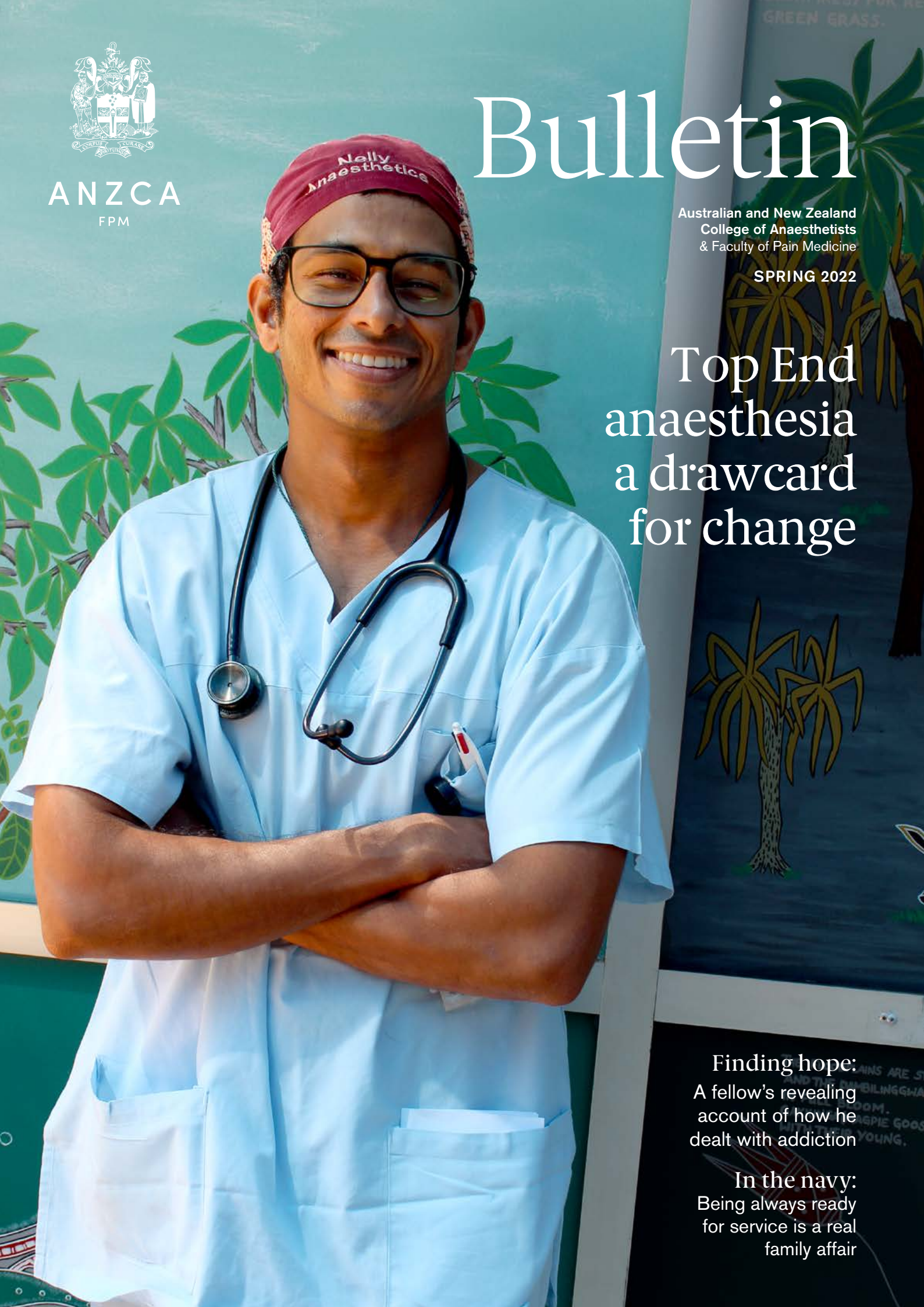

ANZCA
FPM

Bulletin

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

SPRING 2022

Top End anaesthesia a drawcard for change

Finding hope:
A fellow's revealing account of how he dealt with addiction

In the navy:
Being always ready for service is a real family affair

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Cover: Royal Darwin Hospital anaesthesia trainee Dr Nilesh "Nelly" Kumta. Photo: Carolyn Jones

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

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Training and assessment: Getting the balance right

In this Spring edition of the *Bulletin* I will focus on issues relating mainly to anaesthesia trainees but with some relevance for all fellows and specialist international medical graduates.

I would like to address our training assessments, particularly the primary and final exams, the trainee selection process and bullying, discrimination and harassment (BDH). These topics have recently generated intense discussion both within and around the college.

TRAINING ASSESSMENTS

We are extremely lucky to have in our college many fellows with a high degree of educational knowledge and an excellent team in the Education and Research unit.

The recent COVID-19 pandemic has put our exams under pressure and scrutiny and while we were able to sucessfully continue, other colleges had spectacular failures and, in some instances, overseas, examinations were cancelled while trainees still progressed.

Inevitably this has led to a discussion about the future of these high stakes pass/fail summative assessments in medical education.

When I was a trainee many years ago, we sat the primary and final exams, did a special project in our provisional fellowship year, and had few other assessments. The exams are still there but now we also have workplace-based assessments including direct observation of procedural skills, case-based discussions, mini clinical evaluation exercises and multi-source feedback.

What is the right balance of assessments during training?

Even as a non-educationalist I can see the progress of medical education is probably moving away from summative single point exam-type assessments towards a more programmatic approach that is less stressful, more clinically orientated, provides greater opportunity for learning and feedback and may allow trainees to proceed at their own pace.

I can also imagine a future where, as an assessment, trainees would walk into a virtual reality enabled OR and hear "Glad you're here. The patient has just arrested".

These changes are still down the track and I believe our current assessment framework serves us well. In the meantime, we will continue to improve the fidelity of our already highly performing examinations and look at ways of minimising the stress associated with these.

> "We have formed a trainee selection working group ... that will review all aspects of the trainee selection process including monitoring, evaluation and oversight, inequity, consistency and the role of the independent trainee."

TRAINEE SELECTION

The second item I would like to discuss is trainee selection and in particular the issue of independent trainees.

The specialty of anaesthesia is popular with many more doctors applying than current training positions available.

The college has a policy that forms the basis for trainee selection but each state and region have their own system. Many states have one selection process, while some states and New Zealand have multiple training programs, usually administered out of a major tertiary centre.

These state and regional processes are very competitive and involve written applications, interviews and other forms of assessment.

Until 2004 ANZCA accredited individuals but since then we have moved to accrediting hospitals for training so employees at these institutions can apply to be an ANZCA trainee. The reason for this change relates to concerns around having ANZCA trainees and non-trainees in identical roles within a department without allowing specialty progression for the non-trainee.

The advantage for those who are selected into a training program is that access to all the specialty study units is usually guaranteed whereas independent trainees must negotiate their own access to these terms creating difficulties for the bottleneck sub-specialties.

There is also some concern about equity and access to teaching and exam preparation although analysis demonstrates independent trainees have only a marginally prolonged training time and only slightly worse exam outcomes.

In response to comments from our recent Australian Medical Council review and, as part of our training program evolution, we have formed a trainee selection working group, chaired by Dr Kara Allen, that will review all aspects of the trainee selection process including monitoring, evaluation and oversight, inequity, consistency and the role of the independent trainee.

This is a timely review that will give us some guidance into the future of this important area.

BDH

Our CEO, Nigel Fidgeon, and I recently attended a "Culture in medicine" symposium organised by the Medical Board of Australia in response to the trainee survey of 2021 highlighting high levels of bullying, discrimination and harassment (BDH) in the workplace.

Many specialty colleges, associations, trainee groups and health department organisations attended. We heard both expert opinions and harrowing first-hand accounts of the extent of BDH and the consequences and poor outcomes in those subjected to this behaviour.

BDH is not new and was probably worse when I trained but it remains a stubborn, festering wound for the medical community that needs to be addressed.

The problem is complicated by the relationship between ANZCA and the workplace where BDH mostly occurs. As a college we have limited ability to investigate and manage these problems but can do more to ensure that every department has a framework for addressing this issue.

Ideally each department should have staff who are anti-BDH champions, a mechanism for allowing confidential, safe and non-judgemental reporting of incidents and a measured, fair and graded response to handle these. Ideally this should be managed within departments with HR approval and oversight in more severe and repeat episodes.

The anti-BDH champions should be respected members of the senior staff, not necessarily the head of department or supervisor of training, who may have other roles in investigating and managing such incidents.

This is a complex problem we cannot resolve overnight but it is time we started making progress.

Take care as we hopefully emerge from this pandemic again!

Dr Chris Cokis FANZCA
ANZCA President

College continues to meet challenges

"Our Lifelong Learning project will see the implementation of a suite of new systems for the college."

AS WE ENTER Spring after another challenging year associated with the global pandemic, it is clear the consequences of COVID-19 are taking an even greater toll on the health workforce and pressure faced by our health services is increasing.

The relentless furloughing of the workforce, difficulties in taking planned leave and workloads in hospitals have come at a significant cost to many aspects of our daily lives.

When COVID-19 first emerged in early 2020 the entire workforce had to respond to the immediate priorities on our health systems across Australia and New Zealand, and in fact the world. The ANZCA community has not been immune to these many challenges, and we now see the longer-term implications for our health workforce.

Governments across multiple jurisdictions and federally on both sides of the Tasman are grappling with the consequence the pandemic has brought to the health workforce and a wide range of projects have been initiated with new funding.

There are too many to list, but these initiatives are responding to severe labour shortages and staff burnout.

ANZCA continues to be actively involved and engaged across Australia and New Zealand in providing advice and input into meaningful solutions for some of the challenges the system now faces. This will not be an easy, one-size-fits all solution and it will no doubt take several years to readjust and rebuild capacity in our health systems.

All this is in the context of a global health workforce shortage as countries try to lure staff. "Robbing Peter to pay Paul" is a catch phrase that comes to mind.

Responding to growing surgical waiting lists and delayed diagnostics and treatment will play out over a long time, presenting new workforce pressures as the backlog of patient demand is met.

Meanwhile, the work of the college has continued unabated.

We have successfully held exams across Australia and New Zealand and our Lifelong Learning project will see the implementation of a suite of new systems for the college to support our fellows, trainees and specialist international medical graduates.

The initial implementation of a new online training portfolio system has commenced for the Faculty of Pain Medicine and our ultimate plan is to roll this new system out college wide.

Online exam platform pilots have also been successful, and we plan to go live with this system in the second half of 2023 with ANZCA moving to this platform in 2024.

The many changes associated with the new continuing professional development (CPD) requirements of the Medical Board of Australia and the Medical Council of New Zealand have been incorporated into the ANZCA CPD system.

The system will be uplifted to ensure full functionality of the new requirements are available for the changes from January 2023. ANZCA will also transition as part of these changes to the new "CPD homes" framework.

A new learning management system will replace Networks in early 2023, providing a superior, user friendly online course experience for training and CPD activities.

Planning for the 2023 ANZCA Annual Scientific Meeting as a face-to-face event is on target though online content is also planned for registrants.

The ongoing impacts of COVID-19 in its third year continue to require constant agility and ANZCA staff have responded to provide continuing support to seamlessly deliver on a large workplan of college activities, and I am appreciative of the team.

Nigel Fidgeon
ANZCA Chief Executive Officer

Letters to the editor

IS IT TIME FOR A STRUCTURED AND EXPLICIT ANAESTHESIA TRAINING SELECTION PROCESS?

Currently no clear guidance or criteria for applying to anaesthesia training in NSW exists. There is generic advice to "build your CV", however, what this means is a mystery to me. With increasing competition for anaesthesia registrar positions, this appears to lead to rumour about what is needed, leading our junior colleagues to embark on potentially unnecessary extracurricular work which may include expensive postgraduate courses and distract them from learning how to be a good practical clinician.

For example, as a department scholar role tutor, I get regular requests from junior resident medical officers (RMO), critical care RMOs and medical students requesting to perform an audit. Given these requests come from doctors with no or limited experience of anaesthesia, and who are not department members, they require close supervision. This creates a lot of potential work for the supervisor including setting the topic and gold-standard measures, access to limited computing resources, and data analysis requiring software licenses and some skill in using them. Some audit topics likely require assessment by the local ethics committee which for our HREC now requires a fee payment.

While an audit is not an explicit requirement to apply for an anaesthesia position, so long as there exist no clear guidelines many RMOs seem to feel it is essential. If performing an audit is an important application criterion, RMOs really should have equitable access to perform them. It seems unfair to me that essential recruitment criteria be allocated by the chance availability and enthusiasm of a supervisor. I would hate to be the person responsible for not helping a good candidate improve "build their CV". However, with one to two requests for audits per week, I often now feel that I do.

The Royal Australasian College of Surgeons has established a very clear points-based criteria for applying to surgical training (www.surgeons.org/become-a-surgeon/how-do-i-become-a-surgeon/jdocs-by-racs). I wonder if having a more formalised, standardised and explicit process would provide junior doctors and consultant anaesthesia staff with clearer direction. This could help reduce the anxiety induced by uncertainty and focus candidates on activities that would help them develop as a physician in critical care, rather than data entry.

Dr Matthew Miller FANZCA
Staff Specialist, NSW Ambulance Aeromedical Operations
VMO Anaesthetist, St George Hospital NSW

ANZCA responds

ANZCA is undertaking a project focusing on trainee selection in both anaesthesia and pain medicine. As part of this project we have convened a working group that will undertake an environmental scan of selection processes at other medical specialist training colleges and universities with a view to investigating ways to potentially improve the ANZCA processes across Australia and New Zealand. This working group is undertaking the first phase of the work as part of the Training Evolution Project which focuses on the continual improvement of the ANZCA training program.

As part of this work a number of areas will be analysed including:

1. Desire to have greater clarity in selection criteria across jurisdictions.
2. Maintenance of consistency in approach to trainee selection across training networks.
3. Ensuring there is equity in trainee selection.
4. Possible creation of pathways for Aboriginal and Torres Strait Islander and Māori trainees.

As this project progresses the college will endeavour to update the fellowship, trainees and SIMGs on progress and outcomes upon completion.

SECONDING THE CALL FOR VIRTUAL MEETINGS

I laud Dr Richard Barnes' letter to the Autumn *ANZCA Bulletin*, calling for virtual anaesthesia meetings as the way forward in this time critical global climate change crisis.

The COVID-19 pandemic has amply shown that virtual meetings are a very viable and efficient way of holding meetings and conferences, and as Dr Barnes has proposed "carbon neutral medical conferences should be the norm", with virtual meetings shown to reduce conference carbon footprint and energy usage by well over 90 per cent.

But in the same week in June that the major teaching hospital, at which Dr Barnes is a senior anaesthetist, removed desflurane from its theatres in view of its problematic greenhouse gas effect, the Monash University Department of Anaesthesiology and Perioperative Medicine staged the 6th Collaborative Clinical Trials in Anaesthesia Biennial Conference at the hospital's umbrella organisation's centre in Prato, near Florence, Italy.

A conference that doubtless could have been held virtually.

The equivalent number of greenhouse gas emitting VW Golf trips across the Nullarbor from Melbourne to Perth, to staging the Florentine conference would be in the tens of thousands, I suspect.

This seems at best ironic, more possibly hypocritical, at a time when a groundswell of TIVA anaesthesia proponents are driving the derailment of the use of desflurane in contemporary anaesthesia; an agent which if used with due care has very real benefits in certain circumstances, where some anaesthetists find it superior to the hard line mantra of TIVA for all cases.

I must say that I did enjoy the ANZCA virtual meeting held this April/May.

It proceeded flawlessly.

Dr Stuart Skyrme-Jones, FANZCA
Richmond, Victoria

Recognising achievements and contributions:

What's new with our college awards and processes

WITH SO MANY of our fellows, trainees and specialist international medical graduates (SIMGs) proactively and generously contributing to the life of the college and the broader community, it is timely that we undertake a review of our awards. It is important to recognise our fellows, trainees and SIMGs for the good work they do for the college, within their own practice, and in the community.

Our newly formed Awards Advisory Panel (AAP) will provide oversight of the awards process to facilitate transparency, equity and uniformity. The panel will collate and review nominations made for the Robert Orton Medal, ANZCA Medal, ANZCA Citation, ANZCA Star and ANZCA Recognition. Applications for these awards will open from late September. The new process means that three fellows may nominate a peer; none of these fellows need to be on council.

In addition to this, the panel and the college's membership team will work with college committees and units to promote and create awareness around our other college awards. The panel has also been tasked with the responsibility of establishing a process for college nomination of our members for external national awards.

The panel will work towards making the college awards more accessible to members, so we are truly able to recognise the breadth of achievement across Australia and New Zealand. We want to acknowledge those who undertake ground-breaking research, as well as those quiet achievers who are enacting impactful change in their local areas, and those who find the courage to act in times of crisis.

We really want to hear from you, on who you believe has distinguished themselves, gone above and beyond, and whom you believe should be acknowledged for their efforts. These awards will be presented at the 2023 ANZCA Annual Scientific Meeting in Sydney.

Further details on the nomination process, selection criteria for each award and adjudication timelines can be found at www.anzca.edu.au/about-us/our-culture/recognising-excellence and keep an eye on our social media platforms for more information and updates.

I encourage all of you to provide feedback on this new process. I hope you will join me in celebrating the success of our fellows!

Maryann Turner
ANZCA Councillor, Chair of the Awards Advisory Panel

Join us

We're always looking for fellows to join us on the Awards Advisory Panel. For further information email membership@anzca.edu.au.

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Nominations for ANZCA Council awards now open

We encourage fellows to visit the ANZCA website for further information on how to nominate a colleague in recognition of their achievement. Details can be found on each award, along with the selection criteria. Nominations may be made by three fellows of the college using the online nomination form with a supporting nomination letter and a curriculum vitae of the nominee provided. Nominations will be private and confidential, with the close of nominations on 30 November 2022.

We strongly encourage you to nominate your colleagues and peers. Tell us who you believe has distinguished themselves, gone above and beyond, and should be acknowledged for their efforts as well as quiet achievers and those who make impactful change in their community.

These awards will be presented at the 2023 ANZCA Annual Scientific Meeting in Sydney.

- Robert Orton Medal
- ANZCA Medal
- ANZCA Council Citation
- ANZCA Recognition
- ANZCA Star

A fresh approach to engaging with government

THE COLLEGE IS increasingly recognising the importance of engaging directly with governments in Australia and New Zealand to discuss decisions that affect our fellows, trainees, and specialist international medical graduates (SIMGs).

Immediately following the recent change of government in Australia, the college wrote to the cabinet members representing portfolios in health, rural and regional health, and Indigenous Australians. This was followed up with direct contact to their respective ministerial offices. This represents an increasingly proactive engagement with government at state and federal levels, as well as with a wider group of key stakeholders.

The response has been encouraging, with Australia's new Health Minister, Mark Butler, writing to our president outlining the government's respect for ANZCA and the work of its members, as well as its commitment to ANZCA's importance to the National Medical Workforce Strategy and the National Strategic Action Plan for Pain Management.

More importantly, there has been a noticeable increase in the interaction and responses from state and federal governments in recent months.

To date, ANZCA has had high-level meetings with key policy advisors and departmental heads across the federal, state and territory governments in Australia, and with the New Zealand government broadly. At the Australian federal level, ANZCA has been regularly briefing senior representatives in cabinet, and has commitments to meet directly with the minister, and assistant minister for health, as well as the assistant minister for rural and regional health, mental health and suicide prevention.

ANZCA is taking a more proactive approach to wider engagement in departmental affairs – typically represented by our fellows, for example with a focus on positioning to ensure the college is represented on key relevant advisory committees. We are also seeking commitments from key political offices to better include the college in decisions that affect anaesthesia, pain medicine and perioperative medicine, such as changes to Medical Benefits Scheme chronic pain items, trainee wellbeing and support, and rural and regional challenges in healthcare.

For example, there have been high-level meetings with the health department and FPM Dean, Dr Kieran Davis, to brief the Medicare Review Taskforce, and FPM Executive Director, Leone English, to brief the department on the college's work on a national health practitioner education strategy in pain management and its stewardship of the establishment of a National Pain Solutions Research Alliance.

Such representations, both with departments and ministers' offices, will better place the college to advance its goals ahead of the 2023/24 Australian federal budget, and centre ANZCA in the many other political deliberations that occur on a regular basis.

Equally, we are working with our regional committees to better understand and represent their views to state governments around Australia.

A particular focus of our advocacy efforts in recent months has been the college's leadership in pain and perioperative medicine, as part of a wider, multidisciplinary approach to healthcare. A key goal of our advocacy efforts is to ensure government and departments recognise that best practices in medicine – and Australia and New Zealand's health systems more broadly – require ongoing support and meaningful collaboration with stakeholders such as ANZCA.

Concurrently, the college is updating our ministerial briefing packs to better reflect the work and expertise of our fellows and regional committees and special interest groups. These briefings will help to build a healthy working relationship between the many levels of government that our fellows, trainees, and specialist international medical graduates should expect. So far, the college has been met with enhanced recognition and respect, which we can and will continue to build on.

> "To date, ANZCA has had high-level meetings with key policy advisors and departmental heads across the federal, state and territory governments in Australia, and with the New Zealand government broadly."

NEW ZEALAND ADVOCACY

FPM Dean, Dr Kieran Davis, and FPM Executive Director, Leone English, have just completed a New Zealand road trip to meet with fellows, multidisciplinary teams and hospital leadership in Auckland, Hamilton, Wellington and Christchurch.

Along with senior staff from the New Zealand office, the faculty were able to meet fellows in their clinical settings, gain an understanding of local level issues, and discuss the proposed pain model of care.

The faculty has been strategically working with stakeholders to improve services, provide evidence-based advice, and advocate for more pain medicine specialists through a strong relationship with the Ministry of Health, the Accident Compensation Corporation (ACC) and other government agencies that have an interest in the social determinants of health. The road trip was a great opportunity to meet face to face with both the ministry and the ACC.

Leveraging the relationships established through the work of the expert advisory group in the development of the model of care, the faculty is becoming a strategic leader for multidisciplinary pain care in New Zealand. Read more about it on page 10.

SUBMISSIONS

The college prepares submissions and makes representations to government and other stakeholders on a range of policy initiatives and inquiries, many in response to requests for college feedback and input. Unless confidential, our submissions to public inquiries are available on the college website following the iquiries closing date. See www.anzca.edu.au/safety-advocacy/advocacy.

Australia

- Department of Health (Medical Benefits Division): Feedback on Australian Society of Anaesthetists submission to duplicate procedural items into the Relative Value Guide.
- Department of Health (Medical Services Advisory Committee): Chronic pain MedChecks trial.
- New South Wales Health: Valued-based surgery clinical practice guide.
- National Blood Authority: Single Unit Blood Transfusion Flowchart.

New Zealand

- Ministry of Health: Mamaenga Roa – Chronic Pain Model of Care.

A ground-breaking model of care for pain in NZ

The FPM New Zealand National Committee (NZNC) has led a remarkable push for a national model of care for people living with chronic pain. The work has been in partnership with the Ministry of Health over the past couple of years. Adele Broadbent reports.

EQUITY IN ACCESS to high quality pain services in New Zealand is a long standing issue.

Chronic pain services have not been in the mandatory care list for district health boards under the old system so the take up has been patchy. That has had the flow on effect of very few specialist pain medicine physician training positions. However, this may be about to change if work from within the Ministry of Health and across specialties comes to fruition with a comprehensive new plan under the new health systems.

The final version of the New Zealand model of care for people living with chronic pain was agreed by an Expert Advisory Group (EAG) at their last meeting in July. This group, made up of some of our leading thinkers on chronic pain, brought a wealth of diverse experience and expertise to the table to develop an evidence-based model of care that will be equitable and sustainable for New Zealand.

The sheer breadth of the stakeholders involved and the timing, coinciding with the implementation of the country's health reforms on 1 July, means this model of care has the potential to change the landscape for people suffering from chronic pain in New Zealand.

The EAG was led by faculty champions Dr Tipu Aamir (FPM Board member and previous NZNC chair), Dr Duncan Wood (NZNC Chair and pelvic pain specialist), Dr Kieran Davis (FPM Dean), Chair Dr Jane Thomas (Māori and paediatric pain specialist) and Dr Leinani Salamasina Aiono-Le-Tagaloa (Pasifika senior medical officer). The rest of the EAG included leading psychologists, a clinical nurse practitioner, a rural GP, physiotherapists, the New Zealand Pain Society, a Māori health academic, an occupational therapist and academic lead on persistent pain, and a consumer representative. They were ably stewarded by the Chief Allied Health Professions Office head Martin Chadwick and his policy advisors.

Dr Tipu Aamir was tasked with finding the best people for the EAG. He says even though the members came from different professional backgrounds they all agreed on the final draft.

"This clearly represents the success of sociopsychobiomedical model which is championed by FPM for assessment and treatment of chronic pain."

The executive summary includes these points:

- Chronic pain or mamaenga roa, can cause significant challenges for both individuals and society.
- Chronic pain is a significant and complex condition that is highly prevalent in women, older people, Māori, and those with lower socio-economic status.
- Services are inequitable and not resourced to holistically address whānau living with chronic pain in New Zealand.
- The model of care framework has been developed to facilitate and support sector stakeholders who engage with the Ministry of Health to review and consider how best to meet New Zealand's health needs.

The model of care framework is based on a collaborative and inclusive approach examining services, international models, how workforce can be sustainable, how it can be flexible to meet the changing needs of the population and how it can have accountable clinical leadership.

> "This clearly represents the success of the sociopsychobiomedical model which is championed by FPM."

It agreed on some basic principles.

1. Our **Tiriti o Waitangi** obligations and its principles are upheld. Te Whare Tapa Whā (see figure, right) is weaved throughout the model of care. This holistic view of health aligns to evidence-based international pain models of care.
2. **Multi-disciplinary** teams working transdisciplinary to ensure the appropriate skill mix are accessible and available, including people with lived experience as part of service development and delivery to enhance access and uptake of services.
3. Clear **equitable pathways for care** appropriate to the individual.
4. Use of **technology** where appropriate and with a whānau focus.
5. Working as a **team** – sustaining and shared understanding of working and across scopes of practice for best outcomes.
6. Broader **biopsychosocial** training of the workforces – facilitate informed choice for people with pain to access a holistic range of care.
7. **Timely** access to the appropriate level of care.

The model of care has gone to the Minister of Health Andrew Little and to the new health agencies to see where it will fit under the Pae Ora health system.

Dr Aamir says there is still a way to go. "From here the real work starts where push is needed to embed this strategic document in Te Whatu Ora and Te Aka Whai Ora charter. It needs to be operationalised and will need ongoing stewardship."

One model for understanding Māori health is the concept of "Te Whare Tapa Whā" – the four cornerstones (or sides) of Māori health. This model was developed by Sir Mason Durie. It has been widely taught within New Zealand health professions, is easily accessed, and well understood across the country. Te Whare Tapa Whā has been a cornerstone to the chronic pain EAG's thinking and model of care development:

Many Māori modern health services lack recognition of taha wairua (the spiritual dimension). In a traditional Māori approach, the inclusion of the wairua, the role of the whānau (family) and the balance of the hinengaro (mind) are as important as the physical manifestations of illness.

Should one of the four dimensions be missing or in some way damaged, a person, or a collective may become "unbalanced" and subsequently unwell. This is reflected in a contemporary understanding of pain, with strong evidence that mamaenga roa affects taha tinana, taha wairau, taha whānau and taha hinengaro and, in turn, these factors also influence pain and pain-related disability.

TAHA TINANA (PHYSICAL HEALTH)

The capacity for physical growth and development. Good physical health is required for optimal development. Our physical "being" supports our essence and shelters us from the external environment. For Māori the physical dimension is just one aspect of health and wellbeing and cannot be separated from the aspect of mind, spirit and family.

TAHA WAIRUA (SPIRITUAL HEALTH)

The capacity for faith and wider communication. Health is related to unseen and unspoken energies. The spiritual essence of a person is their life force. This determines us as individuals and as a collective, who and what we are, where we have come from and where we are going. A traditional Māori analysis of physical manifestations of illness will focus on the wairua or spirit, to determine whether damage here could be a contributing factor.

