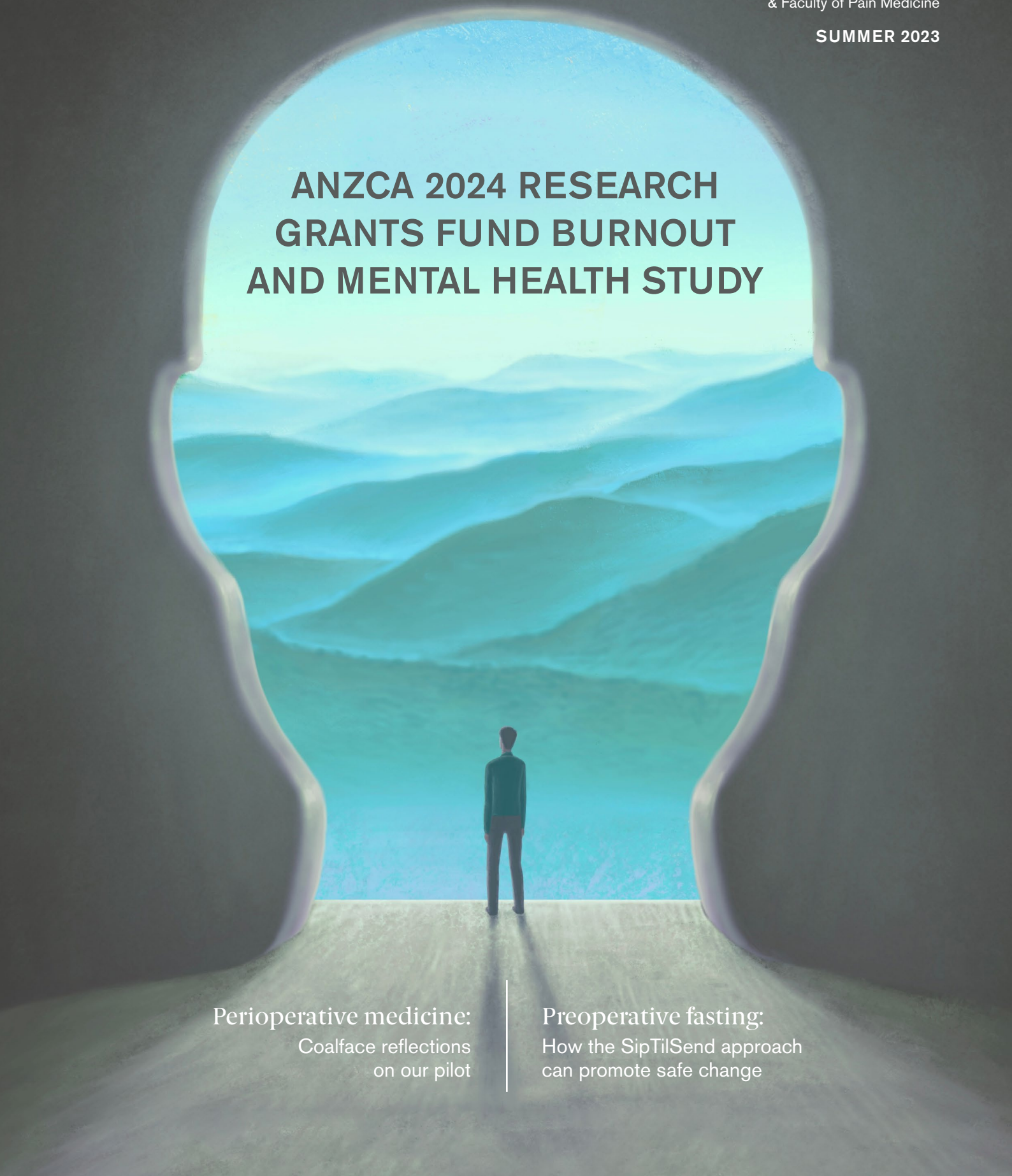
ANZCA
FPM

Bulletin

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

SUMMER 2023



ANZCA 2024 RESEARCH GRANTS FUND BURNOUT AND MENTAL HEALTH STUDY

Perioperative medicine:
Coalface reflections on our pilot

Preoperative fasting:
How the SipTilSend approach can promote safe change

WebAIRS and paediatric incidents
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ANZCA Bulletin
The Australian and New Zealand College of Anaesthetists (ANZCA) is the professional medical body in Australia and New Zealand that conducts education, training and continuing professional development of anaesthetists and 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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Productive year for college

This year has been a very busy one for the college. After a period of enforced hibernation during COVID-19, the past 18 months have been highly productive.

On the educational front ANZCA delivered two qualifications in 2023.

Our new rural generalist anaesthesia qualification replaced one overseen by the Joint Consultative Committee on Anaesthesia (JCCA) and is targeted at general practitioners who perform anaesthesia in rural and regional areas.

The college, in partnership with Royal Australian College of GPs and the Australian College of Rural and Remote Medicine, is central in setting and maintaining standards for anaesthesia in Australia and supporting training of our GP colleagues. Thank you to our ANZCA fellows for supporting this new qualification as supervisors, assessors and those involved in training site accreditation.

Another world-class offering is our perioperative medicine qualification. The first unit of study has just been piloted and we are enrolling candidates for the full ANZCA Course in Perioperative Medicine that starts in February 2024. We have had a massive response from those applying to qualify for our course via the recognition pathway, with 800 submitting their paperwork by the 1 December deadline, including 265 in the final week!

These achievements are in addition to the substantial work that continues in the evolution and development of the anaesthesia curriculum and training program. We have recently updated the anaesthesia curriculum, handbook and regulation 37 and published them for 2024.

Changes include improved alignment of learning outcomes with the Effective Management of Anaesthetic Crises (EMAC) course, and review of appendix 2 to better support trainees in preparing for the primary exam. To further support ongoing development of the training curriculum ANZCA Council recently approved establishing two new committees – the Anaesthesia Curriculum Review Sub-committee and the Assessment Governance Committee, a cross-college committee aiming to bridge assessment approaches across all college programs.

Our continuing professional development (CPD) program – your CPD home – is the gold standard for anaesthetists and pain medicine specialists, contains a wealth of expert support, resources, suggestions and tips for getting you through the annual requirements.

The ANZCA and FPM CPD Committee, CPD review project group, private practice and direct without patient care reference groups and your dedicated CPD team have worked hard to make your CPD program as convenient and accessible as possible after the changes introduced by the Medical Board of Australia in 2022. I am also happy to report our progress towards the development of a CPD app that will be available for use in 2024 and will allow uploading of information to become even easier through our mobile phones.

The ANZCA Foundation has allocated over $A1.5 million dollars to research, Indigenous health and overseas aid activities and I thank all of you who donate to these worthy projects.

Our events staff and the teams in our regional and New Zealand offices have been incredibly busy with 20 continuing medical education and special interest group meetings coming back on line this year. Some of the highlights for me include the Emerging Leaders Conference in the Hunter Valley and the ANZCA Annual Scientific Meeting (ASM) in Sydney. The desire for us to reconnect was strong and palpable with over 2000 delegates in Sydney, and I'm looking forward to the 2024 ASM in Brisbane.

Another memorable meeting was the FPM 25th anniversary meeting in Adelaide in October. The commemorative dinner was fabulous and attended by many previous deans and luminaries of the pain world.

This year we have rekindled our relationships with our overseas partners in Hong Kong, the UK, Ireland and Canada and profited from being able to meet in person again. International collaboration is part of our 2023-2025 strategy and there is a tangible benefit in sharing ideas and seeking solutions with our sibling colleges overseas.

Information technology is another area that is developing and evolving at a rapid pace.

Our lifelong learning project involves the upgrade of many of our older systems and has already created an FPM training e-portfolio to replace the old paper-based model. We have recently elected to develop a cloud-based design to upgrade our anaesthesia training portfolio system with work commencing soon.

Cybersecurity is a significant issue for all organisations and this year ANZCA has taken steps to make our systems and information as secure as possible.

Artificial intelligence has the potential to be a major game-changer so late this year we approved a high-level analysis of its potential impact on our college, due to report to council in February.

The Training Accreditation Committee and the Specialist International Medical Graduates (SIMG) Committee have both come under some scrutiny this year from the Australian health department and regulatory bodies but continue to operate in their usual professional and timely manner. We have engaged and contributed to many reports, from the Kruk report on regulatory settings for overseas trained practitioners to the National Health Practitioners Ombudsman's review on hospital accreditation. This is in addition to our contributions to the many jurisdictional reviews where the focus has mostly been on workforce.

Safety and quality is a feature of the college and highly regarded by our members as we know through our fellowship surveys. The final version of *PG09 (G) Guideline on Procedural Sedation* was approved by council in December and is a collaborative document that will improve the care and safety of our patients.

We strive to communicate and stay in touch with our trainees, fellows and SIMGs in an ever-changing social media environment. The *Bulletin* continues to have an impact with our members and has created some debate this year with fellows expressing their views. I have also personally received a lot of feedback and always welcome the opportunity to engage with members.

I am very proud of our Voice to Parliament statement from ANZCA Council and the FPM Board and, despite the outcome, we will continue our commitment to advocate for any measure that improves the health and welfare of our First Nations people.

In 2023 we had our second council meeting in Wellington where it was a pleasure to meet the ANZCA team, attend a Marae and meet some of the local fellows in an informal gathering. This year ANZCA officially recognised Te Tiriti o Waitangi and has started work on a comprehensive strategy to ensure our commitment to Māori trainees, fellows and patients.

In this and my recent emailed president's message I have really just skimmed over the many activities your college has engaged in this year.

I would like to thank the staff at ANZCA for their hard work, dedication and commitment to our college. It has been a busy year and I hope they all get some rest before it all starts up again in 2024. Thanks also to our amazing volunteer workforce and I hope you get a chance to take some well-deserved time off and recharge.

Best wishes to all for the festive season.

Dr Chris Cokis
ANZCA President

Health reforms and the college

The summer break is upon us after another year of which we can all be proud.

November marked the end of the exam season, and it was pleasing to see how smoothly things went.

We recently held our first exams for our new qualification for rural generalist anaesthesia and we developed and delivered a new e-Portfolio and an online exam system for the Faculty of Pain Medicine.

We celebrated the 25th anniversary of the faculty this year at the October Spring Meeting in Adelaide where we also launched the *National Strategy for Health Practitioner Pain Management Education* for which we received a significant Australian government grant.

A great deal of work has gone into the development of our new ANZCA Course in Perioperative Medicine which is part of the new Chapter of Perioperative Medicine. It has been extremely rewarding to see this unique qualification evolve as we prepare to take our first candidates in February 2024.

This follows the pilot of unit of study 1 between September and November which went extremely well. The feedback from candidates and supervisors alike will certainly enhance the course.

This was the first year of our new anaesthesia qualification for rural generalists that we developed with the Royal Australian College of GPs and the Australian College for Rural and Remote Medicine, with exams recently held.

We also have also signed a memorandum of understanding with the College of Intensive Care Medicine to develop a dual training pathway that is planned for launch in 2025.

We have seen the rise of "CPD (continuing professional development) homes" this year, offering alternatives to what some of the colleges have been providing. We are confident the ANZCA CPD Program is still the best available and in 2024 it will be enhanced with 13 new CPD activities added and the development of an app to make CPD easier for all.

Our 2023 ANZCA Annual Scientific Meeting (ASM) in Sydney was a wonderful success with over 2500 attendees. Registrations for the 2024 ASM and the FPM Symposium in Brisbane are now open and the response has been phenomenal with hundreds registering within days. I'm looking forward to a bumper meeting in Brisbane in May.

There has been significant advocacy this year with the Australian government examining strategies to reduce the long surgical waiting lists. We have been carefully watching and seeking to influence discussions about accreditation and specialist international medical graduate (SIMG) assessments.

Our stance, as always, is to ensure that any reforms are not at the expense of patient safety and standards.

In New Zealand, after a long post-election wait, we have a new government and health minister. Lots of changes are afoot.

Artificial intelligence has become a major source of discussion this year and the college has formed a working group to establish a policy with guiding principles for ANZCA.

System breaches and hacks at well-known organisations have shone a spotlight on the security of our information and data and our IT and Security team has been focusing on the continual improvement of our systems and processes.

A huge thank you to ANZCA staff who have supported all these activities this year and will do so again in 2024. I'd particularly like to acknowledge our fellows on staff, especially our outgoing directors of professional affairs (DPAs) Dr Peter Roessler, Dr Lindy Roberts and Dr Vaughan Laurenson who take with them many, many years of valued experience. Their service to the college has been extraordinary.

They are being very ably replaced by our new DPAs Dr Michelle Mulligan, Professor David A Scott, Professor Jennifer Weller, Associate Professor Kara Allen, Dr Suzanne Bertrand and Dr Vanessa Beavis.

I wish you all the very best for the festive season and I hope you get to enjoy some time with friends and family.

Nigel Fidgeon
ANZCA Chief Executive Officer

Upcoming ANZCA and FPM elections

ANZCA COUNCIL ELECTIONS

Fellows are invited to nominate for four vacancies (three councillors and one new-fellow councillor) on ANZCA Council. The nomination period opens on Friday 15 December and must be submitted to the ANZCA chief executive officer by 5pm (AEST) on Friday 16 February 2024. Prior to submission, each nomination form must be signed by two fellows of the college, as well as by the nominee.

If the number of nominations exceeds the number of positions vacant, a 2024 ANZCA Council election will take place from 1-29 March 2024 via an electronic ballot.

Results of the ballot will be announced at the ANZCA 2024 Annual General Meeting (AGM) which will be held on Monday 6 May during the 2024 ANZCA Annual Scientific Meeting in Brisbane.

FPM BOARD ELECTION

The call for nominations, for two elected vacancies on the 2024 FPM Board closed on 8 November. As the number of nominations exceeded the number of vacancies, the faculty will proceed to a ballot which will be held from 20 January to 8 February 2024.

Further details on the FPM Board election process can be found on the website.

Results of the ballot will be announced at the FPM Annual Business Meeting which will be held on Sunday 5 May during the 2024 ANZCA Annual Scientific Meeting in Brisbane.

ANZCA AND FPM REGIONAL AND NATIONAL COMMITTEE ELECTIONS

ANZCA regional and national committees

The next elections of the ANZCA Australia regional committees and the New Zealand National Committee are scheduled for March/April 2024. We will invite eligible fellows to submit nominations in February 2024 and will hold an electronic election where the number of nominations received exceeds the number of vacancies for each.

ANZCA Council will confirm the appointment of office bearers, committee chairs and membership nominations at the ANZCA New Council Meeting held on 7 May 2024.

FPM regional and national committees

The next FPM Australian regional committee elections are scheduled for March/April 2024 and eligible fellows will be invited to submit nominations in February 2024. We will hold an electronic election for each of the regions where the number of nominations received exceeds the number of vacancies.

The next FPM New Zealand National Committee election will be held in 2025.

The FPM Board will confirm the appointment of office bearers, committee chairs and membership nominations at the FPM New Board Meeting.

ANZCA TRAINEE COMMITTEE ELECTIONS

The 2024 ANZCA Trainee Committee elections were held in October/November 2023 and ratified by the Education Executive Management Committee (EEMC).

The chairs of the Australian and New Zealand trainee committees make up membership of the ANZCA Trainee Committee. An Australian and New Zealand chair of the ANZCA Trainee Committee will be announced in March.

VOTING

If you intend to vote in any of the elections, please ensure your preferred email address is up to date on the MyANZCA Portal (www.anzca.edu.au/portal) or by contacting ceo@anzca.edu.au.

To avoid your voting keys going to spam folders, please add noreply@electionrunner.com to your safe sender list.

For more information on all elections please visit the elections webpage.

Election	Nomination period	Election period	Official announcement date
ANZCA Council	Friday 15 December 2023 to Friday 16 February 2024	Friday 1 March 2024 to Friday 29 March 2024	Monday 6 May 2024 at ANZCA Annual General Meeting
FPM Board	Wednesday 11 October 2023 to Wednesday 8 November 2023	Saturday 20 January 2024 to Thursday 8 February 2024	Sunday 5 May 2024 at FPM Annual Business Meeting
ANZCA Australian regional committees	Thursday 1 February 2024 to Thursday 22 February 2024	Thursday 21 March 2024 to Thursday 11 April 2024	Tuesday 7 May 2024 at ANZCA New Council Meeting
ANZCA New Zealand National Committee	Wednesday 14 February 2024 to Monday 11 March 2024	Thursday 21 March 2024 to Thursday 11 April 2024	Tuesday 7 May 2024 at ANZCA New Council Meeting
FPM Australia regional committees	Thursday 1 February 2024 to Thursday 22 February 2024	Thursday 21 March 2024 to Thursday 11 April 2024	Thursday 16 May 2024 at FPM New Board Meeting
FPM New Zealand National Committee	2025	2025	2025
ANZCA Trainee Committee	Thursday 5 October 2023 to Friday 27 October 2023	Friday 10 November 2023 to Friday 24 November 2023	Tuesday 28 November 2023

Letters to the editor

GLYCINE USAGE

Thank you Associate Professor Sutherland for your safety and quality article in the Spring edition of the *ANZCA Bulletin* regarding glycine usage for transurethral resection of the prostate (TURP).

As noted, anaesthetists of a "certain age" are fully cognisant of the risks with the use of glycine for the monopolar resection of prostatomegaly.

Your article, however omitted that some gynaecologists also use glycine for monopolar resection of uterine polyps, which potentially could be a trap for "young players". One of the worst cases of hyponatremia I have been involved with was just this scenario.

I wondered at the time whether this was due to the fact that the uterus is less distensible compared to the bladder and hence the glycine was at pressure resulting in excessive absorption.

Dr Philippa Hall, FANZCA

Thanks to Associate Professor Joanna Sutherland for her reminder of the dangers of glycine in urology *(ANZCA Bulletin,* Spring 2023).

I would like to add to that the dangers of glycine still seen in gynaecological surgery mostly involving hysteroscopic fibroid resections.

Like urology, gynaecology has developed new procedures for tackling this type of surgery such as the MyoSure and bipolar diathermy where normal saline can be a substitute but glycine continues to be used, particularly where these newer devices are not available.

I would add that these patients are at even higher risk, with glycine being forced out the fallopian tubes into the peritoneum where it is absorbed and due to the highly vascular nature of the fibroids being resected.

As such it is most important to keep an accurate record of the volume of glycine containing fluids entering the patient and the calculated deficit.

Dr Jennifer Wheelahan, FANZCA
Mercy Hospital for Women, Heidelberg

THE ART OF ANAESTHESIA INDUCTION OVER THE YEARS

I was amused by one of Professor Emery Brown's comments in the Spring edition of the *ANZCA Bulletin* "*... patients are definitely not asleep – if they were we'd wait till they fell asleep then rush them down to the operating theatre and operate on them.*"

In the mid-1960s, the practice at one of the hospitals where I trained was to give the patient up to 500 mg of pentothal on an operating room (OR) gurney in the ward, rush them down the corridor to the (ancient) lift, held open by someone, and take them up to the OR on the top floor, into theatre and lift them across to the operating table – not the best anaesthesia induction practice, perhaps!

On a another subject from the letters section in the same issue, medicine is practised within the social context of its time. Therefore, I totally support ANZCA speaking out on social, cultural and environmental issues, all of which do impact on our practice and the safety of our patients.

Associate Professor (retired) Michael Davis, FANZCA

SPECIALIST INTERNATIONAL MEDICAL GRADUATES – A MORAL DILEMMA

Mr Nigel Fidgeon's CEO message regarding workforce issues, (Spring *ANZCA Bulletin*) juxtaposed nicely against the subsequent letters to the editor debating the role of the college in political and ethical matters.

If the college is to take a stance on selected political and ethical matters where does it stand on accepting specialists from countries whose need for appropriately trained specialists far outweighs Australia's? (Even if their skill set and training is adequate.)

Australia's medical workforce shortage is minimal compared with most other countries. If the college is genuinely concerned about global health, it should be advocating government not to take doctors from countries where the medical workforce shortage and/or healthcare is worse than our own.

To promote/accept a 'brain drain' from less well-off countries where the standard of health care is less than Australia's is ethically wrong and a double standard from the college's stated point of view. In the global scheme of things, despite Australia's medical workforce shortages, the standard of healthcare in Australia is extraordinarily high. There is also a steady stream of home-grown medical graduates entering the system.

Are we taking SIMGs from the needy/poor to look after the privileged/rich?

Dr Robert Grace, FANZCA

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

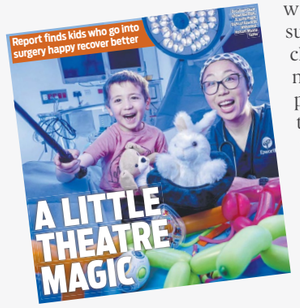
ANZCA and FPM media coverage

Highlights since the Spring *ANZCA Bulletin* include:

A little theatre magic

***(SUNDAY HERALD SUN*, 29 OCTOBER)**

An ANZCA 'Blue Book' chapter on magical distraction for children about to undergo surgery was highlighted in an article in the *Sunday Herald Sun* on 29 October. The author of the article, Perth FANZCA Dr Craig Sims and Melbourne FANZCA Dr Colleen Chew were featured in the article which reached more than 700,000 readers. Dr Chew said her bag of tricks included using flavoured sticks with colourful names such as lemon cream pie, chocolate magic or coconut dreams. Her young patients can use these on the inside of their face masks so they go into a slumber with a familiar smell. "If they go off to sleep with a smile, they wake up with a smile," Dr Chew said.



Desperate for help after years of chronic pain

***(THE PRESS*, 28 OCTOBER)**

FPM New Zealand National Committee Chair Dr Chris Rumball, along with committee member Dr Karen Joseph, spoke with *The Press* for a 28 October article on chronic pain. The article highlighted issues with the Burwood Pain Management Centre and the shortage of specialist pain medicine physicians in New Zealand. Dr Rumball told *The Press* that patients can benefit from different types of pain management at different times. "However, in a system that tends to measure specific 'things', a check-box mentality can take over, where a patient is said to have 'had pain management', and therefore is no longer able to access further input," he explained.

