings of presentations can be found at www.rcoa.ac. au. Those enrolled can watch the sessions on demand, at a time of their choice. Declaration of interest: I have succeeded Dr Brian Kinirons, President of the College of Anaesthetists of Ireland, as the chair of the academy.

AND FINALLY…

Being able to visit ANZCA’s Melbourne base, and especially Ultimo, for the first time in 15 months has brought home to me how much I have missed the camaraderie and sense of purpose that lights 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
Challenges still ahead but small steps are positive

AS WE ENTER the middle of 2021 it’s hard to see where the year has gone as we continue to emerge from the effects of COVID-19 that we experienced in 2020. The “new norm” remains a challenge and there is still a degree of uncertainty for the college and the community, especially in the context of what is happening globally and the devastating experiences of so many countries.

As a college we learn a lot over the past 15 months and have incorporated much of this into our college activities. The recent ANZCA Animal Scientific Meeting was a first, a virtual event with nearly 2000 delegates from as far afield as Europe and North America watched 95+ hours of live and pre-recorded sessions online over eight days. Almost all delegates participated in 75 online workshops and 135 delegates registered for the fully virtual FPM Symposium. A further 350 registered for the joint special interest group meeting, FPM Symposium. A further 350 registered for the fully virtual ANZCA Annual Scientific Meeting was presented in person or virtually for the training program has required changes to regulations.

The past year’s experiences have amplified the pressure on many individuals, families, friends and workplaces which has impacted on relationship dynamics. In many ways this has been a strength, however unfortunately for some it has been a real challenge. For me it has highlighted the importance of teamwork and the support and work that so many people undertake tirelessly, and often without recognition on a daily basis, and the personal cost that comes with this.

Some of the pressures of the past year have resulted in added stress levels in the workplace and on professional lives and relationships. The recent results for ANZCA in the Medical Board of Australia’s medical training survey highlighted that of the 41 per cent of our trainees who responded to the survey, 22 per cent had experienced bullying, harassment or intimidation and 38 per cent had witnessed it.

This was also recognised in the ANZCA trainee survey (see page 77) conducted in the later part of 2020 which had a 42 per cent response rate. Our survey showed that 24 per cent of respondents had personally experienced bullying in the workplace with 40 per cent having witnessed it. Pleasingly, our survey showed a downward trend in reports of these behaviours compared to 2016. However, it shows we have more work to do to address this issue.

The prevalence of workplace bullying and harassment is still a disturbing reality for many and as a college it is something we need to recognise and address with the aim of zero tolerance for this behaviour. At present within the college there is a body of work being undertaken to consider what actions can be put in place to address these issues.

In late 2020, ANZCA updated its “Policy on bullying, discrimination and harassment for fellows, trainees and specialist international medical graduates acting on behalf of the college”. The college considers bullying, discrimination and harassment to be unacceptable behaviours that will not be tolerated under any circumstances. It is acknowledged that some of these situations relate to the employee-employer relationship where ANZCA does not have any authority to take action, however there are ways the college can provide support and advice.

Complaints are managed in accordance with the colleges “Notifications and management of complaints and concerns policy” (see the ANZCA website). If you have experienced or have observed inappropriate behaviour by a colleague representative please bring it to our attention by completing our confidential online form which can be found at onlineapplications.anzca.edu.au/#/login. All notifications are treated as confidential and complaints are managed in accordance with the college’s “Notifications and management of complaints and concerns policy”.

We have continued to refine and build on our experiences. This year we have had to revert to the online option for our Western Australian trainees as a result of local travel restrictions. The obvious impact on the training program has required changes to be adopted by the college, including changes to regulations.

Letter to the editor

ANZCA Staff Recognition Awards

ANZCA fellows should be aware of several unenforceable 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 give one mode of administration favoured status and to deny patient choice.

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 limits discussion, conversation, atmosphere, and ambience.

But this mode is not supported by statewide pharmacies.

Separate authorisations for self-versus practitioner-administration mean that once self-administration is stated, the practitioner cannot intervene. If the procedure fails, the person must be allowed to awaken. However, uncommon, 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 airway obstruction that is a complication of unconsciousness.

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

ANZCA Staff Recognition Awards

College staff have been recognised for achievements in 2020 in the annual staff awards presented by CEO Nigel Fidgeon at ANZCA House in April.

The aim of the Staff Recognition Awards program is to recognise excellence in service delivery and to acknowledge those who have achieved outstanding results that have contributed to ANZCA’s priorities and objectives and/or had a significant impact on work colleagues and others in the college community.

- The winner of the Staff Excellence Award for Innovation or Process Improvement was Moira Besterwitch, Co-ordinator, Primary & DMH Exams.
- The winner of the Team Award was IT Operations – ZOOM and COVID. Team members were Alvin Choon, Kathryn Cooper, Anthony Lam, Christopher Reay and Rima Wassell. The judges also awarded highly commended certificates to Alacia Hamilton – Innovation and Process Improvement and the Website Project Management Team – Alan Dicks, Eric Kuang and Rima Wassell.

Pemobutazone is widely accepted for both oral and intravenous administration and works without a muscle relaxant. Yet, for reasons unrelated, 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 both that decision on information provided by the patient.

Methadone can be used for co-induction with propofol, yet lentanyl, with equally useful actions, cannot be used. Failure to recommend an intravenous induction常务 is for all cases, and a given 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 have had next to no influence on its legislation or implementation. It is hoped this letter will encourage more interest.

Dr Peter G Rehan, ANZCA (retired anaesthetist from WA)

Voluntary Assisted Dying – Time to take more interest?

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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, anaesthesiologists 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 *WA 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”.

Medicinal cannabis to treat lower back pain was supported by the ever-growing number of ANZCA councilors and FPM board members with active accounts. Our Facebook account has almost 6,000 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. Our social media channels were an important way for us to communicate with more members and promote the college and our achievements more widely than ever. ANZCA now has well-established and active profiles on all the key social media platforms; meaning we’re connecting and reaching 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 MJA Insight 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 lower 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 FANZCA Dr Paul Scott was interviewed for a *Ten News Brisbane* segment on 7 May about his safety shield invention for ventilating patients with beards and retied Melbourne anaesthesit Dr Bob Smith and FANZCA 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.

Carolyn Jones Media Manager, ANZCA

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 CleanUp” story with Dr Kerim Wyss, discussing how he found alternatives for blueys to help reduce waste in his 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 for our Gender Equity Subcommittee. These videos can be found in our #IWD story highlight on our Instagram.

Unsurprisingly, doctors' health and wellbeing continues to cause 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 followers 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 638 Tweet impressions and posted 294 tweets from both the ANZCA and FPM accounts. Our mentions are supported by the ever-growing number of ANZCA councilors and FPM board members with active accounts.

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Website update

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 yet with another “new normal.”

**WHAT WE’VE DONE SINCE GO-LIVE**

After fixing a few inevitable glitches, our first priority was to follow up on the frustrations some of you were finding with the new user experience (UX) or user interface (UI). Although the new site received an overwhelmingly positive response from our members, in the eight-week formal feedback period about 80 people identified issues. Most were around navigation and not being able to find content. We made a number of notable changes to the navigation and other front-end functionality, including fewer moving components; less sensitive other front-end functionality, including finding the time to familiarise yourselves yet with 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 or 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 under way 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.
ANZCA 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.

Medicare and telehealth
- $11.7 billion in new and amended items on the MBS (around 56 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 conjunction 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, Epidolex (cannabidiol) has been included on the PBS for use in the treatment of Dravet syndrome.

Digital health
- $361.8 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 ($151 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.

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.