TAHA WHĀNAU (FAMILY HEALTH)

The capacity to belong, to care and to share where individuals are part of wider social systems. Whānau provides us with the strength to be who we are. This is the link to our ancestors, our ties with the past, the present and the future. Understanding the importance of whānau and how whānau (family) can contribute to illness and assist in curing illness is fundamental to understanding Māori health issues.

TAHA HINENGARO (MENTAL HEALTH)

The capacity to communicate, to think and to feel mind and body are inseparable. Thoughts, feelings and emotions are integral components of the body and soul. This is about how we see ourselves in this universe, our interaction with that which is uniquely Māori and the perception that others have of us.

CPD in 2023: What you need to know

Continuing Professional Development (CPD) helps us deliver safe anaesthesia and pain medicine as we work to care for our patients, communities, colleagues and ourselves. Anaesthetists and specialist pain medicine physicians have been diligently recording CPD activities for many years.

The Medical Board of Australia (MBA) and the Medical Council of New Zealand (MCNZ) have recently introduced updated CPD guidelines for all registered medical practitioners. The ANZCA and FPM Continuing Professional Development Committee, CPD Review Project Group and CPD team have worked hard to align our program with the updated requirements.

Although it may seem daunting to navigate the activities outlined in the updated program, the positive is our existing CPD framework largely mirrors the requirements. Our online portfolio will store annual activity uploads with automatic transfer of ANZCA and FPM run events such as the ANZCA Annual Scientific Meeting (ASM) and FPM Symposium.

We have an extensive communications plan to keep you aware of the requirements to reduce the frustration, confusion and stress. Details of upcoming communications are available on the college website. Emails, webinars, e-news items, *Bulletin* articles and updates on our website will continue over the next year until we are all familiar with the annual 50-hour program. We will include dot point information tables and simple FAQ advice. I encourage you to ask our helpful CPD team for individualised advice.

Work has also begun to expand the range of easily accessible educational activities including more online options for those who are time poor or struggle to attend workshops in person. We are bringing respectful, inclusive CPD language and improved cultural safety to align with overarching ANZCA and FPM values.

The introduction of these MBA and MCNZ education updates unfortunately comes amidst pandemic pressures in healthcare however we know anaesthetists and specialist pain medicine physicians have demonstrated their commitment to their professional development. Impressively, the past two cohorts have managed a 100 per cent CPD completion rate despite an era of rapid change.

I'm confident our professions are well placed and up to the task of seamlessly adapting while continuing to maintain our curiosity for new technologies, emerging drug therapies and improved ways of working. We want you to feel supported to meet the updated requirements and encourage you to continue reviewing college communications about the 2023 CPD program.

Dr Debra Devonshire FANZCA
ANZCA Councillor
CPD Committee Chair
CPD Review Project Group Chair

ANZCA is adapting to meet the updated requirements of the Medical Board of Australia (MBA)/Australian Medical Council (AMC) and Medical Council of New Zealand (MCNZ).

So that you meet the updated requirements for CPD registration and recertification from 2023, the ANZCA and FPM CPD Program has been adapted as follows:

- Annual cycle (instead of a triennium).
- Annual plan and evaluation (previously three-yearly).
- Change from CPD credits to 50 hours of CPD per year (see details below).

WHAT IS REMAINING THE SAME?

- The college program is open to all current participants and to others who practice anaesthesia and pain medicine in Australia and New Zealand.
- The three categories of practice evaluation, knowledge and skills and emergency response, with amended requirements to facilitate the annual program.
- Electronic recording of activities with evidence uploaded to the CPD portfolio by participants, along with automatic recording of college activities such as the ASM and FPM Symposium.
- CPD portfolio dashboard, showing your progress against requirements.
- A calendar cycle for CPD.
- Online generation of compliance certificates.
- Links from the CPD portfolio to the ANZCA Library, training portfolio system and CPD handbook.
- Amended requirements for those who don't have direct patient contact.
- Individualised support for you from the ANZCA CPD team – cpd@anzca.edu.au.

WHAT DOES THIS MEAN FOR YOU?

The CPD committee and CPD Review Project Group have updated the CPD program to ensure participants meet regulatory requirements.

Following advice from the AMC that the CPD homes will be formally accredited in 2024, we have developed a staged transition to minimise disruption and streamline your move to the annual program. The transition arrangements for each triennium are illustrated in the below table.

The CPD committee has decided not to conduct a verification of CPD activities (audit) in 2023 to allow participants and staff time to focus on the move to the updated CPD program. This is also reflective of the positive standing of CPD participants in meeting audit requirements, illustrated by the 100 per cent completion achieved by participants during the 2021 verification (audit).

All CPD participants have received a personalised email with more information about arrangements for their individual transition.

<table>
<tr><th colspan="2">2022</th><th colspan="2">2023</th><th colspan="2">2024</th></tr>
<tr><td colspan="2">Determine new 2023 annual CPD program</td><td colspan="2">Transition year, no audit/verification</td><td colspan="2">Reporting compliance to MBA required</td></tr>
<tr><td>2020 – 2022 cohort
(3561 participants)</td><td>Final triennial submission date:
31 Dec 2022</td><td>Start annual program</td><td>First annual submission date:
31 Dec 2023</td><td>2024 annual CPD cycle</td><td>Second annual submission date:
31 Dec 2024</td></tr>
<tr><td rowspan="2">2021 – 2023 cohort
(1867 participants)</td><td colspan="2">18 months' notice before starting annual program</td><td rowspan="2">Final triennial sub-mission date:
31 Dec 2023</td><td rowspan="3">Start annual program</td><td rowspan="3">First annual submission date:
31 Dec 2024</td></tr>
<tr><td colspan="2">Progress with triennial requirements (unchanged)</td></tr>
<tr><td rowspan="2">2022 – 2024 cohort
(1200 participants)</td><td colspan="2">18 months' notice before starting annual program</td><td rowspan="2">Changed final triennial submission date:
31 Dec 2023</td></tr>
<tr><td colspan="2">Change on triennial submission date from 31 December 2023 from 31 December 2024.
*Reduced requirements.</td></tr>
</table>

2023 CPD PROGRAM REQUIREMENTS

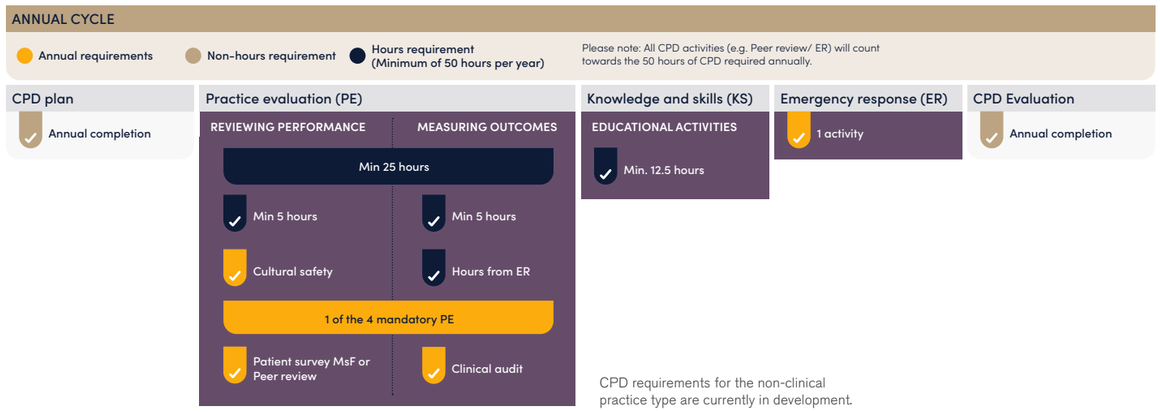
The MBA and MCNZ now require participants to do a minimum of 50 hours of CPD per year, including:

- At least 25 hours of practice evaluation (with a minimum of five hours of reviewing performance and five hours of measuring outcomes).
- At least 12.5 hours of knowledge and skills.
- A further 12.5 hours which can be claimed across the CPD program.

Annual college requirements for the clinical practice type are:

- One emergency response activity per year (with hours claimed under measuring outcomes).
- One of the four mandatory practice evaluation activities (either a patient survey, multi-source feedback, peer review or clinical audit).
- Satisfying the regulatory requirement for cultural safety (for example, one cultural safety activity).

Please note that hours taken to complete the annual college requirements contribute to the 50 hours of CPD required per year.



CPD requirements for the non-clinical practice type are currently in development.

IS YOUR CPD TRIENNIUM ENDING?

The ANZCA and FPM CPD Program is approaching its largest cohort for the 2020-22 triennium with more than 3500 participants. The final submission date for this triennium is 31 December 2022, with the transition to the new CPD program from 2023.

The 2021-23 and 2022-24 triennium will transition to the updated CPD program from 1 January 2024.

The CPD team are sending regular reminder emails to help with ensuring you successfully complete your CPD requirements and smoothly transition to the new annual CPD program.

We hope these targeted emails are helpful with outlining any remaining CPD activities and encourage you to reach out to the CPD team for individualised support.

SELECTED FOR THE 2022 VERIFICATION OF CPD ACTIVITIES?

The selection for the 2022 verification of CPD activities (audit) is complete and all randomly selected participants have been notified. As this is a random selection, it is possible to be selected in consecutive years.

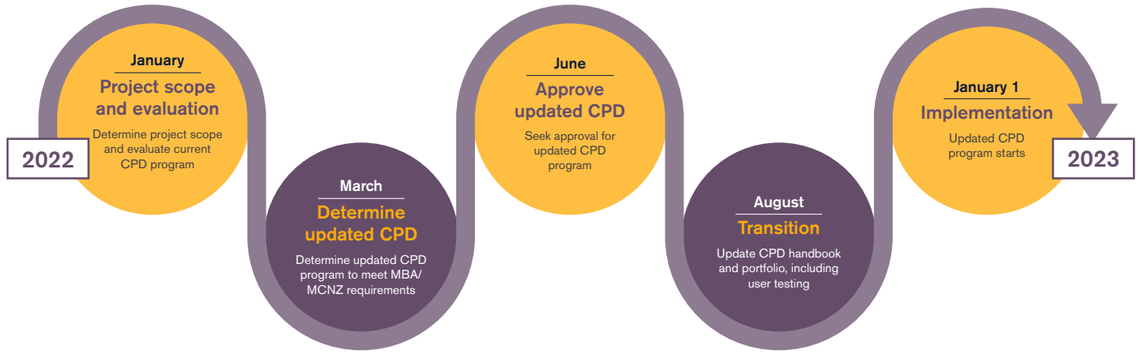
All selected participants will receive automated reminder emails ahead of the final submission date 31 December 2022. We appreciate you may have already completed your CPD requirements or contacted the CPD team to make alternative arrangements.

The reviewing of all CPD portfolios/evidence is expected to take place between January and March 2023, with participants notified in April 2023 of their compliance status.

As advised in 2023 CPD program communications there will be no verification (audit) process for the 2023 transition year, and the 2022 verification (audit) will be the last process for the triennial CPD program. We appreciate your participation and compliance with the verification processes.

If you have any concerns in with meeting your CPD requirements or about the verification process, please do not hesitate to contact the CPD team – cpd@anzca.edu.au – for support.

CPD REVIEW PROJECT PROCESS



CPD REVIEW PROJECT PROGRESS

The CPD Review Project Group (CPD-RPG) formed in October 2021 to evaluate the 2014 ANZCA and FPM CPD Program and develop an updated CPD framework to meet the revised regulatory requirements. The project is member-led, with CPD-RPG members representing a variety of locations, scopes of practice and stages of fellowship. The above diagram provides an overview of the CPD review project process.

To evaluate the 2014 program, the group analysed CPD portfolio survey responses, conducted a literature search and reviewed activity data from the CPD portfolio. Hours entered in the CPD portfolio provided insight into the time taken to complete CPD activities and supported our belief that CPD participants will have no trouble meeting the 50 hours of CPD now required annually. This data will also be helpful for the CPD-RPG when developing suggested hours for activities under the hours-based program.

The decision to require one emergency response activity and one of the four mandatory practice evaluation activities per year was also supported by CPD portfolio data, with 50 per cent of participants already doing three or more emergency response activities per triennium and 68 per cent of participants doing three or more mandatory practice evaluation activities per triennium.

Following evaluation of the current program, the group developed a *Determine the updated CPD framework report*, which was shared with the CPD-RPG, CPD committee, key staff members, fellows and CPD participants for consultation. Respondents represented a broad range of CPD participants, including ANZCA fellows, FPM fellows, specialist international medical graduates, non-fellows and provisional fellowship trainees. Feedback from the consultation supported the development of a single proposal for the updated CPD framework and supporting transition process.

The framework and transition process have now been endorsed by the CPD-RPG, CPD committee and ANZCA Professional Affairs Committee and were approved by ANZCA Council on 23 July 2022. Relevant FPM committees have been kept informed of progress and were asked to endorse FPM-related matters.

Work is continuing to update the CPD standard and handbook. Minor improvements are also being made to the online CPD portfolio, with CPD participants involved in user testing. Please be assured the look and feel of the portfolio will remain familiar.

We will continue to communicate with you over the coming months, sharing project updates, case studies and other helpful items to ensure you feel supported to meet the updated requirements. We ask all participants to continue to keep your CPD portfolio up to date to best prepare you for the transition to the 2023 CPD program.

CULTURAL SAFETY

Embedding cultural safety and a focus on health equity across the CPD program is a key addition to the MCNZ's updated recertification requirements. The AMC also require CPD providers to "refer to culturally safe practice and addressing health inequities". Given the ANZCA and FPM CPD Program caters to participants registered in Australia and New Zealand, we will be moving forward with the more prescriptive MCNZ requirement for participants in both countries.

We plan to work with consultants to design and deliver a consultation process with Māori, Aboriginal and Torres Strait Islander people to determine how to embed cultural safety and a focus on health equity across the program. We anticipate the consultation will take place in late 2022 or early 2023. Embedment of cultural safety and a focus on health equity is a great step forward for our CPD program, as CPD committee member Dr Michael Barlev highlights in his fellow perspective piece (see page 16).

While the scope and aims of the project have been driven by the updates to regulatory requirements, it has also been an excellent opportunity to review the CPD program after seven years of implementation. The team have used an evidence-based and member-centric approach to best meet the needs of participants and support you to continue meeting regulatory requirements and maintain your medical registration.

Further information can be found on the dedicated project webpage.

A step towards culturally sensitive healthcare

Dr Michael Barlev FANZCA from Dunedin Hospital shares his experience with cultural safety and the ANZCA and FPM Continuing Professional Development (CPD) Program

IT WAS A real pleasure to read Dr Jacob Koshy's piece in the Winter *Bulletin* on his experience maintaining CPD requirements. One comment stood out for me. The new CPD framework, which includes "cultural competence and intelligence".

Why is this important to me?

The answer is multifaceted, but here are two reasons. Personally, I will be continuing to undertake culturally significant learning myself. Secondly, I will be providing direct input into the introduction of the cultural safety and competence requirements of our CPD program as a member of the ANZCA and FPM CPD Committee.

My involvement in the CPD committee began in the Winter of 2020. I was undertaking a post-FANZCA fellowship at Fiona Stanley Hospital in Western Australia. Naturally, this experience was influenced by the ambush of COVID-19 pandemic. Among the stress on the system (both healthcare and personally) I noticed Western Australia had a feeling of deep cultural significance.

I have no known roots in Australia yet some of my patients' ancestors have been on the land for tens of thousands of years. Thinking about that was almost overwhelming. I felt it would be tragic for me to lack the basic skills and attributes to make a patient with that cultural background not feel at home in the hospital. Sure, the hospital is not akin to healthcare provided by their ancestors, but their journey will continue once they leave the front doors.

If I could only help make a single step in their healthcare journey more culturally sensitive, I would then feel worthy of standing on that land with them.

Since the COVID-19 pandemic, more and more of our learning is based online. In a fantastic step forward for ourselves and the CPD program itself, the CPD committee has engaged the services of Engaging Well Ltd (NZ). They are a father and son duo who have developed and run a suite of professional development opportunities in cultural competence, safety and intelligence. This type of learning can be claimed under the practice evaluation category in our current CPD program.

I enjoy the opportunity to gain credits in areas of providing healthcare that are not directly clinically related. We see clinical work most days. The CPD committee is doing a great job to ensure such credits are not a tokenistic hook, upon which fellows can hang their CPD hat embedded with a feather of cultural competence. Their purpose is to truly help each of us on our own personal journey towards better health equity.

Writing this piece has taken some reflection, and the importance of reflection cannot be overestimated. Using a broad-brush stroke, it is known that to learn better we must include reflection in our self-education repertoire. I found it surprising and then disappointing (in myself) that it came as a shock to discover the word "reflection" mentioned significantly in two health documents from our respective nations relating to cultural safety[1,2].

Reflection comes from Latin meaning bend back. Shall we bend backwards to see what is behind us to guide us forward? Shall we bend the norms of today to create a better tomorrow? I believe we should.

My experiences in attending cultural intelligence learnings are self-driven. A desire to be a more competent doctor in the eyes of the people I care for guided me. Safety is in the eye of the beholder, not those dishing it out.

I have undertaken short online based sessions from the Ministry of Health (NZ) and sought out courses at universities in New Zealand. Such courses are designed to support and assist healthcare professionals in understanding their own position and understanding of cultural intelligence with the aim to reduce health inequity. It is encouraging to see our CPD committee including such courses in our annual requirements. The college also has an array of available resources including:

- Geoffrey Kaye Museum Djeembana Whakaora – First Nations medicine, health and healing.
- 2021 NZNC Cultural safety and leadership Hui recording on Networks.
- ANZCA Library guide – Indigenous health.

I now find myself reflecting more frequently on patient interactions. I focus on what made me think or behave a certain way with patients, and how I might change that next time. These moments include cultural, race, age and gender differences. I hope others will be as excited to see cultural safety offered in the updated CPD program.

Dr Michael Barlev, FANZCA
Dunedin Hospital

FELLOWS AND CPD PARTICIPANTS WITH CULTURAL SAFETY

In 2020, the CPD activity cultural safety was relocated to our practice evaluation category and increased from 1 to 2 credits per hour. Since this relocation, this activity has been claimed more than 1200 times in participants' CPD portfolios with 582 times in 2020 and 622 in 2021. This is a dramatic increase from the previous results in 2019 claimed 153 times. These changes support the importance of strengthening Indigenous health practices and cultural competency learnings.

Work to embed cultural safety and health equity into the CPD program continues across the 2023 transition year of the CPD review project, meeting the regulatory requirement for cultural safety as an annual requirement for the 2023 ANZCA and FPM CPD program. For details regarding how this work is progressing, please see the website.

GOT A CPD EXPERIENCE YOU'D LIKE TO SHARE?

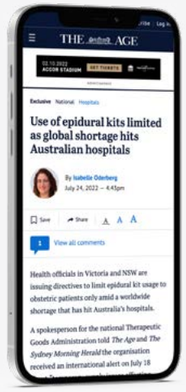
The college is seeking fellows and CPD participants to share their experiences with the CPD program in answering the question "How do you meet your CPD requirements?". Please get in touch with our helpful CPD team at cpd@anzca.edu.au with your interest.

References

1. MCNZ Statement on Cultural Safety https://www.mcnz.org.nz/about-us/news-and-updates/statement-on-cultural-safety/
2. AHPRA & National Boards Aboriginal and Torres Strait Islander Health and Cultural Safety Strategy 2020-2025 https://nacchocommunique.files.wordpress.com/2020/02/aboriginal-and-torres-strait-islander-cultural-health-and-safety-strategy-2020-2025-1.pdf

ANZCA and FPM media coverage

Highlights since the Winter *ANZCA Bulletin* include:



"Use of epidural kits limited as global shortage hits Australian hospitals"

(*THE AGE* AND *SYDNEY MORNING HERALD*, 24 JULY AND ABC RADIO)

ANZCA's Safety and Quality Committee Chair Associate Professor Joanna Sutherland was interviewed on ABC Radio Melbourne's morning program on 25 July about the global epidural kit shortage and its impact on Australian hospitals. Audio "grabs" of the interview also featured in ABC radio morning news bulletins. The interview followed comments by A/Prof Sutherland in an article published in *The Age* and *Sydney Morning Herald* in print and online about the shortage. A/Prof Sutherland was also interviewed on ABC Radio Hobart on 9 August. In New Zealand, fellow Dr Matt Drake was interviewed by stuff.co.nz. The combined media coverage in Australia and New Zealand reached more than a million people.

"ICU patients sent straight home as 'exit block' reveals hospital strain"

(*THE AGE*, 24 JULY)

FANZCA Associate Professor Craig French, director of Intensive Care at Western Health in Melbourne was interviewed for an article in The Age on 24 July about the pressures on the health system and how it affects ICU patients. He confirmed there had been instances at the Footscray and Sunshine hospitals in recent weeks where patients who no longer needed intensive care had been kept in the unit until they were ready to be discharged home.

"Hospital apologises after Wellington mum with endometriosis called 'drug seeker', sent home by ED doctor during pain flare-up"

(*NEWSHUB*, 29 AUGUST)

NZ fellow Dr Karen Joseph was interviewed for a Newshub article on 29 August about endometriosis. Dr Joseph, a member of the FPM New Zealand National Committee runs a pelvic pain clinic in Christchurch. She told Newshub there is an immense unmet need in New Zealand for specialist help for people living with persistent pelvic pain.

"Anaesthesia and surgery after COVID"

(ABC RADIO HOBART, 28 JUNE)

The director of anaesthesia at Royal Hobart Hospital Dr Ruth Matters was interviewed on ABC Radio Hobart's breakfast program on 28 June. In a six-minute segment Dr Matters explained why elective surgery is postponed after a COVID-19 diagnosis because of complications that may arise.

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

BEYOND CITY LIMITS

Top End experience a drawcard for anaesthetists

Above: Darwin's CBD is dotted with murals such as this one by Shona Lee @Shona_lee_creative
Photo: Siobhan Spence

"Sharing knowledge about what health and wellbeing outcomes First Nations people value is a foundation of culturally sensitive care."

Trainee Dr Krushna Patel in theatre at Royal Darwin Hospital.
Photo: Siobhan Spence

SINCE HIS RECENT arrival in Darwin to start his provisional anaesthesia fellowship year Dr Dom Cauldwell has been cycling to work on the bike path along one of the city's most scenic foreshores.

The ride from his home in the suburb of Nightcliff to Royal Darwin Hospital takes just 20 minutes.

The UK-born provisional fellow and his wife Zoe, a GP, have quickly adapted to the Darwin lifestyle having moved from Townsville after he finished his registrar training through the Queensland Anaesthetic Rotational Training Scheme (QARTS). Dr Cauldwell is one of six provisional fellows working in the department of anaesthesia at Royal Darwin Hospital.

He knows his regular commute might be the envy of many fellows and trainees working in large metropolitan cities who often have to battle daily traffic chaos to get to work.

"It hasn't taken us long to adjust to life here. Coming from Townsville Darwin has many similarities. The climate is similar and so too is the patient demographic. But Darwin is also a lot more multicultural and you're aware of that right from the start."

The hospital's department of anaesthesia is headed by Dr Brian Spain who is also the co-director of surgery and critical care at the hospital. Dr Spain and his wife Jenny, a GP, moved to Darwin in the late 1990s from Melbourne via Perth and raised their family in the territory.

Dr Spain is a popular advocate for the specialty and committed mentor to anaesthesia trainees and fellows working in Australia's Top End. He has played a key role in encouraging the development of South Australian and Northern Territory training opportunities for the specialty through the Australian Commonwealth-funded Specialist Training Program (STP) and the STP Integrated Rural Training Pipeline (IRTP) initiative.

On the Tuesday the *ANZCA Bulletin* visited Dr Spain and his team, including deputy director Dr Sam Rigg, the department had just wrapped its weekly morning meeting. Dr Spain encourages fellows and trainees to attend the weekly Tuesday meeting if they can as it features a clinician from the hospital or department speaking on topics such as safety and quality in anaesthesia or perioperative care.

Dr Spain knows that attracting and retaining anaesthetists to work and live in Australian rural and regional areas is challenging. The federal health department recognises this and funds specialist registrar positions through specialist medical colleges including ANZCA under the STP. Additional training positions are also funded through the program's IRTP initiative.

For first year anaesthesia trainees Dr Krushna Patel and Dr Nilesh "Nelly" Kumta, working in Darwin has not only given them a broad scope of clinical practice opportunities but has placed them at the heart of stunning landscapes with tens of thousands of years of First Nations history and culture.

"One of the great aspects of working here in Darwin is that you are exposed to such a variety of work that you might not have the chance to do at other training sites," Dr Patel explains minutes after leaving theatre where she was part of the medical team for a caesarean birth of twins.

Provisional fellow Dr Dom Cauldwell starts his ride home from Royal Darwin Hospital.
Photo: Nicholas Walton-Healey

Anaesthetist Dr Edith Waugh with patient Ronald Palmer and his wife Priscilla. Photo: Nicholas Walton-Healey

"While I've worked on obstetrics cases this morning I've also had some 'plastics' cases to remove skin cancers and a three-hour liver resection. There's a real 'can do' attitude here and we're all supervised by senior consultants."

"Darwin offers something very unique," she says.

"There is such a diverse demographic here. The consultants and specialists are very highly skilled so as a young trainee you feel very supported. It is very hands on.

"We help patients get through their operation in a safe way. Many of the patients are very high risk so you get to learn things quickly and know what resources you can draw on. For example you might have to facilitate a quick dialysis for a patient before their operation so you soon learn how to organise this and make sure the patient gets through their operation safely.

"The breadth of different specialties that you're exposed to is seamless. It's very rewarding and does have its own challenges but it's so satisfying when you get a patient through their surgery."

Dr Cauldwell and Dr Kumta agree. "We have more independent practice here unlike other places where there is a lot less autonomy in the early stages of training. The team here are very supportive," Dr Cauldwell says.

"We have more independent practice here unlike other places where there is a lot less autonomy in the early stages of training. The team here are very supportive."

Trainees Dr Nilesh Kumta and Dr Krushna Patel taking a well-earned coffee break. Photo: Siobhan Spence

Dr Kumta says 70 per cent of the hospital's patients are Aboriginal and Torres Strait Islanders. Many have complex medical conditions such as type 2 diabetes, ischaemic heart disease and rheumatic heart disease.

"On any one day I will see a variety of patients," he explains.

"I could see a five-month-old baby followed by a 20-year-old and then a 75-year-old with end stage renal failure. Many patients require complex treatment and our role is to ensure they get through their operations safely."

Dr Spain has worked closely with ANZCA's SA/NT Regional Committee to secure more funded anaesthesia training opportunities in Darwin and Alice Springs. His department manages 14 registrars and 24.5 full-time equivalent consultant positions that are filled by 30 anaesthetists.

Specialist anaesthetist Dr Edith Waugh has lived and worked in Darwin for over a decade and works closely with the hospital's Aboriginal Service Support Unit and its Aboriginal liaison officers. With the permission of Aranda man Ronald Palmer and his wife Priscilla the *Bulletin* was able to meet and chat with him as he discussed his acute pain management with Dr Waugh.

Mr Palmer explained to the *Bulletin* how he was flown to Royal Darwin Hospital for treatment from his remote, Katherine region community with chest trauma. With optimised pain control and a well-secured chest drain with an under-water seal drain attached to his wheelchair, he was able to leave his hospital room and sit outside in one of the hospital courtyards.

Mr Palmer's acute pain management involved understanding the combination of traditional bush medicine, the western health care system's available analgesia, and importantly, the healing environment. The break from the air-conditioned ward to the warmer courtyard and spending time with family were highly valued by Mr Palmer.

"The hospital's perioperative medicine and pain management (POPM) service has been managing Ronald's comfort while also respecting his cultural needs," Dr Waugh explains. Sharing knowledge about what health and wellbeing outcomes First Nations people value is a foundation of culturally sensitive care. Interpreters and Aboriginal liaison officers assist with safe intercultural communication and mediation in the local health service. This leads to not only a better patient experience but also to the incredible privilege of working in this culturally diverse environment of the Top End."