Social media is really making people sick

***(ADELAIDE ADVERTISER*, 7 OCTOBER)**

An FPM Spring Meeting session on Munchausen syndrome by internet featured in a 550 word article in the *Adelaide Advertiser* on 7 October. Adelaide speaker Dr Trushna Murgahayah was interviewed and photographed for the article by health editor Brad Crouch as a preview to the final day's session of the 2023 meeting in Adelaide. Dr Murgahayah, an Adelaide psychiatry registrar, told the meeting that pain clinics were seeing a rise in Munchausen syndrome where patients present with "complaints of symptoms which they have extracted from the internet in hopes of obtaining certain treatment or getting a particular diagnosis." "Munchausen syndrome by internet is increasingly becoming more common in pain clinics and this is a rising trend worldwide," she said. The article reached nearly 400,000 readers.

Desflurane out from WA public hospitals

(ABC RADIO PERTH, 4 OCTOBER)

Perth FANZCA Dr Adam Crossley was interviewed on ABC Radio Perth Afternoons program on 4 October to explain how the removal of desflurane from WA public hospitals will reduce the carbon footprint of the state's health system and save money. Dr Crossley, Fiona Stanley Fremantle Hospitals Group Medical Lead for Climate Health and Environmental Sustainability, said the move was the result of staff working innovatively to bring about system-level changes. He highlighted how clinicians could be committed to being more environmentally friendly while also maintaining the highest level of patient care. The roll-out of the initiative statewide demonstrates how anaesthetists and other specialists can work towards a more sustainable future in healthcare.

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

ANZCA and government

Workforce a focus for advocacy in 2023

Workforce was a focus of much of the college's advocacy work in 2023 in both Australia and New Zealand as health authorities globally grapple with shortages in the medical workforce. A significant driver is an increasing elective and planned workload, coupled with supply-side issues including reduced skilled migration during the pandemic.

The pandemic highlighted, and accelerated, some workforce changes that were already occurring, such as a trend for our fellows, trainees and specialist international medical graduates (SIMGs) to have a more balanced lifestyle.

Medical training pathways are long and complex, and determining specific workforce requirements is hampered by poor and conflicting data. In Australia, the *National Medical Workforce Strategy 2021-2031* cites anaesthesia as a specialty in a growing oversupply, but this is not supported by the experience of many anaesthesia departments. Nor is this view shared by most state and territory governments.

We are hopeful that many of these difficulties in medical workforce planning will be addressed in the future as stakeholders, including ANZCA, work together with the Commonwealth Department of Health and Aged Care to implement the national medical workforce data strategy.

There are no easy or quick solutions to these issues and any potential solutions must strike an appropriate balance between maintaining our high safety and quality standards and workforce demands. Much of our advocacy on this issue has been to highlight the college's willingness to work with government and regulatory authorities to address workforce capacity, however we will never endorse responses that lower safety and quality standards.

Government responses to the workforce challenges have included requests to medical colleges to increase training numbers, streamlining processes to expedite SIMG applications, transitioning assessments of equivalence for SIMGs from the specialist medical colleges to the Australian Medical Council and expanding the scope of practice for non-physician anaesthesia providers.

With regards to increasing trainees, the college is not directly involved in the selection of trainees in Australia, nor does the college have direct influence over trainee numbers. Anaesthesia trainee selection is a regional and local training site process undertaken by employers, with these processes varying in each jurisdiction. However, in Australia the number of registrar positions at individual hospitals is determined by the employer.

In April, national cabinet in Australia released the interim report of the *Independent review of overseas health practitioner regulatory settings*. The college responded to this report highlighting that:

- ANZCA recognises and values the vital role of SIMGs in meeting our workforce needs.
- The college supports the streamlining of processes for SIMGs entering work in Australia, however, this should never be at the expense of compromising the current high standards of care that Australians expect.
- ANZCA meets and exceeds all metrics for response times in the processing of assessment applications of SIMGs set by the Medical Board of Australia and the Australian Health Practitioner Regulation Agency. ANZCA does not support transitioning equivalence assessments for SIMGs from the specialist medical colleges to the Australian Medical Council as assessing equivalence requires expert knowledge of both the training, qualifications, specialist experience and continuing professional development of a locally trained specialist and the ability to reliably compare that with the applicant.

In New Zealand, Te Kaunihera Putaiao Hauora Aotearoa/ Medical Sciences Council held consultations into the scope of practice for anaesthetic technicians, and Manatū Hauora/ Ministry of Health carried out a targeted consultation via the Council of Medical Colleges regarding the credentialling of physician associates.

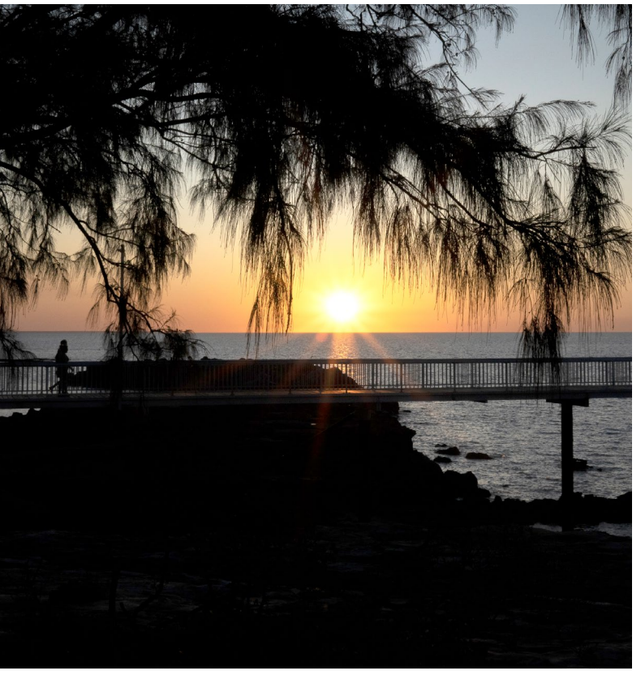
Extensive feedback on the proposals from the Medical Sciences Council to credential graduates from a new Bachelor of Health Science (Perioperative Practice) degree indicated some disquiet among ANZCA fellows about the proposed name, the work-readiness of the new graduates, the broader scopes and wider work settings.

There appeared little understanding by the Medical Sciences Council of the potentially deleterious impacts on the current workforce of anaesthetic technicians, nurse anaesthetists, nurse practitioners and theatre nurses.

ANZCA advocated that the removal of certificate and diploma qualifications for a national anaesthetic technical workforce due to the closure of these courses risked creating new and unnecessary hurdles to routes into the workforce, countering the need to increase the diversity of the health workforce.

Added costs (from university fees, accommodation away from home, longer training, loss of the ability to earn-while-learning on-the-job), will deter students from disadvantaged backgrounds, especially Māori and Pacific students from outside Auckland.

A highly contentious move saw the Ministry of Health seek to find a mechanism by which a new cadre of overseas trained health workers (physicians associates) could be brought under the Health Practitioner Competence Assurance Act.



Scenes from ANZCA's Specialist Training Program locations from left: Scenic pier sunset in Darwin; Royal Hobart Hospital and Royal Hobart anaesthesia trainee Dr Sandeep Sidhu.

ANZCA, in common with many other colleges, found real concerns with the proposals, which appeared to be a rushed and flawed attempt to plug a gap; with the potential to create more risk and problems that it tried to solve. A legal review of process following formal complaints from unions and some colleges has yet to be resolved.

ANZCA contributed to the Royal Commission of Inquiry into COVID led by Professor Tony Blake (University of Otago and University of Melbourne). Our submission highlighted the extensive scholarship and clinical leadership (especially in the early, uncertain stages of the pandemic) provided by fellows and the college, in addition to making recommendations for better future preparedness.

In a surprise move, Medsafe has reclassified cannabidiol from a prescription-only medicine to a restricted medicine. The reclassification allows supply of approved low-dose cannabidiol medicines, by registered pharmacists, without prescription for patients aged 18 years and older. Only cannabidiol medicines approved under the Medicines Act 1981 will be available from a registered pharmacist. There are currently no approved low-dose cannabidiol-containing medicines.

New Zealand health reforms continue, with the required health strategies being released and clinical networks starting to be established. The release of the final two of six strategies – a provisional Health of Disabled People and the Rural Health Strategy – complete the groundwork for "a more equitable, sustainable and responsive health system".

The clinical leads for the first tranche of clinical networks (trauma, cardiac, renal, and stroke) have just been announced. With the change of government and health minister and with pre-election commitments to disestablish Te Aka Whai Ora/ the Māori Health Authority, the health system is braced for yet more uncertainty and change.

REGIONAL AND RURAL WORKFORCE AND THE SPECIALIST TRAINING PROGRAM

In 2021 the college launched a regional and rural workforce strategy, reflecting a commitment to improving health outcomes for rural, regional and remote communities and the health and wellbeing of our fellows, trainees and SIMGs living and working in these areas. Many of our activities under the strategy align with, and are supported by, the Australian government Department of Health and Aged Care's Specialist Training Program (STP). STP provides financial incentives to specialist medical colleges to extend vocational training for specialist registrars into settings outside traditional metropolitan teaching hospitals, including regional, rural and private facilities. ANZCA receives funding for around 54 training posts under different streams of the program.

Successful advocacy and regular engagement with the department and other stakeholders led to some notable highlights for 2023 including:

- The approval of two Department of Health and Aged Care Flexible Approaches to Training in Expanded Settings (FATES) proposals valued at over $1.1 million over the next 18 months:
    - Tasmanian Anaesthetic Simulation, Education and Training Network.
    - Rural training models (a Royal Australasian College of Surgeons-led consortium including ANZCA, the Royal Australian and New Zealand College of Ophthalmologists, the Royal Australasian College of Medical Administrators and the Royal Australasian College of Physicians.
- Securing an additional STP core training post (from 42 to 43) and one additional Integrated Rural Training Pipeline post (from nine to 10) valued at over $1 million over four years.
- Additional funding from the Department of Health and Aged Care to enable the college's popular Critical Incident Debriefing Toolkit to be rolled out in more regional and rural locations. In-person "train-the-trainer" workshops were held during the year in Hobart, Alice Springs and Cairns. In October the department advised the college it had approved a further $150,000 to develop an online education module to support the Critical Incident Debriefing toolkit, as well as conduct further train-the-trainer sessions in 2024.

The Online Centralised Exam Preparation Program is an STP-funded project to support quality anaesthesia education and training by giving rural and STP trainees equitable access to exam preparation resources. To date, trainee and supervisor data has been collected and two workshops have been held to discuss and refine the kind of resource that will be produced. In October a rural stakeholder consultation session was conducted with heads of department, supervisors of training and advanced trainees to obtain their perspective and feedback on the draft resource.

On 13 November the college hosted an STP stakeholder forum. Over 35 participants joined the forum at ANZCA House including representatives from the Department of Health and Aged Care and other specialist medical colleges. Attendees received an update on the program from the Department of Health and Aged Care and discussed collaboration on cultural safety projects, health and wellbeing initiatives and improved engagement with regional training hubs.

SUBMISSIONS

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

Australia

- Agency for Clinical Innovation (New South Wales): Perioperative toolkit.
- Australian Commission on Safety and Quality in Health Care: Osteoarthritis of the knee clinical care standard.
- Council of Therapeutic Advisory Groups: Consultation on draft position statement for Andexanet alfa.
- Medical Board of Australia: Application for recognition of a new field of specialty practice - rural generalist medicine.
- Medical Board of Australia: Standards - Specialist medical college assessment of specialist international medical graduates.
- Parliament of NSW : Special commission of inquiry into the funding of healthcare services provided in NSW.
- Royal Australian and New Zealand College of Psychiatrists: Consultation on the Diploma of Psychiatry.
- Therapeutic Goods Administration: Australian medicine labelling rules – TGO 91 and TGO 92 – consultation.
- Victorian Department of Health: Ministerial review of Victorian public sector medical staff.

New Zealand

- Health Quality and Safety Commission/Te Tāhū Hauora: Draft clinical governance framework.
- Ministry of Health/Manatū Hauora: Proposal to regulate physician associates under the Health Practitioners Competence Assurance Act.
- New Zealand Royal Commission: Inquiry into COVID-19: Lessons learned.
- Medical Council of New Zealand/ Te Kaunihera Rata o Aotearoa: Disclosure of harm following an adverse event.

Tears and goosebumps for the NZ fellow who helped develop ANZCA's karakia

Arihia Waaka sat in her car, tears welling in her eyes and goosebumps breaking out on her arms. Through her tears, she looked down at her cellphone, reading the ANZCA karakia for the first time.

For Dr Waaka, an anaesthetist based in the New Zealand city of Rotorua, the ANZCA karakia is personal.

Dr Waaka successfully applied for a grant from ANZCA's Health Equity Projects Fund and commissioned the karakia to be written by tohunga (expert practitioner) Mark Kopua.

The karakia, designed to provide pre-surgery comfort to patients and their whānau (family) was launched at the Aotearoa NZ Anaesthesia Annual Scientific Meeting, held in early November.

Karakia are prayers or incantations used by Māori to acknowledge and affirm the spiritual world and their ancestors. In the case of upcoming surgery, karakia offers another element of protection to the patient.

Dr Waaka says the idea of creating a karakia came naturally to her.

"Karakia is super prominent in te ao Māori (the Māori world), most Māori people will karakia before a large meal, before a big trip, if they're feeling angry – it's just so prominent. It was just a natural progression to ask someone to write a karakia for pre-op."

A karakia was another way to provide comfort for families and patients about to undergo anaesthetic.

"It's a stressful time, even with what we think is minor surgery, people still have to go to sleep, there's a fear they won't wake up, they have to be separated from their family, it's super foreign and stressful. A karakia is a way for families to feel like they're helping – and they are helping, by comforting their loved ones and themselves."

The karakia, in both English and te reo Māori, is being distributed by ANZCA to hospitals across New Zealand. It can also be downloaded from the ANZCA website for patients and families to use before an operation. The website also includes audio guides to pronunciation.

Dr Waaka says there is a growing understanding of the importance of spirituality in the healthcare sector.

"There was probably a time when spirituality was scoffed at, but the truth is there are some things we can't explain – even the fact a positive attitude can help you live a longer life. I think spirituality is an observational science. It's an observation of something, not knowing how to explain it, but acknowledging there's a connection beyond our understanding."

She is thrilled with the support she's received from ANZCA to help make the karakia a reality.

ANZCA
FPM
Te Whare Tohu o Te Hau Whakaora

Karakia Poka, nā Mark Kopua

E amo ake ai au i taku toki hahau, e hāhau ai te ora
Ko te ora ki runga, te ora ki raro, te ora ki waho, te ora ki roto
Tēnei toki he toki nā wai? He toki nā Rongo-taketake
I whawhai te kawa tūainuku, tūairangi, tūaitāne-ruānuku
Tāwhiwhia te ngātoro e takoto nei, ki te aho tipua, ki te aho tawhito o Rongomatāne
Ko Tūpore-nuku, Tūpore-rangi, Tūpore-hau e hau atu nei
Tēnā toki ka hīhiri, tēnā toki ka whītiki, taku toki ka iri
Whano whano haramai te toki
Haumi e, Hui e, Tāiki e!

I take up my tool that seeks out wellbeing
Wellbeing that is in all upper, lower, outer, inner spaces
Whose is this tool? It belongs to Rongo-the-ancient
Who battles against all the spiritual and physical ailments that attack mankind
Bind and weave this patient lying here in the thread of healing, the ancient thread of Rongomatāne
That provides terrestrial, celestial and spiritual cares to all that live here
We bind to that tool, we hold that tool and raise it up high
Proceed and move forward
Bind it as one, united!

"ANZCA committed to doing it properly and not appropriating Indigenous knowledge – they were just on board and recognised that I knew the right way to go about it.

"When I first read it (the karakia), I literally got goosebumps, and tears came out of my eyes."

Dr Waaka is hopeful other medical colleges may follow ANZCA's lead and create their own karakia. Organ Donation New Zealand, who Dr Waaka is working with on the tikanga (customary Māori practice) of organ donations, are now investigating the creation of their own karakia.

"I said the spiritual side of an organ donation might be a barrier to Māori families agreeing to organ donation, and one solution might be to write a karakia. I hope other colleges see a situation they think a karakia would be helpful for and find someone to go and research it."

The creation of the karakia has been a special piece of work for Dr Waaka.

Her culture is central to her identity. She has ancestral links to the Māori who settled the Rotorua area in the pre-1700s, her daughters aged two and five only speak te reo Māori, and she's an active competitor in Te Matatini, a nationwide kapa haka (traditional Māori song and dance) festival.

Born in the hospital she now works in, on the land of her people, the creation of the karakia is another way Dr Waaka tries to give back.

"I'm a Māori doctor and that has its own nuances. I don't just work in anaesthetics, I try and do a lot of equity work and Māori health work and serve my Māori community."

Reon Suddaby
Senior Communications Advisor, New Zealand

Opposite page: Dr Arihia Waaka at Te Takinga marae in the village of Mourea, near Rotorua.

Perioperative medicine

ANZCA forms a new Chapter of Perioperative Medicine

A lot has happened in the past few months as we march towards the 12 February 2024 start date of our ANZCA Course in Perioperative Medicine.

CHAPTER OF PERIOPERATIVE MEDICINE

The biggest and most exciting news is the ANZCA Council decision to form a new Chapter of Perioperative Medicine.

Candidates successfully completing the ANZCA Course in Perioperative Medicine (formerly referred to as the Diploma of Perioperative Medicine) will be known as graduates of the Chapter of Perioperative Medicine of ANZCA with the postnominals GChPOM.

And all those leaders in perioperative medicine who have successfully applied for the qualification via the recognition pathway will also be known as graduates of the chapter and should also use the postnominals GChPOM. This includes applicants initially awarded the Diploma of Perioperative Medicine (GChPOM).

We have decided not to pursue the development of a diploma following a decision by the Tertiary Education Quality Standards Agency (TEQSA) that decreed only registered providers could offer this qualification.

ANZCA was one of several colleges that unsuccessfully argued for a change in the legislation. So now TEQSA has instructed all colleges who offer diploma qualifications to either cease using this terminology by the end of 2023 or align with universities or other registered education providers.

Accreditation would have been a costly, resource-intensive process that duplicated what the college already does with the Australian Medical Council and Medical Council of New Zealand.

ENROLMENTS FOR 2024 OPEN

On 23 November, enrolments for our new ANZCA Course in Perioperative Medicine opened.

To be eligible, candidates must be employed at an affiliated hospital offering the clinical immersion component of the course, and also meet all other eligibility criteria.

Visit the perioperative medicine participant toolkit to check eligibility requirements, key dates, enrolment process and access key course resources – www.anzca.edu.au/education-training/perioperative-medicine-qualification/dippom-participant-toolkit.

A limited number of places are available for the course during 2024 with applications considered in order of receipt. Enrolments close on 21 January 2024.

Throughout 2024 we will continue discussions with more hospitals interested in providing a clinical learning environment and will also explore the ability for clinicians who aren't employed at participating hospitals to enrol in the course.

800 RECOGNITION PATHWAY APPLICANTS

We have had a massive response from those applying to qualify for our course via the recognition pathway, with 800 submitting their paperwork by the 1 December 2023 deadline, including 265 in the final week!

More than 270 have been approved with another 100 or so assessed and awaiting the approval of the Recognition Pathways Working Group. The remainder will be evaluated as soon as possible, but we ask for patience from recent applicants as our team works through the longer-than-expected list.

Fellows of the Australian College of Rural and Remote Medicine (ACRRM), Royal Australian College of General Practitioners (RACGP) and the Royal New Zealand College of General Practitioners (RNZGP) have until 1 September 2024 to apply for the GChPOM via the recognition pathway.

Many awarded our qualification through the recognition pathway have been contributing as course supervisors and content writers.

We have so far trained 43 GChPOM (previously DipPOM) holders to be supervisors. There have also been several offers of help from others to join the 59 GChPOM holders who have been writing the online course content guided by the Perioperative Medicine Content and Assessment Working Group chaired by A/Prof Joel Symons.

Meanwhile, the POM Content and Resource Review Working Group has just completed its first review of the Perioperative Care Framework, looking at its recommendations, resources, the currency of reference links and addition of new evidence.

A SUCCESSFUL POM PILOT

Congratulations to the 13 candidates at seven hospitals across Australia and New Zealand who completed the 10-week pilot of our course on 17 November.

We have received valuable feedback on unit of study 1 that will only strengthen our course.

The candidates completed 18 online modules, a workshop in October and 40 hours of perioperative clinical immersion at one of the hospitals participating in the pilot – the Prince of Wales and John Hunter hospitals in NSW, The Alfred and the Austin hospitals in Victoria, Auckland hospital in New Zealand, as well as the Royal Adelaide Hospital in SA and Fiona Stanley hospital in WA.

The clinical component is, of course, a point of difference which makes our course unique amongst other perioperative medicine qualifications around the world.

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

POM pilot a ‘practice changer’

Thirteen candidates at seven hospitals across Australia and New Zealand recently completed the 10-week pilot of the unit of study 1 of the Chapter of Perioperative Medicine course. Here, all the trial site supervisors and some participants tell us what they think about the pilot’s recent rollout at their hospitals.

PILOT SUPERVISORS

John Hunter Hospital, NSW
Dr Gabrielle Papeix, Associate Professor Ross Kerridge and Dr Pragya Ajitsaria

“The John Hunter Hospital anaesthetic department and, more specifically, the perioperative service, were both keen to act as a pilot site for the ANZCA DipPOM (now ANZCA Course in Perioperative Medicine) unit of study 1 as it dovetailed into one of the key goals of our service – to enhance collaboration with other departments in the pursuit of excellent perioperative care.