District health boards to be abolished
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 (CMA), 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 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 system. Te Tiriti o Waitangi and cultural safety will need to be at the heart of the charter, and CMA 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 dismantling the system. It had also not given the recommended MHA any commissioning 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, Riti Rikihana and Senior Policy Advisor, Renaldo Christians attended a meeting with the Minister of Health as well as senior officials from the Transition Unit, the group responsible for implementing the recommended changes. The minister was asked specifically to comment on improving equity as well as DHB funding in relation to current budget deficits. The Transition Unit will meet with ANZCA to further discuss our views on promoting equity in the system.
Submissions

The college prepares submissions and makes representations to government and other stakeholders on a range of policy initiatives and inquiries, many of these in response to requests for college feedback and input. Our submissions to public inquiries are available on the college website following the inquiry closing date. Note that some inquiries and requests for college input are confidential.

AUSTRALIA
- Australian Commission on Safety and Quality in Health Care: Draft Credentialing and Definition of Scope of Practice for Decision Making Framework.
- Department of Health: Consultation on revised regulatory principles for the Health Practitioner Regulation National Law.
- Australian Resuscitation Council: Consultation on draft diploma for interventional radiology.
- Skills IQ: Consultation on draft diploma of anesthetic technology and practice qualification.
- Therapeutic Goods Administration: Repurposing of prescription medicines.
- ANZCA and Government – Building Relationships: ANZCA AND GOVERNMENT – BUILDING RELATIONSHIPS

NEW ZEALAND
- Medical Council of New Zealand: Proposed Council fees and disciplinary levy.
- Ministry of Health/Maori Health Authority: Conducting medical assessments for third parties.
- Ministry of Health/Ministry of Health: Smokefree Aotearoa 2025 action plan.
- Pharmac/Te Pātaka Whaioranga: Support for reclassification of hyalase as a prescription medicine.
- Skills IQ: Consultation on draft diploma for interventional radiology.
- Royal Australian and New Zealand College of Radiologists: Standards of practice for interventional radiology.
- Royal Australian and New Zealand College of Radiologists: Repurposing of prescription medicines.
- TGA: Repurposing of prescription medicines.
- Anzca and Government – Building Relationships: ANZCA AND GOVERNMENT – BUILDING RELATIONSHIPS

ANZCA PRESIDENT
Dr Vanessa Beavis and college colleagues 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 rimmons, 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 from 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 Professor Siouxsie Wiles MNZM (New Zealand), Anaesthesiologist Associate Professor Souzie Wiles at the University of Auckland, 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.”
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
- PFM, 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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Dr Wilga Kottek
Anaesthetist, VIC
Dr Peter Roessler explains ANZCA’s professional documents using practical examples. In this edition he addresses after-hours rostering.

It has been said that growing old is unavoidable but growing up is optional. I have yet to exercise that option! Realizing 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?”

Benmarks 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”. According to Dr Roessler, 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 convey his opinions. How would you respond?

What would you do?

Wherever there appears to be competing needs there is the potential for conflict. Conflict resolution (101) (my version) dictates that redirecting perceptions of competition (you and them) towards perceptions of unity (we) reconfirms 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 tofu to the rescue PS43 Guideline on fatigue risk management to anaesthesia practice recognizes and identifies the risks of fatigue.

It is a recognised concern for all anaesthetists irrespective of age and stage of career. Fatigue risk management is always tempered by the college’s responsibility as the agent for the Medical Board of Australia and the Royal Australian and New Zealand College of Anaesthesiologists (RANZCA) 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 quaternary centre accredited for AH in order to retain their appointment.

What would be the impact in a regional centre where services are provided by a small number of FANZCA’s (either visiting or locum)?

What would be the impact in a regional centre where services are provided by a small number of FANZCA’s (either visiting or locum)?

Bearing that in mind I have exercised the option! After considering the balance was struck between the prime responsibility as the agent for the Medical Board of Australia and the Royal Australian and New Zealand College of Anaesthesiologists...
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 sub-optimal patient care and even direct patient harm in some cases.

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 sub-optimal patient care and even direct patient harm in some cases.

It 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 and this kernel of optimism provided an emerging sense of purpose as I left the intervention and began my rehabilitation process.

Could I return to clinical anaesthesia? I was fortunate to have the support to consider this option and decided to attempt a return. I knew it was a risk however, with as many as 10 per cent of anaesthetists who return to theatre suffering a fatal relapse. Willpower had failed me in the past, but things had changed. It was no longer a secret, I could talk openly about how I was feeling, there would be a support structure around me, and I would be subjected to regular and random toxicology screening.

This latter measure would be key for me, in providing a psychological safety net. A phased return was implemented, and a strategy enacted to ensure key individuals in the department were aware and available.

My colleagues were immensely respectful and supportive which helped to allay my anxieties as I had feared the opposite reception. As the days turned to weeks and months, I consolidated normal practice and left each day feeling satisfied and content rather than anxious and remorseful.

Journaled was an important aspect of my recovery and formed the basis of the article published in Anaesthesia and Intensive Care (DOI: 10.1177/0310057X20969704). Writing the article was an incredibly therapeutic and satisfying undertaking, which has helped my recovery immeasurably. Since its publication, I have received correspondence from around the world thanking me for publicising this issue and helping to initiate important conversations around wellbeing and support. I hope that by telling my story, others in similar situations will see that there is a way through.

Help is available – ask for it.
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. However, while this has happened, the number of complaints that we are aware of has been fewer than expected. We are awaiting information from AHPRA as to whether there has been a rise in reports of patient abandonment through regular prescribers abruptly ceasing medications.

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, paradoxically, an increased likelihood of requiring a dose increase to maintain the same quality of analgesia. 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.
A bowtie analysis of infrastructure and system incidents

Recently published electronic Persistent Pain Outcomes Collaboration (ePOCC) data suggest that multidisciplinary pain services remain by far the most effective way to achieve the optimal outcome of both opioid dose reduction and improved quality of life. As a faculty we will continue to maintain our position that regulatory changes to opioid prescribing are a very blunt tool, and need to be very carefully considered and implemented. Future regulatory reforms need to be thoroughly socialised with consumer and clinician groups and, critically, must be linked to dramatically increased funding and innovative models of care.

While the ePOCC data do show significant benefit from multidisciplinary pain services, a disturbing detail is the enormous dropout rate from such services. Planning is needed to avoid turning pain services into surrogate addiction services for drugs that we usually prescribe only sparingly. It will be a significant challenge to manage this surge in referrals for opioid reduction without turning these patients into “second-class pain citizens” who are being seen only to reduce their doses without engaging with the full range of available treatments on offer. Properly funded services, that are comprehensive in scope, are the only meaningful public health response to the wicked problem. Firstly only one thing is dealt, that more of the same inaction by governments in this respect will just result in more of the same poor outcomes for our patients.

Associate Professor Michael Vaugh Dean, Faculty of Pain Medicine

College response to regulatory changes in relation to opioids prescribing

The recent Therapeutic Goods Administration (TGA) changes to opioids 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, PM01 was transmitted into PS01(PM) Statement regarding the use of opioid analgesics in patients with chronic non-cancer pain (foreground 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 “inherited” 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 cancer 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.

Infrastructure and System Bowtie Diagram

IN THIS EDITION of the Bulletin, a bowtie analysis has been performed on the incidents involving infrastructure and system factors among the first 8000 incidents reported to webAIRS. This main category of incidents accounted for 4.8 per cent of the first 8000 reports in an initial interim analysis. For those readers not familiar with the bowtie diagram, the on-demand session named “WebAIRS: incident reporting – new concepts using incident analysis to improve safety and quality”, released at the ANZCA Annual Scientific Meeting (ASM) in April 2021, will be available for a further 12 months via the ANZCA ASM virtual portal. anzca.edu.au/virtual-delegate/ Please log in using your existing ANZCA ASM registration link or alternatively register using the portal before 31 July.