While the main Royal Darwin Hospital's Casuarina campus has a 24-hour emergency department the opening of the hospital's Palmerston campus in August 2018 has been used largely for day and minor surgery cases though some overnight surgical beds will soon be available to help deal with the backlog of elective surgery patients exacerbated by the COVID-19 pandemic.

"In collaboration with Alice Springs Hospital we have developed an NT independent training program with support from major hospitals in Adelaide such as Flinders Medical Centre and the Women's and Children's Hospital to provide cardiac training and paediatric training. This means we can now provide the whole anaesthesia training program in the NT and encourage more junior doctors to come here," Dr Spain explains.

"We can now provide three years of anaesthesia training in Darwin so junior doctors can get into the Darwin lifestyle and establish their lives up here. This is a huge advance for us and Royal Darwin Hospital.

"We're hoping that this will ultimately mean that we can provide three years of training at Royal Darwin and one year in Alice Springs. There has been strong support from the SA/NT Regional Committee and the STP program for this initiative."

Above: Royal Darwin hospital trainees (from left) Dr Nilesh Kumta, Dr Krushna Patel and provisional fellow Dr Dom Cauldwell. Photo: Siobhan Spence

Left: Head of anaesthesia Dr Brian Spain. Photo: Carolyn Jones

"Darwin is a really interesting place to practice anaesthesia, it's a great young department with lots of enthusiastic specialists and a backdrop of a fantastic place to live."

The ANZCA STP program currently enables Royal Darwin to fund a provisional fellow in perioperative medicine, a registrar level trainee for up to three years and an IRTP position. Two additional roles, including an obstetric fellowship position, are on the STP reserve list.

"There are great learning opportunities even in the pre-vocational space for interns and junior residents," Dr Spain says.

"There is amazing diversity, all the medical specialties are represented with complex intensive care and there's also an excellent infectious diseases department.

"Darwin is a really interesting place to practice anaesthesia, it's a great young department with lots of enthusiastic specialists and a backdrop of a fantastic place to live. It's a small city but there is a lot of great stuff to do outside of work.

"Darwin really is an incredible place. You get to work in Australia's most isolated tertiary hospital that caters to complex health needs and live in one of the most amazing places on earth."

Carolyn Jones
Media Manager, ANZCA

Pathways to training

Melissa Rosas had not thought of studying medicine until she had a chance conversation with a family friend in Darwin while she was studying her Bachelor of Psychology at Charles Darwin University in 2018.

Her friend, who was working for Flinders University at the Casuarina campus, asked Ms Rosas if she had considered exploring the Indigenous student pathway to a medical degree as Flinders University offered such a program through their campus in Darwin.

Ms Rosas, who was born and raised in Katherine, is now in her fourth and final year of the university's Doctor of Medicine and is about to complete her six-week rotation in the department of anaesthesia at Royal Darwin Hospital. She has just had her first intensive introduction to the specialty and has spent the past few weeks intubating patients, learning new procedural skills, observing pain rounds of patients and learning from specialist anaesthetists.

"The hands on experience has been quite incredible and the team here has been so supportive," she tells the *ANZCA Bulletin*.

Ms Rosas wants to stay and work as a medical practitioner in the territory once she completes her degree and internship. Flinders University, through its regional training hub, welcomes Ms Rosas's commitment to the territory and hopes other students will follow her path. There are 26 regional training hubs across rural Australia, including the Flinders NT Regional Training Hub.

Ms Rosas and fellow fourth year Flinders University medical students Thilini Pandithage, Ben Forsyth and Hayley Kelly are all completing their medical degrees at the university's Northern Territory campus. All are bonded to the Northern Territory government for four years after graduation ensuring their higher education contribution scheme fees are waived.

The hub's regional training program manager Eliza Gill says one of the hub's aims is to help address medical workforce needs in the Northern Territory by further developing medical specialist and rural generalist training opportunities. Along with identifying and supporting students and junior doctors with an interest in rural practice and providing support and assistance with career planning placement opportunities.

"It's important to ensure there are medical specialist training opportunities in the Northern Territory to ensure that all junior doctors including those that have return of service obligations have a choice of training pathways to continue living, training and working in the Northern Territory.

The NT Medical Program is an opportunity for Territorians to enrol in a medical degree here and is graduating doctors that are delivering healthcare to the NT".

Student Thilini Pandithage says both her parents are Darwin-based doctors and she has seen how fulfilling her parents' careers have been in the territory.

"My father has spent a lot of time working in rural communities and I've seen how having such a broad set of clinical skills here is useful is anything goes wrong in a rural or remote community."

Hayley Kelly is interested in pursuing retrieval medicine and enjoyed her rotation in the anaesthesia department earlier this year. Ben Forsyth started his degree after working for several years as a mining engineer.

The training hub's medical director Dr Greg McAnulty is based in Alice Springs. He says the hubs were formed by the Australian department of health to encourage the development of a "rural medical training pipeline" that includes medical students, pre-vocational graduates, vocational trainees and, finally, rural generalist GPs and medical specialists such as anaesthetists.

"We're working with relevant colleges, health services and training providers to identify and prioritise the areas of need and in turn, aim to build well co-ordinated, and well supported vocational training pathways in the NT," he explains.

Dr McAnulty, who trained as an intensive care specialist, says retaining medical practitioners and specialists in rural and remote Australia has been an ongoing challenge for the states and territories and specialty colleges.

"There is an understanding that more needs to be done. We support the idea of a pipeline where ideally you have people who have grown up here, and who have developed social connections here, who then decide to stay on in the territory. That may be the case for some but until now, the vast majority of those who are providing specialist medical services in the territory have come from elsewhere," he explains.

"However, a good proportion of those have had a pivotal experience in the territory either as a medical student or as a trainee so the key for us now is to ask where in that training pathway an experience in regional and remote Australia and, in particular, the NT can it make a difference?

"It's important that you're in a place that you enjoy living in, that is intellectually stimulating and are part of a community who you have something in common with. And, of course, where the work you are doing is of value.

"We need to look at what initiatives and structures work so we can best help those who do want to get into specialty training and encourage them to stay here. We need to work out how best to foster that and that will involve us continuing to work with specialty colleges, communities and government," Dr McAnulty says.

Carolyn Jones
Media Manager, ANZCA

From left: Flinders University medical students Thilini Pandithage, Hayley Kelly, Melissa Rosas and Ben Forsyth. Photo: Siobhan Spence

What would you do?

Dr Peter Roessler explains professional documents using practical examples. In this edition he asks “Are you culturally safe?”

WITH THE CONSTANTLY changing landscape of cultural and Indigenous issues, there is a need to ensure that fellows are kept up to date and encouraged to undertake relevant CPD activities.

The college’s commitment to these important areas is evidenced by the establishment of the Indigenous Health Committee, Reconciliation Action Plan Working Group and a Te Tiriti o Waitangi (Treaty of Waitangi) Strategy Working Group (currently being convened).

The college’s Indigenous Health Strategy and accompanying background paper outlines our commitment to addressing the significant inequities in health outcomes that exist between Indigenous and non-Indigenous people in Australia and New Zealand. These health inequities are evident across a wide range of measures and include poorer surgical outcomes, higher rates of suicide and significantly shorter life expectancy at birth – 54.9 years median age at death for an Aboriginal and Torres Strait Islander male compared with 78.6 years for a non-Aboriginal and Torres Strait Islander male in 2017.

Professional document PS62(G) *Position statement on cultural competence* details the college’s commitment to the role and importance of cultural competence in effective clinical practice and patient care. Cultural and Indigenous matters are highly sensitive issues that need to steer a course negotiating human rights for both individual and all members and groups of the community. A primary overriding requirement is respect. Respect for oneself and respect for every human being, irrespective of origin or background.

The latest Medical Board of Australia and Ahpra Medical Training Survey (2021) of doctors-in-training reveals that 36 per cent of Aboriginal or Torres Strait Islander respondents reported they have personally experienced bullying, harassment or discrimination in the past 12 months compared with 22 per cent of all respondents. This is just one statistic that underscores the need for continued action to ensure safe and respectful training environments for our trainees as well as all health service staff and patients.

The following scenario is intended to stimulate reflection on cultural issues.

SCENARIO

A position has come up on your hospital’s medical advisory committee of which you are a member, and the only applicant is strong on the role’s advertised selection criteria with respect to clinical expertise however does not score highly against the hospital’s committee composition diversity matrix, particularly in relation to Aboriginal and Torres Strait Islander peoples.

Would you support their appointment, or would you insist on finding another individual?

What if the applicant identified as LGBTQI+? Or came from an Indigenous culture of another country?

WHAT WOULD YOU DO?

Much work is being done by the college in advocating for First Nations health for Māori in New Zealand and for Aboriginal and Torres Straight Islanders in Australia. There are clearly very strong reasons to support such actions, and there is an undoubted need.

There are differences in the laws across the “ditch” between Australia and New Zealand, of which fellows need to be aware to ensure that they comply with those laws. Note however that Australian laws (Commonwealth and jurisdictional) which prohibit discrimination on the basis of race include provisions that allow employers to adopt “special measures”, including targeted recruitment strategies, to assist disadvantaged racial groups. Similar provisions exist in New Zealand.

In Australia, cultural safety is addressed in the Australian Medical Council (AMC) *Good Medical Practice: A Code of Conduct for Doctors in Australia* in brief and general terms. In New Zealand, cultural safety is enshrined in law and Te Tiriti o Waitangi, from which the Medical Council of New Zealand (MCNZ) has developed its statement on cultural safety.

Throughout 2022, the college has been undergoing full reaccreditation, a 10-yearly multi-stage process with assessment by an AMC-led team with MCNZ representatives. A focus from the medical councils of both countries has been what the college is doing to attract more Aboriginal, Torres Strait Islander and Māori trainees and how we are supporting them to ensure successful fellowship in culturally safe training environments.

In addition to the MCNZ and AMC resources referred to above, more information is available on the college website with links to the Indigenous Health Committee as well as the Indigenous Health Strategy. *PS62(G) Position statement on cultural competence* is due for review and although a helpful guide, it is in need of updating in line with recent advances in the literature and changing perspectives.

Returning to our scenario above, further information surfaces that the applicant is from a European migrant background. Their history is that their parents barely survived the invading army of World War II to be liberated by an oppressive regime. Speaking out against the regime necessitated a hasty escape with only their clothes and their six-month baby to avoid arrest. They had no profession and only limited schooling but on arriving in Australia, worked extremely hard in factories so that their child could go to school and university to finally emerge as a medical practitioner.

Through interviewing the candidate it is clear that they are culturally competent in being aware of the issues faced by other cultures but is also culturally safe as they are aware of the impact on others, of their own culture and its biases.

How would this information influence your vote?

There is no right or wrong answer and as noted, the purpose of this piece is to stimulate self-reflection on cultural issues. Some things that you might consider in deciding whether or not to appoint this candidate to your committee could include:

- The current composition of the committee and the extent to which it reflects a diverse mix of skills and backgrounds. Evidence demonstrates that boards, committees and workforces that reflect the diversity of our community have numerous benefits, including more diverse knowledge and viewpoints, a more inclusive culture, a broader view of risk management, a greater understanding of and responsiveness to the needs of different cultures, and an enhanced ability to deliver culturally appropriate care.
- A multi-faceted view of diversity includes consideration of all dimensions of diversity including race, gender, sexual orientation, depth and breadth of professional and life experiences, and ethnic background.
- Does the committee have an Aboriginal or Torres Strait Islander (if in Australia) or Māori (if in New Zealand) representative? Policies around the inclusion of Indigenous voices on committees play a vital role in addressing health inequity and inequality in a population group that has a life expectancy of up to 20+ years below the general population. These policies work towards addressing years of exclusion from society and from implicit biases and continued discrimination and racism.
- How was the committee vacancy advertised? Were active measures taken to encourage applications from Aboriginal, Torres Strait Islander or Māori doctors – for example through advertising in Australian Indigenous Doctors’ Association’s newsletter?

Dr Peter Roessler
Director of Professional Affairs, Professional Documents

To operate or not to operate: An introduction to PG67(G) End-of-life care

"Into whatsoever houses I enter, I will enter to help the sick, and I will abstain from all intentional wrong doing and harm..."
Hippocrates

PEOPLE ARE LIVING longer and are dying at increasingly older ages despite suffering multiple medical co-morbidities including dementia. There are often multiple medical decision points during this period of decline and the end-of-life (the period when death is anticipated due to disease progression, frailty and general deterioration in physical and/or cognitive function).

Clinicians often express uncertainty when caring for patients near to the end-of-life who are considered for surgery. This may range from moral distress at subjecting patients to invasive procedures that may also be harmful when they are dying, to frustration that a potentially beneficial procedure is being denied.

Additional concerns exist around futile treatment, clinical momentum, and procedural high morbidity and mortality and the uncertainty regarding implications of advance care directives and limitations on medical treatment in the perioperative period. These may be expressed around a patient's decision-making capacity, the legality of an advanced care directive, a goal of care plan or a limitation in treatment directive that may be in place.

So it was with some trepidation that we set out to develop a *Guideline for the care of patients at the end-of-life who are considered for surgery or interventional procedures*. It was essential that *PG67(G)* be a multidisciplinary, co-badged and developed document comprising membership from all appropriate stakeholders.

Consequently, the document is broader than anaesthesia-focused and intended to apply to all relevant registered clinicians involved in the care for patients at the end-of-life who are considered for surgery or interventional procedures. The issues of futile surgery and voluntary assisted dying are separate matters that was considered out of scope for *PG67(G)* development.

Clinically identifying patients at the end-of-life is an important skill for doctors. It was Dr Richard Asher, the renowned clinician and popular teacher, who stated that "clinical knowledge depends upon three processes: observing, recording and thinking."

He described in his lecture series delivered to the Medical Society of London in February 1959 that the "thinking" part described the process of consideration, rumination and deliberation which constitute clinical thought and the initial mental process to which clinical information is subjected is largely unconscious and requires time to assimilate. He concluded one of his lecture series with a definition of clinical common sense as "the capacity to see the obvious even amid confusion and to do the obviously right thing rather than working to rule."

Modern clinical practice is in somewhat contrast to this "clinical sense" as we are constrained to perform within established protocols and procedures and our practice is, to a strong degree, governed and contained by mandatory clinical, legal, and ethical requirements.

PG67(G) was developed in a framework comprising of at least two key aspects in the decision-making process when considering surgery in patients at the end-of-life:

- Evaluating benefits of surgery with respect to the patient's illness trajectory, values and the patients and their family be informed about the (long-term) consequences of surgery at the end-of-life; with explicit information about the consequences/complications/and outcome (temporary, final).
- Mitigating harm from non-beneficial treatment and any additional interventions if surgery proceeds by involving the surgical multi-disciplinary team (including the anaesthetist, and often where appropriate, internal medicine, geriatrics and palliative care).

Surgery can inspire anticipation, fear, and many other feelings in patients who are to undergo surgical procedures. Surgery is not just a medical procedure, it's a chance and hope for someone to get better. The public often has high expectations of curative capacity that exceed reality on the one hand and exhibit widespread concern about bad dying on the other. Clinicians still struggle with treatment limitation decisions and issues related to causation and responsibility for death.

"This means that anaesthetists are often in a quandary: they can anaesthetise but should they?"

Patients who are considered for surgery and interventional procedures in Australia and New Zealand tend to be older, medically complex with multiple co-morbidities, and have a high rate of geriatric syndromes such as frailty, cognitive impairment and functional decline.

Life-prolonging surgery may confer a favourable outcome, although surgical outcome review committees and coronial reports in both countries demonstrates increased in-hospital, 30-day, 90-day and one year mortality following surgery as well as lower quality of life, increased length of hospital stay and lower rates of discharge home. People are dying at increasingly older ages over one to two years, with more significant medical decision points at the end-of-life.

There was a time when nobody would question that if you underwent surgery, the most important outcome was survival (that is, you will die without the surgery), and therefore everything possible would be done to keep you alive. Although the skill of the surgeon is always paramount, the person who "gets you through" the surgery is the anaesthetist.

In the past it was not uncommon to deem patients "unfit for anaesthesia". In modern anaesthesia practice this is rarely the case, so decisions are made to proceed, and it often seems that everyone now "gets a go" regardless of age or disease burden. This means that anaesthetists are often in a quandary: they can anaesthetise but should they?

This often wedges them between surgeons (often pressured by referring colleagues, desperate patients and families, who, on one hand "want something done" hoping that the surgery is curative, and the evidence-based perioperative and holistic clinical assessment of a potential poor outcome, high risk, high morbidity and maybe even ethical discomfort that a dying person is being subjected to a potentially "futile" procedure, on the other.

PG67(G) has been developed to provide an agreed framework to assist in "diagnosing" those at end-of-life and provide principles of care needed to be considered with the intent (that is, good clinical sense) of the proposed surgery or procedure.

Any treatment must promote a shared-care decision making process exploring patient-centred outcomes, promote cultural safety and, importantly, mitigate the potential for clinical momentum if surgery proceeds. Clinicians must now actively manage the limitations on medical treatment (LOMT) in the perioperative period (including medico-legal implications) and be fully cognisant of the goals of care (GOC) framework in the context of the end-of-life surgery (that is, curative/restorative, palliative or terminal).

Clinicians should move away from the almost exclusive focus on human agency and death causation (important though this is) and embrace non-obstruction of the dying process and self-determination so that natural death is seen as having a composite meaning embracing both forensic and existential senses.

In the final analysis, all would surely agree that there is more to a "good" or "good enough" death than causality and accept that it is an important attribute of humanity and dignity to deal with our own dying, then it is also incumbent upon us to accept that just as we come into the world needing help, as we leave it we will probably need the help of others the natural forces take us from the world.

There is a time to accept the inevitable. Surgery should not be considered for patients at the end-of-life who have entered the terminal phase but may be beneficial for some of those in the palliative phase where anticipated survival can be months or even years.

Palliative care is the means by which the realities of dying can be dealt with and is well backed up by public policy, ethics and law. Our health systems and the law are evolving towards care that meets the real needs and wishes of people as the end-of-life approaches including a say in how we die.

PG67(G) should provide confidence to treating clinicians of an agreed framework for the care of patients at the end-of-life who are considered for surgery or interventional procedures in an environment where we need to sensitively, directly and clearly, raise end-of-life, death and dying, risk and prognostic issues, with patients, families, and substitute decision-makers. Our medicolegal obligations vary by country, state or territory and clinicians must take into consideration the relevant legal and institutional requirements and procedures for the jurisdiction and organisation in which they work.

Finally, we are all too aware that not all eventualities can be predicted or discussed with a patient prior to surgery and harm cannot always be averted even with the most beneficent of intentions. The premise of *PG67(G)* is that the intention of surgery or intervention at end-of-life should be useful to the patient, rather than cause no harm and with it, maybe, just maybe, within this framework, we should take a little more time to consider, ruminate and deliberate.

We thank the document development group , representing a wide multi-disciplinary team for their enormous contibution to see the project completed. We particularly thank Dr Peter Roessler and the ANZCA team for their perseverance and oversight of this project.

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- Australian and New Zealand College of Anaesthetists (ANZCA)
- Royal Australasian College of Surgeons (RACS)
- Royal Australasian College of Physicians (RACP)
- Australian College of Rural and Remote Medicine (ACRRM)
- College of Intensive Care Medicine of Australia and New Zealand (CICM)
- Australian College of Emergency Medicine (ACEM)

A collaborative effort for college reaccreditation

ANZCA and FPM are accredited by the Australian Medical Council (AMC) and Medical Council of New Zealand (MCNZ) to deliver our training programs, continuing professional development (CPD) program and specialist international medical graduate (SIMG) assessment process. We submit yearly reports against the AMC and MCNZ accreditation standards and undergo a full reaccreditation every 10 years.

The AMC and MCNZ have been reaccrediting the college, including the Faculty of Pain Medicine, this year. Full reaccreditation is a multi-stage process with assessment by an AMC-led team with MCNZ representatives. To guide this assessment, a team of staff, fellows and trainees from across the college developed a written submission addressing the 10 AMC and MCNZ accreditation standards. We shared the completed submission with the AMC in April 2022.

STAKEHOLDER CONSULTATION

Across June and July 2022, the AMC/MCNZ assessment team collected feedback from stakeholders involved in college activities. This included:

- Surveys to collect feedback from fellows, trainees and SIMGs.
- Submissions from other colleges, medical schools, First Nations organisations and other health bodies.
- Four hospital visits and dozens of satellite meetings, where the team spoke with metro and regional trainees, supervisors, heads of department, regional and national committees, hospital executives, consumer groups, Australian health departments and the New Zealand Ministry of Health.
- Visit week at ANZCA House, during which an eight-member AMC/MCNZ panel met with more than 120 fellows, trainees, SIMGs, consumer representatives and college staff across 20 meetings.

During visit week, the visitors acknowledged the significant work the college is progressing and how we responded to the impact of COVID-19. Sincere thanks to all who made themselves available for the reaccreditation activities – whether developing the written submission, providing feedback via surveys or meeting with the AMC/MCNZ team virtually or in person. The reaccreditation process has been a whole-of-college effort. It's also been a great opportunity to benchmark our performance.

WHAT'S NEXT?

The AMC/MCNZ team is triangulating data from the stakeholder consultation and the written submission to develop an accreditation report which will include commendations, conditions and recommendations. The college has the opportunity to provide feedback on the draft report, before we receive a final report in December 2022.

Dr Sarah Wong and Ms Diana Wong

(Supplied by Australian Defence Force)

Keeping it in the family

The end of 2020 marked a significant sea change for anaesthetist Dr Sarah Wong and her mother Diana Wong, an emergency nurse and midwife with a PhD in disaster health. While Sarah not only received her fellowship papers for ANZCA, both were accepted into the Royal Australian Navy as reserve officers in the Maritime Operational Health Unit (MOHU) based out of HMAS *Penguin*.

A CONSULTANT AT Sydney's Westmead Hospital's surgery trauma referral centre, Lieutenant Commander Wong is one of a few Australian anaesthetists in MOHU. The fact that her first naval exercise on the flagship HMAS *Canberra* last year was alongside her mother Lieutenant Diana Wong isn't lost on her.

"You often see fathers and sons serving together as Reservists, but not mothers and daughters," Sarah explains.

"Joining the Naval Reserve was something that I had always wanted to do. I focused first on medical school and then when I started my fellowship year I started the application process to join the Royal Australian Navy. The process took almost a year as it involved interviews, fitness tests and a final board panel of review. Then there's the Reserve Entry Officer Course which involves four separate phases.

"I completed most of the process with my mother. She had started her recruitment process about six to 12 months before me but we managed to get on to the same Reserve Entry Officer Course together."

The pair served together on board HMAS *Canberra* for three weeks during Exercise Sea Explorer in mid-2021 which, in addition to simulating a series of mass casualty events, reaccredited the ship's hospital facilities. Exercise Sea Explorer involved nearly 1400 soldiers, sailors and aviators practising amphibious landings of soldiers, battle tanks, helicopters and equipment in north Queensland.

As the ship's anaesthetist during the exercise Sarah participated in numerous drills as part of a trauma response unit to a raft of simulations and protocol tests for toxic hazards, flooding and on-board fires. The medical and surgical teams would handle the "casualties" in the ship's hospital through triage, emergency and resuscitation and then "transfer" them to either theatre, intensive care or a medium-dependency unit depending on their needs.

Dr Wong at Westmead Hospital.

Sarah worked with the ship's surgeon to "treat" conditions ranging from fractures, amputations, airway trauma, abdominal trauma and head trauma that needed neurosurgery.

"The hospital is a small place in a warship. There are two operating theatres, five ICU beds and three resuscitation beds," she explains to the *Bulletin*.

"We needed to make sure we could outfit the surgical table and prepare ourselves for surgery as required depending on the trauma involved. The theatre bed is fixed to the deck of the ship so we had to work out how to operate despite the limitations of the space. The scrub nurse is always on the patient's right for instance, so you quickly learn how to work within certain limitations based on the resources and supplies you have.

"While it's about being innovative and resourceful it's also recognising the chain of command is different to that of a civilian hospital. In our normal day-to-day hospital work it's so easy to pick up your phone or run next door to check something with a colleague, whereas on board the ship there is one controller and that person needs to know everything so they can make decisions for you. Getting your mindset around that chain of command is quite challenging because you have less autonomy. As you step into that military environment, instructions become orders which are effectively commands.

"At Westmead everything is electronic so you can see at a glance who your patients are and what's coming next but that technology is not used on the ship. Paper is more reliable when you are on board, especially during operational activities."

When the *ANZCA Bulletin* caught up with Sarah she was in the middle of a three-week junior officer leadership and management course. She relishes the transition from her civilian life to her temporary role as a medical specialist reservist and embraces the challenges in both. She says many of the skills she applies in both settings are interchangeable.

"I quite enjoy balancing my civilian work and bringing those skills into my defence work. I want to make sure I keep my critical and trauma management skills sharp so that I may best contribute to our Defence Force's health capability. The Australian Defence Force is responding to a greater number of humanitarian and disaster relief (HADR) operations in our region and is building its capability as it monitors the situation in the Indo-Pacific (Plan Pelorus 2022).

"The self-challenge and the desire to learn is what drives me. The way I have approached anaesthesia and how I continue to, is the challenge for me to keep learning. I want to focus on becoming the best anaesthetist I can be for my patients.

"For me personally, the Navy Reserve is a new and exciting environment that provides me an opportunity to build on my existing teamwork, leadership and critical thinking skills. These attributes translate across both my work places and are so important in both."

Sarah is adept at juggling her civilian commitments at Westmead Hospital and private practice with her reservist role and is grateful for the hospital's support.

"When you're in the navy you're first and foremost an officer and then a medical specialist so you do role model a certain type of behavior as a reservist when you're on board. Teamwork is key in both my civilian work and in the navy. I'm applying my tradecraft skills outside of Westmead where I have access to everything, to the austere environment on board the ship. That said, the resources on the ship are phenomenal."

Sarah's next challenge is to hopefully complete a submarine rescue course in Western Australia later this year.

She would appreciate the opportunity to undertake further training with Diana, however, recognises this may not be possible.

"It's really like taking your best friend with you when you're doing something outside your comfort zone and not being sure what to expect. It's the perfect balance as you have responsibility but also the ability to have fun.

"My great grandfather was in the Dutch Navy and served in World War II so it's nice to know our military heritage is continuing with our naval service."

Carolyn Jones
Media Manager, ANZCA

Self matters

Name-role hats: improving trainee experiences

The challenge of change

In this edition's article, Dr Munro Brett-Robertson reflects on his passion for change, arising from his early experiences as an introductory trainee. Taking up the #theatrecapchallenge to wear name-role hats, his report reminds us that trainees moving between hospitals must adjust repeatedly to new staff and routines. No doubt this problem is also experienced by medical students, and trainees and students in other health disciplines. For all of us, our teams frequently reconfigure.

Misidentification in the workplace occurs more often for women. Dr Brett-Robertson's female colleagues report this improves when they wear the name-role hats. The outcome of not knowing those around us, particularly in emergent situations, is potentially catastrophic for our patients. It has wellbeing implications for all staff, and is felt particularly by those new in our teams.

I thank Dr Mary-Ann Fox for introducing me to Munro. As always, I welcome ideas for future columns and authors at lroberts@anzca.edu.au.

Dr Lindy Roberts AM
ANZCA Director of Professional Affairs, Education

DO YOU FEEL like nothing ever changes at work? As if the cogs of the healthcare machine are so big there is nothing any one person could do to change anything? I want to tell you a story about how, as a trainee, I felt empowered (with the right support and some luck) to make a difference.

Starting out as a new anaesthesia trainee in theatres can be daunting – a new specialty, new hospital perhaps, almost certainly new staff to get to know. When I started training in 2018, I at least had the benefit of having worked at that hospital for two years in the emergency department (ED). Similar to the giddy feeling of buying your first stethoscope when getting into medical school, I wanted to buy myself a scrub hat for my new job. After all, with everyone in theatres wearing scrubs, hats are one of the few ways we can express ourselves through our attire.

WHY?