Our experience has been overwhelmingly positive. From the perspective of our two candidates (both experienced FANZCAs), the clinical immersion has been a highlight, in particular the opportunity to round with our acute orthogeriatrics service, to attend the complex liver patient multidisciplinary team (MDT) and clinic, and to attend our cardiopulmonary exercise testing sessions and subsequent MDT.

Feedback from our candidates, received by our geriatricians, cited the clinical immersion as being no less than ‘a complete eye opener’ and ‘practice changing’. The unit does generate a significant workload for the candidates, both the online learning and clinical immersion, and we would encourage future candidates to consider carefully if they have the available bandwidth to commit and if they should undertake one or two units at any one time.

From the perspective of the staff involved in co-ordinating the program locally, there has been extensive support from ANZCA which has smoothed out all the small hurdles that reveal themselves with any new program. Time taken upfront to create a detailed matrix of clinical immersion opportunities was worthwhile in facilitating a rich and easily accessible experience for the candidates. The most challenging aspect has been co-ordinating the availability of the supervisor and the candidates to find time to schedule assessments. This has been surmountable, with more flexibility in the timing of assessments than was initially appreciated and the provision of leave from clinical duties for assessors.

We are enthusiastic about continuing our participation in the GChPOM program and are planning on broadening our exposure next year with candidates from other specialist colleges, starting with our geriatrician colleagues.”

Above: John Hunter Hospital POM course pilot participant Dr Gavin Sullivan and pilot supervisor Dr Gabrielle Papeix

“Clinical immersion (has been) no less than ‘a complete eye opener’ and ‘practice changing’.”

Auckland City Hospital, New Zealand
Dr Kate Hudig

“It was our pleasure at Auckland City Hospital to host the pilot for unit one of the Chapter of Perioperative Medicine course. We had one candidate complete the unit.

There were a few teething problems getting the timetable for the clinical immersion set up, but once up and running it went well.

An advantage for both the supervisors and candidates was that we could cement connections across our hospital with geriatric and cardiology teams. We were also able to send our candidate to other hospitals across Auckland, to get an idea of how other institutions are assessing and optimising high risk surgical candidates.

We have three candidates in 2024 and look forward to continuing to host the Chapter of Perioperative Medicine course.”

Above: Associate Professor Joel Symons, pilot supervisor at The Alfred hospital in Melbourne.

Royal Adelaide Hospital, SA
Associate Professor Arthas Flabouris

“From our perspective the key aspects that worked well for the program were the working together of the different disciplines for the first unit of preoperative assessment.

The candidate had the opportunity to be exposed to a range of disciplines with sufficient time for direct supervision and feedback in our high-risk perioperative medicine clinic by supervisors from more than one discipline. This enhanced the educational value of that clinical encounter.

The program was well structured but still offered sufficient flexibility for both supervisors and the candidate.”

Prince of Wales hospital, NSW
Dr Louisa Lowes

“There has been significant interest in the perioperative medicine pilot course at Prince of Wales Hospital. We commenced the course with three candidates and three supervisors, represented by a mix of geriatricians and anaesthetists. This shared undertaking has promoted collaboration between the specialties, beyond just the scope of the pilot itself. Our participation has also served to promote the role of perioperative medicine within our hospital’s surgical service.

Undertaking the pilot has been a rewarding experience for both candidates and supervisors. Candidates have reported an increased depth of understanding of various aspects of preoperative assessment. Personally, as a supervisor, I have valued the opportunity to observe (and learn from) the candidates’ clinical approaches as noted during their assessments. It was particularly useful to see our geriatricians in action! Another plus has been the access that supervisors have had to the coursework. It has been helpful to refer to and explore some of the resources included.

For the candidates, working through the online coursework seemed quite flexible and manageable. We observed that fitting in the 40 hours of clinical immersion time for the preoperative topics was reasonably straightforward for candidates who are anaesthetists, perhaps less so for geriatricians. We expect to see the opposite as we move towards the latter topics where the focus is postoperative.

If I can find one negative, it was challenging to negotiate the clinical assessment timing within everyone’s busy schedules. Part of this will become easier now we are more familiar with what is expected for these assessments, and how to better plan immersion activities to facilitate them occurring. It will also become easier as we accumulate more supervisors both via the recognition pathway and as graduates emerge from the course itself.

It is certainly encouraging to see an ever-growing cohort of staff who are actively engaged in perioperative medicine, especially considering the patient safety and outcome benefits that are expected to come along with this.”

The Alfred hospital, Victoria
Associate Professor Dr Joel Symons

“The Alfred hospital in Melbourne had one participant (a FANZCA) piloting unit 1 of the Perioperative Medicine qualification. It was wonderful to see the immense work undertaken by the college in developing content, assessments and professional documents finally being tested in the clinical situation and the process went very smoothly. Apart from minor hiccups on the new learning management system, what struck me was the engagement of clinicians in beginning to implement the Perioperative Care Framework, the shared mental model of perioperative medicine which ANZCA, in collaboration with the partner medical colleges, hope to implement.

The hybrid model of online learning coupled with clinical experience makes this qualification the first in the world, with learning being a partnership between clinician and participant, the latter identifying personal gaps in their knowledge which are filled during the 10-week block.

This hybrid model clearly works. At the Alfred, we now have a multidisciplinary Preoperative Optimisation Clinic for elective orthopaedic patients which is clearly demonstrating the benefit on patient care by implementing the Perioperative Care Framework. The challenge going forward is going to be finding the time in both the supervisor and participants’ busy work schedule, to complete the 40 hours of clinical immersion and the three face-to-face assessments (micro-clinical assessments and observation of clinical skills). My hope is that with the full roll-out of the program from 2024, minor changes could be made to work practices so that this process will become easier.

The roll out of the full program next year will be daunting, but I am confident that with the team-based approach, this perioperative medicine program will achieve its ultimate aim of improving patient outcomes.”

"An exciting opportunity to be involved with a pioneering, collaborative and cross-specialty approach"

The Austin hospital, Victoria
Dr Ranjan Guha, Dr Justin Nazareth, Dr Saleem Khoyratty

"The pilot was an exciting opportunity to be involved with a pioneering, collaborative and cross-specialty approach to formalised perioperative medicine education. We are confident that the GChPOM will be the premier qualification within the perioperative space once fully developed. ANZCA provided good support and set-up prior to commencement, with a full day supervisors' workshop, regular meetings, a supervisor's group chat and helpful college contacts.

The 10-week program was well-structured without being overly prescriptive. Many learning opportunities were available and therefore clinical immersion plans could be tailored to the individual's background. Candidates were all post-examination and displayed excellent self-directed learning strategies. Although all our candidates were anaesthetists and already performed clinical immersion sessions in their usual practice, they appreciated the opportunity to receive feedback on their skills. Online learning content complemented clinical immersion well. As supervisors it was a great opportunity to watch other clinicians with a strong interest in perioperative medicine at work. We picked up several different ways of doing things!

Looking to the future, the achievability of unit of study 1 bodes well for the six-unit diploma. Both candidates and supervisors get a lot out of it and we all acknowledge the need for a structured training program."

Fiona Stanley Fremantle Hospital groups, WA
Dr Leena Kumari Nagappan

"The Fiona Stanley Fremantle Hospital groups (FSFHG) participated as one of the pilot sites for the unit of study 1 of the ANZCA Course in Perioperative Medicine. Preparing for the program required identifying opportunities that could be mapped to the unit 1 on preoperative assessment which would be in turn matched to participants' schedules for the clinical immersion component.

As a major quaternary hospital in WA, FSFHG had ample options for this purpose, such as orthogeriatrics multi-disciplinary teams (MDTs) and ward rounds, older adults specialised inpatient geriatric service and outpatient geriatric perioperative clinics. Moreover, subspecialty MDTs by various craft groups such as colorectal surgery provided opportunities for immersion in specialised surgical procedures involving high-risk patients. As a centre for Cardiopulmonary exercise testing (CPET), participants also enjoyed allocation to the CPET lab and engaged in case discussions with respiratory physicians.

Some challenges faced include scheduling clashes with clinical service provision requirements by participants and alteration in schedules to accommodate requests by external departments. As a teaching hospital and due to affiliation with universities and colleges, we were cognisant of not overcrowding clinical areas. Nevertheless our outreach was met with highly enthusiastic responses by surgeons, geriatricians and other specialist physicians. Our first three participants were very engaged and flexible, and continuously provided constructive feedback for further improvement of the program. Special thanks to Dr Sneha Nepalli and Dr Mehreen Farrow, the co-leads for POM Education in the department for their work in scheduling for the clinical immersion.

FSFHG will be a training site for the full program from 2024. We look forward to further increasing the number of supervisors of training to accommodate an increase in participant numbers and working alongside other specialised surgical and medical services to expand the training opportunities."

"Our outreach was met with highly enthusiastic responses by surgeons, geriatricians and other specialist physicians"

"I learnt something from every session, especially an ortho-geriatrics ward round and a morning with a social worker."

PILOT PARTICIPANTS

Dr Gavin Sullivan, FRCA FANZCA
Deputy Director Anaesthetics, Belmont District Hospital
Senior Staff Specialist John Hunter Hospital

"I am a senior staff specialist anaesthetist in Newcastle, NSW. I run a weekly perioperative clinic and have done so for the last five years. Eventually I would like to segue to more perioperative medicine as I get more experienced that is, older, and do less theatre. As such to add credence to my skills I thought I'd take on the perioperative diploma (now known as the ANZCA Course in Perioperative Medicine). I could have tried via the recognition pathway but felt it was a good opportunity to refresh my knowledge and bring myself up to date.

The first module was a pilot module at John Hunter Hospital and I was supervised and assessed by FANZCA Dr Gabrielle Papeix.

There are 40 hours of online learning, that is, 20 e-modules but these weren't too arduous as it covered a lot of knowledge I already have. It is certainly doable within the constraints of a busy life.

The clinical immersion, while the most difficult to organise logistically due to a busy schedule, was the most rewarding. We rarely get to "hang out" with our specialty colleagues or allied health. I learnt something from every session, especially an ortho-geriatrics ward round and a morning with a social worker.

I also attended a complex decision-making clinic where I got to witness my anaesthetic colleagues at work – also something we don't do enough of – and once again altered my practice based on what I saw.

The assessments were straightforward as I am fortunately already experienced but coming de novo to them would not be confronting and the learning facilitated by Dr Papeix expanded my focus from "fit for surgery" to "fit for life after surgery".

There are five more modules to do and 36 months in which to do them - I'll take a break between each module for work-life balance.

Thus far it has been a very useful experience that has broadened my knowledge and shown me that we have a lot to do to support our elderly and lower socio-economic patients on their perioperative journeys.

If there is a teachable moment for our patients, there is a teachable moment for all of us – do some exercise. if you ever have an operation you won't regret it."

Dr Bridget Bishop, ANZCA Provisional Fellow
Te Toka Tumai (Auckland City Hospital)

"As the perioperative fellow at the Department of Anaesthesia at Te Toka Tumai Auckland City Hospital, it made sense for me to undertake the pilot unit of study 1 for the ANZCA Course in Perioperative Medicine. Overall, it has complemented my fellowship nicely, and has certainly been a worthwhile experience!

The highlight for me was working closely with my clinical supervisors and undertaking in-person assessments. I can't remember the last time I had a consultant anaesthetist observe me evaluate a patient in clinic, let alone provide me with valuable feedback. In addition, the online content is home to numerous useful resources. I've actually saved a few handy articles so that I can refer back to them as part of my clinical practice in future.

I've also thoroughly enjoyed the clinical immersion activities, and I am very grateful for my supervisors who organised such an interesting timetable over these last 10 weeks. From sitting in with a geriatrician conducting a comprehensive assessment, to attending sub-specialty multi-disciplinary team meetings, it's been a great experience interacting with multiple members of the perioperative team.

I look forward to continuing with the course in 2024!"

Dr Gary Tham, FANZCA
Royal Adelaide Hospital

"The pilot program is truly a once in a lifetime chance to learn more about the emerging sciences related to perioperative medicine. It is a well-structured program which is mostly flexible with regards to time commitment. It supports self-learning at a pace suitable to individual needs, including work-life balance, life circumstances and family commitments.

Its online component is clinically relevant and covers a good range of current topics in perioperative medicine. We are given links to plenty of resources which makes self-learning an easy task to perform. All the modules were highly informative covering a range of topical issues encountered in real-life perioperative medicine.

The in-hospital immersion was a wonderful experience for me as it allowed me to participate in clinics and multidisciplinary team meetings. Witnessing how the experts in perioperative medicine work in the actual clinical setting made the difference in application of knowledge learnt online. My supervisor was a patient teacher and all the sessions which I had attended were informative in all aspects. The work-based learning is an effective method to gain knowledge.

The face-to-face workshop which was held at ANZCA House in Melbourne was the highlight of the first module. Having to prepare for a debating event was new to many of us but in the end, much was gained in terms of knowledge acquisition and collaborative work with team members. The tutorial sessions were interactive which made group-learning fun and exciting. The best session which provided much food for thought came in the last session where two actors were employed to create a realistic clinical experience for many of us.

My participation in the pilot program complemented my ANZCA continuing professional development by enhancing my learning experience in a truly innovative way."

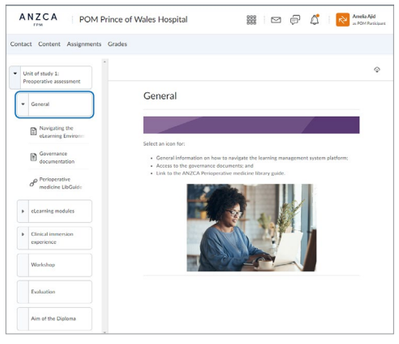
ONLINE LEARNING

There are between 10 and 18 modules within each of the six units of study that make up the ANZCA Course in Perioperative Medicine. These are completed online by course participants:

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

The e-learning modules structure the required reading, case-based activities, reflections and knowledge checks to engage participants and enhance the immersive experience provided in the clinical setting.

The online learning is self-paced and provides opportunity to repeat an activity where additional learning is required. As each participant advances through the content, they achieve tasks of increasing complexity, developing knowledge which they apply and consolidate in the clinical environment.



A sample page from the pilot course online unit.

WORKSHOPS

The ANZCA Course in Perioperative Medicine requires participants to attend a day-long workshop for each unit of study.

For the pilot of unit of study 1, held from September to November, the 13 participants met on 21 October.

The workshop provided them with an opportunity to explore the scope of preoperative assessment using clinical cases, and to engage in discussions of methods to overcome barriers and establish collaborative and positive communication pathways between practitioners, patients and their carers.

The program for each workshop is designed to intentionally focuses on case-based scenarios and reflects the content of the relevant unit of study.

Above: Participants working with Associate Professor Joel Symons (centre) at the perioperative medicine workshop at ANZCA House.

ENROLMENTS NOW OPEN!

ANZCA Course in Perioperative Medicine

To find out if you are eligible for the course starting 12 February 2024 go to the participant toolkit:

www.anzca.edu.au/education-training/perioperative-medicine-qualification

Enrolments close 21 January 2024

The value of shared decision making

Globally, rates of surgery are rising. Technological advancements in the realms of surgery and perioperative medicine have considerably widened the scope of what can be offered in the form of disease-modifying surgical interventions.

With these advancements comes the potential for postoperative complications, prolonged hospital stays, and ultimately, compromised long-term functional outcomes. This effect is amplified in the aging population where the presence of complex comorbidities, and a diminished physiological resilience, render individuals more susceptible to postoperative complications.

Surgical risk is inevitable. However, risk is considered acceptable by patients and clinicians alike because the anticipated benefits outweigh the risks.

Multimorbidity and frailty has meant that, for a growing subset of patients, there is an expanding 'grey zone' where both clinicians and patients may be unsure if the proposed benefits will be realised and the degree of concomitant risk is personally acceptable. In these circumstances, the time and space to reflect and consider alternate care strategies is necessary.

For those patients in the 'grey zone', shared decision making (SDM) can provide explicit decisional support to ensure decisions made around the time of surgery are patient centred, holistic and involve patients to the degree that they wish.

Although definitions vary, at its core, SDM is a collaborative communication process between clinicians and patients that ensures treatment decisions are goal congruent and reflexive to a patient's needs (Elwyn et al., 2017).

HOW DOES SDM IMPROVE THE QUALITY OF PERIOPERATIVE CARE?

1. Ensuring decisions are goal congruent.

During the SDM process, patients are encouraged to consider what their goals for the future are within the context of the proposed treatment. They are also encouraged to prioritise these goals and consider what they are willing to trade off (in either function, time, or burdens of treatment) in order to achieve them.

2. Providing patients with iterative and responsive decisional support

For high-risk patients, surgery is a treatment with a narrow therapeutic index. For drugs with a narrow therapeutic index, small changes in dosage may lead to serious, and potentially irreversible, deleterious effects.

In an analogous fashion, for high-risk patients undergoing complex surgery, small alterations in their condition (such as neoadjuvant treatment effects, unstable comorbidities or the progression of their underlying disease) can lead to a change in their circumstance that narrows the 'therapeutic index of surgery'. In that instance, surgery may no longer be goal congruent or acceptable.

On the contrary, addressing modifiable risk through multidisciplinary prehabilitation programs may mean that the therapeutic window for surgery is widened. Both these eventualities require SDM to provide ongoing decisional support that situates treatment decisions in the patient's current physiological and psychosocial context.

3. Supporting clinicians and promoting multidisciplinary team-based care

Although SDM will help achieve a more idealised version of informed consent, it cannot and will not achieve the utopian aim of preventing all poor functional outcomes after surgery. However, it does have the potential to prevent decision regret should a poor outcome eventuate. This can safeguard clinicians from the moral distress experienced when they feel treatment decisions that result in poor patient outcomes were not explicitly justified.

SDM also fosters collaboration between healthcare teams. To be effective, SDM requires a range of health-care workers to confer and integrate best-available evidence with clinician expertise to arrive at consensus decisions about best case, worst case and most likely case outcomes for individual patients. In this way, SDM provides a natural antidote to silos in health care.

SDM AND THE VALUE PROPOSITION FOR PERIOPERATIVE MEDICINE

The value proposition [for example, value = outcomes (clinical + satisfaction) / cost] for perioperative medicine has been widely embraced (Grocott, 2019). Perioperative medicine creates value by simultaneously reducing modifiable risk (for example, prehabilitation), variability in care (for example, enhanced recovery after surgery (ERAS), and fiscal waste. In order to create new and novel value in perioperative medicine, perioperative clinicians need to continue to enhance the quality of care that patients receive, the quality of the patient experience and the quality of the clinician experience. SDM does this by inextricably linking all three aims. (See figure 1 below).

Figure 1

THE CHALLENGE

The perioperative medicine community should continue striving to identify and create opportunities to fully integrate SDM as a method of realising patient-centred care. There are several ANZCA initiatives and documents that already reflect this paradigm shift including the Perioperative Care Framework document and *PS26(A) Position statement on informed consent for anaesthesia or sedation*. In an ideal world, the principles of SDM would be applicable to all patient encounters and the 'shared' in shared decision making would be implicit. All decision making in healthcare would be, by its very nature and execution, shared. That would be the stretch goal.

However, even if we achieve the stretch goal and SDM becomes embraced as the 'new normal', there will always be cases, and arguably an increasing number, where our normal capabilities are exceeded. For these circumstances, we need to develop specialist SDM models of care to support those patients who require more time and resources to navigate the complexities of their perioperative journey. Trained clinicians who have the skill set and willingness to take on these cases will also be required. Investing in training initiatives, with communication frameworks, and creating a community of practice to foster this will be key opportunities for the future.

Like all new technologies or innovations, the promise of SDM is considerable. However, its implementation will need to be studied carefully so we can understand and optimally harness its effects. It is only through such research efforts that we will be able to leverage SDM to provide optimum value in the field of perioperative medicine.

Dr Debra Leung, FANZCA
Staff Specialist Anaesthetist, Department of Anaesthesia, Perioperative and Pain Medicine, Peter MacCallum Cancer Centre
PhD Candidate: The Sir Peter MacCallum Department of Oncology, The University of Melbourne

**Dr Leung is conducting a study exploring perioperative SDM models of care around Australia and New Zealand. If you are involved in a perioperative SDM service and are willing to take part in an interview, please contact the research team at debra.leung@petermac.org*

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How we celebrated #NAD23

This year's theme, "Anaesthetists: Caring for our sickest patients before, during and after surgery" highlighted ANZCA's perioperative medicine community/patient information campaign.

More than 60 hospital champions in Australia and New Zealand embraced the day on 16 October by displaying posters (including a te reo Māori version), fact sheets, setting up displays in their hospital foyers and in anaesthesia departments, baking cakes and downloading our latest animated video on perioperative medicine.

Fellows also used social media platforms, including X (formerly Twitter), Instagram and Facebook to showcase their support of the day.

In a first for #NAD the college had input from Darwin-based First Nations advisors who worked with Royal Darwin Hospital anaesthetist Dr Edith Waugh to develop the "Coordinated care before, during, and after surgery" fact sheet (see article on page 27). The advisors helped simplify the language in the perioperative care framework diagram (the "nephron").

We prepared three media releases for Australia and New Zealand: "Sickest patients to benefit from new campaign for faster recovery" and "Magic tricks helping to calm children before operations" (highlighting one of the chapters in *Australasian Anaesthesia*, also known as the Blue Book) and "ANZCA pilots new perioperative medicine diploma at New Zealand hospitals".

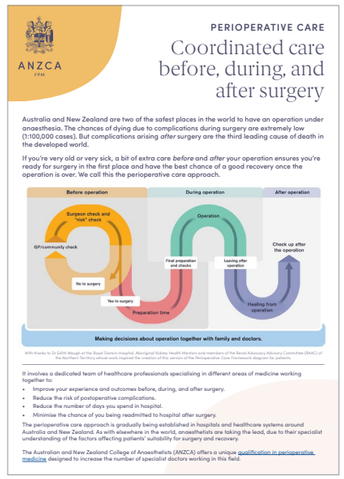
ANZCA Vice-President Professor David Story recorded a series of radio audio grabs for Australian radio networks to promote the day. These were downloaded for broadcast across Australia in metropolitan and regional areas including networks in Tasmania, Wangaratta, Toowoomba, Gippsland, Port Lincoln, Bendigo, Bathurst and Ballarat.