A comprehensive explanation is also available in the article “Unanticipated difficult airway events: a systematic analysis of the current evidence and mapping of the issues involved using a bowtie diagram” published in Australasian Anesthesia in 2019. The left side of a bowtie diagram is designed to prevent a critical incident, which is known as a top event. This process involves identifying hazards, which might lead to the critical incident category that is being analysed and methods to trap these hazards. The right side of the diagram deals with recovery from the event, which involves management methods to rescue from harm, and the final stage is to learn from the outcomes. The shape resembles a bowtie hence the name for the diagram.

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, rescue, learning, and reflection on the outcomes. 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.
**AVOID HAZARDS**

**LEARNING FROM OUTCOMES**

Immediate outcomes | Per cent
---|---
No effects | 49%
Minor effects | 20%
Case cancelled | 8%
Prolonged length of stay | 6%
Unplanned ICU/HDU admission | 11%
Death | 6%
Not specified | 6%
Total | 100%

Final outcomes | Per cent
---|---
Not affected by incident | 64%
Temporary disability | 21%
Permanent disability | 2%
Death | 6%
Not specified | 7%
Total | 100%

The immediate outcomes and the final outcomes are shown in the tables above. The majority of patients (64%) had no degree of harm or inconvenienced in the immediate outcome of the episode of care. There were no immediate effects in 49% and the immediate outcome was not specified or non-known in 6%.

**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 detailed planning and ANZCA Professional Documents may assist. While the incidents reported to WEBARS might involve a wide range of errors, selected patients may require particularly complex equipment or facilties such as ICU and ICU.

Management of the listed care-related factors might include efforts to improve workplace culture, to reduce working while distracted, fatigue, 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 Web Surgery Checklist and by targeting training and ongoing education, such as that provided by EMAC courses, or the WebSurgZ program in New Zealand (www.networkz.ac.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.

**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 still be possible, 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 for or the rest of the day. Underhaste 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 including myself. Dr Bridget Effeney, Dr Chris Hayes, Dr Leesa Monsanto, and the college membership services team.

As in previous years the survey will be managed by an independent, qualified and professional agency, RVP, who will facilitate distributing the online survey and send reminders and provide a detailed analysis back to the college. Importantly RVP will retain the primary data and individual responses from the survey will remain confidential. After analysing responses from fellows, RVP 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 is it a satisfaction survey. Most of the questions will ask about how much fellows value aspects of college activity.

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 website before the end of 2021, and at the 2022 ASM. I encourage you all to proactively respond when you receive your online fellowship survey. Let’s see what you really think.

**References:**
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 have 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.
BEYOND CITY LIMITS

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.
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. All the while I was in South Africa, the situation felt remarkably similar to what we have witnessed in India in recent weeks: utterly despair, death everywhere, hospitals completely swamped, and healthcare systems overridden.

I lost 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, simply by charging R850 ($A79) for a COVID-19 (PCR) test. I watched live on the water as Team NZ successfully defended the last races of the 36th America’s Cup and 250 needing ventilation.

As I touched down, in Durban, on 19 December, daily cases had risen to 8500, with a further 8500 in hospital, more than 1000 in ICU, and 430 ventilated. The day that I became symptomatic, on 6 January 2021, the numbers were extremely grim, with 16,000 new daily cases, 10,400 hospital admissions, nearly 2000 in ICU, and nearly 750 ventilated. By the time I flew out 13 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 masking up, hand sanitising, and distancing. I rarely “went out” apart from visiting my sick brother at his home every day.

While I was in MIQ, when everything was still raw and real, 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.

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 boarded the flight on 9 November, COVID-19 infection rates in South Africa were relatively stable. There were roughly 1500 new cases a day, with 55 deaths. Nearly 2000 cases were in hospital, with 500 in ICU and 230 needing ventilation.

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AT THE HEIGHT of the second wave of COVID-19 infections in Papua New Guinea (PNG), as COVID-19 sweeps through PNG, ANZCA Global Development Committee member 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 then 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 203 patients and it was very busy,” Dr Karu told the Bulletin from Port Moresby.

“They were all ICU patients but at the same time but without the staff to look after them.”

“From July 2020 to April this year we have had 202 patients admitted to isolation and of these 140 recovered and 62 died. Of the 34 patients we ventilated, about 85 per cent died with only about five surviving.”

“We had 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 arrival of an AUSMAT team in mid-March provided drug and equipment supplies including infusion pumps, infusion lines and muscle relaxants. But Dr Karu says the country needs to be prepared for a possible third wave.

The SAPNS 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 (ASCO).

“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.”

Karu explains: “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 registrars and residents 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.”

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. The committee has been working to provide practical support such as online forums, developing educational resources and donating equipment and consumables. An early May Dr Karu chaired a COVID-19 online support forum for anaesthetists and anaesthesia providers in PNG, with representatives from ANZCA, the Royal Australasian College of Surgeons and the Australian Society of Anaesthetists participating.

In early April Dr Karu updated the Global Development Committee via Zoom from Port Moresby. He explained how the Port Moresby General Hospital’s children’s ward had been cleared of patients so it could be repurposed as a COVID ward. The children were moved into the adult wards and oxygen supplies were running low.

Nearly 200 staff at 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 contract 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 6 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 COVID-19 testing is masking the true infection rate in Port Moresby and the provinces where most of PNG’s time millions people live.

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 slowly improving there is still widespread vaccine hesitancy in many parts of the country, largely fuelled by misinformation on social media.

“As the second wave hit the country the government set up temporary COVID-19 hospitals in a Port Moresby sports stadium and an aquatic centre. A decline in cases meant that as of mid-June these were now longer being used to treat COVID patients and the aquatic centre has been converted to a COVID testing centre.

Dr Karu says while the rate of infections appears to have slowed with locals 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

“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.”
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.

THE PACIFIC ONLINE Learning and Education (POLE) working group was established at the end of 2020 to continue our support and maintain our connection with our overseas colleagues. In addition to the college, membership of the group consists of representatives from:
- The Australian Society of Anaesthetists (ASA)
- The New Zealand Society of Anaesthetists
- The Society for Paediatric Anaesthesia in New Zealand and Australia (SPANZA)
- The Society of Anaesthetists of Papua New Guinea
- The University of Papua New Guinea
- Fiji National University College of Medicine
- The Pacific Society of Anaesthetists
- The Micronesia Society of Anaesthetists
- Timor-Leste (Hospital Nacional DIB)
- 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. A total of 58 participants from Papua New Guinea, Timor-Leste, Solomon Islands, Samoa and Fiji attended. Dr Emma 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, anesthetists who are mainly nurses 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 Kim Fuller providing an update on paediatric anaesthesia for trainees and Dr Jess Lim covering basic and advanced life support for anaesthesia and scientific officers.

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 Morris), a program designed to address pain issues in low resource countries. Sessions in May covered regional anaesthesia for ASOs and junior doctors.

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 touch, 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 facilitators learning from our Pacific colleagues, as they do from us. In May, a talk on regional anaesthesia, participant Dr Martha Nicola, 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.

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, an anesthetic scientific officer (ASO) provides the majority of anaesthesia in the country. ASOs are mainly nurses who have received training and have about a year of anaesthesia training before working primarily independently in provincial and rural areas of the country. POLE supported the monthly ASO education in March with online sessions covering topics in pain management over one week. Also during March, other online education sessions continued with Dr Kim Fuller providing an update on paediatric anaesthesia for trainees and Dr Jess Lim covering basic and advanced life support for anaesthesia and scientific officers.