The aim of the 2018 Twitter campaign #theatrecapchallenge was to encourage all theatre staff to wear scrub hats printed with their name and role[1]. This improves patient safety by enhanced closed loop communication and identifies team skill sets, especially during resuscitations. At Starship Hospital in Auckland these hats improved identification and communication for both staff and patients[2]. By encouraging reusable hats, hospitals also reduce costs and waste. There is no evidence that infection control is worse with freshly laundered cotton hats.

This resonated with me – I had no idea who anybody in theatre was and communication would have been so much easier if identification hats were the norm. Alas, no such luck, but at least I could be the change I wanted to see – I ordered a black cap with my name and role embroidered in silver. Not quite as expressive as my colleagues would expect of me now, but a start.

Learning new names never seems to end as a trainee, as we often move hospitals every year or so. At least mine would be one less name for my co-workers to remember. "Just imagine if we all had them!" I thought.

During my training I bought increasingly more colourful hats, but it never seemed to catch on. I didn't see another name-role hat until my final training rotation, three years later at the Royal Adelaide Hospital (RAH). There, anaesthetists Dr Mary-Ann Fox and Dr Cameron Main wore them too. Seeing this encouraged me to do a departmental presentation on the benefits, aiming for momentum in staff uptake. While I received encouraging words from some attendees, no more hats materialised.

HOW?

It was clear passive exposure would not work. This needed some active intervention. Dr Fox and I contacted the RAH chief executive officer (CEO), Professor Lesley Dwyer, through Twitter, requesting financial support. We didn't have to do much convincing as she had already heard of #theatrecapchallenge and its benefits while working in Medway, England. As a trainee, it was intimidating meeting our CEO, but she was enthusiastic, approachable and in a position to provide financial backing. The head of perioperative nursing requested I present to all the theatre nurse unit managers. Their concerns were colour choices, laundering and infection control. I was prepared for these questions, and they gave their blessing. Having CEO support before engaging with the nursing leadership made a big difference in convincing them.

I didn't want to ask for too much at once, so we started with the anaesthetists, anaesthetic nurses and recovery nurses. The supplier arranged a slick web order system that staff could fill themselves via a QR code or email link. Subsequently, the hospital funded one hat for every staff member who wore one at work. This included the orderlies, radiographers, perfusionists, surgeons and other proceduralists. Even the ED got involved. This was motivated by the Autumn 2022 COVID peak, with the hats seen as improving communication while wearing personal protective equipment (PPE).

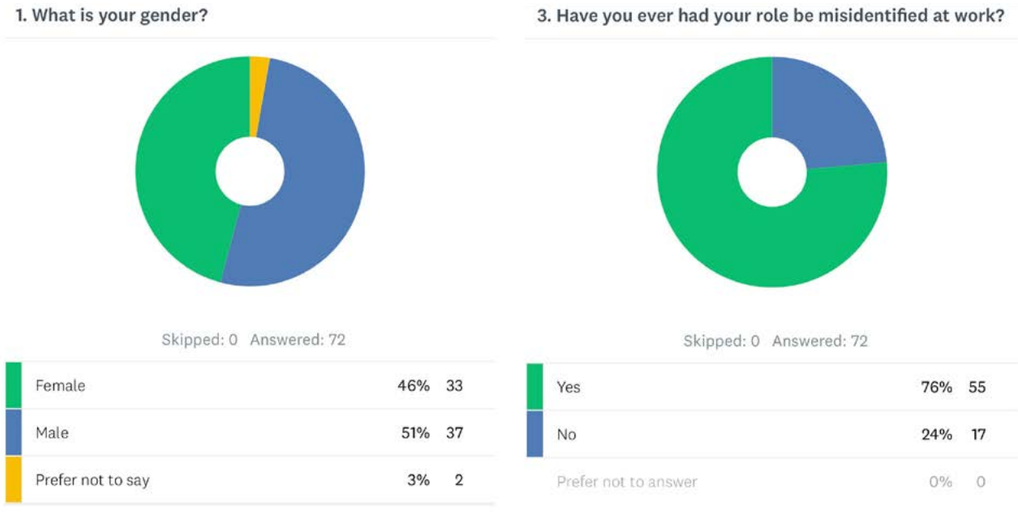
Like Aesop's fable *The North Wind and the Sun*, encouragement is often better than decree for engagement. These hats weren't compulsory, staff could choose their colour and didn't need to use them every day. All were reminded of the importance of regular laundering. Our aim was to generate a critical mass of staff wearing them so that once their benefit was experienced first hand that others would source their own hats for daily wear.

SO, WHAT HAPPENED?

After confirmation that the administration endorsed and funded them, staff were extremely enthusiastic. The hospital purchased 780 hats. Our supplier even made one for a visit by South Australian Minister for Health and Wellbeing, Mr Chris Picton (right), presented to him by Professor Dwyer.

The ED is so pleased with the results that they plan to purchase additional hats every time they have new employees. Following a network-wide email update in which the project was highlighted, I was approached by department leads from another hospital asking if I could

FIGURE 1: SURVEY OF RAH ANAESTHETIC STAFF BEFORE NAME-ROLE HAT ROLL-OUT



Responses from 77 of 137 contacted

Evidence supporting name-role hats

The PatientSafe Network (www.psnetwork.org/theatrecapchallenge-wheres-the-evidence/) webpage #TheatreCapChallenge: Where's the evidence? includes a list of publications and other resources addressing issues, name-role hat benefits and concerns (including about infection-control).

co-ordinate a theatre-wide hat order on their behalf. After a recent anaesthetic Facebook group post, multiple anaesthetists around Australia contacted me seeking help with convincing their own theatre management.

From a wellbeing point-of-view, the benefits include enhanced collegiality, improved staff satisfaction and better communication[2]. Forging new relationships with your colleagues is easier, offsetting the effects of changing hospitals every year. Additionally, the hats promote accurate role identification.

Misidentification is more commonly experienced by women and is associated with physician burnout. In the US, 77 per cent of trainees reported being misidentified weekly, often by patients and their families: being female vastly increased these odds[3]. Burnout was more likely in those reporting misidentification. Identification hats improve role recognition[4].

My pre-rollout survey found that three quarters of departmental members experienced role misidentification (see Figure 1). Following introduction of the hats, I have heard from anaesthesia colleagues, mostly women, that they are no longer misidentified.

If there is something you had wanted to encourage at work but didn't relish the potential struggle for implementation, I would say go for it. With the right support and a bit of luck it can be done.

And now ordering coffee at the hospital café with an unusual name like Munro is no longer difficult!

Dr Munro Brett-Robertson
Anaesthetic Provisional Fellow, SA Health

Acknowledgements: My thanks to Dr Mary-Ann Fox and Dr Lindy Roberts for their assistance with this article.

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Free ANZCA Doctors' Support Program

How to make an appointment:

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

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

Converge international

HELP IS ALSO AVAILABLE VIA THE

Doctors' Health Advisory Services:

NSW and ACT	02 9437 6552
NT and SA	08 8366 0250
Queensland	07 3833 4352
Tasmania and Victoria	03 9280 8712
WA	08 9321 3098
New Zealand	0800 471 2654
Lifeline	13 11 14
beyondblue	1300 224 636

ANZCA
FPM

NATIONAL ANAESTHESIA DAY 2022
17 OCTOBER

Anaesthesia and children — Get ready for National Anaesthesia Day!

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've decided to celebrate on Monday 17 October instead.

This year's theme is "Anaesthesia and children".

As usual, we'll send posters and other resources to participating hospitals in early October. We'll also be launching a new animated patient information video on the day, designed to guide conversations between patients and healthcare professionals, and to provide reassurance and advice to children and their carers.

We'll be running a social media campaign across Twitter, Facebook and Instagram using the hashtag #NAD22.

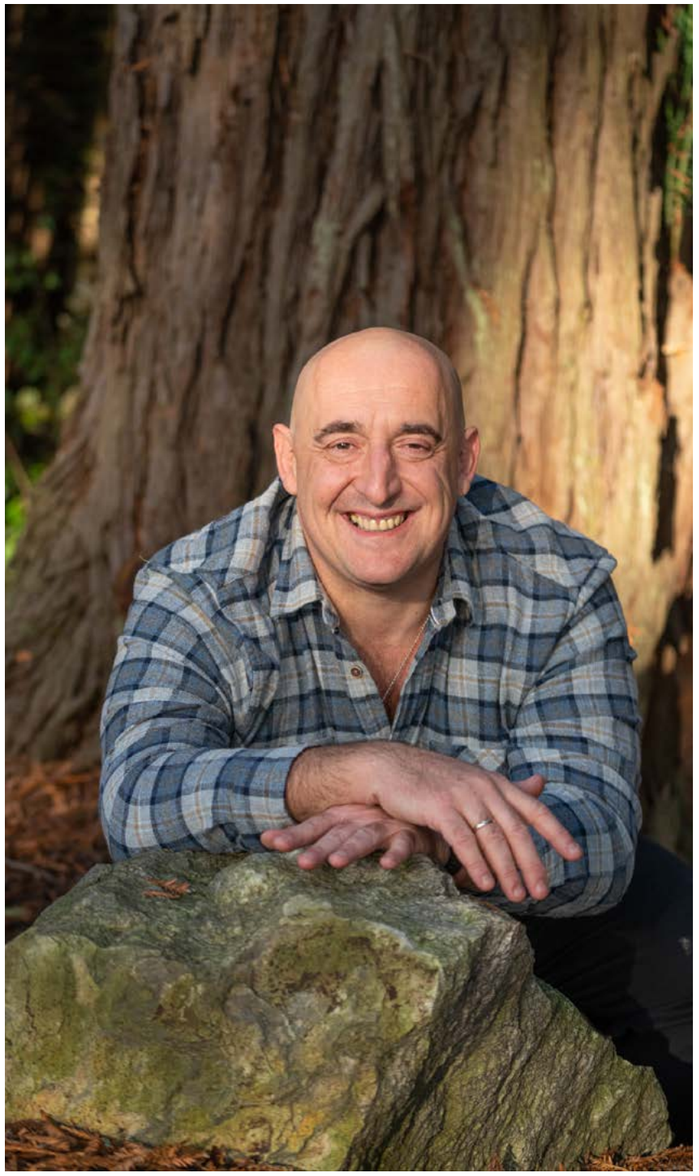
Every year, hundreds of fellows and trainees in dozens of hospitals and private practices around Australia and New Zealand get involved in activities that support our annual theme and raise the profile of our profession in the community. These can range from simple foyer displays and hands-on demonstrations to putting up our posters in prominent areas.

Get in touch

Contact communications@anzca.edu.au to find out more and keep watching our website for updates!

Finding hope in the dark cloud of addiction and depression

Eight years sober, New Zealand anaesthetist Dr Stephan Neff is convinced that everything changes when you stop trying to escape your reality. For him, work and alcohol had become powerful distractors to prevent him having to deal with trauma, post-traumatic stress disorder (PTSD) and bouts of low mood.



"I come from a poor social background in Germany where alcohol was normalised from an early age. At age 13 I was in the wrong place at the wrong time, and I became the victim of a gang assault. The ringleader was sent to jail but said he would kill me when he got out. For years I lived with the fear, so I turned to martial arts, but I was in a dark, dark place. Once I started my medical studies, alcohol was the substance that helped me let my hair down and soften my "Rambo" side. I never learned to deal with negative emotions. Then, in the 80s, PTSD was so much less understood!"

Studying long hours, and later working too hard became a way of life for Dr Neff. Soon he defined himself as an anaesthetist and pain physician. Privately, his workaholic/alcoholic lifestyle meant there was little time for anything else including his wife and two children. A work-life balance was non-existent and the boom-and-bust cycles continued for many years. Regrettably, life did not get easier with many additional traumas and challenges adding to the pressure.

"Depression, PTSD and addiction lie to you. There is hope and there is most certainly help waiting out there for you!"

Anger, resentment, shame and guilt became the dominant emotions in daily life and gradually his alcohol consumption increased to alarming levels. These emotions also created a huge hurdle for Dr Neff to seek help in those rare moments of insight in between phases of complete denial.

In 2014 finally everything became too much.

"I remember (vaguely) sitting drunk in my garage and crying my eyes out in emotional pain. My wife at that stage could have walked away on numerous occasions. Instead, she showed me the ultimate sign of love – with the help of my head of department she organised an in-patient admission to the Capri Rehabilitation Hospital in Auckland. This was when my life changed forever. For the first time in my life, I was forced to stop escaping and to face my demons. These were the hardest, yet the most beautiful four weeks in my life."

Over the following months, Stephan emerged as an empty shell of a man. Today he sees it as the privilege that few people experience in their lives.

"I saw myself as a painter in front of an empty canvas. Who did I want to become as a man? I got to experiment and by trial and error transformed into a new version of myself. A bit like a phoenix from the ashes."

Dr Neff believes anaesthetists may be more likely to baulk from admitting they are not in control than others in society. With around 10,000 anaesthetists, pain fellows and trainees potentially reading this, there will be a number who are facing some part of this journey of addiction and mental health problems. Dr Neff believes he has some words of hope for those who are in a dark place.

"Depression, PTSD and addiction lie to you. There is hope and there is most certainly help waiting out there for you!"

He has written about his journey in his book *My Steps to Sobriety*, and interviews guests on his podcast and YouTube channel under the same name. He focuses on the underlying trauma and many of his guests have gone through hell and back, but kept going. Stephan believes that by being honest and transparent about our past we can become the light in the darkness of others.

He is devoting his spare time to seeking out the stories of transformation from victim to survivor to thriver. His two new books *Depression Lied To Me* and *F*ck Depression* will soon be released and include experiences of depression as told by 16 female and male storytellers. With 300 interviews and 1000+ subscribers his YouTube channel is growing and so is his passion to demystify mental health problems and addiction.

Dr Neff says his recovery has depended on his family, friends, and his colleagues making room for him to heal but also on the understanding and encouragement of the regulatory body, the Medical Council of New Zealand (MCNZ).

His blurb sums up his mission. "I want to show fellow travellers that there is life after alcohol. In fact, I show that the life that is waiting for you is so bountiful and exciting that yesterday is jealous of today! The past does not equal the future!"

Adele Broadbent
Communications Manager, New Zealand

Perioperative medicine

Calling all experienced POM practitioners

DIPLOMA RECOGNITION PATHWAYS

A key step in developing our Diploma in Perioperative Medicine is establishing a cohort of experienced perioperative medicine practitioners to participate as supervisors, facilitators, and topic area co-ordinators for candidates.

We are inviting these leaders to apply for the diploma via our recognition pathways ("grandparenting") process.

This group of highly regarded diploma recipients will also be involved in the ongoing review of diploma content and guidelines.

Applications for the diploma via this method will be assessed by the Recognition Pathways Working Group, formed in mid-July and chaired by Dr Vanessa Beavis. This working group is made up of representatives from anaesthesia, pain medicine, surgery, internal medicine, rehabilitation medicine, intensive care and geriatric medicine.

The application process has been finalised and the group is ready to recommend recipients for the Diploma of Perioperative Medicine via the points pathway and at a reduced cost for the diploma.

See our webpage for more information and to access forms – www.anzca.edu.au/pom.

We recognise that a few pioneers in the field may not qualify using the points pathway but might qualify under the exemption pathway. Details of the exemption pathway will be finalised in the coming months.

DEVELOPMENT OF CURRICULUM CONTINUES

The Perioperative Medicine Content and Assessment Working Group chaired by Dr Joel Symons continues to develop the curriculum as details of the diploma structure, assessments, teaching, and learning activities are refined.

In recent weeks, the working group has concentrated on requirements for the first two (preoperative assessment and preoperative planning) of six topics that reference the Perioperative Care Framework.

The course design has aligned the learning outcomes with the ANZCA Roles in Practice – medical expert, communicator, collaborator, leader and manager, health advocate, scholar and professional.

Each topic is divided into five key themes and resource building and content development is under way.

The diploma assessment strategy has been finalised and the working group is developing the assessment forms and rubrics for each.

At this stage of development all components of the program are tracked on a matrix that ensures that the relationship between key themes, learning outcomes and assessments is clear.

In addition, the online content wireframe has also been developed. This is a diagram of all the online touchpoints for the learner, supervisors, facilitators and ANZCA staff and is the precursor to online program development that will be authored on ANZCA's new learning management platform, the first to be delivered there.

We expect to finalise the curriculum and handbook in 2023.

VALUE OF POM

Our Perioperative Medicine Economics Working Group, which I chair, is overseeing the development of a value proposition prospectus that can be used to highlight the benefits and proposed next steps of perioperative medicine.

This will be a key tool in our advocacy activities.

Hospital engagement discussions have also commenced so that a pilot of the early diploma topic areas can commence in the last quarter of 2023 with a full roll-out of the diploma in 2024.

Professor Guy Ludbrook continues to work with the ANZCA Library on updating the literature reviews undertaken in 2018 and 2019 to assist in the development of a value proposition for perioperative medicine.

There are three main areas of focus where economic benefit seems most likely to be supported by evidence: pre-habilitation; enhanced recovery after surgery (ERAS); and postoperative complications.

The evidence suggests compliance with protocols is an underlying theme for realising benefit for each of these areas.

There are of course other benefits that would not necessarily be financial.

ANNUAL REVIEW OF FRAMEWORK AND CURRICULUM

An annual review of the perioperative medicine curriculum and Perioperative Care Framework will be undertaken by a new working group that is being formed.

This working group will be multi-disciplinary and include advanced trainees. It will keep the framework and curriculum current and evidence-based by providing updated recommendations, resources, and reference links. Definitions and pillars as outlined in the framework will remain unchanged.

Dr Sean McManus FANZCA
Chair, Perioperative Medicine Steering Committee

Anaesthesia and perioperative medicine: Restructuring for success

WITH THE EXPANSION of the perioperative medicine (POM) service at Royal North Shore Hospital, a specific POM registrar term has been developed to provide a more formal training structure for the growth of perioperative skills and knowledge.

Expanding and formalising the POM service at Royal North Shore was an important and necessary step. Beyond serving to acknowledge the immense work that's already being done in this space, creating a more defined staffing structure has helped drive change and progress for the perioperative journey. Applying the same logic, creating a specific preoperative medicine registrar position was a natural step at incorporating these skills within our training program. We wanted to share our experience and the benefits to our registrars, and advocate for other institutions to consider following a similar path.

THE POM REGISTRAR TERM

The goals of the term are to provide an engaging, collaborative educational experience for registrars. The curriculum for the term was developed using the POM learning goals outlined in the ANZCA training curriculum and the principles outlined in the ANZCA Perioperative Care Framework. The vast amount of new information on POM can create a barrier in allowing the trainee to understand POM concepts, so we wanted to provide innovative strategies in a focused environment for trainee growth and enjoyment of perioperative medicine.

STRUCTURE OF THE POM TERM

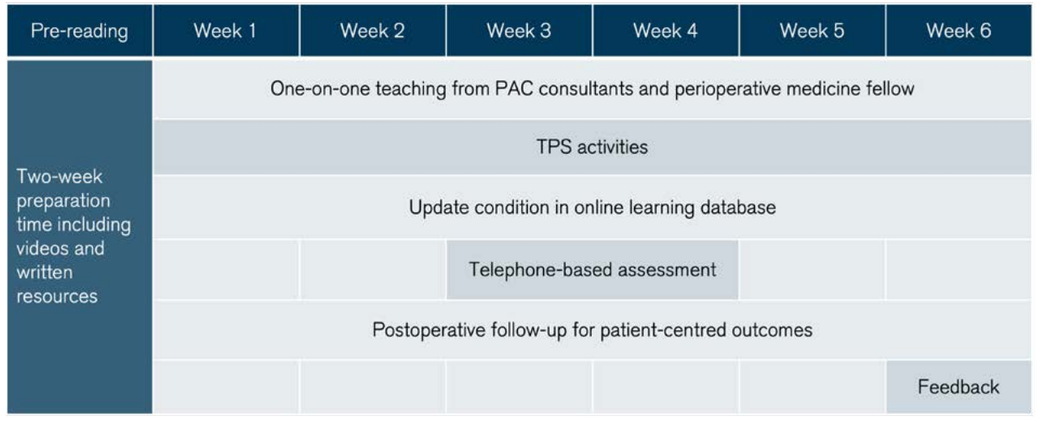
The structure of the term is outlined in figure 1. The term has one registrar for a six week period, being half a standard roster rotation. This time allows for adequate perioperative exposure and follow through of patients. Prior to commencing the term, the registrar's learning goals are identified, and pre-reading is provided in the form of online lectures to introduce core topics such as the assessment of risk for major adverse cardiac events and the indication for common perioperative investigations. The online medium allows for easy access for registrars at peripheral sites as well as the ability for self-paced learning and re-review as necessary.

Their term consists of a variety of one-on-one teaching, self-directed learning, and didactic material. During the term, the registrar spends four to five days a week in the pre-admission clinic (PAC) where they receive one-on-one teaching from consultant anaesthetists on specific perioperative topics. The flow of patients in the PAC is organised to accommodate a dedicated daily 40-minute session for more in-depth exploration of perioperative medicine topics and concepts.

In the afternoon the registrars are involved in a rotating selection of activities including postoperative rounding on complex patients seen in PAC and sub-specialty physician teaching sessions (for example, transthoracic echocardiography with cardiology). We have an anaesthesia provisional fellow who also provides one-on-one teaching during the week for the POM registrar with a particular focus on preparation for the ANZCA final examination.

For each trainee's rotation, they are required to deep-dive into a specific medical condition, for example, pulmonary hypertension and update an internal online learning database. This "deep-dive" consists of conducting a literature review and discussion with a clinical-expert (physician or physician advance trainee) who frequently treats these patients, to gain a specialist perspective on the practical and pragmatic perioperative issues. Over time

FIGURE 1: POM REGISTRAR TERM AT RNSH



Perioperative registrar Dr Kate Leaper and provisional fellow Dr Malin O'Leary at Royal North Shore Hospital.

this serves to build a substantial, evidence-based, learning resource for all members of the department.

The POM registrar term fits into the spiral learning model outlined in the ANZCA training curriculum. During training, registrars are exposed to a breadth of perioperative concepts and this term aims to clarify any misunderstandings, reinforce knowledge, and delve deeper into specific topics.

During the term the trainees also attend the POM meeting where recent POM literature is discussed. This aims to impart principles of critical appraisal and model lifelong learning as well as highlighting the rate and growth of literature in POM.

ASSESSMENTS

Formative assessments are integrated into the term to promote learning and provide objective feedback and benchmarking.

Along with the ANZCA mandatory workplace-based assessments (WBAs) mapped to POM, a number of term-specific WBAs were developed to focus on perioperative concepts. A midterm telephone-based assessment was developed to help identify knowledge gaps during the term, while also providing flexibility in scheduling these sessions.

This mid-term feedback was felt to be critical to allow trainees enough time to build knowledge, discuss topics with anaesthesia consultants they are working and map out learning objectives for the remainder of the term.

These mid-term assessments follow a viva format, in a more relaxed setting. An allocated consultant anaesthetist poses several pragmatic clinical situations and assesses the advice and planning the registrar responds with.

The consultant anaesthetist presents these scenarios in a role-play fashion, as if they were a patient, surgeon, nurse, or other allied health staff. The aim is to help registrars prioritise and communicate their knowledge in a practical way to the variety of essential staff that form part of the perioperative journey. Additionally, the questions provide learning goals for the latter half of the term.

To provide continuity of the perioperative process, registrars are also expected to follow-up at least two patients in the postoperative period, to better understand their movement through their hospital encounter.

SETTING IT UP

This model is replicable in most hospitals.

The structure is predominantly determined by the setup of any PAC, high risk clinic, or other perioperative services that exist.

In our setting, trainees commonly were rotating through the PAC on a day-by-day basis in the mornings, but on an inconsistent roster.

Instituting the POM term changed this ad-hoc attendance and exposure to a predictable and dedicated block of time, which aids in consolidation and organisation of learning. The investment made by the department was that these registrars were in theatres every day in the afternoon prior to the term, whereas now they're in theatre one to two days a week in the afternoon.

We have found that having consultant anaesthetists allocated to a whole day of perioperative medicine has also greatly improved engagement and commitment to implementing this reform. Whole-day consultant and trainee allocation allows adequate opportunity for discussion and planning the day, to ensure service provision and learning opportunities are met and balanced.

It has also created more of a continuous team environment, as opposed to a more task-focused schedule when staff have alternate responsibilities for each half of the day.

BENEFITS OF THE POM TERM

The POM registrar term has created a more protected opportunity for registrars to be involved in quality improvement projects. Having a rostered term has facilitated better follow up of results and identification of ways to improve the service.

Clinic nursing and administration staff have also commented on enjoying having trainee consistency throughout the week and a perception that there is a greater ownership of the patients that present for assessment.

Trainees have also enjoyed the term, saying it gives them an opportunity to immerse themselves in perioperative pathways and concepts as well as provide an opportunity to track interesting patient progress and outcomes.

FUTURE DIRECTIONS

We are fortunate to be establishing the POM registrar term in a supportive department that recognises the importance of training in perioperative medicine.

Likewise, we have a hospital executive that is committed to growing the POM service and a local health district that has made perioperative medicine a strategic priority.

With the imminent launch of ANZCA's Diploma of Perioperative Medicine, this is a fertile plot for further educational experiences. As the service continues to develop, trainees will have the opportunity to participate in shared decision-making clinics, setting prehabilitation goals, and evaluating perioperative decisions based on patient-reported outcome and experience measures.

We're very excited to see what the future holds and encourage other institutions considering a similar change to commit to the investment.

Dr Mincho Marroquin-Harris, FANZCA
Dr Andrew Marks, FANZCA

Safety and quality

Working together to reduce mortality

CASE NOTE: DEATH OF A PATIENT FROM PERIOPERATIVE ANAPHYLAXIS

A medically complex 46-year-old man was scheduled for multiple dental extractions under anaesthesia at a busy tertiary referral hospital. He reported a history of penicillin allergy but had received cephazolin twice previously without incident. He was induced and, while being prepped and draped, was administered 2 grams of cephazolin. Shortly afterwards the ventilator began to alarm due to high airway pressures, and a series of troubleshooting activities soon escalated into emergency response, cardiopulmonary resuscitation and advanced life support, as a working diagnosis of anaphylaxis emerged. More than an hour of effort later, resuscitation ceased and patient was declared dead. Post-mortem analysis revealed elevated tryptase and positive presence of allergen-specific immunoglobulin E for cephazolin.

ABOVE IS A brief summary of a case study included in our report, *Safety of anaesthesia: A review of anaesthesia-related mortality reporting in Australia and New Zealand, 2015-2017*, which we published in 2021.

Anaphylaxis remains a major cause of anaesthesia-related death in Australia and New Zealand. Its management can be complex, labour intensive and prolonged, and yet, despite the best efforts of all involved, death may still ensue.

Lessons from this case include reminders that a history of previous safe exposure does not preclude anaphylaxis on re-exposure, that the absence of rash does not exclude anaphylaxis, and that anaphylaxis must remain a key differential diagnosis for any marked perioperative bronchospasm.

As chair of ANZCA's Mortality Sub-Committee, I have been the editor of our three-yearly *Safety of Anaesthesia* reports for eight years. This latest report found that anaphylaxis and aspiration remain the major causes of anaesthesia-related death. Additionally, patients with higher ASA scores were increasingly represented in mortality, suggesting an increased role for perioperative care.

The Mortality Sub-Committee is a collective of representatives from each of the jurisdictions from which ANZCA draws its membership, who work together to collect and combine our data into the *Safety of Anaesthesia* report. Some of us have held these positions for as many as 15 years; some only joined us in 2022. In some jurisdictions, the anaesthesia mortality review system has extensive independent resourcing, such as via the Clinical Excellence Commission in NSW. In others, anaesthesia is but one subject of interest to a health-system-wide quality committee, or sits as part of the state- or territory-based Audits of Surgical Mortality managed by the Royal Australasian College of Surgeons.

The co-ordination difficulties we face are a perennial subject of discussion. We were proud that in our 2015-2017 report (published in 2021), for the first time, we were able to publish data using uniform parameters from every Australian state and territory, as well as data from New Zealand. We are even prouder that, as the report showed, anaesthesia in Australia and New Zealand continues to be among the safest in the world.