The Blue Book chapter on magical distraction for children about to undergo surgery was highlighted in an article in the *Sunday Herald Sun* on 29 October featuring Melbourne FANZCA Dr Colleen Chew. The article reached more than 700,000 readers.

In New Zealand NAD appeared in the *Otago Daily Times* with an article about activities at Dunedin Hospital and the NZ ANZCA media release appeared on *Scoop* and *New Zealand Doctor.*

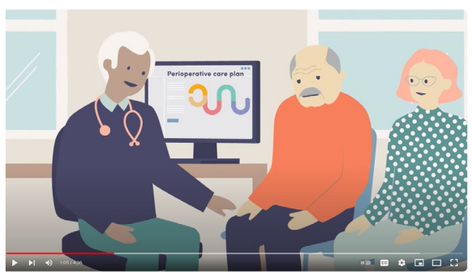
Nominated champions included fellows, trainees and specialist international medical graduates from hospitals in Australia and New Zealand including Princess Alexandra Hospital, Brisbane, Canberra Hospital, Royal Darwin Hospital, The Alfred hospital, the Peter MacCallum Cancer Centre, Calvary John James Hospital (ACT), Royal Hobart Hospital, Monash Health (five sites), Royal Adelaide Hospital, Tamworth Hospital, Toowoomba Hospital, Westmead Hospital, Sunshine Coast University Hospital, Auckland City Hospital, Christchurch Hospital, Hawke's Bay Hospital and North Shore Hospital.

We also created a special #NAD23 social media toolkit with Facebook, Instagram, LinkedIn and X/Twitter tiles for download (in English and te reo Māori) and distributed a special NAD-branded *ANZCA E-Newsletter* on the day.

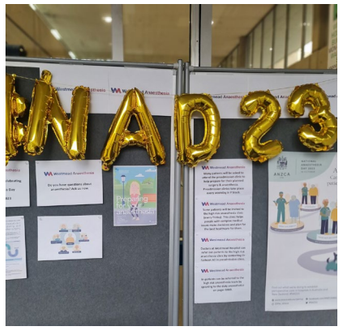


The ANZCA 2023 National Anaesthesia Day fact sheets

#NAD23 posters in English and te Reo.



Screenshot from the #NAD23 video "Anaesthetists: Caring for our sickest patients before, during and after surgery."



Scenes from hospital #NAD23 celebrations clockwise from top left: The Canberra Hospital #NAD team; decorations at Westmead Hospital; ANZCA House cake; Auckland Hospital; North Shore Hospital and Logan Hospital.

SOCIAL MEDIA

Champions and supporters used X (formerly Twitter) to showcase their activities and images including the Royal Darwin Hospital that used the simplified version of the care framework that had been developed with First Nations input. We also saw images from Westmead, the Royal Prince Alfred, Prince of Wales, The Alfred, Logan Hospital and hospitals in Tamworth, Toowoomba, Canberra, Auckland, Hawkes Bay, Dunedin, Whangarei and Wellington. You can see all the photos from hospitals across Australia and New Zealand on our Facebook page.

Changes to X meant we were unable to register the hashtag #NAD23 so there are limited statistics available, other than that we had 10,800 impressions over the day.

The animated video has become the centrepiece of a new “About perioperative medicine” section on the ANZCA website. The video has had nearly 2000 views across our social media channels (X, Facebook, LinkedIn and YouTube). On Instagram we had people posting using our specially designed NAD stickers on Stories.

Carolyn Jones
Media Manager, ANZCA

First Nations peoples and the perioperative journey

Darwin anaesthetist Dr Edith Waugh explains how consultation with First Nations communities led to an adapted framework that maps the operation journey for First Nations peoples in the Northern Territory.

Health disparities present significant challenges to First Nations communities in the Northern Territory, highlighting the urgent need for a perioperative care approach that is both clinically excellent and culturally responsive. ANZCA’s perioperative care framework has provided the foundation for this integration.

The journey to adapt this framework began during co-designing focus group sessions to better understand First Nations peoples’ perspectives, values and experiences relating to the perioperative journey. With experienced Aboriginal Kidney Health Mentors and NT’s Renal Advocacy Advisory Committee (RAAC) members, we shared knowledge and understanding of the healthcare system and First Nations peoples’ worldview of health and wellbeing.

The ANZCA framework, which maps the “operation journey”, was a key visual communication tool during yarning circles (a culturally safe method of conversation that fosters trust and open communication).

Through these sessions, the framework proved invaluable in facilitating discussions about the values of First Nations people. An iterative process of aligning medical terminology with language more suited to the cultural context resulted in a version of the framework that First Nations co-researchers were eager to share within their communities.

The adapted framework also transitioned into an educational tool, reflecting a strong desire to disseminate knowledge about navigating the healthcare system. It evolved beyond a research output to inform the development of practical resources for individuals, their families and communities, and also two-learning with health care staff.

The adapted framework has since become a map of the operation journey that is regularly referenced when discussing perioperative outcomes and future co-designed research projects. Its evolution is an ongoing process, with the framework being a living document that is revisited and reshaped in alignment with community needs and values.

This co-designed framework is more than a guide; it is a testament to the commitment to bridging the gap between clinical practice and the cultural realities of First Nations communities. As we progress, the framework remains central to discussions on perioperative outcomes, embodying the shared commitment to a culturally attuned, patient-centred approach to healthcare.

Dr Edith Waugh, FANZCA
Senior Specialist Anaesthetist, Clinical Lead in Perioperative Medicine, Royal Darwin and Palmerston Hospitals,
PhD Candidate, Menzies School of Health Research, Charles Darwin University, Northern Territory

Dr Waugh (centre) with Dr Thomas Pearson (arm in sling) and Dr Nimangee Mithraratne (far left) from the Department of Anaesthesia and Perioperative Medicine at Royal Darwin Hospital and NT’s Renal Advocacy Advisory Committee (RAAC) members display the adapted Operation Journey in NT framework.

Professional documents

What would you do?

Dr Peter Roessler explains professional documents using practical examples. In this edition, his final "What would you do?" article for the *ANZCA Bulletin*, he reflects on his years with the college as a director of professional affairs (DPA) and how ongoing education through professional documents is a continuing process.

Reflections on fostering our specialist knowledge

After almost 14 years as director of professional affairs (DPA) and 10 years of writing these articles, it is time to pass on the baton. "Finally!" some may say. So, this is my last dispatch.

Roles come with responsibility and fulfilling them requires a strong sense of duty. Relinquishing a role and its associated responsibilities may lighten a load, however, vacating a position and its accompanying sense of duty creates a gap. It is indeed with mixed emotions that I depart this position – joy and happiness. Joy because of the pleasure and privilege of working with and getting to meet so many of you, both colleagues and staff. Happiness as I look forward to devoting more quality time to (and inflicting myself on) my family.

My appointment as DPA was preceded by a little over 30 years of college involvement, which entailed mainly education and assessments for both trainees and specialist international medical graduates (SIMGs). The breadth of my clinical practice comprised the full scale of anaesthesia and intensive care for all ages including neonates. Science and research were core fundamentals steering my clinical support activities. Pioneering the automated anaesthesia record with the support of my director, Tom Lambert, in the 1980s is an example of this.

This background is provided as context for my articles over the years, which have explored many issues stemming from my experience in these areas and my perspectives. Despite the ever-expanding knowledge base, it remains limited and context is boundless. Consequently, there is no absolute right or wrong, and "best" is subject to constant change.

Asking questions is the quintessential means triggering the search for answers, which in turn stimulates research and underpins learning. This is what promotes advances despite the status quo seeming to be adequate. Indeed, my view is that questions challenging the status quo and accepted "knowledge" can be the most valuable ones. Many will have heard me quote that for centuries, everyone knew "the earth is flat". This was well-known common knowledge and accepted "fact" until it was questioned, and then proven incorrect.

My articles have tried to foster thought and discussion with specific focus on appreciating the value of ANZCA's professional documents (prof docs) in providing guidance on matters of professional and clinical performance. A nuanced subtlety was the intention of exploring "What would YOU do?" as opposed to "WHAT would you do?" The prof docs are designed with the intention of being non-prescriptive, non-mandatory, advisory guidance documents to help steer YOU through clinical settings with multiple factors in play to determine WHAT available options you might choose.

Consider the scenario where a younger colleague confides in you that during their training, they viewed you as a role model and a mentor (no, this is not a personal experience). You are contemplating retirement, and they now ask you if you would be willing to continue to be a mentor for them.

WHAT WOULD YOU DO?

On reflection, it is interesting to contemplate the attributes we possess that drive others to engage in relationships with us and kindle a desire to be mentored, as well as the qualities necessary to contribute to skilful and invaluable mentorship. After all, there are few honours that compete with people placing their trust in you.

I was recently asked by a senior colleague of a similar vintage to me (apologies to the sommeliers, no rancour intended) about options for retired anaesthetists wishing to maintain involvement in our craft and putting their experience to good use.

What does the DPA, Professional Documents do in response to such a query? Answer: Support the enquirer by steering them to applicable prof docs, of course! For example, *PS57(A)* lists a broad range of clinical support duties that may trigger an interest. Some of them may even be used towards continuing professional development (CPD) compliance.

Another activity is as a peer review assessor in accordance with *PG65(G)*. We all have time commitments that act as barriers to fulfilling such roles. However, in retirement such service is invaluable to those of our colleagues who have limited or no access to peer reviewers. Apart from

Above: Dr Roessler after attending his last ANZCA Professional Affairs Executive Committee meeting.

filling a need, this role also contributes to CPD for both the participant and the reviewer, especially when the latter is no longer in clinical practice.

On reviewing my time as DPA Professional Documents I have come to appreciate the impact of our prof docs on patient care as well as to recognise their value. Consequently, an area of focus has been to establish a clear understanding of our college's guidelines, their applications, their use, and their standing.

Pivotal to this has been clarifying the difference between the three types – policies (mandatory), position statements (articulating the college's position/expectations on a range of matters), and guidelines (advisory). The WWYD articles have served as the means for continual reinforcement.

Ongoing education through professional documents is a continuing process. To that end, I am elated with the appointments of Professor David Scott and Dr Michelle Mulligan and congratulate them in taking over a role that has continued to evolve and expand.

The qualities that they bring are incalculable and invaluable, and they will serve the college and readership in a most exemplary fashion. They will not only freshen the role but also bring thoughtful and innovative ideas to further benefit patient care and the community, the college, and the fellowship.

Finally, I would like to thank the Communications team for their support in editing my grammar/spelling, and providing ideas. I am deeply grateful to my fellow DPAs for their collegiality and for being a source of ongoing education and congratulate the newly appointed DPAs on their appointment to the outstanding team of DPAs.

To the staff who have supported me in my various roles, I am truly indebted and thankful for allowing me to join with them in working together.

Of course, it goes without saying but a huge thank you to you the readers, who have provided me with encouragement and kind feedback, including those insomniacs who have confessed that they found my articles a cure for their affliction.

With my most sincere gratitude and best wishes.

Dr Peter Roessler FANZCA
Director of Professional Affairs, Professional Documents

SipTilSend: Commentary from a national perspective

In this article, FANZCA Dr Phuong Markman and the SipTilSend Network Australia New Zealand (ANZ) encourage nationwide collaboration in a bid to promote safe change in our practice of preoperative fasting.

The ANZCA fasting guideline *PG07(A) (Appendix 1) 2022* intends to balance the risks of pulmonary aspiration and prolonged fasting from liquids. This article refers to the term "liquids" instead of "fluids" to comply with a new convention adopted by ANZCA in the upcoming update to the *PG07(A)* document.

PG07(A) recommends a minimum two hours fasting from liquids for adults and one hour for children. Yet, paradoxically, audits report that real-world application of the guideline, when combined with the unpredictable flow of operating lists, results in excessive durations of liquid fasting (median seven -12 hours)[1,2].

Prolonged liquid fasting causes psychological and physiological harm to patients, including thirst, post-operative nausea, anxiety, postoperative delirium, difficult cannulation and cardiovascular instability[3-6].

Recognising the need to address prolonged liquid fasting, the Ninewells Hospital in Scotland introduced 'SipTilSend', where patients are allowed to sip up to one standard hospital cup (170ml) of clear liquids per hour until they are sent to theatre.

They reduced the median liquid fasting interval from six hours before SipTilSend to 17 minutes afterwards. Crucially, they did not experience increased rates of aspiration[7]. Subsequently, three Australasian tertiary centres in Sydney, Adelaide and Christchurch have implemented SipTilSend.

These hospitals have reduced their median fasting intervals from 4.6 - 11 hours prior to SipTilSend being implemented to 2.3 - 3.1 hours after its introduction[8]. Interest in SipTilSend continues to spread across Australasia, as other hospitals are at various stages of developing their own programs.

SipTilSend is potentially a "game-changer", its adaptability to changes in theatre scheduling effectively prevents prolonged liquid fasts while apparently maintaining patient safety. SipTilSend is not a new concept, but rather a modern re-branding of "zero-hour" liquid fasting models that have been practiced by some centres for years[9,10].

Above: The SipTilSend team from the Royal Adelaide Hospital

SIPTILSEND NETWORK AUSTRALIA NEW ZEALAND

What does the SipTilSend Network do?

- Facilitate multi-centre data collection to maintain patient safety.
- Share educational resources.
- Promote consistent fasting rules between different hospitals.
- Work alongside ANZCA to revise the fasting guidelines.

Sites wishing to develop SipTilSend can seek assistance from established SipTilSend sites.

Any healthcare practitioner can join the MS Teams group by emailing the network contact: Dr Phuong Markman phuong.markman@health.qld.gov.au.

However, it is acknowledged that SipTilSend's impact on pulmonary aspiration remains unclear. Reassuringly, in a series of peer-reviewed studies to date, zero-hour liquid fasting has been applied to over 14,000 children and 44,000 adults without demonstrating an increased risk of aspiration[7,9-12]. We estimate from the data provided in these reports that at least 12,000 of these patients fasted less than one hour. The data has yet to be incorporated into a single meta-analysis.

The rarity of pulmonary aspiration contributes to difficulty conducting clinical trials to directly address this, as numbers to sufficiently power them are prohibitively large, and a randomised controlled trial likely very expensive and logistically challenging[13]. The ANZCA *PG07(A)* fasting guideline recommends a safe practice based on the best available evidence. The challenge is that the guideline appears to preclude SipTilSend, and potentially poses a medico-legal obstacle.

Interest in SipTilSend has reached a critical mass and more hospitals are keen to implement it. The SipTilSend Network ANZ was formed early in 2023 to facilitate the collaboration between centres that wish to implement SipTilSend. There is representation from every state of Australia and New Zealand. However, the best path forward is unclear. Good background data on the incidence and impact of pulmonary aspiration is essential. Whether a prospective randomised controlled trial, a before-and-after study, or a prospective audit is the most judicious tactic should be discussed by the anaesthetic community.

The SipTilSend Network ANZ aims to generate a cross-site dataset for monitoring the implementation of SipTilSend, in addition to sharing resources and promoting simple and consistent SipTilSend fasting rules between different hospitals. The successful implementation of SipTilSend relies on keeping the fasting rules very simple. The SipTilSend Network ANZ commits to working alongside ANZCA to ensure that any changes to fasting recommendations are safe and beneficial to our patients.

Dr Phuong Markman, FANZCA, Cairns Hospital SipTilSend Network ANZ co-founder

Dr Wal Grimmett, FANZCA, Toowoomba Hospital

Dr Daniel Ramsay, FANZCA, ASA Pacific Fellow, Fiji National University

Dr James Sartain, FANZCA, Director of Anaesthesia and Perioperative Medicine, Cairns Hospital

Dr David Stoeter, FANZCA, Consultant Anaesthetist, Townsville University Hospital

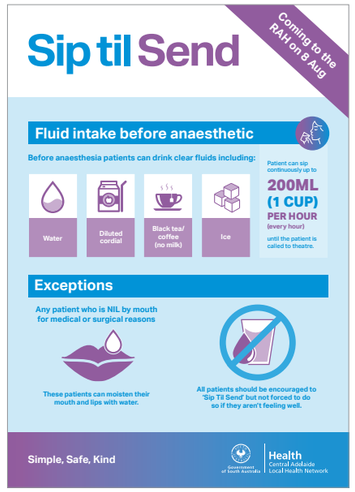
Dr C'havala Jaramillo, FANZCA, Cairns Hospital

Mr Kristian Sanchez, Nurse Lead Surgery, Central Adelaide Local Health Network

Dr Alec Beresford, Provisional Fellow Anaesthesia, Christchurch Hospital, Te Whatu Ora Waitaha – Canterbury

Our thanks to Dr Stephanie Armstrong from Royal Adelaide Hospital and Dr Philip Black from Prince of Wales/Sydney Children's Hospital for providing fasting duration data from their hospitals.

The views expressed in the article represent that of a core group of members and not necessarily that of all members of the SipTilSend ANZ network.



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Safety and quality

Emergency laparotomy clinical care standard

The Australian and New Zealand Emergency Laparotomy Audit – Quality Improvement (ANZELA QI) is a multi-specialty initiative aimed at improving the care of patients potentially requiring an emergency laparotomy.

It began in 2018 and analysis of the first two years of the project demonstrated a reduction in both mortality and length of stay for patients undergoing emergency laparotomy in Australia.[1] Since this 2021 analysis, more sites across the region have joined the project (24 participating in 2021, 44 in November 2023) and further research has spoken to the potential benefits of the ANZELA project.

A recent publication in the *British Journal of Surgery* [2] outlines the early (first 72 hours) reduction in mortality in the ANZELA population. This mortality reduction persists out to 30 days when compared to similar populations internationally. The question is then why? Is it possible to separate out the components of ANZELA that make the most difference and how do we implement them widely?

It is likely that all components of the ANZELA bundle contribute to the benefits but two are felt by some participating sites to be particularly valuable. The first is the early involvement of geriatric physicians in the care of the older patient, and the second is the prompted risk stratification facilitating post operative critical care and avoidance of futile surgery.

The early involvement of the geriatric team is noted by clinicians to add benefit in several ways. Junior medical staff on the surgical team are additionally supported in managing what are often complex patients. Ongoing care and discharge planning become a focus of conversation in the first few days of admission rather than once the patient has recovered from the surgical procedure.

Allied health and community care services are often better coordinated and perhaps most importantly, the surgical team has better access to a pathway of care that may not involve laparotomy. We may still have substantial gains to make in this area with the last reported rate of geriatrician involvement less than 20 per cent.

Emergency theatre and post operative critical care are constrained resources that in the current environment of a stretched hospital system need to be managed carefully. The *National Emergency Laparotomy Audit* (NELA) based risk prediction within the ANZELA population has been shown to have good utility and discriminatory power [3] although the lower mortality observed means that risks are overestimated at their highest levels. The prompted use of risk stratification allows structured discussions around planned post operative critical care for high-risk patients and may help avoid futile surgery.

It is difficult to precisely quantify the number of patients that do not have an emergency laparotomy but the avoidance of surgery in the patient group with the poorest outcomes has both individual and organisational benefits.

So where to from here? How do we reduce variation in the application of the benefits of the ANZELA project? Safer Care Victoria in their 2021 report, 'Improving Care, Before, During and After Surgery'[4] calls for the development of an emergency laparotomy clinical care standard: 'VPCC (*Victorian Perioperative Consultative Council)* has written to the ACSQHC (the Australian Commission on Safety and Quality in Health Care) requesting a clinical care standard be developed for emergency laparotomy (EL), similar to those for hip fractures...'

The ACSQHC has 17 clinical care standards across a wide range of areas from acute anaphylaxis to low back pain, to the treatment of hip fracture. These are defined [5],

'A clinical care standard is a small number of quality statements that describe the care patients should be offered by health professionals and health services for a specific clinical condition or defined clinical pathway in line with current best evidence.'

The clinical care standards define the level of care a person should receive regardless of where they are in Australia and aim to reduce unwanted variation in care. Short notice assessment of these standards is here with the 2023 revision to the Australian Council on Healthcare Standards (ACHS) accreditation. This means that health services will need to have systems in place and part of everyday care that meet the clinical care standard.

Early advice is that there will be an emergency laparotomy clinical care standard developed in 2024/25. ANZELA fits nicely within this framework. It describes a bundle of care that leads to better outcomes. Importantly, much of the groundwork has been done in terms of facilitating collection of the ANZELA dataset. The REDCap based data collection lends itself to automation of many of the datapoints. In WA, Fiona Stanley Hospital has automated approximately 65

per cent of the data collection and in Victoria at the Alfred Hospital hey have more than 80 per cent of data collected directly and automatically from their electronic medical record.

Health care organisations will need to invest in supporting ANZELA, particularly around facilitation of data collection and increasing geriatric perioperative services, however reductions in length of stay and better patient outcomes will more than repay this investment.

Dr Ed O'Loughlin, FANZCA
Fiona Stanley Hospital, WA

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LIST OF HOSPITALS PARTICIPATING IN ANZELA-QI

Hospitals in **bold** have paused data collection/participation due to lack of funding at the hospitals. State funding is only available for Qld, SA and WA only.

There are 14 hospitals (3 Vic, 4 WA,2 SA, 3 Qld, 2 NSW) at the final stages of local governance approval to start participating.