The popularity of the sessions continued to grow with participants from Micronesia, Tonga, and Tokelau in addition to those Pacific nations already mentioned.

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FEEDBACK FROM THE PACIFIC

“Dr Goucke is good at teaching. I found his talking at the right pace, clear and easy to understand. He highlighted what needs to be known about pain.”

DR PAULINE WAKE (PNG)

“At the right pace, clear and easy to understand. He highlighted what needs to be known about pain.”

DR PAULINE WAKE (PNG)

“A timely topic for our team to learn more about, especially during Covid-19. Trying to encourage our trainees to do more regional limb blocks... hopefully will try harder blocks after the session.”

DR MELANY WERROR (PNG)

“I think it’s perfect!”

GOLIATH LEONARD (PNG)

“How you can get involved

Find here to share the timetable, including the Zoom link, with your colleagues and friends in the Pacific: www.anzca.edu.au/safety-advocacy/global-health/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.edu.au

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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 Health 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 actions across the four pillars of governance, partnerships, workforce and advocacy. Some of these include:

- A new te reo Māori name for the college – Te Whare Tohu o Te Hau Whakaora.
- Developing and implementing all college’s Reconciliation Action Plans (RAPs)
- Enabling the development of a new Te Tiriti o Waitangi Implementation Group
- Establishing a career and professional advice service for Indigenous medical students and pre-vocational doctors
- Inviting an Aboriginal and/or Torres Strait Islander and Māori new fellow to attend the Emerging Leaders Conference each year.
- Support for Aboriginal, Torres Strait Islander and Māori trainees to attend regional trainee exam preparation courses.
- Relocation of cultural competency under the continuing professional development (CPD) program to the practice evaluation category (which has resulted in a fivefold increase in the number of participants including this activity as part of their CPD portfolio over the past 12 months)
- The launch of an Aboriginal and Torres Strait Islander Health Award and a Māori Health Award to recognise members who have made a significant and sustainable contribution to First Nations Peoples health.
- Amendments to the Indigenous Health Committee’s terms of reference to allow for a larger and more inclusive membership.
- A guide for staff and members with information on acknowledging First Nations Peoples at official college meetings and events.

While we have made some small but important steps forward over the past four years, we know we still have a long way to go. In 2020 ANZCA Council approved the development of the college’s first Reconciliation Action Plan which represents the next step in the college’s reconciliation journey.

WHAT IS A RECONCILIATION ACTION PLAN OR RAP?

A RAP is 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.

An innovative RAP outlines actions that work towards achieving our unique vision for reconciliation. Commitments within this RAP allow us to be aspirational and innovative in order to help gain a deeper understanding of our source of influence and establish the best approach to advance reconciliation. It is important to remember that developing a RAP is just one step in our reconciliation journey – implementation and continuous improvement are what committing to a reconciliation journey is all about.

ANZCA’s approach to developing an RAP was to first complete the ‘Reflect’ stage as outlined by Reconciliation Australia. This involved a comprehensive assessment of the organisation’s strengths, weaknesses, opportunities and threats (SWOT) to understand the current state of the organisation and its clients.

Following the ‘Reflect’ stage, ANZCA worked with Reconciliation Australia to develop a set of goals and action plans that would enable the college to progress towards these goals.

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An ANZCA’s 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 action plan, the college will commence with an ‘Innovate RAP’. ANZCA RAP Working Group

- Dr Susie Lord, FFPMANZCA
- Dr Dash Nawington, FANZCA
- Dr Angus McNally, trainee
- Dr Sharon MacGregor, FANZCA
- Dr Paul Mills, FANZCA
- Dr Matt Bryant, FFPMANZCA, FANZCA
- Mr Nigel Fidgen, Chief Executive Officer
- Dr Elton Webster, Learning and Innovation Manager
- Ms Kate Davis, Policy Officer
- Ms Laura Foley, Operations Manager, Knowledge Resources
- Ms Laura Bond, Queensland Committees and QARTS Coordinator
- Ms Kiri Rikihana, Executive Director New Zealand
- Ms Marayah Taylor, community representative

“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”
Safety shield invention a boon for patients with beards

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.

BAG-MASKING a patient with a beard has long been a challenge for anaesthetists who often resort to clinging 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 developed and designed and we would love to see it being manufactured in Australia,” he explains.

When patients can’t breathe anaesthetists apply bag valve mask ventilation (BVM) to push oxygen into the patient’s lungs. BVM relies on a tight face seal and having a beard or a misshapen face can make that 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 anaesthetist 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 ems. 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 remembered 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 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.scottanaesthesia.com

Candym Jones
Media Manager, ANZCA

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

2018-2020 CPD END OF TRIENNIAL 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.

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.

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 DHM, pictured) in liaison with the ANZCA and FPM CPD Committee and the Diving and Hyperbaric Medicine Sub-Committee (DHM/SC).

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 (SPMP) introduced in 2020. With the seventh, COVID-19 airway management promptly 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.

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

The ANZCA Educators Sub-Committee is 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.

NEW CONTINUING PROFESSIONAL DEVELOPMENT

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.

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.

Calling future ANZCA educator facilitators

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

“Healthcare itself also fuels climate change with Australian hospital CO2 emissions comprising 7 per cent of national emissions”

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 PRODUCE generates 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 (IPA64: Statement on Environmental Sustainability in Anaesthesia and Pain Medicine Practice).

Trainees tackled these challenges with the use of evidence-based information provided in TRA2SH’s resource packs. Trainees had the opportunity to take on a scholarly role by collating 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, Kimguard (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 prep to a limb before surgery, rolling up 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 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 grass roots 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.com. 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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The evolution of CTN

Research

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 – kctn@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.

Professor Tomas Corcoran with the team of research coordinators at Royal Perth Hospital. From left: Ms Natalie Hird, Ms Yvonne Buller, Professor Tomas Corcoran, Ms Pauline Coutts, Ms Lucy Glazov and Ms Susan March. Photo courtesy of RPH Medical Illustrations.

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.
No increased risk of surgical site infection with dexamethasone for surgical procedures:

The PADDI trial results

THE PADDI TRIAL was the first large randomised trial to evaluate the safety of dexamethasone in terms of its influence of surgical site infection and was the culmination of 10 years of investigations from concept development and preliminary research through to trial completion.

Dexamethasone is widely used by anaesthetists in the perioperative period, principally as an effective anxiolytic 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 maxillofacial surgery and to reduce the risk of respiratory complications during cardiac surgery. Because it is a potent glucocorticoid, it has immunosuppressive and hyperglycaemia 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 patients costing 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 8880 adult patients were enrolled and randomly assigned to 8 mg dexamethasone or matched placebo shortly after the induction of anaesthesia and before incision, and randomisation or matched placebo shortly after the induction of

The primary endpoint was the onset of surgical site infection within 30 days of surgery. Secondary outcomes included other infections such 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 post-surgical 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 anxiolytic 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.

For more information about the PADDI study visit www.paggi.org.au.

Professor Tomás Corcoran, PADDI chief principal investigator at Royal Perth Hospital, drawing up dexamethasone. Photo courtesy of RPH Medical Illustrations.