GET INVOLVED

Report your incidents

Arrangements for incident reporting vary by jurisdiction. In places where reporting is voluntary, I urge you to report, and where reporting is mandatory, I urge you to report as fully and frankly as possible. Doing so offers a valuable opportunity to receive confidential peer feedback on your practice, while contributing to the advancement of our profession and the safety of future patients.

Become a peer reviewer

Many jurisdictions use peer reviewers to provide assessment and feedback on reports. Becoming a peer reviewer can be a fascinating and rewarding way to give back to the profession. Contact your jurisdictional representative for advice on how to get involved.

Safety of anaesthesia: A review of anaesthesia-related mortality reporting in Australia and New Zealand, 2015-2017 (2021) is available for download from www.anzca.edu.au/safety-advocacy/standards-of-practice/anaesthetic-incident-reporting.

Dr Simon Jenkins FANZCA
Chair, ANZCA Mortality Sub-Committee

Mortality committees in Australia and New Zealand

These representatives of each jurisdictional mortality committee make up the Mortality Sub-Committee that reports to ANZCA's Safety and Quality Committee.

NSW

Special Committee Investigating Deaths Under Anaesthesia (SCIDUA)

Dr Carl D'Souza, chair

SCIDUA is an expert committee appointed by the secretary, NSW Health, under delegation by the health minister. Its terms of reference are to subject all deaths occurring while under, as a result of, or within 24 hours after the administration of anaesthesia or sedation to peer review so as to identify any areas of clinical management where alternative methods could have led to a more favourable result.

By law, all such incidents must be reported to the NSW health secretary via SCIDUA by the health practitioner who is responsible for the administration of the anaesthetic or sedative.

More information:
www.cec.health.nsw.gov.au/Review-incidents/mortality-review-authorised-committees/scidua

Contact: CEC-SCIDUA@health.nsw.gov.au

VICTORIA

Victorian Perioperative Consultative Council (VPCC)

Dr Ben Slater, member

VPCC oversees, reviews and monitors perioperative care in Victoria to improve outcomes for patients before, during and after surgery.

All cases relating to perioperative mortality and morbidity, including surgical and anaesthesia, are reviewed by VPCC.

More information:
www.safercare.vic.gov.au/about/vpcc

Contact: ben.slater@svha.org.au

QUEENSLAND

Queensland Perioperative and Periprocedural Anaesthetic Mortality Review Committee (QPPAMRC)

Dr James Troup, chair

QPPAMRC collects and analyses clinical information regarding perioperative and periprocedural anaesthetic mortality in Queensland to identify statewide specific trends. The committee functions collaboratively with the Statewide Anaesthesia and Perioperative Care Clinical Network (SWAPNET), other related networks and the Private Hospitals Association of Queensland.

The committee registers, investigates and classifies deaths occurring during, as a result of, or within 30 days of a procedure performed under anaesthesia or sedation. Where further information is required, it requests such information under guarantee of confidentiality from the attending practitioner(s). Practitioners may also self-report.

More information:
clinicalexcellence.qld.gov.au/priority-areas/safety-and-quality/queensland-perioperative-and-periprocedural-anaesthetic-mortality

Contact: QPPAMRC@health.qld.gov.au

WESTERN AUSTRALIA

Western Australian Anaesthetic Mortality Committee (WAAMC)

Dr Jennifer (Jay) Bruce, chair

WAAMC analyses adverse event information, specifically patient mortality, from health services related to anaesthesia with the objective of recommending quality improvement initiatives.

In WA, it is compulsory to report deaths to the chief health officer within 48 hours of an anaesthetic. If a third party was the notifier of the case, the anaesthetist involved will be asked to supply a report.

The case is reviewed initially by a peer investigator appointed by the minister. If the death is considered anaesthesia-related, it is then reviewed by the committee.

More information:
www.anzca.edu.au/safety-advocacy/standards-of-practice/anaesthetic-incident-reporting

Contact: Jennifer.bruce@health.wa.gov.au

SOUTH AUSTRALIA

South Australian Anaesthetic Mortality Committee (SAAMC)

Dr Simon Jenkins, chair

SAAMC reviews adverse event information, specifically patient mortality, from health services related to anaesthesia with the objective of recommending quality improvement initiatives. It shares information with the SA Audit of Surgical Mortality.

Reporting is voluntary. Reports are encouraged to be made for deaths within 48 hours of an anaesthetic. While most reports are made by anaesthetists, surgeons and proceduralists may also report.

More information:
www.anzca.edu.au/safety-advocacy/standards-of-practice/anaesthetic-incident-reporting

Contact: Simon.Jenkins@sa.gov.au

TASMANIA

Tasmanian Audit of Anaesthesia Mortality (TAAM)

Dr Margaret Walker, member, Tasmanian Audit of Surgical Mortality (TASM) Management Committee

TAAM is an external, independent peer review process that reviews the clinical management surrounding deaths occurring following administration of anaesthesia. It operates in conjunction with TASM as a joint initiative of RACS and the Tasmanian Department of Health. TASM is notified of all deaths within 30 days of a surgical procedure and anaesthetic case forms are sent to the treating anaesthetist. Anaesthetists may also self-report. Participation is voluntary, but strongly encouraged by hospital credentialling bodies.

More information:
www.surgeons.org/research-audit/surgical-mortality-audits/regional-audits/tasm

Contact: M.b.walker@bigpond.com

AUSTRALIAN CAPITAL TERRITORY

ACT Audit of Anaesthesia Mortality

Dr Carmel McInerney, co-ordinator

The ACT Audit of Anaesthesia Mortality occurs alongside the ACT Audit of Surgical Mortality (ACTASM). ACTASM provides an independent, external peer review of all deaths that occur during an episode of surgical care, to provide opportunities for improvements in patient outcomes. Qualified privilege is granted by the Commonwealth.

ACTASM is notified by the hospital of all deaths that occurred during a surgical admission, the surgeon completes a case form detailing events and if an anaesthesia component is identified, then the anaesthetist is asked to complete an anaesthesia case form. Anaesthetists may also self report. Participation is compulsory for surgeons but voluntary for anaesthetists.

More information:
www.surgeons.org/research-audit/surgical-mortality-audits/regional-audits/actasm/anzca-process

Contact: carmelmci@hotmail.com

NORTHERN TERRITORY

Northern Territory Audit of Surgical Mortality (NTASM)

Dr Philip Blum, member, NTASM Management Committee

NTASM is an external, independent, peer review audit of the process of care associated with surgically related deaths in the territory.

The college and NTASM collaborate in the collection of anaesthetic-related surgical mortality. In cases where the possibility of an anaesthesia component of the death is identified, NTASM will send an anaesthesia case form to the treating anaesthetist for voluntary completion. An anaesthetist may also self-report a case.

More information:
www.surgeons.org/research-audit/surgical-mortality-audits/regional-audits/ntasm

Contact: philip.blum@nt.gov.au

NEW ZEALAND

New Zealand Perioperative Mortality Review Committee (POMRC)

Dr Kerry Gunn, member

The POMRC is an independent statutory committee that reviews and reports on perioperative deaths in New Zealand and advises the Health Quality & Safety Commission (HQSC) on how to reduce that number. Confidential reporting of deaths that occurred during or after a surgical procedure is mandatory in New Zealand under conditions described in the Coroners Act 2006. The committee engages in epidemiological analysis of all relevant deaths, as well as peer review of selected cases of interest. The committee has investigated the issue of inequity in outcomes of perioperative death in New Zealand.

More information: www.hqsc.govt.nz/our-work/mortality-review-committees/perioperative-mortality-review-committee/

Contact: kerrygunn@icloud.com

A modified Bowtie diagram used to depict the analysis of webAIRS data

THE AUSTRALIAN AND New Zealand Tripartite Anaesthetic Data Committee (ANZTADC) has recently been using modified colour-coded Bowtie diagrams to aid in analysing and visually displaying incidents reported to webAIRS, the web-based Australian and New Zealand anaesthetic incident reporting system. Reports of incidents are regularly published in peer-reviewed journals, the *ANZCA Bulletin*, the ASA *Australian Anaesthetist*, and the NZSA *New Zealand Anaesthesia* magazines. In addition, findings are presented at professional meetings, and the modified Bowtie diagram is frequently used.

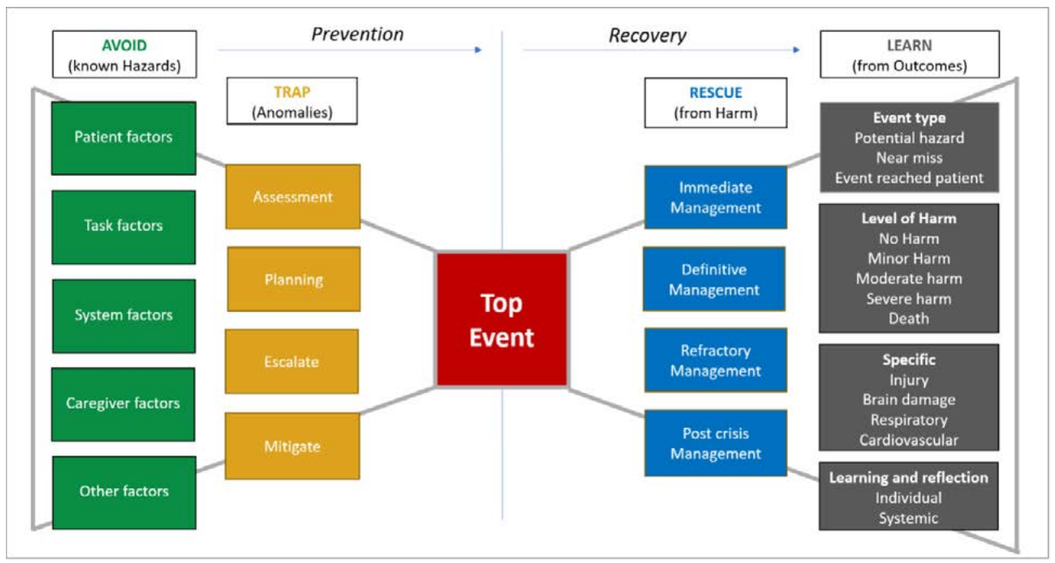
Bowtie diagrams were first described in 1979[1] as a further development of Butterfly diagrams and have been used in high-risk industries for many years. Recently they have gained popularity in healthcare. The diagram combines the well-known Swiss Cheese diagram and the less well-known Event Tree. While the Swiss Cheese diagram displays gaps in the barriers leading to an incident, the Event Tree describes the period immediately during and after a critical incident, including rescue attempts and incident outcomes. The Bowtie diagram represents the fusion of those two diagrams, with the incident, which is named "Top Event", connecting those two[1].

Members of the committee have modified the components of the original Bowtie. While traditional Bowtie diagrams, which are not colour coded, use lines to show a pathway from Hazards to the Top Event, the complexity of anaesthetic emergencies makes a set of direct pathways complicated and confusing to depict, requiring many lines.

Instead, the Bowtie used for webAIRS analysis has been modified to use conceptual pathways, with blocks to show the name and function of each barrier. In addition, the original Bowtie has been re-designed to map anaesthetic incidents logically and thoroughly and match it with existing anaesthetic nomenclature. The modified version has been colour-coded, following known psychological and evolutionary principles; the pathways generally flowing along lines of escalating criticality.

The first column of the left-hand side of the Bowtie has been named "AVOID hazards", describing potential latent factors in each of the divided categories, including patient factors, task factors, caregiver factors, system factors and other factors. This column is green, denoting a "routine" or "safe" state. The aim is to proceed with the patient's care while avoiding these known hazards from progressing to an incident.

FIGURE 1: GENERIC BOWTIE DIAGRAM



Nevertheless, any of these hazards can lead to an incident. Therefore, the second column, "TRAP anomalies", lists methods and barriers devised to detect and trap developing hazards. This column is amber, signalling to a "non-routine state", where it is unclear whether this represents an imminent threat. Like the yellow colour at a traffic light, the priority is to increase vigilance to trap, prevent and check on deviations from the norm.

These two columns on the left-hand side of the diagram consist of strategies to prevent the Top Event.

In the middle of the Bowtie diagram, the Top Event is coloured red, signalling a critical state where an overt threat to the patient is identified. Priorities are to make decisions and initiate interventions to mitigate this threat. Immediately to the right of the Top Event, the blue column lists management options to recover from this event and is named "RESCUE from harm".

The options are immediate management, definitive management, refractory management, and post-crisis management. Failure to recover in this phase may trigger other Top Events and therefore link to new Bowties. The colour blue was chosen as this colour is commonly used in medical terminology in association with an unstable critical state (for example, Code Blue).

The last column on the right describes the grey zone, where possible outcomes and learning in the aftermath of the incident are described. The colour grey was chosen to portray knowledge and wisdom rather than finality, which would otherwise have been implied if the boxes were black. While the incident and the outcome can no longer be influenced, outcomes for future patients might be improved, based on reflection and learning from that incident.

To summarise, the first two zones, green (known hazards) and amber (prevention) aim to describe barriers to prevent the Top event which is red (critical). In the red zone there is an intersection of prevention and recovery measures. These three colours follow the well-known traffic light paradigm. The two columns to the right of the Top Event focus on recovery from the incident in the short and longer term. Blue indicates the emergency rescue phases, and dark grey indicates a final phase of reflection and learning.

Several webAIRS analysers have found the modified Bowtie diagram helpful in analysing and displaying the findings of incidents reported in Australia and New Zealand. A list of ANZTADC publications including those using Bowtie diagrams is available on the webAIRS website. A codified analyser program has been developed by the ANZTADC medical director and is expected to support efficient and comprehensive data analysis. A presentation was given at the virtual meetings of both ANZCA and the ASA in 2021 and is available to view in the logged-in user area of the webAIRS website.

WebAIRS is owned and funded by ANZCA, the ASA and the NZSA. This web-based program is free and available to all members of these organisations. WebAIRS may be used to complement local Morbidity and Mortality (M&M) meetings and individual audits. Data is protected by qualified privilege, and members are entitled to two CPD points per hour of reporting incident data to ANZTADC.

To learn more about the Bowtie diagram visit the webAIRS website and view a copy of the virtual presentation created by the authors for the virtual ANZCA ASM in 2020 Bowtie Evolution in Anaesthesia. The presentation will be opened when the article is released, and kept open for 60 days. Visit the webAIRS website to register or email anztadc@anzca.edu.au for more information.

Dr Yasmin Endlich, Dr Stavros Prineas and Dr Martin Culwick on behalf of the ANZTADC Case Report Writing Group.

Reference

1. The Bowtie diagram: a simple tool for analysis and planning in anesthesia. Culwick M, Endlich Y and Prineas S. Current Opinion in Anesthesiology: December 2020 - Volume 33 - Issue 6 - p 808-814

Safety alerts

Safety alerts appear in the "Safety and quality news" section of the *ANZCA E-newsletter* each month. A full list is available on the ANZCA website: www.anzca.edu.au/safety-advocacy/safety-alerts.

Recent alerts:

- Management of potential supply disruption to epidural kits (new update)
- Defect: Aisys CS2/Avance CS2/Avance CS2 Pro Anaesthesia Systems, switched O2/air pressure reading
- Safer Care Victoria Alert: Xylocaine 2% with Epinephrine batch #9949864 (update)
- Product Defect Alert: Pressure Plates used in Level 1 Fast Fluid Flow Fluid Warmers
- Australian Recall: Medtronic Covidien Shiley Hi/Low-Contour Oral/Nasal Tracheal Tubes Cuffed
- Compatibility of intravenous access connectors with pre-filled syringes - especially glass
- Defect: Gentec 286MB 25LY2A click-style oxygen regulators – SIS seal collar is removable
- Recall: Cook Medical Fixed Core & Roadrunner Hydrophilic Wire Guides –compromised sterility
- AU recall: Philips BiPAP A40 – non-conforming materials could cause off-gassing or device failure
- AU recall: ITL Australia catheter kit - compromised sterility of specific models/lots
- New Zealand recall: CareSens KetoSens Test Strip – specific batch returns false readings
- AU recall: AMSORB PLUS Prefilled G-Can 1.0L anaesthesia absorber cartridge, possible gas leakage

Regional hospital trials new approach to diabetes management

Anaesthetist Dr Wojciech Wierzejski is part of a small team at Broken Hill Base Hospital in regional NSW who have developed a new perioperative protocol for managing type 2 diabetes patients.

SODIUM-GLUCOSE CO-TRANSPORTER 2 inhibitors (SGLT2i) are being increasingly utilised for managing type 2 diabetes. Although the SGLT2i group has proved beneficial in the treatment of type 2 diabetes they are subject to side effects. The most concerning complication, especially in the perioperative setting, is the potential to develop euglycemic diabetic ketoacidosis (eDKA)[1,5].

To reduce the likelihood of this occurring, the joint consensus of the Australian Diabetes Society, the Australian Diabetes Educators Society and ANZCA, recommends stopping this medication for about three days before surgery if there is a risk of reduced oral intake during the perioperative period[2]. This becomes complicated when the patient who is due to have an elective procedure has been prescribed SGLT2i combined into one tablet formulation with other oral hypoglycaemic drug of a different type like Metformin (Xigduo, Jardiamet, Segluromet) or gliptins (Glyxambi, Qtern, Steglujan). Simple cessation of this formulation can put the patient at risk of a hyperglycaemia episode with subsequent consequences and risk of cancellation of the procedure[2].

Broken Hill Base Hospital is a small, rural, remote hospital with about 88 beds. The operating theatre provides elective and non-elective services for several surgical specialties. However, all the surgical consultants, except general surgeons and gynaecology and obstetrics specialists, are visiting medical officers who work there for one to two days. To cover all surgical lists, the hospital has two anaesthetists who provide the in-and-out-of-theatre anaesthesia duties.

Establishing and maintaining the perioperative protocols with such diverse, numerous, and sometimes unpredictable numbers of professionals can be challenging.

Nevertheless, in co-operation with the hospital's pharmacy department we have developed a protocol to supplement patients with Metformin, Sitagliptin and Linagliptin to replace the dual agent medication containing SGLT2i. The dose of the replacement medication corresponds to the dose prescribed in the original formulation. The pharmacy department supplies two days' worth of pre-labelled boxes, and the pre-admission nurse fills in the patient's details. This protocol aims to avoid the risk of potentially life-threatening complications like eDKA and maintains sufficient glycaemic control in the perioperative period.

Above (from left): Clinical pharmacist Ben Yassa, clinical nurse specialist Chenny Fazulla and Dr Wojciech Wierzejski.

PROCEDURE

The process starts when the patient is referred to Broken Hill Base Hospital for elective surgery by the surgeon at the outpatient clinic. The surgeon completes a referral for admission (RFA) form, which contains information about the planned procedure and the patient's medical background. The patient then completes a health questionnaire in the RFA.

The generic patient health questionnaire section of the RFA does not always reflect a patient's true health history. It has become standard practice that a medical summary from the patient's GP is supplied and attached to the patient's RFA.

As we know, patients quite often don't fully understand their medications, especially the names and dosages and this proves to be problematic when the patient completes the medications section of their RFA. A GP medical summary is of extreme importance when deciding the patient's preoperative medication instructions.

The patient's RFA, medical health questionnaire and GP medical summary are all reviewed by the anaesthetist and triaged accordingly to the information provided. In some cases more information is required and the patient is given an appointment with the pre-admission nurse and/or a pre-anaesthesia review with the anaesthetist. For those patients living in remote areas with limited access to specialists, being thorough is key to preventing complications which require, in most cases, transfer to a tertiary hospital.

During the anaesthesia triage process, patients on dual agent diabetic medications with SGLT2i are identified and an appointment with a pre-admission nurse is organised. The pre-admission nurse educates the patient about diabetic medication management, which includes the cessation of the dual agent medication. The pre-admission nurse then supplies the patient with an adequate number and dose of Metformin tablets or gliptins respectively to the original prescription (see Figure 1).

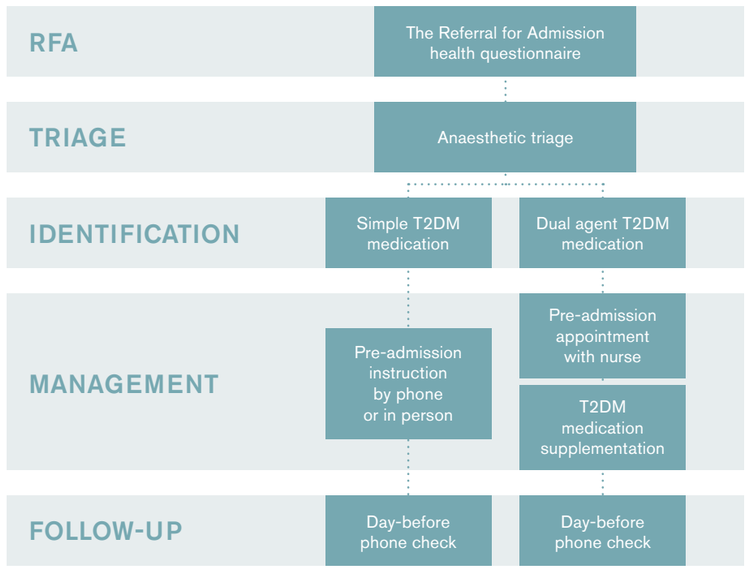
FUTURE DEVELOPMENTS

The next step of the protocol development will be to provide patients with pharmacy prepared medication dispensers such as a "Webster-pak." But this requires closer co-operation with local pharmacies to replace the combined medication with single-agent medication.

The perioperative management of diabetes is a complex issue. The protocol described above is only one part of the management plan which includes withholding other diabetic medications and insulin dose adjustment. We believe however, that it significantly improves the safety of our patients and ultimately their surgical outcome.

Dr Wojciech Wierzejski, specialist anaesthetist, Broken Hill Base Hospital
Chenny Fazulla, clinical nurse specialist, Broken Hill Base Hospital
Ben Yassa, clinical pharmacist, Broken Hill Base Hospital

FIGURE 1. Pre-admission management of the diabetic patient flowchart.



RFA – the referral for admission. T2DM – type 2 diabetes mellitus.

The Broken Hill Base Hospital team with key diabetes medication.

ANZCA and diabetes

ANZCA has published a joint statement with diabetes groups in Australia and New Zealand on periprocedural diabetic ketoacidosis and SGLT2i use.

The statement outlines a number of key considerations and suggested management strategies when seeing patients who are taking SGLT2i medication.

References

1. Rosenstock J, Ferrannini E. Euglycemic Diabetic Ketoacidosis: A Predictable, Detectable, and Preventable Safety Concern With SGLT2 Inhibitors. Diabetes Care. 2015 Sep;38(9):1638-42. doi: 10.2337/dc15-1380. PMID: 26294774.
2. ADS Position Statement ALERT - Periprocedural Diabetic Ketoacidosis (DKA) with SGLT2 Inhibitor Use In People with Diabetes. From https://diabetessociety.com.au/downloads/20220209%202021%20ADS_DKA_SGLT2i_Alert_highlighted%20changes_Jan%2022%20.pdf
3. Peter S. Hamblin, Rosemary Wong, Elif I. Ekinci, Shoshana Sztal-Mazer, Shananthan Balachandran, Aviva Frydman, Timothy P. Hanrahan, Raymond Hu, Shara N. Ket, Alan Moss, Mark Ng, Sashikala Ragunathan, Leon A. Bach; Capillary Ketone Concentrations at the Time of Colonoscopy: A Cross-Sectional Study With Implications for SGLT2 Inhibitor–Treated Type 2 Diabetes. *Diabetes Care* 1 June 2021; 44 (6): e124–e126. https://doi.org/10.2337/dc21-0256

Anaesthesia-related deaths

Example case from SCIDUA's 2019 Special Report

The New South Wales Special Committee Investigating Deaths Under Anaesthesia (SCIDUA) has been reviewing deaths associated with anaesthesia and sedation since 1960. Example cases from the 2019 Special Report are being reproduced in the *ANZCA Bulletin* in an effort to enhance reporting back to the medical community. All fellows of the college are encouraged to read the SCIDUA report in its entirety. The detailed cases and data analysis presented are paving the way forward to a more informative and educational mortality analysis in New South Wales.

CASE 1: GENERAL SURGERY

An 86-year-old female for emergency laparotomy.

Background history

A laparotomy for perforated viscus was done two weeks earlier. She had postoperative respiratory decline with consolidation and effusions on chest x-ray. The patient needed to return to theatre due to wound dehiscence with bowel on display.

Preoperative assessment revealed a well looking lady suffering no pain or nausea. Had eaten breakfast three hours prior comfortably. A plan was made for a rapid sequence induction with a video laryngoscope.

Intravenous access was very difficult. An 18g cannula was inserted under ultrasound guidance in cubital fossa. An arterial line was inserted prior to induction.

Anaesthesia details

1mg midazolam and 50mg propofol was given – volatile commenced.

The patient was asleep but still responding to jaw thrust – rocuronium given. She was noted to be still breathing and coughing.

The suspicion that the IV cannula had tissued was raised and a second IVC was sought.

This took roughly two minutes, after which further propofol and rocuronium was administered. The patient was intubated but the trachea noted to be heavily soiled.

The patient was now difficult to ventilate, and oxygen saturations were below 90. The endotracheal tube was suctioned, and bronchoscopy/lavage performed with limited success.

During preparation of central venous access, the patient deteriorated further becoming haemodynamically unstable requiring adrenaline boluses.

At this point a discussion with the team ensued and a decision made to palliate the patient. She died 90 minutes later.

Learning points

- Risk of aspiration* increases 10-fold when patients are not fasted. Proceeding with an anaesthetic with unfasted patients sometimes is unavoidable, but, if at all possible, ensuring the patient is fasted should be a priority.
- Ensure intravenous access is patent prior to induction.
- Consider central access prior to induction in these patients when intravenous access is difficult or likely to fail.
- Intramuscular suxamethonium is an option if IV access fails during induction.

Source:

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

**Aspiration refers to the regurgitation of gastric contents and subsequent inhalation into the lungs, resulting in physical blockage of airways and inflammation leading to hypoxia and potentially death. It primarily occurs in unfasted patients or those who have delayed gastric emptying, who are unable to protect their own airway due to general anaesthesia.*

Anaesthetists usually manage this risk by using strict fasting protocols in elective or semi-urgent surgery (that is, "low risk" of aspiration) or by using alternative techniques, such as regional anaesthesia or rapid sequence induction (RSI), where fasting is not feasible or gastric emptying may be delayed (that is, "high risk"). ANZCA Safety of Anaesthesia Report 2015-2017, p19. March 2021.

Faculty of Pain Medicine

Faculty pushes for support of local pain services

TAKING UP THE role as dean of the faculty is initially daunting and when it coincides with the once-in-10-years review of the college and faculty by the Australian Medical Council (AMC) and Medical Council of New Zealand (MCNZ) it rapidly became overwhelming.

You will all be pleased to know I survived and now a few months in the fog has begun to lift. On reflection the AMC/MCNZ accreditation was a perfect way to start the dean role in that it ensured we had a 360-degree look at how we function as a training and standard setting organisation.

We now know that programmatic assessment processes, training our educators and creating world class learning environments is not optional – it is imperative. These processes will take time and doing them right is more important than doing them quickly. We also need to ensure we bring our fellowship and our trainees along with us. I will focus more on this in a future dean's message.

The Australian Commission on Safety and Quality in Health Care has released its Low Back Pain Clinical Care Standard, which is a very long-winded title for what is an excellent document. The document is structured with each section divided into patient information, clinician information and health services information and it is written in plain English which makes it a document for multiple audiences. The document has been endorsed by the faculty and we will be providing a link to it in our next *Synapse* e-newsletter.

Our New Zealand National Committee has just completed a significant piece of work with the Ministry of Health which, despite the pandemic, has progressed to a model of care for pain medicine for the country. The model needs to be operationalised but for the first time we have a plan on how pain services should look across the country. The process to develop this model started formally in 2019 with the formation of an expert advisory group but the advocacy to push for change started several years earlier with the Sapere report, which was commissioned by the faculty to collate and document the state of pain services in New Zealand.

The faculty then used the report's findings to push the Ministry of Health into improving pain medicine services. The timing was opportune in that the ministry was looking at how it could improve services for small specialties. The faculty, with the backing of ANZCA, was in pole position. There was no guarantee that there would be funding for any new services but with the new health authorities, Te Whatu Ora and the Māori health authority, it turned out to be good timing.