1	Albany Hospital	WA
2	Albury Wodonga Health	NSW
3	Alfred Health	Vic
4	**Armidale Rural Referral Hospital**	**NSW**
5	Ballarat Health Service	Vic
6	Barwon Health	Vic
7	Bendigo Health	Vic
8	Bunbury Hospital	WA
9	Bundaberg Hospital	Qld
10	Caboolture Hospital	Qld
11	**Canberra Hospital**	**ACT**
12	Casey Hospital Monash Health	Vic
13	Clayton Hospital Monash Health	Vic
14	**Dandenong Hospital Monash Health**	**Vic**
15	Fiona Stanley Hospital	WA
16	Flinders Medical Centre	SA
17	Gold Coast University Hospital	Qld
18	Hervey Bay Hospital	Qld
19	Ipswich Hospital	Qld
20	Latrobe Regional Hospital	Vic
21	Lismore Base Hospital	NSW
22	Logan Hospital	Qld
23	Lyell Mc Ewin	SA
24	**Mackay Base Hospital**	**Qld**
25	Mater Hospital Brisbane	Qld
26	Mt Gambier And Districts Health Service	SA
27	Nepean Hospital	NSW
28	Northern Hospital Epping	Vic
29	Peninsula Health	Vic
30	**Port Macquarie Base Hospital**	**NSW**
31	Princess Alexandra Hospital	Qld
32	QEII Jubilee Hospital	Qld
33	Redcliffe Hospital	Qld
34	**Redland Hospital**	**Qld**
35	Rockhampton Base Hospital	Qld
36	Royal Adelaide Hospital	SA
37	Royal Darwin Hospital	NT
38	Royal Hobart Hospital	Tas
39	Royal Melbourne Hospital	Vic
40	Royal Perth Hospital	WA
41	Sir Charles Gairdner Hospital	WA
42	St John Of God Midland Public and Private Hospitals	WA
43	St Vincent's Hospital Melbourne	Vic
44	**St Vincent's Hospital Sydney**	**NSW**
45	Sunshine Coast University Hospital	Qld
46	The Queen Elizabeth Hospital	SA
47	**The Tweed Hospital**	**NSW**
48	Toowoomba Hospital	Qld
49	Western Health	Vic

WebAIRS: Paediatric anaesthetic incidents

More than 1000 paediatric anaesthesia incidents have been reported to webAIRS. We are looking for paediatric anaesthetists to join our analyser team.

Since 2009 more than 1709 reports relating to paediatric anaesthetic incidents across Australia and New Zealand have been reported to webAIRS. WebAIRS is a bi-national web-based anaesthetic incident reporting system with the mission to improve the safety and quality of anaesthesia for patients in Australia and New Zealand. WebAIRS provides an enduring capability to capture, analyse and disseminate information about de-identified incidents relative to the safety and quality of anaesthesia in Australia and New Zealand.

As of October 2023, more than 10,800 incidents have been reported to webAIRS from 240 registered sites, making it one of the largest accessible and workable anaesthetic databases worldwide.

Ten per cent of the reported incidents are related to paediatric anaesthetic incidents. Nearly half of these were ASA 1 patients, about a third were emergency cases, more than 80% of the paediatric incidents occurred during regular daytime hours, almost 90% involved general anaesthesia and the majority (60%) used an intravenous and inhalational technique. Less than 1% received sedation. The majority of events (64%) occurred in the operating theatre room. Ear nose and throat (ENT) (20%), general surgery (16%) and orthopaedic (14%) accounted for around half of the procedures. There were 14 deaths reported. These affected patients undergoing a range of different procedures, including general surgery (n=3), neurosurgery (n=2), ENT (n=1), endoscopy (n=1), obstetrics and gynaecology (n=1), not specified procedures (n=3) and patients not undergoing any surgical procedures (n=3). Detailed analysis of these events will provide useful insights into paediatric anaesthetic mortality.

Forty-one per cent of the incidents are categorised by the reporters as respiratory or airway events. Not surprisingly, laryngospasms are reported most commonly in this category accounting for 25% of all respiratory events. The next largest category is incidents classified as "other". Future detailed analysis will provide insight into this category. The next most common events describe aspiration, bronchospasm or other airway obstruction.

Medication related incidents are the next widely reported category of paediatric events, featuring in 14% of all paediatric reports. Drug overdoses are described in almost 30% of these reports, followed by anaphylactic and other allergic reactions in around 20%. The subsequent most commonly reported category involves events describing equipment related issues, most reported as "device (user error)" or "device (malfunction)".

This is in contrast to incidents involving adult patients, where most incidents relate to airway/respiratory events, followed by cardiovascular events and incidents involving medication errors. While the webAIRS group has published multiple reports on incidents involving adults, only one paediatric anaesthesia webAIRS incident analysis has been published to date, "Incidents relating to paediatric regional anaesthesia in the first 8000 cases reported to webAIRS by Manisha Mistry et al". The latest report providing an overview of paediatric anaesthetic incidents in Australia was the analysis by the *Australian Incident Monitoring Study (AIMS)* team, published in 1993. While there are paediatric trials and incident audits published in Europe or the US there is currently limited information about the nature and incidence of everyday adverse events in paediatric anaesthesia in Australian and New Zealand hospitals. WebAIRS provides the ideal platform to collect, review and analyse paediatric anaesthetic incidents and has already collected a wealth of information and data of more than 1000 incidents involving paediatric patients.

A collaboration with interested paediatric anaesthetists will provide an excellent opportunity to provide insight into paediatric anaesthetic practice across Australia and New Zealand. Having access to such an extensive database and the large number of events promises to give a lot of valuable learning possibilities. Analyses might include cross-sectional overviews of larger themes but also detailed incident-specific narrative or subcategory analyses. All webAIRS analysers are supported by a team of experienced webAIRS incident analysers and the ANZTADC committee.

The distribution of the findings of these analyses will help provide an important opportunity to learn about hazards and patient safety factors, develop mitigation strategies, and share tips, tricks, and pitfalls for crisis management with the broader community.

If you are a paediatric anaesthetist interested in data and incident analysis and being part of a webAIRS paediatric analyser subgroup, then please get in touch with us at anztadc@anzca.edu.au.

Dr Yasmin Endlich and
the ANZTADC Case Report Writing Group

PAEDIATRIC CASES

Main Category	Number	% of Events	% of Reports
Respiratory/Airway	513	41%	48%
Medication	150	12%	14%
Medical Device/Equipment	134	11%	12%
Cardiovascular	99	8%	9%
Miscellaneous/Other	87	7%	8%
Neurological	33	3%	3%
Infrastructure/System	29	2%	3%
Assessment/Documentation	28	2%	3%
Not Specified	154	12%	14%
Other Organ	18	1%	2%
Total	1245	100%	116%

1245 events recorded from 1079 reports.

RESPIRATORY AND AIRWAY

Subcategory	Number	% of Events	% of Reports
Laryngospasm	154	25%	30%
Other	91	15%	18%
Aspiration	76	12%	15%
Bronchospasm/Asthma	56	9%	11%
Airway Obstruction (other)	51	8%	10%
Hypoxia (SaO2<85%)	44	7%	9%
Ventilation difficulty/failure	24	4%	5%
Extubation problem	17	3%	3%
Intubation difficult	14	2%	3%
Regurgitation/Vomiting (no aspiration)	14	2%	3%
ETT blocked/kinked	11	2%	2%
Intubation failed	11	2%	2%
Respiratory Arrest (unintended)	9	1%	2%
Pneumothorax	6	1%	1%
Anaphylactic/Anaphylactoid reaction	5	1%	1%
ETT endobronchial (unintended)	5	1%	1%
High airway pressure	5	1%	1%
Pulmonary Oedema (non-cardiac)	5	1%	1%
ETT oesophageal	4	1%	1%
LMA (reinserted)	1	0%	0%
Not Specified	24	4%	5%
Total	627	100%	122%

627 events recorded from 513 reports.

MEDICATION

Subcategory	Number	% of Events	% of Reports
Wrong Dose (overdose)	43	24%	29%
Other	35	20%	23%
Anaphylactic/Anaphylactoid reaction	24	14%	16%
Untoward reaction (Other)	14	8%	9%
Wrong Drug (given in error)	12	7%	8%
Wrong Drug (syringe swap)	10	6%	7%
Wrong Drug (almost given in error)	7	4%	5%
Allergic reaction (Other)	6	3%	4%
Wrong Dose (underdose)	6	3%	4%
Wrong Dose (almost given in error)	4	2%	3%
Medication incorrectly stored	2	1%	1%
Wrong Drug (contraindication)	2	1%	1%
Wrong Frequency	2	1%	1%
Wrong Route	2	1%	1%
Not Specified	9	5%	6%
Total	178	100%	119%

178 events recorded from 150 reports.

MEDICAL DEVICE/EQUIPMENT

Subcategory	Number	% of Events	% of Reports
Device (Malfunction)	54	39%	40%
Device (User Error)	49	35%	37%
Other	21	15%	16%
Device (Wrong selection)	8	6%	6%
Device (Not available)	5	4%	4%
Not Specified	3	2%	2%
Total	140	100%	105%

140 events recorded from 134 reports.

TRAILBLAZER BOWS OUT

As the year comes to an end, so too does the tenure of Dr Martin Culwick as the inaugural Medical Director for the Australian and New Zealand Tripartite Anaesthetic Data Committee (ANZTADC) and the web-based anaesthesia incident reporting system webAIRS.

Like many landmark projects that ANZCA has undertaken, ANZTADC was born out of the taskforces set up by Professor Michael Cousins in 2005. Dr Martin Culwick contributed to the ANZCA Quality and Safety Taskforce.

Through these processes a decision was made to establish a tripartite committee from ANZCA, the Australian Society of Anaesthetists and the New Zealand Society of Anaesthetists to improve the safety and quality of anaesthesia for patients by providing an enduring capability to capture, analyse and disseminate information about incidents (de-identified).

Dr Culwick was appointed medical director of ANZTADC in November 2007 and contributed to the design and programming of the webAIRS website as a craft group-specific anaesthesia incident reporting system for Australia and New Zealand.

His clinical expertise, extensive knowledge of information technology and tireless dedication to anaesthesia incident reporting is evident in the world-leading database that is webAIRS, with over 5000 registered users across almost 250 sites in Australia and New Zealand having contributed more than 11,000 incident reports to the database. While Dr Culwick will maintain an interest and involvement in conducting analyses of the webAIRS database, we wish him well in his retirement from the medical director role.

May the coming years provide him more opportunities to enjoy his love of sailing and guitar, and seeing his beloved Brisbane Lions win another flag!

Anaesthesia-related deaths

Gastroscopy and a full stomach

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

CASE 4: GENERAL SURGERY

A 76-year-old male for gastroscopy +/- stent insertion.

Background history

The patient was diagnosed with adenocarcinoma of the oesophagus four months prior. There were metastases to liver and lungs, and he was treated with chemotherapy.

He was admitted three weeks prior to the hospital with lethargy and inability to tolerate oral intake. Recent worsening cough and shortness of breath.

An abdominal X-ray and abdominal CT scan showed dilated loops of bowel consistent with an ileus. Surgical review was sought but an open procedure was deemed inappropriate. Preoperative bloods revealed acute renal failure and pancytopenia.

Anaesthetic details

For the procedure, the patient was sedated slowly with propofol (100mg) and a Hudson mask was used. Almost immediately the patient vomited. He was suctioned.

The procedure was not attempted but a nasogastric tube was passed by the endoscopist. One litre of fluid was drained. The patient was taken to recovery and a decision made not to escalate care. He died three hours later.

Learning points

- A full stomach was not appreciated in this case.
- Full stomach should equal rapid tracheal intubation.
- There are many valid methods to do this, but all include good preoxygenation a rapidly acting paralytic agent and avoidance of bag mask ventilation.
- Paralysis prevents active regurgitation while avoiding bag mask ventilation and a head-up position avoids passive regurgitation.

Source

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

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

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:

- Corticosteroids in short supply
- Glycine toxicity and TURP syndrome
- Tranexamic acid labelling deaths

ANZCA
FPM

LIMITLESS

ANZCA ASM 2024 3–7 May, Brisbane

#ASM24BRIS

The 2024 Regional Organising Committee are looking forward to reconnecting with you, so make sure you join us for...

Science! The program is an exciting mix of cutting-edge science from challenging clinical scenarios to operating rooms of the future and stimulating workshops.

Social events! The gala dinner will be an affair to remember, held at the iconic Brisbane City Hall. Dress with a touch of gold and meet your friends under the famous clock tower by moonlight.

Sun! Brisbane is a fabulous city to spend a few days. Walk, drive or cycle to the top of Mt Coot-tha for views across the city, wander through South Bank among the bougainvillea, or take a ride down the Brisbane River on our famous City Cats.

Your summer "to do" list for the ANZCA ASM

- ☑ Visit the website to make your plan for the week of the ASM –something for everyone; science, social, sun.
- ☑ If you are a prospective author or researcher, submit your abstract – submissions close 21 January 2024.
- ☑ Register for the ASM – early bird closes 11 March 2024.
- ☑ Finally... enjoy the festive season, it's been a big year!

All you ever wanted for your CPD

You asked; we listened. There are new ways to meet your hour based annual CPD requirements in 2024 including a planned CPD app and increased support to complete your CPD cycles.

NEW CPD ACTIVITIES FROM 1 JANUARY 2024

We're adding 13 new continuing professional development (CPD) activities to the ANZCA and FPM CPD program from 1 January 2024.

ANZCA Council approved implementation of the new CPD activities from 1 January 2024, following work by the CPD review project group (CPD-RPG) and its two reference groups (practice without direct patient care and private practice), ANZCA and FPM CPD Committee and CPD team.

This significant update will increase opportunities for you to claim CPD hours under the annual program and across a broad range of work contexts.

What are the 13 new CPD activities?

The new activities cover all three CPD program categories as listed below:

Table 1: List of 13 new CPD activities from 2024 in ANZCA and FPM CPD program

CPD category		Activity
Category 1: Practice evaluation	Measuring outcomes	Analysing healthcare outcomes
		Clinical governance
		Clinical governance/quality assurance committee work
		Quality improvement projects
		Practice audit (Clinical support)
	Reviewing performance	Critical reflection
		Mentoring
		Peer review of educational practice
		Peer support groups
Category 2: Knowledge and skills Leadership and management skills development		Education development
Category 3: Emergency response Malignant Hyperthermia		Opioid-induced ventilatory impairment (OIVI)

These new activities bring the total number of claimable CPD activities to 56. They will be available in your annual CPD portfolio from 1 January 2024. Watch out for the updated CPD handbook, and CPD webpage pages.

CPD ACTIVITIES DEVELOPMENT PROCESS

The CPD review project consists of two phases. Completed in 2022, the first phase involved updating the 2014 triennial ANZCA and FPM CPD Program to incorporate revised Medical Board of Australia (MBA) and Medical Council of New Zealand (MCNZ) requirements, most notably the change from a triennium to an annual program, and from a weighted credits to an hours-based program. The resulting 2023 annual CPD program launched on 1 January 2023.

The second phase in 2023 focused on further enhancing the CPD program to meet members' needs. Under phase two, the CPD-RPG, its two reference groups - practice without direct patient care and private practice – and CPD Committee members reviewed CPD program activities. The key goal was to expand activity offerings and assist fellows and other CPD participants in meeting their annual hour-based requirements.

We would like to acknowledge all ANZCA and FPM CPD Committee, CPD-RPG and the two reference groups members who contributed valuable time and insights to this work, particularly in developing new activity guidelines and resources.

CPD APP IN 2024

A new CPD app is due to launch in the first half of 2024.

We're always looking for ways to make your continuing professional development (CPD) experience easier and simpler. This co-developed mobile app will complement your online CPD portfolio, and enhance the way you record, monitor, and provide evidence for your completed CPD activities.

We appreciate there has been a lot of change in the CPD environment – and that you want a tool that inspires you and lets you take control over your CPD progress. The key focus of the app will enable integration with the online CPD portfolio to deliver a coherent and compliant CPD offering.

Want to get involved?

Your input will be vital to ensuring the new CPD app meets each member's needs. If you want to get involved with design and testing the CPD app, please reach out to Life Long Learning team via lifelonglearning@anzca.edu.au.

What support is available for me in the meantime?

The current CPD portfolio can be viewed on your smart phone with a support video for the online CPD portfolio – 2023 annual program designed to help you navigate the online CPD portfolio for the new 2023 annual CPD program.

As the CPD portfolio is accessible on all mobile devices, the video also walks through how it can be saved as a mobile responsive app for quick access.

MBA 2024 CPD SPECIALIST HIGH-LEVEL CPD REQUIREMENTS

The Medical Board of Australia has approved the college's proposal for consistent program and high-level requirements for the 2024 CPD year.

Specialist high-level requirements describe any education, performance review or measuring outcomes activities that must be included in an Australian specialist's CPD program. The MBA approves and publishes high-level requirements for specialists registered in MBA recognised specialties and fields of specialty practice.

This means, any practitioner registered as a specialist in Australia must complete the relevant high-level requirements, regardless of their CPD home.

These are the approved specialist high-level requirements for Australian anaesthetists and pain medicine physicians:

Table 2: Medical Board of Australia (MBA) 2024 specialist high-level requirements for anaesthesia and pain medicine

Specialty	High-level requirement	CPD type
Anaesthesia/ Pain medicine	complete at least one emergency response activity per year	education activity
	complete at least one of the following activities per year to directly evaluate and reflect on their own clinical practice: • patient experience survey • multi-source feedback (MSF) • peer review • audit	reviewing performance and/or measuring outcomes activity

Full details on our specialty high-level requirements are available on the ANZCA website and the MBA website.

ALL CPD PORTFOLIOS TO BE UPDATED BY 31 DEC 2023

Thank you to all the fellows and CPD participants who have connected with the CPD team and updated their online CPD portfolio before the 31 December 2023 submission date.

If you have an active online CPD portfolio with the ANZCA and FPM CPD program, you will need to update it before the end of the year. This is the largest CPD cohort the college has experienced, in transitioning over 7000 fellows and other CPD participants to the annual CPD program from 2024.

CPD team on hand to help

To support the end of CPD cycle process, the CPD team will be sending regular communications to assist you to successfully update your CPD portfolio and complete your CPD requirements.

Our goal is to smoothly transition everyone to the updated annual CPD program from 1 January 2024. We hope these targeted emails/communications are helpful to outline any remaining CPD activities and suggested resources. We enjoy hearing from our fellows and other CPD participants and are delighted to provide support via emails and phone calls. We appreciate it can be hard to balance completing CPD with other commitments and are happy to organise a time to go through your CPD portfolio with you.

If you have any concerns about meeting your CPD requirements, accessing your CPD portfolio, or just want some helpful advice, please contact the CPD team via cpd@anzca.edu.au

I'm finishing my triennium, how do the annual CPD requirements map across?

The good news is much remains the same and mirrors many key features of the triennial CPD program. The key changes to meet the revised regulatory requirements are:

- **Annual calendar year cycle:** CPD program will run from 1 January to 31 December, with all fellows and CPD participants having the same 31 December submission date.
- **Claiming hours instead of credits:** CPD activities are measured in hours to meet the MBA's minimum 50-hour requirement for all medical practitioners. There are no limits on the time which can be recorded for each activity, and you should record the time an activity takes, including preparatory time if relevant.

Table 3: Triennial CPD requirements mapped to annual CPD requirements

CPD requirements	Triennial CPD requirements (2014 program)	Annual CPD requirements (2023 program)
Plan & Evaluation	• three-yearly • No credits	• Annual • Hours counted under PE – reviewing performance
Practice evaluation (PE)	• 100 credits • Two mandatory activities (Multi-source feedback (MSF), peer review, patient experience survey or audit)	• Min 25 hours • Min five hours across reviewing performance/measuring outcomes • One mandatory activities (either MSF, peer review or patient experience survey, audit)
Knowledge & Skills (KS)	• 80 credits	• 12.5 hours
Emergency response	• Two activities	• One activity • Hours counted under KS
Cultural safety	• Receives credits, encouraged not required.	• Annual activity (flexible, guidance) • Hours counted under PE – reviewing performance.

We've put together case studies, guidance and support resources to help you understand how to meet your requirements under the annual CPD program. Please visit the 'How can I meet my CPD requirements' pages for full details.

Emergency response facilitators can claim CPD ER activity

Course providers/facilitators for an emergency response (ER) course/workshop with recognition of suitability for CPD program can claim the ER activity. Since 2014, the CPD program has recognised providers/facilitators in their own category separate to the ER they facilitate. It has now been confirmed that, with immediate effect, all ER facilitators can claim the ER activity. Until the end of 2024, the ER recognition code (e.g., ER-23-XX-XXX) provided through the current ER recognition of suitability process can be used when recording this in your CPD portfolio.

In 2024, the CPD review project will seek to develop a process to formally recognise all CPD allocations and present a recommendation for ER codes specific to ER facilitators. Using the same recognition code until a new process has been determined is to avoid any additional administration for ER facilitators, pending changes in the coming years.

This decision also recognises the expertise of facilitators and the significant work of dedicated volunteers to deliver the highest standard of professional development to support better patient care.

We appreciate the patience of ER facilitators to the ongoing communication about the CPD allocations.

If any ER workshop/course has been altered in any way from the original version that was approved by the college, a new application may be required. Full details on the providers and process are available on the college website at www.anzca.edu.au/education-training/anzca-and-fpm-cpd-program/cpd-emergency-response-category. Please contact the CPD team at cpd@anzca.edu.au if you require any further clarification or further support.

DID YOU KNOW THERE ARE ER ONLINE MODULES?

There are three online ER modules that fellows and other CPD participants can complete to meet their ER requirement:

- The college's Learn@ANZCA - Perioperative anaphylaxis response module (anaphylaxis), refreshed in 2022 to align to the most recent Australian and New Zealand Anaesthetic Allergy Group (ANZAAG) standards.
- External provider BloodSafe elearning Australia – Critical bleeding module (major haemorrhage).
- External provider BloodSafe elearning Australia - Postpartum haemorrhage (major haemorrhage).

Full details on all recognised emergency activities, including recognition codes are available on the college website.