The BIS™ brain monitoring system helps to enhance the delivery of anaesthesia. And with BIS™ index value-guided TIVA it enables:

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Professor Tomás Corcoran
Chief principal investigator, PADDI trial
Director of Research in the Department of Anaesthesia and Pain Medicine, Royal Perth Hospital
Adjunct Clinical Professor in the Central Clinical School at Monash University

Monash University
Adjunct Clinical Professor in the Central Clinical School at
Director of Research in the Department of Anaesthesia

Chief principal investigator, PADDI trial

Reliance on the BIS™ system alone for anaesthetic management is not recommended. The BIS™ monitoring system should not be used as the sole basis for diagnosis or therapy and is intended only as an adjunct in patient assessment. Relying on the BIS™ system alone for anaesthetic management is not recommended.

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For more information about the PADDI study visit www.paggi.org.au.
2021 ANZCA National Anaesthesia Day

- Mark Monday 18 October in your diaries.
- Nominate someone to organise your activities.
- Book your hospital foyer space.

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 ANZCA@anzca.edu.au.

WHILE IMPORTANT TO regularly report the latest news on the important work in medical research and health equity, the foundation supports, it is just as important to recognise those who make that work possible - our generous and committed donors.

We encourage readers to refer to the ANZCA website and recent foundation newsletter for exciting highlights of the work. Many project outcomes will be reported in forthcoming issues of the ANZCA Bulletin, with several studies nearing completion and the grants programs recommencing this year with encouraging numbers of new applications.

In this issue, we take time to recognise and sincerely thank a selection of our most influential donors. Their passion and sincerely thank a selection of our most influential donors. Their passion and efforts to support continuous improvement in patient outcomes and equity through anaesthesia, pain and perioperative medicine, is a common theme, clearly evident among foundation donors at all levels of giving.

Mrs Ann Cole and family
Since 2014, Mrs Ann Cole, with the support of her daughters Rowena and Victoria, has provided full funding for a substantial and generous annual grant for medical research in pain medicine, with a focus on the alleviation of cancer-related pain, through the Russell Cole Memorial ANZCA Research Award. The award commemorates the career contributions of the late Dr Russell Cole, an innovator in the field including establishment of dedicated pain management departments within Victorian hospitals.

Dr Peter Lowe
Also since 2014, Dr Peter Lowe, a retired Melbourne anaesthetist, has provided annual grants aimed particularly at assisting young researchers in the process of establishing their research careers.

Initially establishing 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 delivering 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 biennially donating 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.

Robin Smallwood Request
A visionary philanthropic gift from Mrs Rosalind Smallwood, resulting 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 Request, an annual grant for medical research led by an ANZCA 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 Kluer Bequest
Another very generous bequest was left to the foundation by Dr Elaine Lilian Kluer, 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 Kluger 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.

Announcing the Skantha Vallipuram ANZCA Research Scholarship
As we honour the wonderful ongoing contributions of our donors, it is fitting and exciting to announce the new Skantha Vallipuram ANZCA Research Scholarship. The foundation is enormously grateful to Mrs Asoka Vallipuram, who has worked with us to establish this new scholarship to assist emerging investigators pursuing higher research degrees. The scholarship will be an ongoing annual award, with a grant of $15,000, through the foundation and the ANZCA Research Committee.

Mrs Vallipuram has established the new scholarship in memory of her late husband, Dr Skantha Vallipuram (ANZCA FPM ANZCA). Skantha was widely known and respected as a Melbourne-based pain medicine physician and anaesthesiologist, a long-time foundation Life Patron donor, and philanthropist with a deep passion for overseas aid.

The foundation is deeply honoured to play a part in the perpetrual recognition of Dr Skantha Vallipuram, and his lifetime of dedicated contributions to patients and the specialties.

Gifts in wills
To leave a perpetual legacy in your will to support continuous improvement in science, evidence, practice, and global equity in anaesthesia, pain or perioperative medicine, please contact Iob Pucker at the foundation.

ANZCA Research Foundation
To donate online, search “GiftOptions – ANZCA” in your browser.

For general queries, contact:
Rob Packer
General Manager, ANZCA Research Foundation
rpacker@anzca.edu.au
+61 3 (0)409 481 295

Kayla Smith
ksmith@anzca.edu.au

Randy J. Kale
Funraising Administration Office
anzca@anzca.edu.au

For research project grants, queries can be directed to Susie Collins, Research and Administration Coordinator, scollins@anzca.edu.au.

Winter 2021
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 Pham. 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 Fall, the scientific committee was able to secure Professor Donal Buggy, Dr Kariem El-Boghdadly, Professor Paul Wischmeyer, Dr Florian Faller and Associate Professor Laura Duggan.

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**First virtual meeting a great success**

Reflecting on an extraordinary meeting

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**ASM SNAPSHOT**

- Delegates 2504 and counting!
- Speakers and facilitators 260
- Plenary sessions 7
- Concurrent sessions 38
- Workshops 75
- E-posters 12
- ENGAGE hubs in nine locations, around Australia, New Zealand, and Hong Kong
- Number of virtual platform logins 19,632
- Most watched session “Pandemic” plenary session

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**Scientific program**

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**ASM Convenor Associate Professor Chris Bell with Scientific Convenor Dr Lachlan Miles.**

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**David Toumier a Boonwurrung Senior Cultural Officer and his daughter Tahlia Toumier.**

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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.**
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 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 – totalling 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 program 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-silica” 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.

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 ENGAGE hubs were a great success and were held in nine locations around Australia, New Zealand and Hong Kong. Clockwise from top: Adelaide, Brisbane, Sydney, Canberra, Auckland, and Melbourne.

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 Intubate, 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 300 cameras a full mixing desk and audiovisual technicians provided a television quality experience for more than 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 experience even though we couldn’t come together in person. 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 #ASM2021MEL 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 option to take it for a test drive. With limited live action at ASM Central, we had to get creative and crowdsource. We shared causal, behind-the-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 cleaning smoking ceremony, performed by representatives of the Boon Wurrung People before the Opening Plenary. 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.

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 Korak 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 sem.anzca.edu.au.

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

Dr Noam Winter
FPM Symposium Convenor

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 #ASM2021MEL 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 opportunity to take it for a test drive. With limited live action at ASM Central, we had to get creative and crowdsource. We shared causal, behind-the-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 closing smoking ceremony, performed by representatives of the Boon Wurrung People before the Opening Plenary. 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.

The Numbers

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5,946
642

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Media coverage

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

Melbourne FANZCA Dr Meg Allen’s research on opioid prescribing in hospitals was reported in a page 6 article in the Herald Sun on 3 May “Too many kills a problem” 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 McIntyre 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.
Ground control to ANZCA ASM

At first glance it looks like a fancy computer set-up—a serious gamer might use but encased in an array 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 these custom-made one system constellation racks that are the engines driving the college’s first virtual ASM.

Mr McCartney operates his rack inside the ASM’s “mission control”—the room at the MCEC that serves as the command centre for delivering more than 95 hours of live and pre-recorded content across the scientific program including panel discussions, workshops and plenaries (pre-records and live sessions) panel discussions, workshops and poster presentations.

Wallfy’s managing director Gear 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.

“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 all the technology and tricky bits we need to live-stream,” Mr Yarwood explained.

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

“You can actually see how we pull everything together then there’s this perspective 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 show creates 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 Elly have worked for Wallfy 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 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 sources 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’s 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 4pm 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 recordings 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 underway 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 your session or event they were able to connect, sit 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 worrying 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 crew 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 on 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 ANZCA’s mission control centre Mr Yarwood and his team direct 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.

“In the opening plenary we had a global heat map revealed that more than 650 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 STA sessions would be popular they had to make it quick 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 three 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 mail-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
Awards, presentations and prizes

Prizes

Gilbert Brown Prize
2020
Dr Lasharon 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 (HINOP2)”.  