With this model of care being released it was a good time for myself and FPM Executive Director, Leone English, to travel around New Zealand to meet fellows as well as the Accident Compensation Corporation (ACC) and the ministry's chief allied health professions officer. The tour started in Tāmaki Makaurau Auckland with a meeting of the local fellows before we went to the Waikato and met with three of our Kirikiriroa Hamilton-based fellows.

There is variation between the Auckland-based services where functional teams are trying to improve services, to Waikato where dedicated clinicians are struggling to provide basic pain services to a geographically, socially and culturally diverse population. This variation in services highlights the inequity of access in pain services and the lack of access in many small central north island towns.

We then travelled to Te Whanganui-a-Tara Wellington to meet with ACC and the ministry. Our trip then took us to Kokiri Marae in Lower Hutt that has developed a culturally appropriate pain management program, as well as Marae-based clinics. The outcome of this is that we will go with them to the Māori Health authority to seek funding to expand this to other maraes around the country.

Our final stop was Ōtautahi Christchurch to meet with clinicians from Burwood and Ōepoti Dunedin. Again the concept of a national model of care was well received, but as with many pain services our colleagues are struggling to give their patients the quality of care they know they can provide.

We are continuing to develop an advocacy strategy for Australia. The first stage involves assessing services at the local level, asking what are the key concerns and then working out how the faculty can support fellows within their local networks and at a state and federal level.

I am happy to be contacted if fellows see opportunity for us to be involved or if they have concerns about local services.

Dr Kieran Davis
FPM Dean

Chronic pain model of care for pain medicine in New Zealand

To read more about how the FPM New Zealand National Committee led a push for a national model of care for people living with chronic pain, see page 10.

Vale Associate Professor Ben Marosszeky

Having grown up in Hungary during the Second World War, an 18-year-old Jeno Emil Marosszeky fled the land of his birth following the revolution of 1956 and its aftermath. He settled in Sydney and qualified MBBS from the University of Sydney in 1967.

A restless and relentless innovator, Ben was a key figure in the creation of the Australian College of Rehabilitation Medicine in 1979. He provided advice in the creation of the Australian College of Sports Physicians, who awarded him an honorary fellowship in 1991. Among his voluminous achievements in the rehabilitation sphere, he is recognised as the creator of the Westmead PTA Scale, a fundamentally important clinical tool in brain injury rehabilitation, as well as the inaugural Clinical Director of the Australian Rehabilitation Outcomes Centre (AROC) upon which the ePOCC dataset was modelled. He was also instrumental in creating the training and recognition of paediatric rehabilitation medicine within the Royal Australasian College of Physicians and Australasian Faculty of Rehabilitation Medicine.

Given his dedication to improving the care of people with chronic pain and his intimate knowledge of governance matters, he was an ideal candidate to be nominated as the AFRM board member when the Faculty of Pain Medicine Board was formed in 1998. He served two terms as a board member of the faculty; on the initial foundation board from 1998-2000 and again for a year between 2004-5 as a co-opted member.

For his enormous contributions to the lives of Australians with disabilities, he was awarded a Member of the Order of Australia (AM) in 2013, the year that he retired from clinical practice.

Ben will be remembered for his enormous energy, playful wit and willingness to engineer systemic solutions to the problems facing people living with disabling conditions, including persistent pain. He was an intellectual innovator, a broad and deep thinker, an inclusive and inspiring professional leader, and a delightful human being to encounter on a personal level.

Associate Professor Michael Vagg
Immediate Past Dean

Training unit accreditation

The following units have been accredited for pain medicine training:

- Fiona Stanley Hospital (WA).
- Pain Specialists Australia (Vic).
- Royal North Shore Hospital (NSW).
- Queen Elizabeth Hospital (Hong Kong).
- Westmead Hospital (NSW).

New fellows

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

Dr Nicholas Aitcheson, FAFRM (RACP), FFPMANZCA (Qld).

Dr Poshitha De Silva, FRACGP, FFPMANZCA (Qld).

Dr Pouya Hafezi, FAFRM (RACP), FFPMANZCA (Vic).

Dr Rachel Halpin-Evans, MRCPCH, FFPMANZCA (WA).

Dr Navid Hamedani, FRACGP, FFPMANZCA (Vic).

Dr Claudia Higgs, FANZCA, FFPMANZCA (NSW).

Dr Elaine Shek, FRACGP, FFPMANZCA (Qld).

Dr Amanda Wisely, FACRM, FAChPM, FFPMANZCA (NSW).

Dr Hassan Zahoor, FACEM, FFPMANZCA (WA).

Acute Pain Management: Scientific Evidence 6th edition – seeking interested fellows

We're in the first stages of preparing the sixth edition of *Acute Pain Management: Scientific Evidence* (APMSE).

We're seeking expressions of interest for:

- A lead for the editorial committee (replacing Professor Stephan Schug).
- Additional new members of the editorial committee.

The lead editor would have an anticipated 1.5 year commitment from 2023-2025.

Depending on the sixth edition's format and the number of editorial committee members to manage, this will initially be a part-time role and may require a full-time commitment as completion approaches. There is some remuneration available, but this amount will not cover the full amount of work anticipated. The lead and additional editorial committee members may consider applying for sabbatical leave for their involvement in the project.

To find out more or express interest in one of these positions, please contact fpm@anzca.edu.au before the end of October 2022.

Become an accredited procedural supervisor

We encourage fellows looking to become an accredited procedural supervisor in 2023 to start the application process which includes endorsement through the Practice Assessment Pathway. We'll consider applications in October/November. For further information please see the website or contact the faculty.

New Zealand road trip

FPM DEAN Dr Kieran Davis and FPM Executive Director Leone English completed a successful "road-trip" in New Zealand on 11 August with a demanding schedule of meetings across the country.

The Auckland Regional Pain Service hosted the first catch up at Greenlane in the country's largest city. This is home to the country's most well-funded and possibly busiest service with a strong multi-disciplinary team. It was the first of many chances to socialise the new Chronic Pain Model of Care (see page 10 in the *Bulletin*). The fellows present discussed the important issue of equitable access to quality pain care with a focus on Māori, Pacifica peoples and regional communities. It is hoped that the move to a national model will assist in addressing this issue.

The same day they drove south to the Waikato region to meet with four pain fellows based in Hamilton. Discussions again went to the issue of "access" to quality pain services with our fellows struggling to support a very large and diverse portion of the North Island. The remoteness of communities, lack of GPs, and the lower socioeconomic status all stack up to making this region an area of high need. Dr Davis says good clinicians are struggling to provide adequate services to patients in need. "We have to keep advocating for our fellows."

On Wednesday 10 August the team flew to Wellington. They were joined by the chair and former chair of the FPM New Zealand National Committee, Dr Duncan Wood and Dr Tipu Aamir, as well as the ANZCA NZ Executive Director Stephanie Clare and policy advisor Renaldo Christians at a meeting with the chief of Allied Health Mr Martin Chadwick at the Ministry of Health. At the meeting, Mr Chadwick shared the exciting news that the director general had recently signed off on the draft Chronic Pain Model of Care, with the next steps being to take it to the minister of health for approval.

Meeting with the Ministry of Health in Wellington, from left: Ms Stephanie Clare, Ms Leone English, Dr Martin Chadwick, Dr Tipu Aamir, Dr Duncan Wood and FPM Dean, Dr Kieran Davis.

The FPM team were welcomed into the Kokiri Marae in Wellington to learn about the Whanau Pain Management Program – a unique community-based model.

This was very welcome news for a team that has been working closely with the ministry for the past two years to get this model across the line. Pending ministerial approval, the model will be circulated for feedback to stakeholders across the country as the details of an operational plan are developed. "We have a model of care, we now need to make things happen at the clinical level," says Dr Davis.

The other highlight of the Wellington leg of the trip was being hosted at the Kokiri Marae across the harbour from the capital city. There the group met with researchers and health professionals who use a whānau pain management program. This is a highly successful kaupapa Māori-led pain clinic where the group saw firsthand the strength of community-led initiatives and the critical role that pain medicine has in under-served communities. Ms English said, "We were so privileged to be invited into the marae to hear about this community-empowering model. It is a true 'pocket of excellence' in pain care and the faculty looks forward to advocating for government support in growing this model in other areas of the country."

The last day of the trip was in Christchurch for a get together with South Island fellows. There were multiple meetings happening at the same time in different locations in the morning.

Some of the group spent time with the Canterbury Clinical Network to introduce the model of care while others took time to work with the Burwood Pain Centre multidisciplinary team as the process to recruit and rebuild towards achieving re-accreditation as a training centre begins.

In the afternoon, pain fellows from across the South Island gathered to hear about the model of care and discuss solutions for the many issues they currently face.

Adele Broadbent
Communications Manager, New Zealand

FPM

Faculty of Pain Medicine
ANZCA

2022 FPM SPRING MEETING

Better together

14-16 October 2022,
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Villas Noosa Heads, Queensland

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2023 FPM
SYMPOSIUM

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5 MAY 2023 I ICC SYDNEY I #FPM23SYD

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Dr Tanya Selak, Co-Convenor
Associate Professor Stefan Dieleman, Scientific Convenor
Associate Professor Kok E Khor, FPM ASM Scientific Convenor
Dr Candice Wallman, FPM ASM Deputy Scientific Convenor
Dr Andrea Binks, Workshop and SGD Co-Convenor
Dr Tim Cooper, Workshop and SGD Co-convenor
Dr Ben Moran, ePoster Convenor
Dr Amy Lawrence, HCI Convenor
Dr Cameron Dunn, Trainee Representative
Dr Jessica Lim, Emerging Leaders Conference Co-Convenor
Dr Chris Yong, Emerging Leaders Conference Co-Convenor
Associate Professor Leonie Watterson, ANZCA Councillor
Associate Professor Nicole Phillips, Director of Professional Affairs, ASM
Dr Noam Winter, FPM ASM Officer

Training and education

ANZCA and CICM Dual Training Pathway

In February 2021 ANZCA Council endorsed a recommendation to develop a dual anaesthesia and intensive care training pathway in collaboration with the College of Intensive Care Medicine (CICM). The pathway offers a mechanism for combining training towards FANZCA and FCICM in less time than it currently takes to complete both training programs. The development of a dual training pathway recognises transferability of skills between the two vocational scopes and may encourage a greater number of medical graduates to undertake dual training.

ADDRESSING COMMUNITY NEED

Anaesthetists and intensive care medicine specialists can be accommodated separately within larger Australian and New Zealand centres.

In both countries, regional and rural hospitals report that one of the major barriers to staffing their intensive care and high dependency units with trained intensive care specialists is the requirement for a specialist to cover both roles as part of their job description, especially after hours.

Furthermore, relying on FANZCA-trained specialists to cover ICU has become increasingly difficult, as there is limited exposure and training in intensive care medicine during anaesthesia training.

It is desirable that patients and their communities, regardless of geography, have access to appropriately trained anaesthetists and appropriately trained intensivists. It may be highly advantageous to rural and regional Australian and New Zealand centres if the same person could work in both scopes of practice.

A successful dual training pathway will offer completion in less time (7.5 years) than both training programs undertaken separately (10.5 years), by taking advantage of skills transferability while ensuring that the dual graduate has achieved equivalent learning outcomes to graduates of each individual training pathway. The result will be a specialist who has both a FANZCA and a FCICM. It is anticipated this will help address one of the unmet needs in our communities.

GOVERNANCE AND DEVELOPMENT

A memorandum of understanding (MOU) has been signed between ANZCA and CICM which establishes the collaboration for joint recognition of a dual training pathway with the aim to actively cultivate and maintain the highest principles and standards in the training, practice and ethics of anaesthesia and intensive care medicine. The MOU also defines the project governance and terms of reference for the conjoint committee that will oversee the development of the dual training pathway.

The conjoint committee will be established shortly to oversee the activities of the already established Dual Training Pathway Curriculum Working Group and bring to fruition the launch of the dual training pathway program. Professor Peter Morley AM is chair of the Dual Training Pathway Curriculum Working Group which has 12 members comprising:

- Dual fellows with educational expertise, supervision and assessment expertise, and training site accreditation expertise.
- Directors of professional affairs from each college.
- ANZCA Education, Development and Evaluation Committee (EDEC) member.
- Dual trainees from New Zealand and Australia.
- Māori and Aboriginal or Torres Strait Islander representatives.

The Dual Training Pathway Curriculum Working Group is tasked with the development and delivery of the program, identifying the necessary educational resources, information technology support, marketing, and communication activities.

IN SUMMARY

A dual training pathway will demonstrate ANZCA and CICM's commitment to addressing inequitable access to specialists. Along with responding to regional and rural centres across Australia and New Zealand, this joint venture will also foster relationship between the two colleges in advancing an integrated care model in perioperative medicine.

The dual training pathway development has already begun and will continue through 2022-2023 in preparation for its launch by 2025. For further information about the ANZCA CICM Dual Training Pathway project please email Stephenie Cook, Education Development Lead at scook@anzca.edu.au or visit the frequently asked questions page on ANZCA website – www.anzca.edu.au/dtp.

Professor Peter Morley AM
Chair, Dual Training Pathway Curriculum Working Group

From Tokyo to Perth
An anaesthetist's story

Dr Naoko Nakaigawa moved from Tokyo to Perth in 2016 so she could practise anaesthesia in Australia. Here, she writes about her journey as a specialist international medical graduate and her motivation.

Dr Nakaigawa with her Busselton Ironman event medal.

I PASSED MY final anaesthesia exam in June. It has been a very long process of hard work, discipline and setbacks but to receive the words "congratulations" on the email telling me I had passed was the best feeling I had ever experienced.

I am Japanese and graduated from medical school in 2004 in Japan. I began anaesthesia training in Japan in 2006 and in 2013 passed the final exam to qualify as a specialist anaesthetist through the Japanese Society of Anaesthetists. All my university and training was undertaken in Japanese language so in many ways I followed the standard career trajectory that you would expect.

I was very close to my father who had led a very interesting career as a scientist and had travelled and lived all over the world. Perhaps I gained my sense of adventure to live somewhere other than Japan from him. Sadly, my father passed away in 2015, so I decided the time was right to look overseas for the next stage of my career.

I had visited Australia to compete in an Ironman triathlon event in Busselton, in Western Australia. I loved the beach and the laid-back lifestyle was very different to Tokyo. I decided to choose Perth for the next stage of my medical career, understanding that English was very much my second language. I had much study ahead of me and this involved learning English to a required level and starting as a senior registrar with all the training and study to obtain my FANZCA.

I moved to Australia in 2016, and studied English language full-time in Melbourne, passing the occupational English test in December of that year. I then returned to Tokyo to maintain my specialist license in Japan where I worked as a consultant at St Luke's International Hospital. I also started preparing my paperwork for Australia, including visa and job applications. It was a daunting process as the system in Australia is obviously very different to Japan.

I returned to Melbourne for the specialist international medical graduate (SIMG) interview in Melbourne, in November 2017 (specialist pathway, assessment of international medical graduates) and achieved the result of "partially comparable" which meant I had to:

- Complete 24 months of supervised clinical practice.
- Complete an Effective Management of Anaesthetic Crises (EMAC) course.
- Participate in the ANZCA Continuing Professional Development (CPD) program.
- Sit the SIMG examination (ANZCA Part 2 exam, exempt from the written sections).

These measures were all required within four years from my date of employment.

I began working at Royal Perth Hospital as a senior registrar in August 2018. While I was happy to be in Australia it was a really hard time as I initially struggled to get used to the Australian system and the new environment. And of course everything was in English. I was exhausted after work every day for the first six months as I was trying to learn a new system, do my job well and concentrate on everything in English. What was great was the environment at Royal Perth Hospital where there are many SIMGs who all made me feel very welcome.

From left: Dr Naoko Nakaigawa (front) with colleagues at Royal Perth Hospital; Dr Nakaigawa.

In June 2019, I started studying for the exam by attending the ANZCA Part 2 course. This was so challenging as I had no idea what to expect or what it involved as it was very different to my Japanese experience. The next three years was an incredibly tough road, and my life was only work and study. While dealing with COVID-19 was a stressful time, perhaps the reduced freedom and lack of distraction helped my study.

During these three years, I completed a range of study courses and additional English support sessions to improve my standard, especially for the viva and these included:

- Weekly speech pathology and speech coaching sessions.
- Viva practice with SIMG colleagues, and consultants at the hospital.
- Observation at obstetric and paediatric hospitals to familiarise myself for the exam.
- Part 2 tutorial program WA/viva practice in a Perth hospital through the WA ANZCA final preparation course.
- Viva boot camp for the ANZCA final exam 2021.
- The SIMG fellowship exam course 2021 run by Dr Lahiru Amaratunge and Dr Narguess Jahangiri.
- Final exam practice viva online sessions by Dr Vida Viliunas (Australian Society of Anaesthetists).
- Multiple webinars.

Despite all my efforts and dedication and support from so many people, I was notified that I needed to attend another SIMG interview to discuss opportunities and strategies to help prepare me for the next exam sitting.

While I found it hard receiving the letter, the advice from the ANZCA SIMG Committee was excellent as I felt they understood my situation and would tailor the areas I needed to focus on. For me, this was mainly to do with the "verbal jousting" and improvement needed to perform in the viva oral setting. This gave me reassurance and motivation to keep going. I was very grateful for the interview process.

After a thre-year study journey I finally passed my exam. I couldn't have achieved this without the significant support and help I received from so many.

Thanks to my many friends, colleagues, and consultants who kept encouraging me and providing me with a supportive environment. Several consultants gave up their personal time to help with my study. I felt so much kindness and support through this exam journey.

Australia is a wonderful place to work and the openness to accept people from diverse backgrounds is to be commended . It has been a great experience for me.

I love working here. I am excited to continue my profession as a consultant and further my learning.

What's new in the foundation

INAUGURAL DONOR-FUNDED AWARDS

The foundation is proud to announce that the ANZCA Research Committee was able to confer several new awards at its grant meeting on 2 September, thanks to the generosity of foundation donors.

Patricia Mackay Memorial ANZCA Research Award

The first Patricia Mackay Memorial ANZCA Research Award was made to Dr Edith Waugh of Royal Darwin Hospital and her team, for their project "Research into older patients' anaesthesia and surgery outcome numbers in the Northern Territory: A feasibility trial".

This prestigious new award recognises the late Dr Patricia Mackay OAM, a highly-respected Victorian anaesthetist who made major contributions to quality and patient safety in anaesthesia. The new award has been made possible by a generous donation from Mrs Indi Mackay, which has been invested to provide ongoing perpetual income support.

The committee made the award to the application judged to best align with Dr Mackay's special interests in quality and safety in patient outcomes, and the identification and reduction of adverse events.

Inaugural ANZCA Emerging Investigator Patrons Award

The first ANZCA Patrons Emerging Investigator Research Award was made to Dr Chloe Heath and her team at Perth Children's Hospital, for their study "CHIPMUNK - A chocolate-based innovative formulation of prednisolone-making unpalatable steroids nice for kids".

This new award was created to encourage emerging investigators moving between the novice and advanced stages of their research careers. It has been assisted by, and is in recognition of, the generous long-term support provided to the foundation by the annual pledge giving of its highly-valued patron-level donors.

Skantha Vallipuram ANZCA Research Scholarship

This scholarship, new in 2022, was awarded for 2023 to Dr Patrick Tan of Melbourne's Royal Women's Hospital, to assist him in pursuing his PhD based on his project "High flow nasal oxygen to prevent desaturation for labouring women using remifentanil PCA (HOPE-for-REMI study)".

The new scholarship has been made possible by a generous annual donation pledge by Mrs Asoka Vallipuram, in memory of the greatly respected anaesthetist and specialist pain medicine physician, the late Dr Skantha Vallipuram.

With appreciation

The foundation and the new award recipients are deeply grateful to the generous and visionary donors who have made these awards possible: Mrs Indi Mackay, Mrs Asoka Vallipuram, and all of the foundation's generous patrons.

WELCOME TO A NEW LIFE PATRON

The foundation warmly welcomes our newest life patron, Dr Lahiru Amaratunge, who has made a generous commitment of $A25,000 to the foundation on behalf of the online learning platform "ABCs of anaesthesia". The platform creates educational material and shares knowledge and practical tips in anaesthesia.

Dr Amaratunge started ABCs of anaesthesia initially to help trainees in their first few weeks of training by delivering early morning tutorials for residents in the basics of anaesthesia. Since then, the program has developed from interactive lectures and exam coaching sessions to also include a Facebook page and very popular YouTube channel. His vision is to improve education and share resources with an international audience, while donating all income to reputable charities to support the disadvantaged and increase opportunities.

ANZCA FOUNDATION FORUM: REDUCING PERIOPERATIVE COMPLICATIONS

On Saturday 15 October the ANZCA Foundation will hold its inaugural dinner forum at the Royal Perth Yacht Club in Perth, WA, to discuss the need to reduce complications in perioperative medicine as a national health priority.

The forum will highlight the important role of research, the strong track record of ANZCA-sponsored research in this area, and promote the need for increased investment and collaboration.

Speakers will include ANZCA Vice-President Professor David Story, Past President Professor David A Scott, Professor Britta Regli-Von Ungern Sternberg, Associate Professor Lis Evered, and Dr Jennifer Reilly.

BEQUESTS SUSTAINS OUR WORK

Leaving a gift to the foundation in your will helps protect the future of foundation's support for innovation in research and education led by anaesthestists and pain medicine physicians.

Bequests can be dedicated to being fully used for specific projects, or targeted to the foundation's investment fund as a highly effective way of ensuring funding is always available to provide support for the foundation's vital work in perpetuity.

For those who wish to be part of building this long-term institutional support, the foundation can advise on options, including future recognition either in the donor's name or that of a family member or colleague. To discuss, please get in touch.

Patrons and donors

Once again I warmly thank our generous donors who make the support we provide possible – particularly our foundation patrons, who pledge annual gifts that help sustain the foundation and its supportive capacity.

If you are not yet a patron, please contact me or go to the ANZCA website to join this prestigious program.

Rob Packer
General Manager, The ANZCA Foundation

CONTACT US

To donate search "GiftOptions – ANZCA" in your browser. For foundation queries, contact:

- **Rob Packer**
  General Manager
  +61 3 (0)409 481 295, rpacker@anzca.edu.au
- **Leah Wolf**
  Fundraising Administration Officer, lwolf@anzca.edu.au

For research grants program queries:

- **Susan Collins**
  Research & Administration Co-ordinator, scollins@anzca.edu.au

ANZCA
FPM

College bursaries

Did you know each year ANZCA offers a number of bursaries to trainees who are experiencing financial hardship?

Eligible trainees can receive up to a 50 per cent reduction in their annual training fees. All applicants will also receive an extension to the annual training fee due date.

Applications for 2022 will open in mid-November.

Applicants must be registered as a trainee with ANZCA or FPM.

Applications close 31 January 2023.

For further information, please contact the ANZCA Training and Assessments team via email at **training@anzca.edu.au** or call +61 3 9510 6299.

ANZCA
FPM

Steuart Henderson Award

Nominations are being received for the 2023 ANZCA Steuart Henderson Award: 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. All fellows of ANZCA and FPM are eligible for the award.

For nomination information including eligibility criteria visit the ANZCA website.

Nominations close
15 February 2023.

The path to creating a world-class library

AS ONE OF the only anaesthesia and pain medicine specialist libraries worldwide, the ANZCA Library is often seen as the "jewel in the crown" for ANZCA fellows and trainees.

Since 2014, the library has transformed from a small predominantly print-based service – with a limited electronic footprint – into a thriving online and print service providing access to 900+ full-text e-journals and 14,000+ e-books, and which offers a suite of medical databases, research tools and literature search services comparable to those of a large tertiary institution.

Much of this development is due to the college's response to a 2014 library services review – conducted by Dr Angela Bridgland – which sought to reposition the library in the context of its support for the "needs and expectations of the fellows and trainees, with a view to enhancing service delivery and raising awareness of the library, its collection and value to fellows and trainees".

The review included 30 recommendations grouped into six categories focusing on ANZCA's strategic priorities (based on the then current ANZCA Strategic Plan 2013-2017), stakeholders, resources, efficiency, effectiveness, and communication.

Recently, the library completed a follow up report to this review, detailing the numerous developments that have occurred in the intervening period. To read the selected highlights from the full report provided to ANZCA Council in March 2022 please visit the ANZCA Library on the college website – www.anzca.edu.au/library.

CONTACT THE LIBRARY: +61 3 9093 4967 library@anzca.edu.au anzca.edu.au/resources/library

ANZCA
FPM

Dr Ray Hader Award for Pastoral Care

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

Application forms can be found on our website and must be emailed to training@anzca.edu.au by Monday 31 October 2022.

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

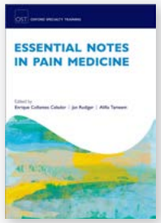
The winner of the award receives $A2000 to be used for training or educational purposes. Any ANZCA fellow and/or trainee can be nominated for this award. Individuals must be nominated and seconded by an accredited ANZCA trainee or fellow and supply the details of two additional referees (other than the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

New books

NEW EXAM BOOKS

A number of new primary and exam prep titles are now available online:

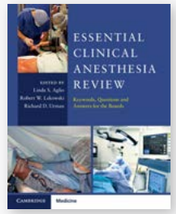
https://libguides.anzca.edu.au/training-hub



Essential notes in pain medicine

Collantes CE, Rüdiger J, Tameem A [eds]. Oxford: Oxford University Press, 2022.

Note: Also available in print.

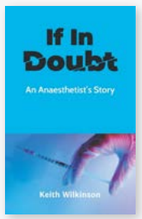


Essential clinical anesthesia review: keywords, questions and answers for the boards

Cambridge Aglio LS, Lekowski RW, Urman RD [eds]. England: Cambridge University Press, 2015.

NEW BOOK FOR LOAN

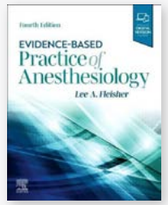
Books can be requested via the *ANZCA Library discovery service*: www.anzca.edu.au/resources/library/borrowing



If in doubt: an anaesthetist's story

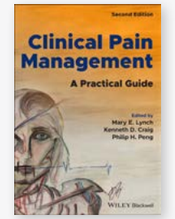
Wilkinson K. New Generation Publishing, 2021.

NEW EBOOKS



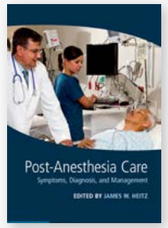
Evidence-based practice of anesthesiology, 4e

Fleisher LA [ed]. Philadelphia, PA: Elsevier, [2023].



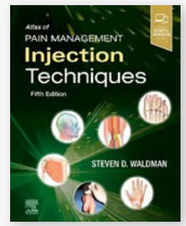
Clinical pain management: a practical guide, 2e

Lynch ME, Craig KD, Peng PWH [eds]. Hoboken, NJ: John Wiley & Sons, 2022.



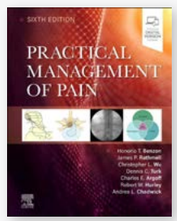
Post-anesthesia care: symptoms, diagnosis, and management

Heitz JW [ed]. Cambridge, United Kingdom: Cambridge University Press, 2016.



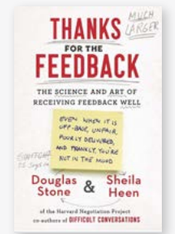
Atlas of pain management injection techniques, 5e

Waldman SD. Philadelphia, PA: Elsevier, 2023.



Practical management of pain, 6e

Benzon HT, Rathmell JP, Wu CL, et al [eds]. Philadelphia, PA: Elsevier, [2023].



Thanks for the feedback: the science and art of receiving feedback well

Stone D, Heen S. London: Portfolio Penguin, 2015.

Note: also available in print.

Dr John Francis Nunn

1925 – 2022

WE HAVE LOST another of ANZCA's honorary fellows (1984) and a doyen of world anaesthesia.

Dr John Francis Nunn would be well known to most anaesthetists around the world as one of Britain's top researchers in the broad fields of anaesthesia, respiratory physiology, mechanisms of anaesthesia and biochemical aspects of anaesthetic agents (particularly nitrous oxide) to mention only the major items of his anaesthetic research interests.