Self matters

Anti-racism is everyone's business

This regular column explores doctors' health by highlighting practical ways to support anaesthetists' and pain specialists' wellbeing. This edition looks at the impacts of racism and what needs to change.

Our patterns of behaviour are long-ingrained and underpinned by a complex foundation that requires conscious effort to unpick and deliberate practice to change. Awareness is a critical first step and I thank Dr Susie Lord for her piece on racism and the power relationships that perpetuate it. She speaks of the need for honesty, especially with ourselves. She also provides some places to start.

We must all do better – for our colleagues and for our fellow citizens. Intrinsic morality and professionalism should drive our commitment to necessary changes to support everyone's wellbeing, but if you need further impetus then our professional codes of conduct require it. A recent high-profile incident of racism against a Yuggera, Warangoo and Wiradjuri specialist colleague demonstrates that our regulatory bodies are watching and will act.

If you have a wellbeing story you'd like to share in a future *Bulletin* edition, please email me at bulletin@anzca.edu.au

Dr Lindy Roberts AM
ANZCA Director of Professional Affairs, Education

Colonisation, colonial policy and decision-makers wove racism through the tapestry of our two nations. While there is deserved focus on systemic racism as the root cause of racialised health inequity for patients, this piece focuses on anti-racism as a means of improving the health and wellbeing of doctors – in particular, ANZCA and FPM trainees, specialist international medical graduates (SIMGs) and fellows.

WHY ME?

I'm a white non-Indigenous cis-female doctor, privileged to live and work on unceded Awabakal and Worimi Lands in so-called NSW Australia. What would I know of racism? Why isn't this piece authored by someone with lived experience of racism? Is this a "white saviour" or ally act? I asked myself these reflexive questions and more.

What I decided I could bring is honesty – I have been racism's perpetrator and accomplice. It was only as recently as 10 years ago that I transitioned from rudimentary understandings of racism to becoming privilege and racism-aware. After my first immersive cultural competency workshop, I committed to unlearn my biases, to change myself and the waters in which I swim.

Having learned to recognise racism beyond the overt, I now witness racism and its fallout every day in our education, health and social systems. I have an inkling of its impacts on people's individual and collective identities (whānau, hapū, iwi), cultural strengths, wellbeing reserves and careers. However, being of the presiding settler-colonial culture, I cannot know racism's felt wounds. Through recognising my own privilege, I came to understand my obligation to call out racism and practice anti-racism.

Calling out racism is far less "courageous" for me than it would be for some of my colleagues who, by virtue of skin tone, culture or the visible symbols of religion, bear the scars of cumulative racist cuts. Sharing one's lived experience of racism publicly risks reopening wounds and potentially identifying people involved, with possible repercussions – hence my authorship.

RACISM

Racism is more than just prejudice in thought, individual or collective action. It is the combination of prejudice plus power – the power to discriminate against, oppress or limit the human rights of others based on a radicalised construct.[1]

RACISM = PREJUDICE + POWER

This is why so-called "reverse racism" is a non sequitur. Australian stand-up comedian, Aamer Rahman's 2.5 minute Reverse Racism youtube clip[2] explains this well.

EXPOSURE TO RACISM

Racism adapts and changes over time, with racism towards different groups intensifying in different historical moments. Examples include spikes in racism:

- Toward Aboriginal and Torres Strait Islander people during the lead-up to the Australian Voice to Parliament Referendum 2023.
- Toward Asian, Asian-Australian or Asian-New Zealander people during the early COVID-19 pandemic.
- Through Islamophobia, anti-Semitism and anti-Palestinian racism following various world events.

In 2022, the Australian Reconciliation Barometer[3] revealed 60 per cent of Aboriginal and/or Torres Strait Islander people had been exposed to at least one form of racial prejudice in the past six months; up from 52 per cent in 2020, and 43 per cent in 2018. For detailed de-identified examples of Aboriginal and/or Torres Strait Islander people's experiences see: Call It Out[4] or Thesis, E Elvidge[5] Chapters 11 and 12 – covert and overt racism [Please consider your mind state, and social and emotional reserves before accessing this material].

In Aotearoa, the large 2021 Whakatika Survey[6] of Māori experiences of racism reported the vast majority of Māori (93 per cent) felt racism had an impact on them on a daily basis and even more (96 per cent) said that racism was a problem for their wider whānau at least to some extent.

THE IMPACT OF RACISM

Recent systematic reviews in Australia[7] and Aotearoa New Zealand[8] have shown that self-reported exposure to racism is associated with negative overall wellbeing and major health outcomes. Furthermore, the Mayi Kuwayu Study (National Study of Aboriginal and Torres Strait Islander Wellbeing)[9] demonstrated a dose-dependent impact of discrimination, and discrimination ascribed to Indigeneity, on wellbeing and health.

DOCTORS' EXPOSURE TO RACISM

As Dr Jess Barry wrote in the Spring *ANZCA Bulletin* Self Matters column, "All doctors are people too". Doctors can be racialised by the presiding majority and subjected to racial oppression and discrimination too.

The Australian Medical Training Survey 2022[10] reported that 34 per cent of all medical trainees and 55 per cent of Aboriginal and Torres Strait Islander trainees experienced and/or witnessed bullying, harassment, discrimination and racism. More than half of those who experienced racism, experienced intersecting bullying, harassment and/or discrimination. Of those with experiences, 70 per cent did not report them – 55 per cent due to concerns about repercussions, and/or 51 per cent felt nothing would be done if they did report. The Australian Indigenous Doctors' Association (AIDA) backs up this experience.[11]

Senior medical staff (48 per cent) or other medical colleagues in training (37 per cent) were commonly responsible for the bullying, harassment, discrimination and racism. Of concern given power inequity, 43 per cent affirmed their supervisor was the person responsible, and 11 per cent preferred not to say. Over a third reported the incident(s) had a moderate-major impact on career progression.

We know this affects ANZCA and FPM trainees, SIMGs and fellows. Although not stratified for anaesthesia or pain medicine training, data suggest the critical need to support service leaders and supervisors of training to grow and maintain cultural competency and anti-racist praxis to prevent individual trainee and department exposures.

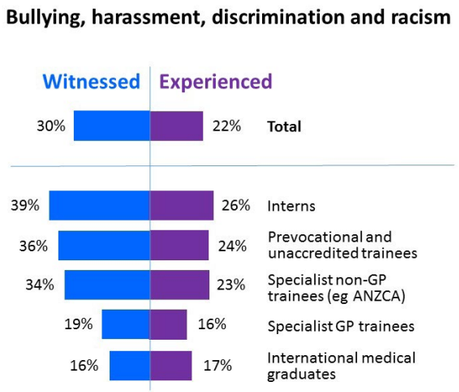

Image: Data from the Australian Medical Training Survey 202210 question 42: *'Thinking about your workplace, in the last 12 months, have you experienced or witnessed bullying, harassment, discrimination and/or racism?'* (%yes)

CULTURAL DETERMINANTS OF POSITIVE WELLBEING

Diverse Aboriginal, Torres Strait Islander, Māori and Pasifika cultures – ways of being, knowing and doing – kept First Peoples physically, socially and emotionally thriving for millennia before colonisation, and cultural dispossession and trauma. These living cultures, where they are uninterrupted or restored and evolving, continue to provide individual and collective identity, connection, and strengths.

For many First Peoples, significant emotionally-activated events are followed by replenishment ceremonies that refill or rebalance community members' wellbeing. For example, Tujague & Ryan (Kabi Kabi, Gaua descendants) write: "replenishment was always part of rebalancing the collective after a journey or after a major event … Aboriginal people would come together to rest and recover. This was often followed by dance, song, giving thanks, expressing grief … There would be storytelling for men and women, teaching the young ones of the challenges and celebrating both the blessings and the lessons learned".[12]

Personal meaning-making for Sorry Day, the anniversary of the Australian government apology to members of the Stolen Generations.

Non-Indigenous people of cultures that are marginalised by the presiding majority, may also find strength in cultural belonging, connecting and diverse traditional practices.

The impacts of periods of intensified racism, and cumulative every day racism may be somewhat mitigated through cultural connection. An ally's role is to respect, value and hold space for these important wellbeing replenishment practices. Practically this might mean:

- Learning what culture means to you and to each of your team members.
- Bringing team awareness to culturally significant dates and world events.
- Appreciating cultural load will vary between team members and across time – stay flexible.
- Avoiding stereotyping or assuming – instead, ask and offer.
- Commemorating and celebrating together.

TOWARD ANTI-RACISM

Anti-racism praxis involves actively opposing racism in all its forms. For more insights and practical strategies explore the Racism: It Stops With Me[13] website and resources. ANZCA's LibGuide[14] has more information relevant to Aboriginal, Torres Strait Islander, Māori and Pasifika cultures.

However, it is not enough to recognise and reduce prejudice. To create training, work and healthcare environments free of racism, we must also shift the balance of power (because racism = prejudice + power). Our two countries are at different places along that road, but we are not at an impasse – Aboriginal and Torres Strait Islander peoples' sovereignty remains unceded, and the UN Declaration on the Rights of Indigenous Peoples[15] cannot be extinguished by popular vote.

Be a Good Ally

- ❑ Learn about the real history of the Lands you live and work on
- ❑ Understand your privilege (not compared to peers, but to all humanity)
- ❑ Call out racism when witnessed
- ❑ Support your trainees and colleagues in addressing racist incidents
- ❑ Know your organisation & college[16] policies on racism and discrimination
- ❑ Be aware of cultural load in your trainees and colleagues
- ❑ Celebrate diversity

Adapted from: https://aida.org.au/app/uploads/2023/03/AIDA-FAQ-Addressing-racism.pdf

Dr Susie Lord FANZCA, FFPMANZCA
Member, FPM Board
John Hunter Children's Hospital, NSW

Wellbeing HUBS

FOR ABORIGINAL AND/OR TORRES STRAIT ISLANDER PEOPLES

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

FOR MĀORI

Kaupapa Māori wellbeing services at https://www.wellbeingsupport.health.nz/available-wellbeing-support/kaupapa-maori-wellbeing-services/

Te Aka Whai Ora website at https://www.teakawhaiora.nz/our-work/advocating-for-change/rongoa/

Te Whare Tapa Whā at https://www.teakawhaiora.nz/nga-rauemi-resources/te-whare-tapa-wha/

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Changes for ANZCA's DPAs

There have been some new appointments and some departures from our team of directors of professional affairs (DPAs) led by Executive DPA and former ANZCA President Dr Leona Wilson.

The new appointments are:

DPA Policy: Dr Michelle Mulligan and Professor David A Scott have replaced Dr Peter Roessler (DPA, Professional Documents) as DPA Policy.

DPA Education: Professor Jennifer Weller and Associate Professor Kara Allen are the new DPAs, Education from February 2024 replacing Dr Lindy Roberts.

DPA Assessor: Dr Suzanne Bertrand (starting January 2024) and Dr Vanessa Beavis (starting May 2024). Dr Beavis replaces Dr Vaughan Laurenson and Dr Bertrand's is a new role to take account of the increasing number of educational programs being offered by the college.

They join Associate Professor Nicole Phillips (DPA, Annual Scientific Meeting), Dr Maggie Wong (DPA, Assessor), Associate Professor Mick Vagg (DPA, FPM) and Dr Melissa Viney (DPA, FPM Education).

Our DPAs are all medically qualified and are fellows of the college/faculty. They are part-time, and most have other work as specialist anaesthetists or specialist pain medicine physicians. They work with many business units in ANZCA and provide advice that is best given by someone with their specialised knowledge and expertise.

While attached to a specific role, they can also be asked to work across departments if they have the relevant knowledge and expertise. The work they are asked to do requires accuracy, timely responses, knowledge of the practice and culture of anaesthesia and/or pain medicine and in-depth knowledge of current college strategy, regulations and policies.

Our new DPAs

DPA POLICY

PROFESSOR DAVID A SCOTT, FANZCA, FFPMANZCA

Professor Scott is a professor in the Department of Critical Care, School of Medicine, University of Melbourne, and a senior cardiac anaesthetist in the Department of Anaesthesia and Acute Pain Medicine at St Vincent's Hospital Melbourne. He is also chair of the Victorian Perioperative Consultative Council. He is a past president of ANZCA and has had many other roles including as a member and chair of the ANZCA Safety and Quality Committee. He is an active researcher into perioperative outcomes, especially the neurocognitive effects of anaesthesia and surgery.

DPA POLICY

DR MICHELLE MULLIGAN OAM, FANZCA, FAICD

Dr Mulligan practises anaesthesia in public and private hospitals in Sydney and has worked as a visiting medical officer in the UK, rural NSW and the ACT. She has extensive leadership and management experience in both surgery and anaesthesia at a hospital, district and state-wide level. Dr Mulligan is a sitting member for NSW Medical Council matters, board member of Northern Sydney Local Health District and the NSW Clinical Excellence Commission and is a member of the NSW Health System Advisory Council.

DPA EDUCATION

PROFESSOR JENNIFER WELLER, FANZCA

Professor Weller is a professor in the School of Medicine, Auckland University, and head of the Centre for Medical and Health Sciences which undertakes medical education research, offers a Master of Clinical Education and provides support for clinical teachers. Her research expertise is in simulation-based team training, patient safety and competency-based medical education. She leads NetworkZ, a NZ simulation-based team training program. She has had many roles in ANZCA across research, education and as a final examiner. She is on the editorial board of the *British Journal of Anaesthesia*, and has recently been appointed as section editor for patient safety in *Anesthesia and Analgesia*. In her spare time she is a singer, runner, German language student, wife, mother and grandma.

DPA EDUCATION

ASSOCIATE PROFESSOR KARA ALLEN, FANZCA

Associate Professor Allen is a specialist anaesthetist and head of education in the Department of Anaesthesia and Pain Management, Royal Melbourne Hospital. She has a Master of Clinical Education, co-developed the CRASH course, a bi-national return to work course, and has research interests in equity and the learning environment. She has been deputy chair of the Education Development and Evaluation (EDEC) Committee, Chair of the Trainee Selection Working Group and is a past lead facilitator of the ANZCA Educators Program. She has an academic appointment with the Department of Critical Care at the University of Melbourne.

DPA ASSESSOR

DR SUZANNE BERTRAND, FANZCA

Dr Bertrand has been working as a specialist anaesthetist since 2003 and works in public and private practice in Queensland with a particular interest in obstetric anaesthesia. She has worked as an ANZCA supervisor of training and has been the deputy education officer in Queensland since 2013. In addition, she is a facilitator for the ANZCA Educators Program and a keen educator for ANZCA trainees.

DPA ASSESSOR

DR VANESSA BEAVIS, FANZCA

Dr Beavis is the immediate past president of ANZCA. In her more than 25 years of contributing to college activities, she chaired the Continuing Professional Development Committee, the Training and Accreditation Committee, the New Zealand National Committee and is a former ANZCA Annual Scientific Meeting officer (pre DPA days). She has been a final examiner, led the development of several professional documents, established the Leadership and Management Special Interest Group (SIG) and the Perioperative Medicine SIG. She was for 16 years (under various titles) the Director of Perioperative Services at Auckland City Hospital, before stepping down to become president of ANZCA. Her major focus now is on introducing the Chapter of Perioperative Medicine and expanding it into clinical practice.

Departing DPAs

ANZCA's DPAs play a critical role in the success of our college. We thank our outgoing DPAs for their extraordinary service.

DR PETER ROESSLER, FANZCA

Dr Roessler, the outgoing DPA, Professional Documents, is a practising clinician in solo private practice in Melbourne with many years of service to the college. He was appointed DPA in June 2010 to oversee the development and review of the college's professional documents and respond to queries and complaints about standards from organisations, fellows and the public. His formal college roles for the first 15 years as a fellow were in education in teaching and examiner positions. He developed the basic sciences syllabus and multiple-choice questions for the Part 1 exam and was an invited examiner for the Hong Kong College of Anaesthesiologists as ANZCA representative. His other college roles have included deputy chair Specialist International Medical Graduates (SIMG) Committee, member of the Safety and Quality Committee, the Professional Affairs Executive Committee and the CPD Committee. He is continuing as an assessor and interview panellist for the SIMG process.

DR LINDY ROBERTS AM, FANZCA, FFPMANZCA, FAICD

Dr Roberts is the inaugural DPA Education (2016-2023), having served on ANZCA Council from 2004-2016, as president from 2012-2014. She has leadership roles on Australian Medical Council committees responsible for accreditation of college specialist training. Her quarter century of contributions reflects a wide scope of college educational leadership and advisory roles – including as assessor; FPM examiner and supervisor of training; WA education officer; in governance, policy and curriculum development for the 2013 anaesthesia curriculum; 2014 CPD program redesign; and chairing key education committees.

She has provided educational leadership and support for many recent college projects – Accreditation and Learning Environment, Australian Medical Council/Medical Council of New Zealand reaccreditation, CPD redesign, the rural generalist anaesthesia curriculum, dual ANZCA-College of Intensive Care Medicine training pathway, the college-wide monitoring and evaluation framework, trainee selection and DHM curriculum redesign. Her values of equity and justice are reflected in contributions to gender equity, trainee wellbeing and BDSH, LGBTQI+ policy, and the quarterly *Self Matters* column in the *ANZCA Bulletin*. In 2016 she was awarded a Member of the Order of Australia for services to medicine and professional organisations.

With her retirement from the DPA role she is looking forward to more time for her partner, clarinet and piano playing, film studies, history reading, bridge and volunteering in her local community.

DR VAUGHAN LAURENSON, FANZCA

Dr Laurenson lives near Christchurch, New Zealand. It is now 50 years since he did his first anaesthesia job as a house surgeon and he has enjoyed a fascinating career.

He spent two formative years in Vanuatu working as a general duties doctor (including anaesthesia), and as a district medical officer. He then completed his anaesthesia training in Christchurch and Adelaide. He was a clinical anaesthetist in the Christchurch anaesthesia department from 1981 to 2016 with roles which included part time intensive care, research, and five years as head of department. His college roles include being a member of the New Zealand National Committee including three years as chair, 11 years as a final part examiner, and 20 years involvement in specialist international medical graduate assessment. He started as an assessor in 2010 and has seen the transition from paper to electronic training records.

He is looking forward to spending more time on his farm and trying to master the art of flying radio-controlled aeroplanes.

Clinicians lead climate health action in WA

In a major development for the delivery of anaesthesia in Australia, WA Health has become the first state to remove desflurane from all public hospitals.

The campaign to reduce and then remove desflurane has been a carefully constructed path over several years. It began with a few enthusiastic clinicians from different health services, coming together to drive change. Inspiration came from our anaesthesia trainees through TRA2SH and their "Ditch the Des" campaign. From the earliest stages, this project was data-driven – tracking volatile and propofol usage at individual sites across the state to guide interventions and demonstrate progress, including financial savings. Thanks must go to Dr Chris Mitchell for his invaluable work with this.

Alongside the data, we used consistent education in as many forums as possible to align views and bring our colleagues with us on the journey. We spread the word state-wide via the WA Green Theatres Network, sharing resources such as posters and putting the data into the hands of local staff so that they could enact change.

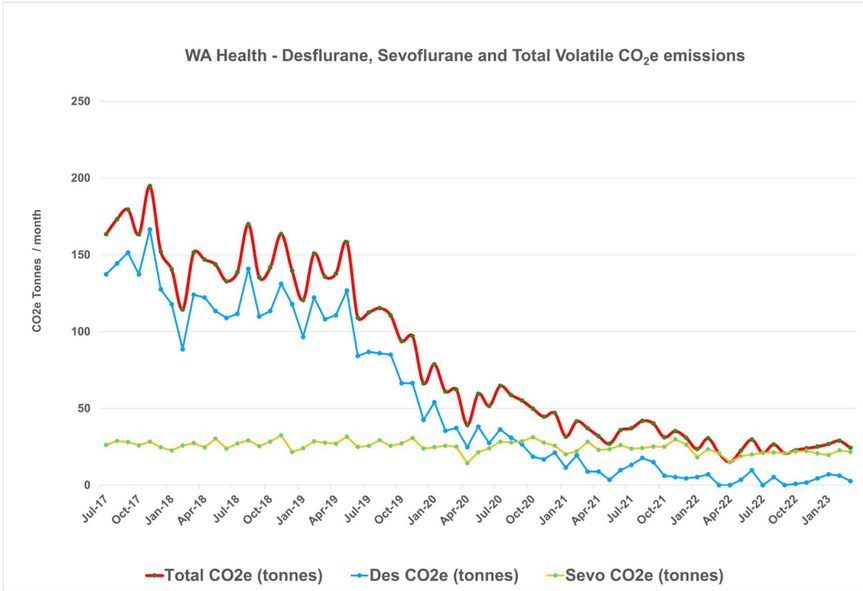
It soon became clear that the tide had turned on desflurane usage in WA, with very few public hospitals using it at all by late 2022. We felt it was likely that the remaining use was only related to habit or easy availability. We also knew that positive local changes could be transient unless there was a system-wide commitment to the cause.

De-listing desflurane from the state formulary was a logical next step, but first we needed to unite clinical staff and their existing action with the appropriate governing bodies. Consultation with multiple stakeholders occurred and was centrally coordinated by the Sustainable Development Unit (SDU) in the WA Department of Health. Written submissions were obtained from multiple heads of departments of anaesthesia, surgeons, pharmacists, climate health leads and sustainable anaesthesia networks. The evidence was submitted to the WA Therapeutics Advisory Group and subsequently to the WA Drug Evaluation Panel (WADEP) who agreed that this was an obvious step to reduce our carbon footprint. We thank Dr Emma-Leigh Synnott and Dr Sarah Joyce of the SDU for their facilitation of this process.

This achievement clearly demonstrates the potential for clinicians to lead positive system-wide action and reduce the impact of healthcare on the environment. A "clinical community" organising approach means that the people who best know their clinical area are facilitated and supported to enact change. In this instance, anaesthetists have identified one of their biggest contributors to declining planetary health and corrected it. Linking enthusiastic people together in sustainability networks spreads these messages and shares the workload.