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 Elsey for “A comparison of the Cleargrip™ finger cuff with invasive arterial pressure measurements in patients with Class III obesity. A Pilot Study”.

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

FPM Dean’s Prize
2020
Dr Rosopa 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”.

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 Kosak, “Nociplastic pain – why should anaesthetists care?”

Robert Orton Medal

PROFESSOR MILTON L COHEN AM
2020 RECIPIENT
The Robert Orton Medal is awarded at the discretion of ANZCA Council, the sole criterion being distinguished service to anaesthesia, preoperative medicine and/or pain medicine.

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 1986. 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 founding board member and third dean of the Faculty of Pain Medicine from 2004-26. 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 Corp in memory of his friend Dr Ray Hader, a Victorian trainee who passed away in 1984 due to an accidental drug overdose.

Dr Christopher Sparks, FANZCA, is the recipient of 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.

Keynote presentations

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

Organising Committee Visitor Lecture
Associate Professor Meghna Lome-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”.

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Dr Ray Hader Award for Pastoral Care

2020 RECIPIENT
Dr Christopher J Sparks
FPM Immediate Past Dean

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

ANZCA Bulletin
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 Guys 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 PS61-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 convener 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 executive. 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.”

Further information given, and the Faculty and Painaustralia will be collaborating to uncover more details about what this means. It is potentially an enormous missed opportunity to provide the structural means to improve access to effective care for community patients.

In New Zealand, the major barrier to equitable access to high-quality care is also structural. It is not mandated for district health boards to provide pain services, and consequently there is a concentration of expertise in large tertiary centres, and no plan for provision of regional or community level care anywhere else. The national committee of the Faculty in New Zealand is collaborating with the health ministry on a project to address this with a model of care that is both equitable and high quality. In the middle of this, we are also dealing with lack of funding support for our major South Island unit in Christchurch. If this unit is not adequately supported, it will leave a population of just over 1 million people without a level I training unit, and all of the clinical expertise that goes with it.

The advocacy we need right now has to be directed at the clinical expertise that goes with it. It is an enormous clinical resource that is available to us, and we need to work with it.

The creation of the electronic persistent pain outcomes collaboration (ePPOC) as a binational outcomes data set was a joint project led by the Pain Management Research Institute and the Faculty of Pain Medicine. 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 multidisciplinary 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 endorment 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.

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.

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

**Meet our new board members**

**DR TIPOU AAMIR** is a specialist pain physician and trained in psychiatry as well. He is a 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 (tace 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.

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.

The board, with its expanded numbers, will have the opportunity to consider new candidates for its next round of elections.

**DR RENATA BAZINA** joined the board in 2020 and is chair of the FPM New South Wales Regional Committee, a member of the Examination Committee and a contributor to the Procedures in Pain Medicine project.

**DR GEORGE FELDEWINE** was elected to the board in 2019 after previously having been the president of the Australian Pain Society. Dr Speldewinde has contributed to the Procedures in Pain Medicine project, been an examiner and supervised pain medicine trainees.

The board has considered the diversity matrix and 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 (NZ) 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 member, 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**

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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 (NZ) and Dr Stephanie Oak (NSW).

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Hitting the 10,000 target – high demand for faculty education modules

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 event that followed the AGM.

Painaustralia AGM heralded a change of the board from Emeritus Professor Ian Chubb AC. The meeting also saw approval of proposed constitutional changes which will mean that ANZCA and the faculty will cease to be “category B members”, as this classification will no longer exist, and as of 1 July 2021 will become “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 Craigie will remain on the board as individual directors to serve their term 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 Group 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.

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’s 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

National Strategic Action Plan for Pain Management launch

NEW FELLOWS

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

• Dr Chor-San Alfred Chan, FANZCA, FFPMPANZCA (Hong Kong)
• Dr James Forbes, FANZCA, FFPMPANZCA (Qld)
• Dr Lauren Kite, FANZCOG, FFPMPANZCA (NSW)
• Dr Karen Park, FANZCA, FFPMPANZCA (New Zealand)
• Dr Natin Yogesh, MCh Neurosurgery, FFPMPANZCA (Tasmania)

TRAINING UNIT ACCREDITATION

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

• Alfred Health, Victoria
• Austin Health, Victoria
• PainScience Group, WA
• Queen Mary Hospital, Hong Kong

Expert Advisory Group starts work on chronic pain model of care

The Ministry of Health/Faculty of Pain Medicine Expert Advisory Group (EAG) held 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 in 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 Kerian Davis and committee member Dr Leinani Aiono-Le Tagaloa 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 Super Report on chronic pain) being seen as the best model to remediate what he says they all agreed is, “the current diabolical inequitable services that exist across the country.”

The group, chaired by the Ministry of Health, will meet again in July to look specifically at how the system will work across primary, secondary and tertiary services.

WHAT’S NEW IN BETTER PAIN 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.

Mid-year the faculty iscommencing work on reviewing and revising a number of key BPM 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 its performance in successfully reaching and influencing agreed target prescriber audiences.

We are sincerely grateful to all those who have helped drive this educational program across their respective hospitals, clinics and university locations.

The faculty is regularly promoting this course in key college e-newsletters.

Seventy per cent individual course completion across all Australian states.

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

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.

The faculty is pleased to report that it will reach its target of allocating 10,000 licences for the federally funded “safer opioid prescribing” online learning program well ahead of the 30 June deadline.

Sponsored through the Therapeutic Goods Administration (TGA) our six-module online learning package, derived from the Better Pain Management (BPM) program, is assisting healthcare professionals to develop sustainable and effective pain management programs for appropriate and safe opioid therapy.

When it began in June last year, ‘Better Pain Prescribing: Clarity and confidence in opioid prescribing’ was actively marketed across key health professional segments – with consistent messaging to drive awareness of this key initiative.

Vu direct email, paid advertising, social media, online webinars and print editorial content. BPM reached targeted medical and allied healthcare associations, general practitioners, pharmacists, universities, hospital groups and nursing professionals. The faculty also regularly promoted this course in key college e-newsletters.

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.

PAIN MANAGEMENT?

• Dr Karen Park
• Dr Lauren Kite
• Dr Chor-San Alfred Chan

FACUL TY OF PAIN MEDICINE
FPM Symposium

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.

2021 FPM and HKCA Virtual Spring Meeting
Moving with pain
Saturday 16 October 2021
#painCSM21
Self matters

This edition’s column is by Dr Joanna Sinclair, anaesthetist at Counties Manukau Health, Wellbeing SIG executive member, and chair of the Long Lives Healthly 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@anzca.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 systems 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 tool kit implementation, is designed to support anaesthetists and executive 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, SMO 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 Rounds4, 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 frontline 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 sickness leave and so on. Unfortunately, reversioning 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 workplace5. They propose eight ideal work elements for organisational resilience (Figure 1).

The Pandemic Kindness Movement in Australia6 presents a model for organisation leader support based on Maslow’s hierarchy of needs (Figure 2) and emphasises that attending to basic physiological needs, and physical and psychological safety, will allow healthcare workers to feel secure and supported enough at work to achieve job satisfaction and enable them to provide the best care for our patients. Organisations might begin this work by finding those small things that are easiest to change and make a difference, as well as having two-way conversations about things like managing resource constraints to increase transparency and co-creation of solutions.

Getting executive buy-in to my organisation has taken time but has ultimately been a richly rewarding process which has allowed me to achieve more than I previously thought possible.

Dr Joanna Sinclair, FANZCA
joanna.sinclair@middlemore.co.nz
@josinclairnz

ANZCA’s DOCTORS’ HEALTH AND WELLBEING RESOURCES

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

This is an independent counselling and coaching service available via the helpline online chat, the 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 387 432. Go to www.anzca.edu.au/about-us/doctors-health-and-wellbeing.