He was born in Colwyn Bay, North Wales. His father, a solicitor, already had an adult family of four (a son and three daughters) remarrying following the death of his first wife, and who then died when John was four, effectively leaving him as an only child with a solo mother. She had been a nurse who served in Salonika in World War I but did not go back to work after marrying.

After his father's death his mother moved to Coventry where John's early education started. He later boarded at Wrekin College in Shropshire.

On the occasion of the unveiling of Nunn's Dean's portrait (by Kees van Kooten) at the Royal College of Surgeons, London.

Photo: AB Baker 1982

Nunn had decided quite early that he wanted to study medicine and in 1943 enrolled in Birmingham University where he undertook a shortened course of five years due to World War II. At university he became involved in mountaineering (president of the university mountaineering club and climbing Mt Blanc in 1947) and fencing (captain of the university fencing team as a sabreist).

Through mountaineering he met geology students who enticed him to join them the day after his graduation on an expedition funded by the Scott Polar Institute to Spitzbergen, where as well as expedition doctor, mountaineer and "rock carrier" he also had surveying tasks, which led to his mapping 100 square miles of Spitzbergen not previously mapped.

This exposure to geology led to a lifelong interest in geology, and eventually to election as a fellow of the Geological Society. On return from this expedition, he registered via medical and paediatric house jobs which became important as he had discovered that instead of two years of national service he could spend three years as a doctor in Malaya. This would also enable him to take his new wife with him which national service would not allow!

Normally such doctors were sent on arrival in Malaya to the inland to an isolated medical outpost, but as Nunn had not done a pre-registration surgical term he was initially kept in Penang to brush up on some surgery.

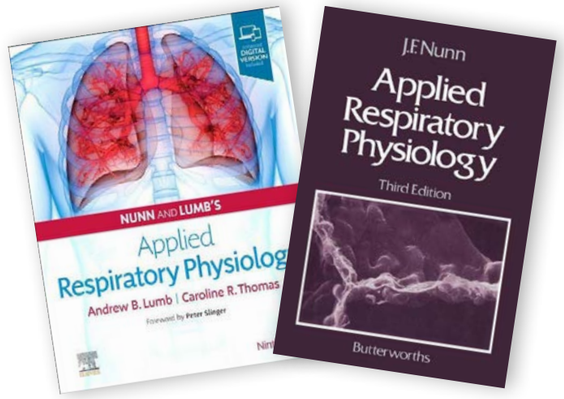
The first day in surgery a newly arrived surgeon wanted to operate and there was no one else to give the anaesthetic so Nunn became the anaesthetist and carried on in this position for his three year tour of duty.

He claimed that his Birmingham medical course had provided very good instruction with 20 compulsory open ether anaesthetics and included blind nasal intubation experience so that he was able to provide anaesthetics for the maxillofacial surgeon whose arrival in Penang had coincided with his own.

However only chloroform was initially available so his very first patient was a two-year-old using chloroform for the first time, and later he also had to teach himself to breathe patients down with chloroform so that he could then insert the blind nasal endotracheal tube listening to the breath sounds.

He read widely and even introduced curare into his practice in 1951, just four years after its generalised uptake in Australia! He taught himself to use controlled hypotension which during a sabbatical month in Singapore he was able to teach to the Singaporean anaesthetists who in return had been teaching him much. During his time in Penang he also built three sailing boats and established a sailing club.

Before returning to England he enrolled in a correspondence course for the FFARCS and on arrival in England immediately sat the primary and three weeks later the final. However, Birmingham where he had obtained a position as an anaesthetist



insisted that he couldn't be an anaesthetist, because despite his FFA he had not had any supervision, so he became a trainee instead.

Unfortunately they didn't provide any supervision either, so he started doing research along with his anaesthesia to help him understand what was happening with the lung and circulation during anaesthesia.

One day the professor of medicine Sir Melville Arnott found out about his isolated and very basic investigations – "My boy you cannot carry on like this" – and very soon he had arranged for Nunn to transfer to a PhD research position in the department of medicine to study *Factors affecting the carbon dioxide partial pressure during anaesthesia*.

Near the end of this research in Birmingham he obtained the Leverhulme Research Fellowship at the newly established Research Department of Anaesthetics at the Royal College of Surgeons, London, where among other things he founded, along with Jimmy Payne and the support of Professor Woolmer, the UK Anaesthetic Research Group which still functions (as the Anaesthetic Research Society), and has been responsible for encouraging many British anaesthetists into research and for establishing the high standing of anaesthetic research in the UK.

After eight years at the Royal College of Surgeons, Nunn was invited to be the inaugural Professor of Anaesthetics at Leeds University in 1964. Four years later he transferred back to London, again by invitation, to head up the anaesthesia department at the newly established MRC Clinical Research Centre (CRC) and hospital at Northwick Park from which he retired in 1991 at a time when the CRC was being disbanded, so his time there coincided with that clinical experiment's lifetime.

He held many other successful associated positions including president of the Section of Anaesthetics at the Royal Society of Medicine (RSM), vice-president of the Association of Anaesthetists of Great Britain and Ireland (AAGBI), and three years as dean of the Faculty of Anaesthetists, RCS (1979-82).

He was also elected as an honorary fellow of ANZCA, the Royal College of Anaesthetists, the College of Anaesthesiologists of Ireland, the Royal College of Surgeons of London, an honorary member of the AAGBI, and awarded the Henry Hill Hickman Medal of the RSM.

In 1969 he published his monumental work on *Applied Respiratory Physiology* for which he was awarded his MD (with Hons), and which he subsequently re-edited for three further editions and now exists as Nunn & Lumb's *Applied Respiratory Physiology* in its ninth edition.

This is the definitive text for applied respiratory physiology and known to all anaesthetists as a vital text for the primary. He also edited *General Anaesthesia* the classic English text by TC Gray on anaesthesia, for three editions.

Not only was he famous for his respiratory and cardiovascular physiological research he established basic measuring techniques for this research, investigated cellular functions of anaesthesia and teratogenic effects and performed many clinical studies. His research publications, many of which are now classic presentations, number more than 230 with his most recent ones on climate change.

On retirement he expanded his 20 years of learning to read Egyptian hieroglyphs at the British Museum, possibly stimulated by his father being present at the opening of Tutankhamun's Tomb in Egypt, to translating Egyptian medical papyri and publishing in 1996 the landmark *Ancient Egyptian Medicine*.

He is the only known hieroglyph medical translator who also was a medical graduate. He followed this with a translation with RB Parkinson of Beatrix Potter's *The Tale of Peter Rabbit – hieroglyph edition* as an introduction to hieroglyphs for children. Also in retirement he completed a stratigraphic survey of Durlston Bay, Dorset, for which he was awarded the Richardson Prize of the Geological Society, the only lay geologist to ever receive that prize.

Sadly, his last years were destroyed by vascular dementia. A tragedy to have such a brilliant mind deteriorate in advanced old age. He claimed that his greatest achievement was to have mentored 22 junior research assistants to full professorships.

The world will remember his intense scholarship and research contributions in three widely different areas of respiratory physiology, ancient Egyptian medicine, and geology.

John's very supportive wife Sheila predeceased him, and he is survived by a son (Geoff) and two daughters Carolyn and Shelley, seven grandchildren and five great grandchildren.

Appreciation with research for this obituary is extended to Dr Geoff Nunn, who is also a retired anaesthetist.

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

Exhibits at the Geoffrey Kaye Museum of Anaesthetic History at ANZCA House in Melbourne.

Museum achieves reaccreditation

IN 2015 THE Geoffrey Kaye Museum of Anaesthetic History underwent an accreditation process with the Victorian branch of Museums Australia (now called Australian Museums and Galleries Association, AMaGA). Accreditation is aligned to the *National Standards for Australian Museums and Galleries* which provide benchmarks for best practice. The museum achieved accreditation and received a number of commendations along with way. Notably, the peer review panel was impressed with the way the museum aligned its activities with ANZCA's strategic priorities.

Under normal conditions, reaccreditation would happen after five years. The five-year mark, 2020, was marred by the emergence of the global pandemic but coincidentally the program was suspended anyway, as it was having a whole-of-program review.

The Geoffrey Kaye Museum was the first museum to go through the redesigned program when it reopened in April 2022. The process required submission of an updated collections policy, interpretation policy, forward plan and "future focus" document. The future focus document requirement had no specific parameters built around it. The museum chose to create a document which could act like a strategic plan, setting out aspirational goals. This document, called *Thinking About the Future* is available on the ANZCA website.

The new online portal also included a brief questionnaire investigating changes to the museum since accreditation in 2015. After submission, a peer review panel was convened, consisting of three accreditation managers with AMaGA and an external museum professional.

On the day of the site visit, the peer review panel sat down with ANZCA Chief Executive Officer Nigel Fidgeon, Executive Director, Fellowship Affairs Jan Sharrock, Operations Manager, Knowledge Resources, Laura Foley, Honorary Curator, Dr Chris Ball, and Museum Curator, Monica Cronin. The discussion focused on the changes within the museum over the past seven years, its achievements, areas of concern, and its plans for the future.

The site visit concluded with a quick tour of the museum and the collection store.

The peer review panel was very impressed with everything they heard and saw, and the museum has been reaccredited for another five years. Highlights from the report include recognition of the co-creation process put in place for the development of *Djeembana Whakaora: First Peoples medicine, health and healing*, aligning with and in some areas exceeding, the newly drafted (but not yet published) *National Standards for Australian Museums and Galleries* which incorporates "First Peoples engagement and cultural protocols, digital engagement, and environmental sustainability", and the museum's "dynamic and effective online presence".

Recommendations from the peer review panel were designed to enhance the work already done or under way. These included utilising the five pillars of health developed as part of Djeembana Whakaora for future interpretive work, formally documenting the newly established processes and protocols for First Nations consultation including custodianship agreements with creators, and establishing a First Nations Advisory Panel.

Ahoy for PIRATE day

Pre-hospital Initial Response and Treatment Education

"IS THERE A DOCTOR IN THE HOUSE?"

It's a phrase some doctors dread especially if they have not been trained to deal with pre-hospital incidents or accidents in an aircraft, or a multiple casualty event.

For the 12 doctors who turned up to Ardmore Airport south of Auckland city early one Saturday morning recently for PIRATE Day (Pre-hospital Initial Response and Treatment Education), there was both enthusiasm and trepidation.

The course is the brainchild of ANZCA fellow Dr Kerry Holmes who works for the Waitemata anaesthesia department on Auckland's North Shore. He is also a pre-hospital and retrieval medicine (PHRM) doctor, and airway lead for the Auckland Rescue Helicopter Trust. Auckland is the only region in New Zealand where senior doctors are part of the helicopter emergency medical service (HEMS) teams.

Dr Holmes identified a perfect partnership – upskilling specialist doctors to deal with trauma and medical incidents in the community while raising money for the rescue service. That led to PIRATE Day.

With other PHRM doctors and an impressive team of critical care paramedics they put the participants through their paces with uncompromising firmness but grace and humour. They point out that up to 39 per cent of trauma deaths in New Zealand a year are survivable. And they let that number sink in.

The opening introduction was a whip around: "Tell us your specialty and what scares you the most about coming across an accident scene where you are the only doctor." Almost all the specialists – urologist, geriatrician, orthopedic surgeon, anaesthetist, or intensive care specialist – said they were most scared by injured children.

Luckily, Dr Holmes and his team had anticipated this and had prepared accident scenarios that involved children and babies.

After a couple of lectures, the doctors were given an overview of helicopter rescues and a bonus flight over the rural area surrounding the airport. Then the workshops began. These included working with the local volunteer fire service to cut vehicle crash passengers from a car. It's not widely known but that small logo on a car window is there for a reason – it indicates the point at which a decent tap will shatter the whole window and quite dramatically.

Dr Holmes requested that the *ANZCA Bulletin* not reveal too much detail about the scenarios as they will be used for future PIRATE days.

However, the *Bulletin* can reveal that making doctors exercise vigorously to elevate their heart rate and then blasting them with really bad music while having "distressed and sometimes threatening adults" (read paramedics or training paramedics) scream at them does actually affect their cognitive ability to assess the scene and the patient. Forgetting to call the emergency number was a frequent slip-up under stress.

"I think most doctors are scared that they might be overwhelmed being the first on the scene of a major accident. So, to go through a scenario and go through the motions after learning some simple algorithms to help, means they can de-stress it," Dr Holmes explains.

Dr Holmes says the "take home" for doctors who are first on the scene of an accident is "take your time" and approach the scene slowly and methodically. He says the PIRATE Day is a different sort of continuing professional development that seems to be universally loved.

The fees charged for the course contribute to a continuing medical education fund for the paramedics and purchasing educational equipment for the rescue service.

The *Bulletin* followed two of the four anaesthetists on the course for this article. We shadowed Dr Grant Ryan from Middlemore and Dr Catherine White from North Shore, both from Auckland.

See if you can guess the scenarios from the accompanying photographs.

Adele Broadbent
ANZCA Communications Manager, NZ

Clockwise from above: Trainee paramedics play panicked family at drowning; Dr Catherine White at the scene of a car accident; Dr Catherine White with the jaws of life.

CTN wrap up

THE 2022 CLINICAL TRIALS NETWORK (CTN) Strategic Research Workshop was recently held in Brisbane to continue the core business of developing new trials. Delegates were welcomed with warm weather and smiling faces, as they embraced the opportunity to network throughout the weekend. We also had 30 delegates join us online from around Australia and New Zealand through the online event portal and delegate app.

Day one started with thought-provoking talks by our keynote statisticians, Professor Tim Houle (US) and Dr Anurika de Silva (Vic) speaking respectively on what statistical editors are looking for, and reminding us what they are not looking for, and clarifying clinical trial aims and analysis using the estimand framework. Delegates then heard the latest clinical trial updates from Australian and New Zealand-based speakers as well as lessons learned. The CALIPSO trial team also presented what's involved in getting the trial under way at hospital sites. The CALIPSO trial led by Associate Professor Trisha Peel was recently funded $A8 million by the Medical Research Future Fund to investigate the optimal antibiotic duration in 9000 patients undergoing cardiac surgery.

Twelve new research proposals were presented where methodology and concepts were workshopped with peers and keynote statisticians with critical feedback.

Day two kicked off with a stimulating open science panel discussion on access, open source, and open data. Platforms, technology, infrastructure and ethical and logistical challenges on data access and sharing were discussed by Mr David Hansen Chief Executive Officer, Australian e-Health Research Centre, CSIRO, Professor Tim Houle, Associate Professor Victoria Eley, Professor Kate Leslie and Professor Paul Myles.

Words of wisdom were shared from chief investigators and trial co-ordinators on the lessons learned on running a trial during the past couple of years. As expected, the pandemic continues to remain a challenge to recruit participants to trials due to research coordinator redeployment, suspension of elective surgery, study drug supply issues and healthcare workforce strain. However, with many new trials now under way including LOLIPOP, TRICS-IV and CALIPSO, we are looking forward to a brighter future.

The meeting concluded with Anaesthesia Research Co-ordinators Network (ARCN) and CTN business meetings. CTN Executive Chair and workshop co-convenor, Professor Andrew Davidson, tabled strategic priorities for CTN. The top priorities voted by delegates included promoting regional development, furthering integration of ARCN into the design of clinical trials, developing a strategy to train and mentor emerging trialists, supporting higher degree students and consumer engagement.

The workshop paved the way for many events to resume face-to-face as we emerge from the pandemic. Social events were held in well-ventilated or alfresco dining settings, giving our delegates an opportunity to network and discuss research ideas. Research co-ordinators also had the chance to meet their peers ahead of the meeting and the emerging investigators breakfast hosted by Dr Jennifer Reilly provided emerging investigators an opportunity to network ahead of the Sunday workshop on multicentre studies and new proposals.

From top: Delegates at the emerging investigators workshop on new research proposals; Dr Anurika De Silva delivering a keynote presentation on the estimand framework

Thank you to all delegates, speakers, chairs and moderators. A special thank you also to the working group, Professor Andrew Davidson, Dr David Highton, Ms Karen Goulding, Ms Paige Druce, Ms Dhiraj Bhatia Dwivedi, Ms Majella Coco, Ms Rebecca Hull, and AV partner Wallfly.

Delegates can rewatch presentation recordings for up to 12 months through the online event platform and if you didn't get a chance to register prior, registration is still open until the end of September.

Save the date for 2023

You're invited to attend the 2023 CTN workshop which will be held 3-6 August in Coogee Beach.

Are you an emerging leader in anaesthesia or pain medicine?
Do you want to meet and learn from likeminded emerging leaders?
Do you want to enhance your leadership within your workplace?
Are you within five years of fellowship (taking into account career disruption)?

THEN APPLY NOW FOR THE 2023 ELC!

Please submit a selection criteria application form (found on the 2023 ELC webpage), accompanied by your resume, to Majella Coco at events@anzca.edu.au by **Friday 21 October 2022**. Successful applicants will be notified in early December.

THINKING OF APPLYING FOR THE 2023 EMERGING LEADERS CONFERENCE?

Check out what a few of our 2022 delegates had to say about their experience.

After a two-year delay and a last minute switch to an online format, the Emerging Leaders Conference organisers showed commendable flexibility in organising a dynamic and engaging conference. Primed with pre-conference introductions to mentor groups and the arrival of mystery packages, enthusiasm was high and the program didn't fail to deliver. Highlights included workshops on unconscious bias, tips for managing sticky situations, insights from military leadership – and utilising those mystery package supplies in a "West coast style" cocktail masterclass. The virtual format was very successful due to creative use of Zoom (a "speed-dating" quick fire session on the last day in particular was an innovative way of utilising Zoom breakout rooms) and the content delivery was flawless. In the post-COVID surge of online content delivery, the ANZCA ELC was the most well-organised and seamless virtual format I have attended. I want to thank ANZCA, the ELC conveners and Wallfly for all their work.

Dr Shannon Morrison FANZCA

Congratulations to the 2022 committee in delivering a high-quality Zoom-based Emerging Leaders Conference. As an anaesthetist in a regional setting, connecting with peers across Australasia provided me with a fantastic opportunity to reflect upon and share the non-technical components of our roles as anaesthetists (anaesthesiologists!?) and clinicians within our communities. I enjoyed meeting my very talented colleagues and listening to stimulating and thought-provoking presentations from medical and business leaders from all over the world. I would highly recommend any new fellow to take the opportunity and apply for 2023.

Ngā mihi,

Dr Jonathan Panckhurst FANZCA

The Emerging Leaders Conference was held virtually and I was surprised how well it worked. The format included many small scenario based groups in "break out rooms" which allowed us to get to know the other delegates. Participants attended from all over the world and it included many highly respected names. I found the unconscious bias workshop interesting – as always we don't think we have bias to some issues but the data from assessments proves otherwise. Managing difficult feedback is always a useful session as we all need to know how to encourage better performance without bruising trainees. The session on lessons from military leadership was interesting as they do hierarchy, expectations and roles much more clearly than we do in medicine. To keep it from being completely academic, even though virtual, they included a cocktail making session and we were delivered cocktail shakers and all the ingredients as well as a huge box of snacks. Overall, it was an excellent conference and I am grateful I was given the opportunity to attend.

Dr Candice Wallman FFPMANZCA

Fellow appointed to new sustainable healthcare role

Professor Eugenie Kayak

"Perhaps the carbon intense nature of our practice . . . has influenced many anaesthetists and trainees to be genuinely interested in addressing the environmental impact of healthcare."

ANZCA FELLOW PROFESSOR Eugenie Kayak has spent more than a decade as a leader advocating for greater awareness and action around healthcare's environmental footprint.

She has now been appointed to a key university medical school role that formally recognises sustainable healthcare as an important emerging discipline.

Professor Kayak, a consultant anaesthetist at the Austin Hospital and Alfred Health has recently started her new position as Enterprise Professor in Sustainable Healthcare in the Department of Critical Care at the Melbourne Medical School.

Through her advocacy work with Doctors for the Environment Australia (DEA) and anaesthesia, Professor Kayak is recognised as an influential Australian and global voice on sustainable healthcare for helping raise awareness about the environmental impact of the healthcare sector and its responsibility to lead in urgently mitigating these impacts, including carbon emissions.

"Healthcare needs to be part of the solution. At present it is part of the problem in contributing to global warming and related climate events that adversely impact on our health," she explains.

Her appointment is believed to be the first of its kind in an Australian medical school.

Professor Kayak will work closely with Professor Kathryn Bowen from the Melbourne School of Population and Global Health and Melbourne Climate Futures to develop sustainable healthcare initiatives in research, teaching and engagement across the University of Melbourne, its hospital partners and the wider community.

More than 7 per cent of Australia's carbon emissions are estimated to be from the healthcare sector. Professor Kayak is calling for a national sustainable healthcare unit that will lead the collection and benchmarking of healthcare emissions data from all states and territories and co-ordinate the development of evidence-based "road maps" for decarbonisation of the sector.

"Part of the problem for healthcare in Australia is that detailed measurements of our carbon footprint is lacking. A national sustainable healthcare unit would lead collaboration and systemic benchmarking to enable targeted reduction of emissions and associated roadmaps," she says.

"While there are good initiatives happening across the country both at a health department and health service level they tend to be siloed. NSW and Western Australian Health are developing quite comprehensive sustainable healthcare units with clinical leads and Mercy Health and Hunter New England Local Health District are working towards meeting very ambitious net zero targets for both carbon and waste."

Professor Kayak says anaesthetists are playing a significant role as active leaders in the race for healthcare to decarbonise.

"There are many reasons why health professionals, including anaesthetists, should be involved. Climate change is a health emergency and doctors have a powerful recognised voice to influence both healthcare practices and policy change. Doctors and health professionals have the skills to translate complex scientific evidence to policy makers, the general public and fellow professionals.

"We have led action and policy change previously to protect public health, such as with tobacco and drink driving legislation, and we need to do it again to mitigate the threats of climate change.

"Education is also integral. Medical specialties and universities have an important role, to not only equip our present and future medical workforce to incorporate environmental sustainability into their practices, but to also ensure the highest standards of healthcare can be delivered by health services and professionals already being impacted by increasing extreme weather events."

She notes that ANZCA has been one of Australia and New Zealand's leading specialty voices on the environment and sustainable healthcare.

"ANZCA should be congratulated for this. They joined with several other colleges in declaring a climate emergency in 2019 and released *PS64: Position statement on environmental sustainability in anaesthesia and pain medicine practice*. ANZCA has also developed an Environmental Sustainability Audit Tool and formed an Environmental Sustainability Network."

Professor Kayak said efforts by senior anaesthetists and trainees, including through the TRA_2SH initiative, at individual hospitals to reduce and eventually phase out desflurane is one example of how the specialty is influencing sector-wide change.

Large hospitals such as The Alfred have committed to removing desflurane as has Western Health in Melbourne.

"This has been the result of wonderful advocacy by TRA_2SH and others," she says.

"The amount of desflurane in the public hospital system is decreasing significantly and a lot of that is due to our trainees who have raised awareness of its significant global warming potential.

"Perhaps the carbon intense nature of our practice (work environments, medications, equipment, waste amounts) has influenced many anaesthetists and trainees to be genuinely interested in addressing the environmental impact of healthcare? What we do at work is important, work practices and choices can be more impactful on our carbon emissions than those within our personal lives."

Professor Kayak says the early signs are that Australia's new federal government will support a sustainable healthcare agenda.

"The new federal government has recommitted to developing a climate and health strategy. The details and timeframes are not confirmed but I'm confident that the government will incorporate addressing the healthcare sector's carbon and environmental footprint," she says.

The DEA, the Australian Medical Association and the Australian Nursing and Midwifery Federation are calling for Australian healthcare emissions to decrease by 80 per cent by 2030 and net zero by 2040.

"It has to be achievable," Professor Kayak says. "If we are to have any chance of keeping global warming to 1.5 or 2 degrees then we need to significantly reduce carbon emissions by the end of 2030. Every sector needs to play its part, though healthcare which exists to maintain and improve health has an added responsibility to lead and get its own house in order."

Professor Kayak notes that several Australian hospital and health networks have already committed to significant carbon emissions reductions. Some are planning to build all-electric facilities to be powered on 100 per cent renewable energy with no gas infrastructure, such as the Canberra Hospital extension, the new Adelaide Women's and Children's Hospital and the new Melton Hospital in Victoria. She says anaesthetists are well placed to influence new hospital builds to ensure they are not reliant on fossil fuels for future decades.

Carolyn Jones
Media Manager, ANZCA

ESN/MAC combined conference

Breaking new ground and a first for both the ANZCA Environmental Sustainability Network and Mackay Anaesthetic Community (MAC) was their combined June conference with environmental sustainability at its core. Delegates too were very pleased to be able to attend an in-person meeting, one of the first for the college and MAC since the beginning of the pandemic.

The theme of the meeting was "Adapting to the changing world" with a variety of workshops, presentations and networking opportunities available and of great interest was hearing about the work being done to reduce hospital and anaesthetic waste and improve sustainability within health services. The meeting convenors, Dr Suresh Singaravelu and Dr Scott Ma produced a diverse and creative program drawing together scientists, academics, clinical experts and the health care industry to debate, learn and share their experiences.

A highlight of the meeting was the number of opportunities to network and to discuss with colleagues real experiences, hurdles and successes with the TRA2SH and Environmental Sustainability Network (ESN) networking meeting a real highlight, especially seeing how impactful trainees can be in challenging how we work sustainably.

Taking advantage of the beautiful surroundings of Airlie Beach, the delegates also enjoyed a range of social activities from morning yoga to lunches and dinner by the sea; beach volleyball or a cruise on the Whitsundays anyone?

For the real life delegate experience of attending the conference and to read more about the excellent program and experiences please head to the ANZCA website – anzca.edu.au/Airlie22 – where Dr Ryan Williams, Dr Sabrina Chan and Dr Vaishnavi Vasanthi Sridhar have written up their time at ESN/MAC combined conference. It is well worth the visit.

Queensland

Physician Heal Thyself panel discussion with chairs Dr George Kennedy and Dr Katie Sewell, and panel members from left, Dr Edward Pilling, Dr Jasmine Pang, Dr Kavindri Jayatileka and Dr Margaret Kay.

ACE MEETING

The 2022 Queensland ACE meeting "Making waves" was held on 16-17 July at the Peppers Noosa Resort. The meeting attracted 150 delegates, speakers and workshop facilitators across the weekend.

We were delighted that so many could join us at the first face-to-face Queensland ACE meeting in three years, and grateful for the opportunity to re-connect and learn together in a relaxed, picturesque setting.

Delegates from all over Australia and New Zealand attended the meeting and were treated to a variety of interesting and insightful presentations from local Queensland and interstate speakers.

We were also delighted to offer an extensive range of workshops to fulfil CPD requirements.

Thank you to all the speakers and workshop facilitators who dedicated their valuable time to make the meeting a success.

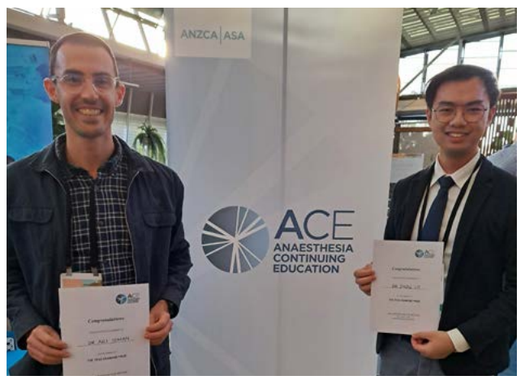
The trainee research prize sessions continue to be a success at the annual meeting, providing the opportunity for trainees, new fellows, and junior doctors to present anaesthesia or pain medicine-related research performed as part of their training.

Following the outstanding presentations from ANZCA trainees on Saturday 16 July, the Tess Cramond Prize was shared between Dr Zhou Lu for his research "An audit of the utilization of emergency anaesthetic drugs", and Dr Ari Isman for "Taking the sting out of Irukandji syndrome: the role of clonidine in reducing opioid requirements".