Dr Adam Crossley, Member, ANZCA Environmental Sustainability Network (ESN) Executive, WA Green Theatres Network Committee

Dr Archana Shrivathsa, Chair, ANZCA ESN Executive, WA Green Theatres Network Committee



ANZCA Environmental Sustainability Network update

This year has been a busy and productive one for the ANZCA Environmental Sustainability Network (ESN). Our main focus this year has been on creating connections between members and supporting the work of ESN working groups in developing resources and guidance for anaesthetists around the region.

The ESN Executive membership now includes Dr Gretel Davidson representing the Faculty of Pain Medicine and Dr Kate Romeril representing New Zealand. We thank Dr Scott Ma, outgoing chair, for his tireless work in setting up ESN. Dr Archana Shrivathsa is now chair with deputy chair Dr Eugenie Kayak.

ADVANCING SUSTAINABLE PRACTICE

Sustainability Matters: ESN discussion forum

On 18 March ESN held its first online discussion forum led by Dr Beth Hall and Dr Archana Shrivathsa featuring a sample clinical scenario examining current practice through a sustainability lens followed by breakout groups to discuss opportunities to collaborate. The session concluded with a question and answer session and open networking session.

MS Teams collaboration site

Following the discussion forum and consultation with ESN Executive and members, Microsoft Teams has been launched as a collaboration site and rolled out to the 320 ESN members. This consists of channels for each state and individual projects such as nitrous oxide mitigation, sharps and pharmaceutical waste and fossil fuels. This is the first time the college has offered a communication platform of this type and we look forward to some lively discussion.

AUSTRALIA'S NATIONAL HEALTH AND CLIMATE STRATEGY

A comprehensive submission for the National Health and Climate Strategy was put forward by ESN Executive members Dr Eugenie Kayak and Dr Adam Crossley. The strategy developed by the Australian government will identify areas to reduce greenhouse gas emissions in the healthcare system and establish a plan to manage the impacts of climate change.

CLIMATE CHANGE AND SUSTAINABILITY: LEADERSHIP AND ACTION WEBINAR

The college's progress on sustainability and the work of the ESN was presented at the Australian Medical Association (AMA) and Doctors for the Environment Australia (DEA) Climate Change and Sustainability: Leadership and Action webinar on 12 September.

PROMOTING SUSTAINABILITY RESEARCH

Nitrous oxide working group

A working group for nitrous oxide mitigation, led by Dr Cas Woinarski (Vic) has been formed comprising existing groups from several states. This group is working on developing guidance for fellows in reducing leaks from nitrous oxide manifolds and pipelines.

SHARPS AND PHARMACEUTICAL WASTE WORKING GROUP

A document on disposal of sharps and pharmaceutical waste is nearing completion with content tailored to each state, providing recommendations for the ecologically safe disposal of waste based on individual state legislation. This group is led by Dr Raj Pachchigar (Qld) with contributors from across Australia.

SUPPORTING SUSTAINABILITY EDUCATION

ESN session at 2023 ANZCA Annual Scientific Meeting (ASM)

A concurrent session on environmental sustainability was run at the ASM with presentations by Associate Professor Kerstin Wyssusek, Dr George Zhong and Dr Justin Skowno and was chaired by Dr Scott Ma and Dr Archana Shrivathsa.

TRA2SH workshop at ASM 2023

A workshop was facilitated by TRA2SH members Dr Alistair Park, Dr George Zhong, Dr Sukhi Hegde, Dr Kenhui Heng, Dr Cameron Dunn, Dr Archana Shrivathsa and Dr Jess Develin-Hegedus on practical and meaningful ways to improve environmental sustainability in the operating theatre.

CLEAN & GREEN: BALANCING SUSTAINABILITY AND INFECTION CONTROL WEBINAR

ESN held a webinar on 21 November discussing the tension between sustainability initiatives and infection control and disposable versus reusable items in terms of infection transmission risks. The webinar was co-chaired by Dr Mary O'Shea and Dr Archana Shrivathsa and featured talks by WA infectious diseases and microbiology consultant Dr David New, WA anaesthetist Dr Justin Hii and Queensland Children's Hospital environmental sustainability consultant Renae McBrien.

From left: Dr Alistair Park, Dr Archana Shirvathsa, Dr Cameron Dunn, Dr Sukhi Hedge, Dr George Zhong and Dr Adam Crossley.

FUTURE DIRECTIONS FOR ESN

TRA2SH

Following consultation with TRA2SH members and the ESN Executive, the trainee-led research and audit in anaesthesia for sustainable healthcare (TRA2SH) group will integrate with the ESN by February 2024. The ESN would like to thank TRA2SH for their pioneering efforts in promoting sustainable anaesthesia practice in Australia and New Zealand, and hope that together we can continue this important work.

ASM 2024

The ESN and TRA2SH members will run a concurrent session, a workshop and a small group discussion during the meeting in Brisbane. In addition, Dr Eugenie Kayak has been invited to speak in a 2024 ASM plenary session.

GREENCOLLEGE GUIDELINES

ANZCA Council has approved the endorsement of Doctors for the Environment and the Australian Medical Association GreenCollege guidelines. The guidelines advocate for medical colleges to incorporate environmentally sustainable principles into their governance, education, research and operations in an effort to move the health care sector closer to net zero. The college is now meeting 46 out of 63 criteria specified in the guidelines and planning is underway regarding how we can improve emissions reduction related to college activities.

INTERESTED IN OUR WORK?

ESN is open to all healthcare professionals with an interest in reducing the impact of anaesthesia, surgery and perioperative care on the environment. All anaesthetists, anaesthesia trainees, surgeons, nurses and anaesthesia assistants, and all other healthcare professionals are welcome to join. Please consider joining at https://www.surveymonkey.com/r/ESN-registration – there are no obligations and collaboration is strongly supported and encouraged.

Dr Archana Shrivathsa, FANZCA
Chair, ANZCA Environmental Sustainability Network Executive

Research

Research grants for 2024

With the ongoing burden from COVID-19, which has been particularly challenging for fellows' and trainees' clinical workloads, research projects governance, and recruitment of patients, it was very encouraging to receive a high number of applications for research grant funding for 2024.

The ANZCA Research Committee has awarded funding of $A1.7 million through the ANZCA Foundation for 2024 research grants: 18 new project grants, seven second year project grants, four novice investigator grants, the Patrons Emerging Investigator Grant, one Professional Practice Research Grant, the Skantha Vallipuram ANZCA Research Scholarship, and an allocation for Clinical Trial Network pilot grants.

Thirty-two investigators and teams will be supported in 2024. Their important research will be carried out in leading hospitals and universities in Australia, New Zealand and Hong Kong, and is a vital part of ANZCA's continuous advancement of safe, high-quality evidence-based patient care in anaesthesia, intensive care, perioperative medicine and pain medicine, through high quality, medical research and its translation and implementation within clinical practice.

The foundation is very appreciative of the generosity of all of its donors and supporters, especially the regular giving of our patrons, and those who provide named research awards, bequests, and major grants: Mrs Ann Cole, Mrs Indi Mackay, the late Dr Robin Smallwood, the late Dr John Boyd Craig, the estates of the late Dr Nerida Dilworth and Dr Elaine Lillian Kluver, Dr Peter Lowe, Mrs Asoka Vallipuram, and the Medibank Better Health Foundation. In particular, we would like to recognise the establishment of the new ANZCA Innovation and Technology Research Award, the latest in our ever-growing portfolio of prestigious ANZCA Foundation named research awards, with thanks to Governor Patron Dr Stan Tay.

Professor Britta Regli-von Ungern-Sternberg
Chair, ANZCA Research Committee

Mr Rob Packer
General Manager, ANZCA Foundation

Opposite page, from left: Ms Christine Wood, opioid-free anaesthesia study co-ordinator, Dr Anthony Eidan (Royal Brisbane and Women's Hospital) and Ms Margarette Somerville (Clinical Research Nurse, Queensland Health) were awarded a novice investigator grant for their multicentre randomised controlled trial.

NAMED RESEARCH AWARDS

Harry Daly Research Award

Established by the Faculty of Anaesthetists, Royal Australasian College of Surgeons, in 1981. The award is made each year to the grant ranked most highly by the ANZCA Research Committee.

PROFESSIONAL PRACTICE RESEARCH GRANT

Psychological distress in anaesthetists: Prevalence and assessment of efficacy of current strategies and resources for mental health optimisation

Anaesthetists conduct their work in a challenging and unpredictable environment where errors can result in patient morbidity and mortality. It is a decade since the National Mental Health Survey of Doctors provided information on the mental well-being of doctors including anaesthetists. The advent of COVID-19 increased demands on anaesthetists with many being redeployed to emergency departments and ICUs. In addition, surgical backlogs imposed further workload pressures, which are ongoing. This has raised the potential for increased psychological distress and burnout with resultant poor work performance and clinician attrition. Costs to health organisations include increased absenteeism, delivery of substandard care and reduced staff retention. This in turn has implications for efficient management of waiting lists and the potential for adverse patient outcomes.

There is no recent evaluation of psychological distress in medical practitioners and evidence relating to effective interventions is lacking. Consequently, in the proposed study we aim to assess the current prevalence of psychological distress in anaesthetists across Australia and New Zealand and examine efficacy and factors that facilitate or undermine staff access to existing support programs.

Findings may be used to enhance or redesign existing programs. This research has the potential to improve outcomes for anaesthetists, patients and health organisations.

Dr Neil Paterson, Associate Professor Paul Lee-Archer, Dr Mark Trembath, Queensland Children's Hospital; Dr Laura Ferris, Associate Professor Niklas Steffens, The University of Queensland; Dr Marie Avanis, The Children's Hospital at Westmead, NSW; Dr Maryann Turner, The Royal Children's Hospital, Melbourne.

$A69,750

NAMED RESEARCH AWARDS

The Russell Cole Memorial ANZCA Research Award

Established following a generous ongoing commitment to the ANZCA Foundation from Mrs Ann Cole, in memory of the late Dr Russell Cole, to support a highly ranked pain-related research grant.

Is complex regional pain syndrome associated with structural or functional changes in the locus coeruleus?

The first aim of this project is to investigate the brainstem structure of patients with complex regional pain syndrome (CRPS). Specifically, we will use neuromelanin-enhanced magnetic resonance imaging to measure signal intensity in the locus coeruleus; voxel-based morphometry to carry out a volumetric assessment of the brainstem; and a multi-shell diffusion MRI scan of the brainstem to assess microstructural features such as neurite density and neuronal organisation. The second aim is to assess functional signs of locus coeruleus activity in CRPS by measuring pain, inhibitory pain modulation and autonomic (pupillary, cardiac and electrodermal) responses to a painful stimulus (applying ice to the temple and heat to a limb); and to a painless stimulus (an acoustic startle stimulus). We will then explore links between structural and functional signs of deficit in locus coeruleus activity. We hope that these studies will clarify the source of sensory disturbances and pain in CRPS and will encourage new approaches to treatment.

Dr Philip Finch, Professor Peter Drummond, Murdoch University, Western Australia; Dr Sjoerd Vos, Harry Perkins Institute of Medical Research, University of Western Australia.

$A69,416

John Boyd Craig Research Award

Established following generous donations from Dr John Boyd Craig to the ANZCA Foundation to support pain related research by fellows, particularly Western Australians.

Investigating oximetry and capnography to assess impact of opiate infusions on patients undergoing palatoplasties (OCTOPUS)

Whilst oximetry is regularly measured in patients post-palatoplasty, carbon dioxide monitoring is not a feature of the standard monitoring that palatoplasty patients receive. The overnight ventilation profile of palatoplasty patients is therefore unknown. Whilst Oxygen saturation (SpO^2) can be used in these patients to assess oxygenation, it has been shown that this alone does not fully represent a patient's respiratory status. The vulnerability of this patient group together with the use of opiate infusions makes this a major gap in our understanding of their treatments.

This single-centre observational pilot study at Perth Children's Hospital, in Western Australia will recruit children aged 0 to 18 months undergoing cleft palate repair under general anaesthesia who will be receiving a post-operative opiate infusion. We aim to gather information on oxygenation and ventilation measurements in infants on prescribed opioid infusions after palatoplasty repair.

This study will provide novel evidence on the feasibility and value of continuous, concurrent oxygenation and ventilation monitoring on infants post-palatoplasty. The results of this study will inform future research into the effects of opiate infusions on patients recovering from palatoplasty so that the impacts of such treatments can be better understood.

Professor Britta Regli-von Ungern-Sternberg, Dr David Gillett, Perth Children's Hospital, Western Australia.

$A70,000

Robin Smallwood Bequest

Established following a generous bequest from the late Dr Robin Smallwood to support a highly ranked grant in anaesthesia, intensive care or pain medicine.

A comparison of nausea and vomiting in postoperative paediatric patients with patient-controlled analgesia (PCA): morphine vs oxycodone - POPCORN trial

The POPCORN trial will randomise post-operative children to receive either patient-controlled analgesia with morphine or patient-controlled analgesia with oxycodone. The primary outcome will be need for an antiemetic. Efficacy of analgesia, opioid consumption, sedation, itch and constipation will also be compared.

The trial is unique in that it is entirely embedded in the electronic medical record (EMR). The EMR can identify which children might be suitable to go into the trial and automatically alert the treating doctor. They can then discuss the trial with the family and then, if the family consent, the EMR can be used to randomly assign children to morphine or oxycodone. The trial also uses only information that is already routinely collected within the EMR as part of usual clinical care so all baseline variables, outcome measures and safety measures are collected without the need for any extra research staff. This design is very efficient and if feasible can substantially reduce the cost of trials. Thus, a secondary aim of this trial is to determine the feasibility of such a totally embedded trial in the peri-operative setting.

Professor Andrew Davidson, Dr Su May Koh, Associate Professor Greta Palmer, Associate Professor George Chalkiadis, Royal Children's Hospital, Melbourne.

$A13,731

The Elaine Lillian Kluver ANZCA Research Award

Established following a generous gift to the ANZCA Foundation from the estate of the late Dr Elaine Kluver to support a highly ranked pain-related research grant.

The PREVENT AGITATION Trial II

Postoperative agitation/emergence agitation is a common clinical condition in which the child experiences a variety of behavioural disturbances including crying, thrashing, and disorientation during early awakening from anaesthesia. In early postoperative recovery phase, pain is also a common experience and together with emergence delirium are often referred to as "early postoperative negative behaviour" or emergence agitation. No drug is licensed for prevention or treatment of emergence agitation in children. Clonidine is increasingly used off-label in paediatric anaesthesia, for example, as premedication, in regional blocks, to prevent or treat emergence agitation. It is also commonly used in paediatric intensive care units for sedation and the prevention of withdrawal symptoms. The PREVENT AGITATION I trial showed intraoperative clonidine could half the incidence in boys aged one to five years. The PREVENT AGITATION Trial II is an international, multicentre, randomised, double-blinded, placebo-controlled clinical trial evaluating effectiveness and safety of a single intraoperative dose of clonidine in 320 infants aged three -12 months. This funding is for Perth Children's Hospital. Infants receiving clonidine are likely to experience decreased emergence agitation, be more comfortable and have a decreased need of supplemental opioid in post-anaesthesia care units (PACU). We will also examine for side effects and time spent in PACU in this younger cohort.

Associate Professor David Sommerfield, Perth Children's Hospital, Western Australia; Associate Professor Arash Afshari, Copenhagen University Hospital, Denmark.

$A70,000

Skantha Vallipuram ANZCA Research Scholarship

The scholarship has been set up by the family of Dr Skantha Vallipuram, FANZCA, FFPMANZCA to assist fellows or trainees to help establish their research careers.

Dr Chuan-Whei Lee was awarded the Skantha Vallipuram ANZCA Research Scholarship to support her in pursuing a PhD at the University of Melbourne with her thesis topic of surgery at the end of life: a paradigm for assessing futile treatment. Dr Lee's research will focus on postoperative survival and quality of life outcomes of older and high-risk patients with different end-of-life illness phases and trajectories who are considered for surgery.

Dr Chuan-Whei Lee, Royal Melbourne Hospital, Melbourne.

$A15,000

Patricia Mackay ANZCA Research Award

Established following a generous donation to the ANZCA Foundation from Mrs Indi Mackay, to support a highly ranked grant that aligns with Dr Patricia Mackay's known special interests in quality and safety in patient outcomes and the related identification and reduction of adverse events.

How effective is intraoperative cell salvage (ICS) and a leuco-depletion filter (LDF) in removing cancer cells and bacteria during pelvic exenteration surgery?

Many advantages of intraoperative cell salvage (ICS) as an alternative to allogeneic (donated) blood transfusion (ABT) were confirmed, including a potential reduction in adverse outcomes, and improved immune competence. Remaining obstacles include potential risk of 1) systemic bacteraemia in the presence of bacterial contamination from the surgical field and 2) of systemic cancer cell dissemination during surgery for malignant tumours. We recently confirmed that 10.8 per cent (119/1176, 2022) of cancer procedures at the Royal Brisbane and Women's Hospital (RBWH), where ICS is avoided due to these perceived risks, require transfusion. Intraoperative haemorrhage during pelvic exenteration surgery, can be sudden, rapid and catastrophic, often requiring massive blood product transfusion. This collaborative study team will enable patient recruitment and salvaged sample collection at various stages of the ICS process and surgery, by an experienced exemplar ICS team. The analysis approach (including flow cytometry) will consider removal of adenocarcinoma cells and bacterial contamination. Through expert collaboration between anaesthetists, surgeons and pathologists (RBWH), immunology and transfusion scientists (University of the Sunshine coast) and cancer researchers (the University of Queensland Centre for Clinical Research), this pilot study aims to refine methods, and to gather information to support a larger future clinical trial essential to improve patient outcomes.

Dr Michelle Roets, Dr Angela Tognolini, Dr Craig Harris, Dr Mahendra Singh, Royal Brisbane and Women's Hospital, Queensland; Dr Melinda Dean, University of the Sunshine Coast, Queensland; Associate Professor Peter Simpson, Dr Andrew Dalley, University of Queensland Centre for Clinical Research; Associate Professor David Sturgess, Surgical Treatment and Rehabilitation Service, Brisbane.

$A66,231

ANZCA Innovation and Technology Research Award

Established following generous donations to the ANZCA Foundation from Dr Stan Tay, a Foundation Governor Patron, to support a highly ranked research study that involves the innovative use or development of technology.

Machine learning to predict postoperative hypotension in a tertiary Australian hospital

Machine learning is an ever-improving technology that has the potential to use the vast amounts of data contained in the modern electronic medical record to improve patient care. Through the application of machine learning techniques, trends in patient data can be analysed and predictions made about patients' risk, giving clinicians an opportunity to mitigate those risks earlier.

Postoperative hypotension is a complex clinical problem that is associated with significant harm during the postoperative period. Data analysis and machine learning techniques represent an opportunity to better understand the magnitude of this problem and predict which patients might be at risk of postoperative hypotension.

The aim of this research is to develop and validate a machine learning model to predict hypotension in postoperative patients. This research is part of a wider program of work to implement an alternative model of postoperative care in our institution. A machine learning model may be helpful as a decision support tool to assist clinicians to identify which patients would most benefit from this alternative model of postoperative care.

Gold Coast University Hospital anaesthesia clinicians Dr Rachel Bourke and Dr Halia O'Shea have partnered with data analysts, Associate Professor Paulina Stehlik (Griffith University) and Principal Research Scientist Dr Sankalp Khanna at the CSIRO Australian e-health research centre.

Dr Rachel Bourke, Dr Halia O'Shea, Dr David Evans, Gold Coast University Hospital, Queensland, Professor Steven Stern, Bond University, Queensland, Associate Professor Paulina Stehlik, Griffith University, Queensland, Dr Sankalp Khanna, Dr Aida Brankovic, CSIRO Australian e-Health Research Centre, Queensland.

$A70,000

Provisional/New Fellow (PNF) ANZCA Research Award

Established following a generous donation from Professor Barry Baker, retired anaesthetist, a former ANZCA Dean of Education, and former Nuffield Professor of Anaesthetics, University of Sydney, to the ANZCA Foundation to support a highly ranked novice investigator.

Plasmalyte versus Normal Saline as a wash solution in cell salvage

The process of cell salvage allows for autologous blood transfusion during surgical procedures by collecting and washing a patient's blood that has been lost in the surgical field. The effect of the wash solutions used on cell salvage blood quality is an evolving field of research, with some limited preliminary studies suggesting plasmalyte as a potentially superior solution.

This project aims to investigate if the choice of wash solution used during the washing of cell salvaged blood has effects on the quality of the red blood cells that are reinfused into patients. Through the analysis of red blood cell physiology at the Griffith University Biorheology Laboratory, this project will compare the cell salvage wash solutions normal saline and plasmalyte. We aim to identify if the wash solutions used during cell salvage have deleterious effects on cell salvage blood quality through a comprehensive assessment of haemolysis and blood rheology. As this is a pilot laboratory study, the researchers hope the results will assist in the future translation of the project into a clinical setting in order to help identify a superior cell salvage wash solution that will ultimately facilitate the longevity of red blood cells reinfused after cell salvage.

Dr Elizabeth Forrest, Griffith University and Princess Alexandra Hospital, Queensland; Dr Alistair Kan, Gold Coast University Hospital and Griffith University, Queensland; Associate Professor Michael Simmonds, Griffith University, Queensland.

$A18,426

NOVICE INVESTIGATOR GRANTS

Long-term effects of a cannabis-based medication on insomnia in chronic back pain: a randomised crossover trial

As specialist pain medicine physicians, our patients frequently ask about the benefits of cannabis-based medication (CBM), with increasing pressure to prescribe despite little evidence. Placebo-controlled studies have suggested only a modest analgesic effect at best. Nevertheless, CBM continues to be widely used worldwide for chronic pain.

There has been some evidence of potential improvement in sleep quality in patients with chronic pain with the use of CBM. We have thus designed a rigorous, long-term study that will provide high-quality evidence to inform the use of CBM in patients with chronic pain and comorbid insomnia.