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

ANZCA’s Doctors’ Health and Wellbeing program.

REFERENCES
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 Covidence trial 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 PMH: 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 summarizes – 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.

Recommendation: This app is ideal for tracking newly published content and for bookmarking articles for CFP purposes.

AIRR ANZCA Institutional Research Repository

Recent contributions to AIRR – airr.anzca.edu.au.


New books for loan

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

NEW EXAM BOOKS

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

The complete recovery room book, 6e

Clinical anesthesia, 8e

CRQs for the final FRCA

New EBOOKS

Medication safety during anesthesia and the perioperative period

Interventional pain: a step-by-step guide to the FIPP exam
Training

2020 ANZCA trainee survey results

**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 have 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 (0.3 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 workplace bullying, discrimination or sexual harassment has slightly decreased this year from 30 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 volume of practice targets (89 per cent agree/strongly agree).
- The overall usability of the training portfolio system (85% agree/strongly agree).
- The supervisor of training had been supportive in helping to meet training goals (94 per cent agree/strongly agree).
- They had been able to take leave when required (92 per cent agree/strongly agree).
- The consultants in the department had been fair in their assessment of performance (97 per cent agree/strongly agree).

Trainees were asked to identify the most recent hospitals at which they had worked and were given the opportunity of identifying up to three. A series of questions were then asked of trainees with reference to each of the hospitals identified.

While satisfaction is overall relatively strong across most key elements of the hospital training environment there are some areas where satisfaction is lower than in 2018. This is likely related to the delayed examinations trainees experienced driven by limitations caused by COVID-19.

HOSPITAL TRAINING ENVIRONMENT

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

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.

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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.

The Education and Research unit will be co-ordinating an action plan in consultation with the ANZCA Trainee Committee and relevant education committees from the results of both the 2020 ANZCA Trainee Survey and the 2020 Medical Board of Australia Medical Training Survey. When the analysis is complete and themes and issues fully identified, the results will be widely shared.

Thank you to all of the trainees who participated in the survey. It is important that your voice is heard by the college and your feedback will be used to continue to improve our world-class training program.

Dr Katherine Gough
Co-Chair, ANZCA Trainee Committee (2020)
Chair, 2020 ANZCA Trainee Survey Working Group

Dr Nicole Muir
Co-Chair, ANZCA Trainee Committee (2020)
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 Dando
Liam Daniel Cikoson
Darcy Mark McFarland
Dharam William Sukumar
Edward Charles White

New South Wales

Dani Martin Bachmann
Harrison Ray Bell
Bradley Robert Bridge
Vanessa Sheen Yuan Chen
Srijana Nicole Crowther
Andrew Do
Kieran Ralph Easter
Byron John Economos
Simon William Graham Ellis
Catherine Rose Epstein
Ami Forrest
Sjorjina Nichole Crowther
Vanessa Shwen Yuen Chen
Bradley Robert Bridge
Harrison Ray Bell
Dani Martin Bachmann
Edward Charles White

Victoria

Kieran Peter Bates
Patrick Lloyd Boall
Alexandra Amy Bogler
Macushla Clare Byrne
Madeline Grace Cole
Patrick Julian Lloyd Donald
Stefanie Fabrizi
Dominique Math Grant
Leonie Madeline Harold
Robert Joffe
Hamish Westcott Lanyon
Natalie Lok Huan Law
Simon Paul Leckebury
Elisattos Maglogiannis
Mata Fernanda Perez Miranda
Thomas Patrick Mullaney
Braden Lee Preston
Thomas Patrick Mullaney
Richard John Emmerton
Alphonse Joseph Feneley
Si Ying Lim
Jingjing Luo
David Andrew Robertson
Kieran Patrick Robinson
Rian Sean Silbersenn
Natalie Sarah Elizabeth Smith
Nicholas Thomas Ward
Jacob Daniel Woodward

New Zealand

Kirsty Luisa Parnas Aamundsen
Alisa Axianszka
Thomas Matthew Barr
Alexander Edward Beatson
Joseph William Collinson
Andrew Neil Curtis
Jenna Elizabeth Donaldson
Jan Duleba

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:

Neenab Balayasoderan, Qld
Louise Marie Rafter, Qld
Kieran Patrick Robinson, WA
Joseph William Collinson, NZ

ANZCA PRIMARY EXAMINERS

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

NEW ZEALAND

ANZCA PRIMARY EXAMINERS

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

NEW ZEALAND

ANZCA PRIMARY EXAMINERS

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

NEW ZEALAND

ANZCA PRIMARY EXAMINERS

Clockwise from left: Primary Exam examiners in New Zealand, New South Wales, Victoria and Queensland.
ANZCA Final Examination

202.0 Exam
Seventy-six candidates successfully completed the final fellowship examination:

AUSTRALIA
Australian Capital Territory
Cameron Douglass Maxwell

New South Wales
Benjamin James Bartlett
Mark Chenhall
Tejas Chikkerur

South Australia
Dana Louise Bolt
James Andrew Briggs
Shaun Peter Campbell
Kedar Sanmoo Joshi
Mitchell Keith Petersen-Tyn

Tasmania
Chas Peirce

Victoria
James William Charles Ballantyne

Western Australia
Nicholas Anthony Eraser
Laura Jane Hamilton
Jonathan Richard Hills
Ana Readford Loko
Gabrielle Eve Sican

NEW ZEALAND

South Australia
Charles Robert Wrenn Allen
Oliver Greg Bell
Matthew James Beaud
Jonathan Paul Bennett
Kate Elizabeth Campbell
Trent George Cumts
Emma Elizabeth Foster
Michelle Ann Cutter
Qiao He
Aminia Isabelle Taylor Howie
Zeyn Li
Matthew Jeremy Low
Keiyn Dale McLeay
Shun Fen Moy
Ching Wern Ong
Maria Duranta Serenity
Michael Thomas Wadsworth
Michael Craig Waterhouse

New Zealand

ANZCA Bulletin

January 2021

SIMG examination

Two candidates successfully completed the specialist international medical graduate examination:

Simi Sana Sheth
Shivam Pratap

ANZCA Bulletin

January 2021

CECIL GRAY PRIZE

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

MERIT CERTIFICATES

Merit certificates were awarded to:

Trent George Cutts, NZ
Michael Craig Waterhouse, NZ

ANZCA Bulletin

January 2021

2021.1 Exam

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

AUSTRALIA
Australian Capital Territory
Anneke Kerr
Kurtis Tadeusz Zapsutisk

New South Wales
Patrick Marie Francois Buzin
Maximilian Geoffrey D’Ittas
Bennet
Daniel Francis Broderick
Gregory John Dale
Christophor John Davison
Jason Paul Denneche
Cameron James Dunn
Timothy Lou Duong
Stephanie Leanne Gaundrell
Andrew John Gilmore
Nheb Gouar
Andrew John Inglis
Melissa Ann Ingolf
Andrea Kha keeper Jeyendra
Polwattie Kannanathakke
Gaston Leon Yorke
Jessica Ida Elizabeth Lack
Yan Tong Lai
Jarmoow Lowery Laneuk Sura Letatuk
Natalie Marla Lukus
Angus Stuart Charles McNab
Briana Loomba Miller
Melissa Anne Oliver
Timothy Francis Ong
Myfawny Sarah Ani Pamer
Pumta Patil
Lauren Pateon
Daphne Sabina Pimnearn
Bridget Mary Kay
Emma Elise Priek
Broden Robert Lowery Rivers
David Michael Mark Saarens
Nicholas Edward Stewart
Simon Treo Fong Ting
Simone Relbeq Yorng
Wenting Liu Zhao