The ePoster Prize, kindly sponsored by Greenslopes Anaesthesia Services, was awarded to junior doctor Dr Bhanuka Ben Dissanayake, for his research "National trends in regional anaesthesia: a 20-year review". Congratulations to Dr Lu, Dr Isman and Dr Dissanayake.

The two-day meeting was a huge success both scientifically and socially, generating extremely positive feedback. We look forward to seeing you again in 2023. More information will be available on the ANZCA website in the coming months.

Advanced Life Support (ALS) workshop.



Tess Cramond Prize joint winners Dr Ari Isman and Dr Zhou Lu.

Australian Capital Territory

SCAN AND SKI WORKSHOP SUCCESS

Third time's the charm! After the postponement of our favourite event in both 2020 and 2021 we finally made it to Thredbo for this year's Scan and Ski Workshop and it didn't disappoint. The excitement and anticipation of the event delighted the 42 delegates who arrived in Thredbo on 11 August for the two-day workshop. The workshop focused on hands-on ultrasound scanning for upper and lower limb, spine, trunk and paravertebral nerve blocks. Eight world-class instructors led the delegates through morning and afternoon scanning sessions, while leaving the middle of the day free for skiing or sightseeing. The superb venue, delicious catering, engaged delegates and supremely knowledgeable instructors made this workshop very successful.

The logistics of running an event such as this in an alpine environment are quite onerous. Transportation of the ultrasound machines is a big undertaking and we thank our sponsor Sonosite for their amazing efforts to get everything to the venue. Thank you also to our sponsor BTC Health whose ongoing financial commitment to the workshop helps to keep the costs to a minimum for our delegates.

Four of our wonderful instructors from left: Dr Peter Hebbard, Dr Katrina Webster, Dr Harmeet Aneja and Dr Alwin Chuan.

Small group sizes meant plenty of scanning time for all delegates.

Dr Ross Peake demonstrates an upper limb scan.

Due to the popularity of this event, we are planning to run it again in 2023 (instead of 2024). Please check the ANZCA website for more details (noting that next year's event will be launched in October 2022). The event sells out very quickly so if you are keen to attend please ask to be placed on our waiting list by contacting Kym in the ACT office – act@anzca.edu.au.

A big thank you to the eight instructors, Dr Harmeet Aneja, Dr Alwin Chuan, Dr Peter Hebbard, Dr Monika Kenig, Dr Andrew Lansdown, Dr Chris Mitchell, Dr Ross Peake, and Dr Katrina Webster for their commitment to the workshop and enthusiastic teaching over the two days. Bring on 2023!

We finished off the workshop with a very informative Q&A panel session.

South Australia and Northern Territory

FPM CME MEETING

The first face-to-face SA FPM CME meeting for 2022 was held on 20 June. The focus of the evening was an update on pain research in the state. Topics included unravelling the mechanisms of bladder pain, persistent pelvic pain guidelines and exercise therapy and pathophysiological mechanisms for chronic neck pain. We would like to thank our presenters, Dr Luke Grundy, Ms Amelia Marden and Dr Rutger de Zoete for this informative presentation.

Ms Amelia Marden, Dr Luke Grundy and Dr Rutger de Zoete.

ASBD ER WORKSHOP

The SA/NT Continuing Medical Education Committee were pleased to be able to offer Acute Severe Behavioural Disturbance (ASBD) emergency response workshops in Adelaide on 18 June. Local and interstate delegates braved the cold weather and participated in case-based discussions relating to patients presenting with an ASBD.

The committee would like to thank facilitators Dr Johanna Somfleth, Dr Elise Kingston and Dr Irina Hollington for their time in putting together the successful workshops.

From top: ASBD workshop facilitators, Dr Irina Hollington, Dr Elise Kingston and Dr Johanna Somfleth; ASBD workshop delegates, Dr Nick Harrington and Dr Nikki Dyson.

PRIMARY EXAM REFRESHER COURSE

The 2022.2 SA Primary Exam Refresher Course was held from 27 June to 1 July. It was an intensive week for attendees who did extensive amounts of SAQ practice while also attending tutorials by several SA primary examiners and other experts in their topics. Once again we need to thank course convenor, Dr Gary Tham, who tirelessly prepared and presented excellent resources for the trainees and special thanks to co-convenors, Dr Adelaide Schumann and Dr Joanne Tan (Orange Jo), for their superb efforts throughout the week.

From top: SA Primary Exam Refresher Course attendees and viva volunteers; SA Primary Exam Refresher Course Co-Convenors Dr Adelaide Schumann and Dr Joanne Tan.

ACE MEETING

Dr Robyn Gillies, Chief Medical Information Officer and Head of the Malignant Hyperthermia Unit at the Royal Melbourne Hospital travelled to Adelaide for a face-to-face ACE meeting on the topic of malignant hyperthermia, after two unsuccessful attempts in 2021 due to COVID lockdowns. Held at the Lion Hotel on 25 July, delegates braved the rainy weather to hear Dr Gillies speak. The SA/NT CME Committee are very grateful to Dr Gillies for being so generous with her time.

INTRODUCTION TO ANAESTHESIA

The mid-year Introduction to Anaesthesia course was held on 23 July for new trainees commencing training in August.

Deputy Education Officer Rowan Ousley, Education Officer Christine Hildyard, Lynette Lau, Brianna Martin, course convenors Edwina Stenner and Noopur Mehta, Tegan Asser, Teo Mocioaca and Tess Chee.

Tasmania

WINTER MEETING

On a bright and crisp morning just outside of Launceston among the green pastures and vineyards of Relbia, 42 delegates and speakers made their way to Josef Chromy Winery. Here they enjoyed the stunning scenery and array of informative and expert speakers, some travelling from Sydney, ACT and Melbourne with local speakers from Launceston and Hobart.

Josef Chromy is famous for not only its wine, but also their food, beautiful location and great service and once again didn't disappoint.

The convenor Dr Ryan Hughes and organising committee members Dr Sam Walker and Dr Rowena Lawson were pleased with how the meeting went and appreciated the quality of the presentations and the relaxed feeling of the day.

Ryan was grateful for the support and involvement of the four trade sponsors – MSD, Seqirus, Avant and Credabl – with the representatives travelling from Melbourne and Hobart to attend the meeting.

It was the first time that the Event App was used at a meeting in Tasmania and many delegates commented on the ease to upload and navigate it.

Delegates appreciated the variety and quality of presentations. These included presentations on: social media for the anaesthetist and anaesthesia for head and neck free flaps by Dr Tanya Selak; a pain update by Luke Murtagh and Tasmanian speakers; Dr Adam Mahoney speaking on trauma in Tasmania in 2022: Smooth the path from roadside to rehabilitation; and Dr Pravin Dahal on thoraco-abdominal plane blocks.

After a delicious lunch, two pre-recorded presentations by Dr Lahiru Amaratunge on "Unlocking the opportunities of lockdowns – the unexpected rewards of educating online" and Associate Professor Deborah Wilson on "The Diploma of Rural Generalist Anaesthesia – coming to a hospital near you in 2023". Both pre-recorded presentations were followed by lively Zoom question and answer sessions. Delegates also enjoyed Dr Frank Clark, a staff obstetrician and gynaecologist in Launceston presentation on "Speculums and largyngoscopes – unlikely bedfellows" where he shared his experiences in the Antarctic.

The last talk on the day was appropriate to the winery venue and appreciated by all those in attendance, on "The Australian Wine Industry in the 2020s – the challenges and a few solutions" by Mr Chris Barnes, who travelled from Melbourne; armed with 30 years of experience in the wine industry both as a consultant and academic at the University of Melbourne.

Delegates appreciated the opportunity to relax and socialise with canapes and pre-dinner drinks following the meeting, overlooking the vineyard and followed by a delicious three-course meal full of high quality Tasmanian fresh produce.

Convenor, Dr Ryan Hughes was pleased with how the day went. "A lot of planning went into the meeting and it's a great feeling to see how well the day went and how much everyone enjoyed it."

Superb catering and views at Josef Chromy Winery

ACE ANNUAL SCIENTIFIC MEETING AND TRAINEE DAY

Get ready! Registrations will open in mid October for the meeting that will make your summer! Kick off your 2023 CPD year with a trip down south to Tasmania!

Hobart will be hosting the Tasmanian Annual Scientific Meeting (ASM) from 25-26 February 2023. Over two days we'll be "Making connections" through a day of lectures and a day of workshops, exploring the realms of airway management, perioperative medicine, pain management and sustainability.

Our perioperative session will be led by Professor Bernhard Riedel from the Peter MacCallum Cancer Centre. Pain expert, Dr Suyin Tan from Nepean Hospital will be guiding us through the connections of analgesia and anaesthesia in a patient's journey. Our scientific session will cover airway and onco-anaesthesia updates from Professors Reny Segal and Bernhard Riedel, respectively and Liz Crowe, renowned advanced clinical social worker, will be presenting and running an exciting communication workshop. Our local speakers will be providing insights into Tasmanian challenges and updates in perioperative medicine, airway management, regional anaesthesia and sustainability.

The Hotel Grand Chancellor, our new venue, will ensure a spacious, COVID-safe but social environment. Our social function is not to be missed; a cocktail style affair enjoying water views at the renowned Aloft Restaurant.

The annual trainee day will precede the meeting on Friday 24 February 2023 at Hadley's Orient Hotel. To stay updated on when registrations open, please email tas@ANZCA.edu.au

Dr Stephanie Cruice and Dr Jana Vitesnikova
Co-Convenors, 2023 Tasmanian ASM

CPD IN A DAY

Get in quickly!

Registrations are now open and filling up fast for "CPD in a day" to be held on 5 November 2022 at the Medical Science Precinct in Hobart. On offer are four emergency response workshops – ASBD, CICO, ALS and major haemorrhage.

The convenors are excited for the day and feel that the workshop day is a much-needed meeting in Tasmania. The day will finish off with a fun and relaxing social gathering at Boodle Beasely in North Hobart.

Dr Nat Jackson and Dr Harry Laughlin
Co-Convenors, CPD in a day

Victoria

MELBOURNE WINTER MEETING

The two-day conference opened with co-conveners Dr Lakmini (Lucky) DeSilva and Dr Nam Le welcoming more than 150 delegates at the Melbourne Sofitel. They eagerly introduced this year's diverse program that delivered fascinating and innovative plenary sessions, interactive quality assurance group discussions, and workshops covering myriad aspects of anaesthesia practice.

Not surprisingly, COVID-19 was at the forefront once again at this year's event with a particular focus on perioperative care after infection. Dr Traudi Almhofer discussed the practical implementation of the current ANZCA guidelines around COVID infection and surgery and the evidence behind the recommendations.

Saturday's program explored 13 other thought-provoking sessions. Topics covered women in pain medicine, duty of candour, anaphylaxis management update, management of accidental epidural puncture, measuring the unquantifiable, managing SGLT-2 inhibitors in the perioperative period, perioperative anxiety reduction in children, along with updates in haematology and pain medicine.

In addition to the quality assurance group sessions in the afternoon, delegates had the opportunity to relax with Jo Gibbs, founder and director of Treat, offering evidence-based wellness activities. At the end of a long day, delegates also enjoyed networking with drinks and canapes.

Sunday's workshops explored anaphylaxis, TIVA for toddles and trees, anaesthesia for the cardiac patient undergoing non-cardiac surgery and veterinary anaesthesia. Dr Jennifer Fu and Dr Jennifer Dixon gave an inspiring overview into the care technologies, pharmacological, physical, radiological and transfusion treatments available to prevent and control obstetric haemorrhage.

We hope everyone that attended enjoyed this year's meeting and we look forward to seeing those that can make our next one – save the date for the last weekend in July 2023!

ANNUAL FPM FORUM

FPM VRC hosted its first ever Annual FPM Victorian Forum on 27 July with delegates attending in person at ANZCA House and online.

After two long and challenging years, 28 state-based FPM fellows were reunited along with decision makers to discuss key emerging issues facing the faculty over the next 12 months.

Dr Louise Brennan, FPM VRC Chair, guided panel discussions with guest speakers including Dr Kieran Davis, FPM Dean, Dr Patrick Johnson, Associate Professor Malcom Hogg, Dr Malcolm Dobbin, Dr Mendelson and Ms Jan Sharrock.

In the time of COVID-19, issues such as physicians' wellbeing, safe script and opioid management in Victoria, ICD-11 diagnoses related to acute and chronic pain as well as MBS changes were magnified. As such, panel discussions served to better understand these issues and determine next steps for moving forward.

UNCONSCIOUS BIAS WORKSHOP

In healthcare "unconscious or implicit bias" is a familiar concept but what impact do these interchangeable terms have on clinical outcomes?

Spearheading discussions on unconscious bias in healthcare, Professor Kirsty Forrest, a consultant anaesthetist at Gold Coast University Hospital and Dean of Medicine at Bond University was welcomed by Dr Kaylee Jordan, CME Convenor, on 11 August. More than 80 delegates joined the online workshop.

Professor Forrest spoke on the growing body of evidence that suggests unconscious bias leading to false assumptions and negative clinical outcomes. Specifically, examining the role of health practitioner's attitudes and beliefs towards race, ethnicity, age, ability, gender, or other characteristics, influencing patient-provider relations, treatment decisions, treatment adherence and patient health outcomes.

As part of the online workshop, participants engaged in evaluating sample cases within smaller break out groups to raise awareness around approaches that help mitigate mental shortcuts that lead to snap judgements and decisions.

UPCOMING EVENTS & COURSES

Victorian Registrars' Scientific meeting – Friday 4 November

Supervisors of Training meeting – Tuesday 8 November

FPM VRC CME meeting – Wednesday 9 November

Primary Refresher Course – Monday 14 to Friday 25 November

Above from left: Group wellness activities with Jo Gibbs, founder and director of Treat; FPM Q&A panel discussions.

Western Australia

WHAT'S NEW IN '22?

Registrations have opened for the ACE WA Country Conference 2022, which will be held from 28-30 October at the Pullman Resort in Bunker Bay. The theme is "What's new in '22?" and is convened by St John of God Midland Public and Private Hospitals with the WA ACE CME Committee.

Dr Michael Paech will provide an obstetric anaesthesia update, Dr Leena Nagappan will be providing a perioperative medicine update and Dr Neil Hauser will share updates from the ANZCA ASM 2022. Dr Ted Murphy will speak about anaesthesia in the digital age; Dr Steven Webb will present about randomised embedded adaptive platform trials in relation to best treatment of severe COVID; and Dr Hannah Seymour will speak about the WA NOF registry.

The social calendar includes a welcome dinner at the Pullman Resort and an evening at Wise Winery. A mini-conference for children will be held on the Saturday afternoon. Registrations are filling up fast and with accommodation in the southwest of WA being in high demand, we recommend you book early to avoid missing out!

PRIMARY EXAM PIT STOP INFORMATION AND NETWORKING EVENING

The WA Trainee Committee hosted the first trainee-led primary exam information evening for trainees preparing for the exam in 2023. There were 14 rotational and non-rotational trainees who attended, providing an opportunity for networking and formation of study groups. Five speakers who had successfully completed the exam shared their resources, strategies and tips on how to pass the exam in an interactive session, allowing trainees to share their concerns and ask questions. The evening was kindly sponsored by the Australian Society of Anaesthetists.

Dr Jolene Lim
Co-Chair WA Trainee Committee

WA ROTATIONAL ANAESTHESIA TRAINING PROGRAM SELECTIONS

In Western Australia, the Rotational Anaesthesia Training Program (RATP) undertakes its annual trainee selection process in late August each year. Anaesthesia remains a very popular career choice in WA, and competition is fierce for the highly prized positions in this very successful, state-wide training scheme. A rigorous and intensive selection process is undertaken each year to select the most suitable candidates to become anaesthesia trainees and future anaesthetists.

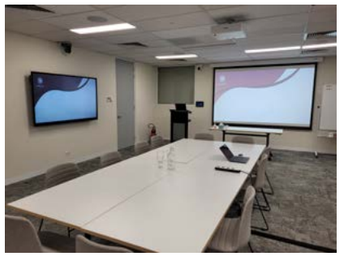
Approximately 120 candidates apply to the WA RATP selection process each year and 40-45 candidates are shortlisted and invited to progress to the next stage of the process.

Over three days at the end of August, candidates attend in person for their selection day, where a range of selection modalities are used to assess different aspects of the selection criteria. A combination of face-to-face interviews, a presentation and two simulation stations allow candidates to demonstrate their skills and their strengths in multiple ways. This multimodal approach has now been used in WA for 12 years.

Results from the written submission, the interview, the presentation and the simulations all form part of the final selection scoring, with 10-20 candidates successfully appointed to the WA RATP each year.

While this annual process is effort-intensive and time-consuming, it is recognised that this selection process is a crucial undertaking for the future of our specialty. And that a highly robust and rigorous selection process such as this, is essential to recruit the most suitable candidates to our training program.

This process uses numerous consultant anaesthetists and simulation fellows each year. Our thanks go to all the individuals as well as the departments who support the process each year.



ZOOM ROOM

Over the past few months, the WA Regional Office has been upgraded with new presentation, Zoom, network and wireless equipment. We look forward to being able to host events again soon and put these improvements to good use.

WRITTEN EXAMS

Written examinations were hosted at the WA ANZCA Office on 10 August for the Diving and Hyperbaric Medicine Diploma, on 16 August for the primary exams and 25 August for the final exams. We wish all the candidates the best of luck.

FINAL EXAM PREPARATION COURSE

If you are a trainee studying for your final exam, you may want to consider registering for the WA Final Exam Preparation Course, a program of almost weekly tutorials for 12 months leading up to your exam. Visit the Events Calendar on the ANZCA website to register.

TRAINEES

Trainees can contact the members of WA Trainee Committee confidentially. If you have any queries or concerns that you would like to discuss with a member of the WA Trainee Committee, you are welcome to contact them direct via their private email – anzca.watc@gmail.com.

New South Wales

PRIMARY EXAM REFRESHER COURSE

The NSW Primary Exam Refresher Course was held on 4-8 July at Northside Conference Centre (St Leonard's). The course was delivered as a hybrid format with 23 in-person and 12 Zoom candidates. We were able to successfully deliver this course for 35 candidates with the help of 17 presenters and staffs at Northside Conference Centre.

The NSW ANZCA team and trainees would like to thank our course convenor Dr David Fahey for orchestrating this course. A special thank you to all the presenters for your dedication to supporting our trainees and their exam preparation. Our amazing presenters are Professor Ross MacPherson, Dr Mincho Marroquin-Harris, Dr Furqan Arshad, Dr Rosmarin Zacher, Dr Frank Sun, Dr Larissa Cowley, Dr Priya Dhillon, Dr George Lim, Dr Dave Healy, Dr Jeff Kim, Dr Tim Hodgson, Dr Christine Velayuthen, Dr Joanne Chapman, Dr Malin O'Leary, Dr Tiffany Fulde and Dr Rebecca McNamara.

SAVE THE DATES

NSW ACE Spring Meeting
Terrigal – Saturday 12 and Sunday 13 November 2022

NSW ACE Anatomy Workshop
Sydney – Saturday 26 November 2022

NSW ACE Spring Meeting
Coffs Harbour – Saturday 18 and Sunday 19 November 2023

Dr Max Griffith

1924-2022

BORN IN 1924 in the northern suburbs of Melbourne, Dr Max Griffith grew up in a war service household. His dad had served at Gallipoli and had been hit by shrapnel, causing his right leg to lose stability. When he was eight years old, his father was transferred to Warracknabeal, a few miles north of Horsham. This was a complete change from suburban Melbourne with open spaces to play in, dams to chase the yabbies and sand hills just a couple of hundred metres from the house where, Dr Griffith, along with his younger brother and sister, would play and invent games – it was a wonderful sense of freedom.

Dr Griffith was a war veteran too. In 1942 he volunteered his service in the navy and spent time at sea in HMAS Manoora, in operations in the South China Sea. The ship carried troops but acted as a hospital ship after they were discharged. It was here that he gave his first anaesthetic – prior to any formal medical training. He was discharged from service in 1946.

After this experience he decided he wanted to study medicine. Dr Griffith failed his first year but repeated the year successfully. His second year was a disaster. He was unwell for many months and subsequently missed a lot of lectures. He failed the course, and it was then no longer paid for by Veteran Affairs. He took up a part time job working in a butter factory to help pay for school as he was determined to finish. He passed his second and third year with third class honours in biochemistry and submitted a request to Veteran Affairs. He was accepted back into the scheme and graduated in 1954 and worked as a student and resident medical officer (RMO) at The Alfred hospital.

At the end of his junior RMO year, Dr Robert (Bob) Orton, director of anaesthesia at The Alfred hospital, approached him with an offer of training in anaesthesia stating that it would help him make up the time he lost in the navy. Dr Griffith achieved his fellowship of the Faculty of Anaesthetists of the Royal Australasian College of Surgeons in 1958.

His time with The Alfred anaesthesia department was challenging but rich with experiences. He once had an 80-year-old patient with a lung cyst for cholecystectomy. In those days they didn't know whether the cyst was being ventilated and the question of controlled respiration posed a problem. Dr Griffith suggested he use open ether and spontaneous ventilation. Its long analgesic action was a benefit, but it's a challenge to keep it light. He was possibly one of the last anaesthetists to use ether.

He was appointed as the first assistant within the department of anaesthesia and resuscitation in 1959 after Dr Bob Gray resigned. He then succeeded Dr Orton as the director of anaesthesia at The Alfred in 1966. He was unsure how to continue the high standard set by Dr Orton and Dr Gray. His instinct was to do something different to the other anaesthesia directors in Melbourne. He believed there was a need for the director to have more involvement in teaching within the hospital and so he approached the registrars and asked if they'd be willing to attend 7am tutorials, which he was prepared to conduct five days a week. The response was enthusiastic. This arrangement continued for 11 years until he left The Alfred in 1975.

After 11 years at The Alfred, he applied for a position at Wimmera Base Hospital in Horsham and was appointed medical administrator. His time in Horsham was challenging but rewarding as he started a new position, calmed the fears of the local medical officers, established the Accident and Emergency Plan, ran The Blood Bank, and established a public dental clinic. It was a very satisfying position as he was friend and advisor to all levels of hospital staff.

Dr Griffith retired in 1984 to the south coast of New South Wales, first to Narooma and then Batemans Bay. He had a wonderful retirement with more time to focus on his hobby of playing the organ. He went on trips to the Netherlands where they have some of the most beautiful organs in the world, several over three centuries old – beautifully restored and maintained.

His other interests were fishing, photography, racing cars around Albert Park before the days of formula one, and playing squash.

Dr Griffith is survived by his son Rod, daughter Bronwyn and five grandchildren.

Dr Ian Rechtman, FANZCA
Dr John Paull, FANZCA

Dr Kerry Delaney

1939-2021

DR KERRY DELANEY died on 25 January 2021 after a tough 12 months of illness, having achieved much as a doctor, naval officer, administrator, grazier, husband and father.

Born in Wollongong, he had the classic adventurous childhood of yore, despite the war, and retained close friendships from this time throughout his life. His initial degree was in pharmacy at the University of Sydney where he continued in medicine. His residency years were spent at Royal Prince Alfred Hospital (RPAH) with two rotations to Dubbo where he gained much clinical experience in remote and rural medicine. He continued at RPAH as an anaesthesia trainee obtaining his fellowship in 1971.

He then embarked on part-time private clinical practice in Sydney alongside part-time work for the pharmaceutical giant Abbott International which was increasing its commitment to anaesthesia and related products at this time. He provided Abbott with medical guidance to aid the passage of new pharmaceuticals through the hoops of national drug regulatory bodies which provided some interesting challenges.

One such time came about when the regulatory body required an animal study to confirm the safety of long-term (several weeks) exposure to a new volatile anaesthetic. There was no such study in the world literature, but there was a "long-term" box to tick in the regulatory approval guidelines. So, with the support of his erstwhile professor of anaesthesia, multiple small and large animals were anaesthetised over several weeks to provide, successfully, the approval data to the regulator.

Kerry's time with Abbott also involved trials of sunscreen efficacy and safety, drug bioavailability studies, parenteral nutrition, neonatal nutrition, and other areas well beyond a focus on anaesthesia, requiring new learning but providing great interest.

Since 1971, Kerry had been a specialist anaesthetist to the Royal Australian Navy (RAN) as part of his medical practice. In 1973, he became an active medical officer in the RAN Reserve. After leaving Abbott in 1976, he transferred his commission to full-time services until his retirement from the navy in 1994. During his time with RAN, Kerry saw service at sea and overseas with foreign forces. In September 1990, he was appointed by the chief of the Defence Force to command members of the Defence Force attached for service as medical personnel on board United States Navy ships in the vicinity of the Persian Gulf. His appointment as officer-in-charge of the Australian Task Group Medical Support Element for Operation Damask on board the US Navy Hospital ship USNS *Comfort* was a career highlight for Kerry. The ship operated in an area of the Persian Gulf north of Bahrain. For his service aboard *Comfort*, Kerry was awarded a US Secretary of the Navy Commendation for his "superb performance" and was applauded for being instrumental in rapidly bringing the support element to a functional state of readiness. The commendation also acknowledged Kerry's exceptional leadership, professional knowledge and management ability, and stated that his work was "critical in enabling the *Comfort* to achieve the operational capacity required by theatre forces".

Additionally, during his navy career, Kerry spent time with the British Army, the Royal Navy, the US Department of Defense, and the Canadian Defence Force where he gained specialist expertise in medical aspects of nuclear, biological and chemical warfare, and radiation protection. These activities resulted in specialist recognition as a fellow of occupational medicine.

During his time at sea, Kerry notched up two general anaesthetics and one solo general anaesthetic/appendicectomy while with RAN. In 1990-91, while on USS Comfort, he extended this to 20 general anaesthetics administered. In 1992/93, RAN granted Kerry two years sabbatical leave for full-time refresher training in anaesthesia. This occurred variously at Liverpool, Royal Prince Alfred and Woden Valley Hospitals and the Royal Alexandra Hospital for Children, as well as doing the Part 1 and 2 courses. On retirement from RAN as a captain, he resumed anaesthesia practice in Canberra, both private and public. He often worked in the emergency theatre and would begin organising the day's work as he drove in from the farm so that there was (un)usually a patient in the anaesthesia bay when he arrived. This organisation extended to his work environment with all leads coiled and stowed neatly! Kerry was a good leader and had the enviable ability to get even the most recalcitrant person to work cheerfully and well.

He undertook executive administration roles at The Canberra Hospital (TCH) including being closely involved in the start-up and early years of the SouthCare Helicopter Aeromedical Retrieval Service both as a retrieval consultant and as the inaugural director of the service from 1998 to 2000. He was also involved latterly in clinical performance and governance matters as an advisor to the chief executive of TCH. Kerry retired from anaesthesia practice in December 2002.

During his time as executive director of clinical services at TCH, he was instrumental in the development of a medical, dental and emergency support plan for a royal visit. For his efforts he received an accolade from the royal household staff that the operational order he had developed for the visit "was the best of any previous overseas royal visit". The Australian Navy's loss was certainly a gain for Canberra.

Kerry's passion for flying was fulfilled after he finished university when in his spare time before commencing as an intern he commenced learning to fly, completing his first solo in December 1966. Always one to embrace challenges and learn new skills, Kerry later gained his instrument flight rules endorsement in 1995. He continued flying for recreation as well as volunteering as a pilot with Angel Flight until illness grounded him in 2019. His most recent flying instructor, assessor and mentor, Fred Kell (also an octogenarian who flew a DC 10 for historical flights out of Wollongong) remembers Kerry as an enthusiastic, diligent and competent pilot who always strove to improve his flying ability.

Through all this, Kerry ran a fine wool enterprise with his third wife Zoe, with all the attendant chores of a farm: re-stumping old shearing sheds, fencing, treating fly-struck sheep, raising orphaned lambs, and dealing with pest species both vertebrate and plant.

Despite his personal and professional achievements, Kerry was a humble and modest man, thoughtful and generous. His leadership in various roles in health in Canberra was especially superior. He is survived by his wife Zoe, his children Pamela, Andrew and Kathleen from his marriage to his first wife Dorothy, and son Rory from his marriage to his second wife Virginia. His daughter Elizabeth predeceased him.

Dr Carmel McInerney FANZCA
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