Northern Territory
Kobi Lee Haworth
Matthew Nikola Pavic
Daniel James Stone

Queensland
Adam Frank Bartlett
Ruth Mitran Blak
Kristopher Michael Blucher
Roslynn Care Boyd
Grant James Breadall

Western Australia
Nicholas Anthony Eraser
Laura Jane Hamilton
Jonathan Richard Hills
Ana Readford Loko
Gabrielle Eve Sican

NEW ZEALAND

South Australia
Charles Robert Wrenn Allen
Oliver Greg Bell
Matthew James Beaud
Jonathan Paul Bennett
Kate Elizabeth Campbell
Trent George Cumts
Emma Elizabeth Foster
Michelle Ann Cutter
Qiao He
Aminia Isabelle Taylor Howie
Zeyn Li
Matthew Jeremy Low
Keiyn Dale McLeay
Shun Fen Moy
Ching Wern Ong
Maria Duranta Serenity
Michael Thomas Wadsworth
Michael Craig Waterhouse

New Zealand

ANZCA Bulletin

January 2021

SIMG examination

Seven candidates successfully completed the specialist international medical graduate examination:

Mathias Stefan Legrand
SA
Kamal Khosrow, Tasmania

Neha Raha, Victoria
Rajesh Kumar Chena
Pantambaru, Western Australia

Manisha Desai, WA
Kiran Bhathen Venkatesh, WA

WA
Darrel Brook

ANZCA Bulletin

January 2021

CECIL GRAY PRIZE

No candidates were awarded the Cecil Gray Prize for the 2021.1 final examination.

MERIT CERTIFICATES

Merit certificates were awarded to:

Devon John De Groot
Walston Reginald Martis, NZ
Michael John Russer, Queensland
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) to 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 Tanja Rottensten 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.robbins@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 difference, allowing trainees to learn when it suits them.

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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 lahiruandstan@gmail.com.
Te Whare Hau o Te Hau Ora (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 (HBO) 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.

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.

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 opreated 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 intermittently, 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 lurch 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, FRNZCP, FRHMNZ, DipAdvDHM (ANZCA), Medical Director, Christchurch Hyperbaric Medicine Unit and Te Whare Hau o Te Hau Ora. The New Zealand Hyperbaric Medicine Unit recently received approval for advanced training in Diving and Hyperbaric Medicine (DHM) from ANZCA’s DHM subcommittee.

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Dr Greg van der Hulst, FRNZCP, FRHMNZ, DipAdvDHM (ANZCA)
Australian Capital Territory

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 Irrosi (RPA, Sydney), Professor Bernhard Riedel (Peter Mac, Melbourne), Associate Professor Forbes McGain (Western Health, Melbourne), Dr Peter Hebbard (Northeast Health, Wangaratta), and plenty of our best 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 at Australia’s largest celebration of spring which showcases one million flowers in bloom throughout Commonwealth Park. Why not bring the family, enjoy a unique experience in the nation’s capital. Registration is now open so jump on the college website and secure your spot for the weekend and enjoy a unique experience in the nation’s capital.

New South Wales

INTRODUCTION TO ANAESTHESIA

The ANZCA NSW Regional Committee are pleased to announce the introduction to anaesthesia course will be held on Saturday 13 November 2021. The venue will be confirmed soon. 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 Convenor

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 Odey Street and Pole Lane, Crows Nest NSW 2065
- $A469

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. Further information please email nswcourses@anzca.edu.au or phone +61 2 9966 9085.

Dr Natalie Kent Convenor

FINAL EXAM REFRESHER

The course is a full-time 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 Odey Street and Pole Lane, Crows Nest NSW 2065
- $A825

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. Further information please email nswcourses@anzca.edu.au or phone +61 2 9966 9085.

QUEENSLAND

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 McMasters, Dr Christopher Stonnell, and Dr Paul Lee-Archer for hosting the ENGAGE hub, and also to Dr Sean McMasters, 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

Left, from top: College ceremony; Associate Professor Newman Harris presenting The Barbara Walker Prize to Dr Hannah Bennett.
From top: ASM presenting fellows; Immediate past FPM dean Dr Meredith Craige; councilor Dr Scott Ma and ANZCA staff were delighted to congratulate and celebrate the Renown Prize Winner Dr Andrew Burch and the 16 new fellows, including Ceci Gray Pithe winner Dr Craig Morrison.

It was a wonderful opportunity to meet proud and beaming partners and family members, some of whom had travelled from interstate and from New Zealand, and a unique occasion to rejoice with the new fellows in achieving the rewards of the many years of hard work and commitment.

From top: Dr Lyd Strawbridge, Dr Sandy Spell, Dr Ruth Rarbou and Dr Allan Cyna and Dr Richard Walsh; NT ACE Conference Dinner – Dr Lia Freestone, Chair, Tasmanian Regional Committee hosting the event.

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

The theme “Links to the future” explores the future holds in relation to pediatrics, the environment and sustainability, both on a personal and professional level.

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**Victoria**

**RECENT COURSES AND EVENTS**

A series of evening sessions were hosted for our trainees to attend. These included practice nights over 1.2 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 live 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. Unfortunately, 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 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) on how 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 Tarin Ward, the presenters, rotation supervisors and convenor Dr Alex Henry, Dr Tim McIver and Dr Deas Brouwer. The A supervisors of training meeting was held in early June.

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 have any queries and/or a date to express interest in attending either of our courses/events by emailing vic@anzca.edu.au or phone +61 3 8517 5313.

**Exam prep course dates**

- **Final Refresher Course** (Monday 19 to Friday 23 July)
- **Final Anatomy Course** (Monday 26 July)
- **Primary viva practice nights** (Monday 6, Wednesday 8, Monday 13, and Wednesday 15 September)
- **Final viva practice nights** (Monday 4, Wednesday 6, Monday 11, Wednesday 13 October)
- **Primary Refresher Course** (Monday 13 to Friday 26 November)

**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. victauaetheticregistrants@gmail.com.

**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 calendar!

- **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**

- **Primary Refresher Course** (Monday 19 to Friday 23 July)
- **Final Anatomy Course** (Monday 26 July)
- **Primary viva practice nights** (Monday 6, Wednesday 8, Monday 13, and Wednesday 15 September)
- **Final viva practice nights** (Monday 4, Wednesday 6, Monday 11, Wednesday 13 October)
- **Primary Refresher Course** (Monday 13 to Friday 26 November)

**Western Australia**

**PPE IN THE OPERATING THEATRE**

2020 was the year of the rat and it was also the year that COVD19 smashed 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 Gardner 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 unique 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 use this device than with most N95 masks but the benefits (comfort for use when worn for long periods, high level of protection, re-usable) 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 high-grade protection of staff.

Dr David Kingsbury, Dr Scott Sargent, Dr Bridget Hogan, Dr Cat Goddard and Dr Tania Rogerson
St Charles Gardner 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 Halket will be speaking on ITA for kids, Dr Priya Thalayasingam will present on scared kids and anxious parents and Dr Chris Gibson, Dr Marlene Johnson and Dr Ian Forsyth will present an anaesthetic case-based discussion. Jon Mould will provide a pandemic advanced life support workshop and Dr Tom Fleet will provide an anaesthesia workshop.

The social calendar includes a welcome dinner at the Pullman Resort and an evening at Bunker’s 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.
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 Mony Mythen (UK), Professor Randini Moonesinghe (UK), Associate Professor David Healy (USA), Associate Professor Lisa Leffert (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.
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