This study will be a randomised, double-blind, placebo-controlled, 196-day study on the efficacy of a New Zealand-produced CBM (Cannasouth evalaCann) on treating insomnia in patients with chronic back pain in the Bay of Plenty.

This work has the potential to inform the use of CBM in the treatment of sleep disorders in patients with chronic pain. Given the number of patients with such disorders, this could have substantial potential clinical benefit.

The proposed study will be a part of Dr Saad Anis's doctoral research program at the University of Auckland.

Dr Saad Anis, University of Auckland & Hauora A Toi Bay of Plenty, New Zealand

$A19,664

Quality of recovery comparison between opioid-free anaesthesia (OFA) and opioid-containing anaesthesia for elective laparoscopic surgery

This multicentre randomised controlled trial (RCT) explores new opioid-free techniques using large doses of opioid-sparing analgesic medications instead of opioids, for elective laparoscopic cholecystectomy or laparoscopic tubal ligation surgery. We will compare two groups, one that receives a particular standardised opioid free technique with another group that receives standardised opioid-based anaesthesia. We will compare patient-centred outcomes between the groups, including QoR-15, pain scores and opioid-induced side effects. This prospective, randomized, parallel group, single-blind study, with concealed allocation of 80 participants aged 18-65 years old with body mass index of 35 kg/m2 or less, scheduled for elective laparoscopic cholecystectomy or laparoscopic tubal ligation surgery, with ASA Score of I-II.

Opioid free anaesthesia may reduce sedation, nausea, itch, and constipation. Cost benefits may result from fewer unplanned intensive care and high dependency unit admissions for respiratory depression or sedation. The Australian and New Zealand College of Anaesthetists recognises the rising prescription and risk of opioids and supports opioid stewardship programs. Our project aligns with this aim, of maximising the effect of opioid sparing agents to reduce overall opioid use and reduced healthcare costs to the community. Our results may support the widespread adoption of OFA, with the benefits of reduced side-effects.

Dr Anthony Eidan, Royal Brisbane and Women's Hospital, Queensland.

$A19,134

Assessing perioperative outcomes in Victoria

Assessing perioperative outcomes in Victoria (APOV) will use Victorian admitted episode dataset and linked data (from the Centre for Victorian Data Linkage and other sources) to characterise perioperative care and outcomes in Victoria and potentially identify factors associated with safety and quality. Anaesthetic, procedural and patient factors which shall be analysed include regional anaesthesia, surgical/procedural technique, centre volumes, and demographics such as regional and Aboriginal and Torres Strait Islander status. We shall compare these outcomes to international benchmarks and practices and, if identified, highlight, and investigate "red flags suggestive of poor care" and potentially modifiable practices.

Dr Alexander Clarke, Dr Nathaniel Hiscock, St Vincent's Hospital, Melbourne.

$A10,000

PATRONS EMERGING INVESTIGATOR GRANT

Integration of the duke activity status and frailty indices into cardiovascular evaluation before high-risk noncardiac surgery (ENDURANCE Study)

Myocardial injury after noncardiac surgery (MINS) and postoperative myocardial infarction (MI) are common and associated with substantial mortality risk. Unfortunately, approximately 93 per cent of MINS and 68 per cent of postoperative MI are clinically silent, and therefore cannot be diagnosed reliably without systematic troponin testing. Whilst international society guidelines recommend postoperative troponin surveillance in high-risk patients, a pressing knowledge gap is how preoperative assessment can accurately identify individuals at high risk of MINS and postoperative MI, who will benefit from postoperative troponin screening.

This feasibility study will examine how the combination of functional capacity (measured by the Duke Activity Status Index), frailty and other measures of health status predicts postoperative cardiac complications in older patients undergoing intermediate-to-major noncardiac surgery. Furthermore, this study will evaluate the costs and feasibility of a postoperative troponin screening program within Australia. Accurate identification of such high-risk individuals will enable initiation of appropriate postoperative surveillance and open potential avenues for secondary prevention therapy. Amongst our elderly surgical cohort, this will be expected to have a profound impact on postoperative cardiovascular complications, long-term patient health outcomes and quality of life.

Dr Earlene Silvapulle, Royal Melbourne Hospital, Parkville Victoria.

$A89,241 with scholarship

PROJECT GRANTS

Pilot study of dual antiplatelet therapy and heart failure medication to manage myocardial injury in non-cardiac surgery

Annually, between 10–15 million (3.3–5 per cent) patients will experience an acute perioperative myocardial infarction (PMI) or myocardial injury following non-cardiac surgery. Clinically apparent events only represent < 20 per cent of heart injuries, with more patients sustaining subclinical myocardial injuries (MINS). Risk of morbidity and mortality significantly elevate after MINS, yet insufficient evidence exists to inform treatment recommendations. The SHIELD trial aims to fill this evidence gap, guide MINS management, and improve post-surgical patient outcomes.

Increased susceptibility following MINS for early recurrent MI and late heart failure makes secondary prevention of these events ideal therapeutic targets. Documented success of dual antiplatelet therapy (DAPT) in reducing the risk of recurrent MI following non-operative MI management and sodium-glucose cotransporter-2 inhibitor (SGLT2i) in prevention of heart failure progression suggests their potential use as secondary prevention strategies.

The SHIELD pilot will randomise 50 participants to daily clopidogrel/placebo and aspirin (DAPT) and daily dapagliflozin/placebo (SGLT2i) for six months. Participants will have undergone major non-cardiac surgery and be identified by routine troponin screening to have suffered MINS. The pilot will evaluate factors including the screening and recruitment rates, drop-out rates, and trial processes. Pilot data will be used to optimise the protocol for the definitive trial.

Associate Professor Jonathon Fanning, Royal Brisbane and Women's Hospital, Queensland; Professor Graham Hillis, Royal Perth Hospital, Western Australia; Professor Derek Chew, Monash Health, Melbourne; Associate Professor David Highton, Princess Alexandra Hospital, Queensland; Professor Gemma Figtree, Royal North Shore Hospital, NSW.

$A69,972

Artificial intelligence based surgical risk calculator for cancer surgery. (The ANCHOR project)

One in four surgery patients encounters major complications, making surgery the third leading global cause of mortality. In Australia, one in five citizens are diagnosed with cancer, with 60 per cent requiring surgery.

Electronic Health Records (EHR) promise to reshape patient care by constructing risk predictive models. Existing risk calculators designed for non-cancer surgeries overlook the unique needs of Australian cancer patients.

Dr Hilmy Ismail developed an AI-based caseline predictive model, in collaboration with the Melbourne Data Analytics Platform (MDAP) using a North American dataset. ANCHOR seeks to validate this model for Australian cancer surgical patients, using data from the Peter MacCallum Cancer Centre (PMCC). Utilising artificial intelligence, the project aims to craft a surgical risk calculator tailored to the nuances of cancer surgery. Supported by PMCC's department of digital innovation, MDAP, and the clinical leadership of Chief Investigator A (CIA) Dr Ismail, and associate investigators Professor Bernhard Riedel and Professor Linda Denehy, with a decade-long focus on cancer surgery pre-optimization, the project will Integrate a clinical decision support system (CDSS) to guide clinicians optimise modifiable risks and reshape patient outcomes. The collaboration of health informatics, data analytics, artificial intelligence, and clinical expertise holds transformative potential for cancer perioperative care in Australia.

Dr Hilmy Ismail, Associate Professor Kate Burbury, Dr Jason Li, Peter MacCallum Cancer Centre, Melbourne.

$A89,267 (including scholarship)

International study of cerebral oxygenation and electrical activity during major neonatal surgery

This multi-centre international prospective observational study will improve our understanding of near infrared spectroscopy (NIRS) and electroencephalogram (EEG) patterns and effects of sedation and anaesthesia on brain activity in infants undergoing neonatal surgery. Prior work by this group, funded by ANZCA, has demonstrated that many infants undergoing anaesthesia show periods of isoelectricity, suggesting a very deep degree of anaesthesia. This follow-up project focusses on neonates undergoing significant surgery and will add cerebral oximetry measurements to better understand the neurocirculatory and electroencephalographic effects of anaesthesia and surgery on the developing brain, including the postoperative period in the neonatal intensive care unit.

Associate Professor Justin Skowno, Dr Reza Kahlaee, Children's Hospital at Westmead, NSW; Associate Professor Neil Hauser, Perth Children's Hospital, Western Australia; Associate Professor Yuan, Children's Hospital of Philadelphia, US

$A69,806

Anaesthesia reversal agents: investigating a presynaptic target mechanism

Our previous research found that propofol has a significant effect on presynaptic release mechanisms, which presents new approaches to uncovering reversal agents. Here, we investigate a promising candidate reversal agent: a fluorinated analogue of propofol called propofluor. We cover two different levels of investigation: molecular biology and structural biology.

The investigators will use *in vitro* cell culture methods to study how propofluor might be overturning the effects of propofol on neurotransmission. This involves two levels of imaging: quantifying neurotransmitter release from neurosecretory cells and tracking presynaptic protein dynamics in these same cells. Single-molecule imaging readouts provide information about the effects of propofluor on two known interacting protein targets of propofol in the synaptic release machinery, syntaxin1A and munc-18.

Proteomic analysis of drug binding to amino acid residues will reveal structural mechanisms of drug action, informing how propofol and its analogue propofluor might interact with presynaptic proteins of interest. The results from this objective will provide insight into whether propofluor is binding to the same targets as propofol, highlighting if there are competitive binding sites and thereby uncovering a potential presynaptic mechanism of action. We will be studying these proteins in the same neurosecretory cells, to provide an explanation for our functional observations.

The benefit of this basic neuroscience research is to find anaesthesia reversal drugs that 'work', and knowing why they work, as a necessary prequel to further pre-clinical testing.

Professor André van Zundert, Royal Brisbane and Women's Hospital, Queensland.

$A70,000

A pilot randomised controlled trial of midodrine or atomoxetine to prevent ward hypotension in surgical patients at high risk of hypotension

Hypotension on the ward after surgery is common and is associated with higher risk of myocardial injury, acute kidney injury and death. Most research has focused on treating hypotension using intravenous vasopressors that require intensive care unit admission. Oral vasopressor treatment has been proposed to deal with this problem in ward environments. Midodrine (an alpha agonist) is currently being used in perioperative practice despite limited evidence. Recently atomoxetine (a noradrenaline reuptake inhibitor) has been used off-label to treat central orthostatic hypotension but has not been previously assessed to treat postoperative hypotension.

The trial is a pilot double-blinded randomised controlled trial of midodrine, atomoxetine or placebo to prevent ward hypotension in patients who are hypotensive in recovery. The project aims to establish the feasibility of the trial procedures and gather information about the efficacy of the agents and acceptability of the intervention and resource requirements for the conduct of a definitive trial.

Dr Ned Douglas, Associate Professor Jeff Presneil, Associate Professor Adam Deane, Professor Kate Leslie, Associate Professor Jai Darvall, Royal Melbourne Hospital and Department of Critical Care, University of Melbourne.

$A65,311

Comparison of programmed intermittent bolus versus continuous infusion local anaesthesia regimens via erector spinae catheter for rib fractures: RESPIRO trial

The RESPIRO trial is a multicentre, randomised, double-blind, intention to treat study. In patients with rib fractures and pulmonary contusions severe pain significantly limits the ability to cough and breathe deeply. Adequate analgesia is vital to functional recovery after rib fractures and prevention of respiratory morbidity. Erector spinae plane (ESP) catheter provide an alternative regional technique for analgesia by infusion of local anaesthesia between the erector spinae muscle and transverse process of the vertebrae. ESP catheters were associated with improved inspiratory capacity measured using spirometry and analgesic outcomes following rib fracture. Currently, there is a lack of uniformity and consensus on the best regimen for local anaesthesia infusion: whether using a programmed intermittent bolus (PIB), or a continuous infusion (CI), regimen. The two regimens have been compared in a variety of continuous nerve blocks techniques with variable results. Theoretical and anatomical considerations, with initial confirmation by in vitro cadaveric and low-quality evidence clinical studies, suggest that PIB provides better local anaesthesia spread. This study will evaluate if PIB is superior to CI via ESP catheters using clinically relevant outcomes of pain scores, opioid consumption, and improved respiratory function.

Dr Tim Joseph, Nepean Hospital, NSW, Dr Ben Moran, Gosford Hospital, NSW, Associate Professor Alwin Chuan, Liverpool Hospital, NSW

$A54,255

Interim analyses in two-by-two factorial designs: A simulation study

Professor Bernhard Riedel, in close collaboration with Ms Sabine Braat, Dr Anurika De Silva, and Ms Meg Tully from the University of Melbourne's Methods and Implementation Support for Clinical and Health Research Hub, will embark on an extensive simulation study with a specific focus on the interplay between factorial randomised trials and interim analyses.

The study is poised to yield practical insights that hold universal relevance for all RCTs employing or considering the implementation of interim analysis in factorial study designs – which deliver a multitude of advantages, including heightened trial efficiency, cost-effectiveness, and unwavering commitment to ethical standards.

The outcomes of this research endeavour will contribute significantly to the understanding and the underlying parameters that govern these trials.

Professor Bernhard Riedel, Peter MacCallum Cancer Centre, Melbourne; Ms Meg Tully, Dr Anurika De Silva, and Ms Sabine Braat, University of Melbourne.

$A25,386

Angiotensin II versus noradrenaline infusion to reduce length of hospital stay after cardiac surgery (the PORTHOS study)

In Australia more than 20,000 cardiac surgical operations are carried out each year. Median length of hospital stay after cardiac surgery is 9.5 days. Longer stays often reflect the accumulation of complications and result in increased healthcare costs. A reduction in these would have significant benefit to patients and the health system. Systemic vascular resistance (SVR), and consequently blood pressure is commonly low during and after cardiac surgery due to the combined effects of drugs and the surgical inflammatory response. Vasopressor infusions are used in up to 80 per cent of patients to restore SVR. In our previous ANZCA funded pilot study comparing angiotensin II to noradrenaline we found that a double-blind, randomised controlled trial comparing these two drugs was feasible. While the study did not have sufficient power to test hypotheses, the length of hospital stay was shorter in the angiotensin II group vs noradrenaline (6.3 vs 8.1 days, p=0.04). In this study we will carry out a double blind, randomised controlled trial in 400 patients, comparing perioperative angiotensin II infusion to noradrenaline infusion in adult patients undergoing cardiac surgery to determine if angiotensin II infusion reduces length of hospital stay compared to noradrenaline.

Dr Tim Coulson, Professor Silvana Marasco, Professor David Pilcher, The Alfred Hospital, Melbourne; Associate Professor Lachlan Miles, Austin Health, Melbourne; Dr Daniel Frei, Wellington Hospital, New Zealand

$A69,556

The pressure field: a Software-based Model for Optimisation of the Adult Circulation during Surgery (SMOACS)

When managing perfusion, there remains a lack of clarity regarding when to administer fluid, inotropes, and/or vasoactive drugs. The pressure field is a software-based method for managing perfusion with real-time visualisation of the beat-to-beat contributions of the heart and vasculature (stroke volume and systemic elastance) to blood pressure. We hypothesise that the pressure field method enables anaesthetists to better differentiate circulation phenotypes and underlying causes of changes in blood pressure, enabling more targeted interventions, greater haemodynamic stability, and fewer hypotensive episodes and postoperative complications. We aim to assess feasibility of an outcomes trial and implementability in a two-centre, prospective, two-arm, randomised controlled feasibility trial with parallel process evaluation. Eligible patients are adults scheduled for elective intermediate-to high-risk abdominal surgical procedures, with the intervention group managed by an anaesthetist using the pressure field method and software, and the control group receiving standard of care. The primary outcome is percentage of patients with complete haemodynamic and intervention data.

Dr Stephen Woodford, Professor Laurence Weinberg, Austin Health, Melbourne; Dr Sanne Peter, University of Melbourne.

$A57,386

A paradigm shift in understanding anaesthesia

Awareness with memory of events during general anaesthesia is rare, but a larger number of patients may have experiences that they do not remember (defined by response with a hand squeeze on the isolated forearm test). These events are not well detected by current "depth of anaesthesia" monitors. In our recent ConsCIOUS2 cohort study, 11 per cent of patients under 40 years old responded with a hand squeeze after intubation, indicating they were conscious and able to respond to their environment. Given that these events cannot be accurately predicted with current monitors, a paradigm shift in research is required to provide the necessary revolution in patient care. A better fundamental understanding of the mechanisms of anaesthesia is pivotal to inform these advances.

The investigators propose a novel approach to understand the anaesthetic state, dividing anaesthesia into three key pillars: consciousness (the ability to have a conscious experience, connectedness (conscious experience driven by the external world) and responsiveness (behavioural response). In order to advance anaesthesia science, we must change our model of anaesthetic discovery and focus on defining the mechanism of each of these three functions. In this grant we will analyse data from volunteers and patients, with states defined by these pillars of the anaesthetic state, to better understand the mechanisms of each.

Professor Robert Sanders, University of Sydney, NSW; Professor Jamie Sleigh, Dr Amy Gaskell, University of Auckland, Waikato Hospital, New Zealand.

$A69,032

Abdominal surgery using intrathecal morphine: (The AIM study)

Our primary aim is to evaluate whether a single preoperative spinal injection of intrathecal morphine (ITM) improves the quality of recovery for patients after minimally invasive major abdominal surgery.

Major abdominal surgery is common and is associated with significant morbidity. Effective analgesia reduces the incidence of post-operative complications, persistent post-surgical pain and improves quality of life and functional recovery. Opioid-sparing techniques are associated with early mobilisation, fewer complications, faster return of bowel function and shorter hospital stay. Less invasive surgical techniques are increasingly utilised for major abdominal surgery. A recent meta-analysis concluded that epidural analgesia offers no clinical benefit within enhanced recovery after surgery (ERAS) protocols in laparoscopic surgery. Our feasibility study demonstrated successful recruitment of patients and excellent protocol adherence and suggested a more favourable post-operative recovery with ITM than in the control group. However, ITM is not devoid of limitations or adverse effects, and is supported by relatively small, single centre studies.

This randomised controlled, double-blind multicentre trial will be conducted across multiple tertiary centres. 280 patients will be randomly assigned to receive either 200mcg ITM (intervention group) or a sham injection of subcutaneous saline in the lumbar region (control group).

Dr Katrina Pirie, Professor Paul Myles, Alfred Hospital, Professor Wendy Brown, Monash University, Melbourne.

$A89,920 (including scholarship)

Early postoperative care – identifying high value through economic analysis

National conversations have shown an emerging large unmet need for high value improvements in perioperative care. A model of enhanced postoperative care for 'medium-risk' patients termed Advanced Recovery Room Care, or ARRC, has shown very large benefits in terms of outcome, cost and, with formal Markov cost-effectiveness modelling, large improvements in value – 'better and cheaper'.

The next step is to better define the optimal group of patients to target. This study will collect data on outcomes and resource across a wide range of co-morbidities and surgeries and apply Markov modelling to identify those patient and surgical groups for which ARRC provides most value. In that, it recognises that efficiency and value are essential domains of quality. It has cost-effectiveness at its core, and primary endpoint, as this provides detailed data on outcomes (with improved outcome as an essential element) but adds cost elements to define value.

Data will initially be collected at Royal Adelaide, but with the aim to grow the database to other hospitals as ARRC units emerge, to create an ARRC network.

Professor Guy Ludbrook, Dr Esrom Leaman, Royal Adelaide Hospital, South Australia; Professor Michael Grocott, Biomedical Research Centre, University Hospital Southampton, UK.

$A69,843

All of these ANZCA research grants are funded by the foundation. If you would like to donate to support this important work, please scan the QR code.

Grant review process

On behalf of the college, the ANZCA Research Committee thanks all reviewers who reviewed one and in many cases more grant applications for their invaluable contributions to the peer-review process. A full list of reviewers can be found on the ANZCA website.

Much effort continues to be made to ensure that the process is as fair and rigorous as possible. Each year ANZCA Research Committee members consider the grant applications and select three reviewers for each grant, based on their relevant expertise. One reviewer, a member of the research committee is appointed "spokesperson", while the other two are from outside the committee. These reviewers include expert researchers from anaesthesia, perioperative medicine, pain medicine, and other disciplines as required and include reviewers from overseas. The reviewer comments are sent back to the researcher applicant for responses, and the spokesperson then collates the information (including the reviewer scores, comments, and applicant's responses) into a synopsis with an overall score. Each application is then discussed in detail by the whole research committee during a day-long face-to-face meeting, with the final scores determined by the averages of ballot scores (out of seven) from each committee member, provided in secret to minimise bias.

Conflicts of interest are declared and recorded, and members of the committee are excluded from discussion and scoring of any applications for which they have conflicts. The presence of Mr Andrew Brookes, our community representative with an extensive experience in ethics committees, medical research grants and corporate governance adds an extra safeguard.

Finally, funding is allocated to the proposed projects considered to be of 'fundable' quality in descending order of the final averaged committee member scores, within the limits of the funds available. Inevitably, in any competitive process some applicants are unsuccessful. As with most grant programs, detailed feedback is not provided to applicants after the committee has finalised its decisions, except to novice investigators. However, detailed feedback on applications is formally provided during the review process through reviewers' comments to applicants, which reflect most of the factors that will influence committee decisions. Most committee members have themselves experienced many unsuccessful applications to ANZCA and other granting agencies and recognise the disappointment felt when a submission is unsuccessful. However, unsuccessful applications also help applicants to develop grant writing skills for future success, and perhaps it is this persistent pursuit of continual improvement that most characterises all ANZCA grant applicants. The research committee recognises the significant time and effort involved in grant writing, extends its thanks and encouragement to all applicants, and strongly encourages all fellows and trainees considering applications to apply for the 2025 grants round which opened on 1 December 2023.

Every year committee members, reviewers and ANZCA staff continue to work to maintain and improve our high-quality research grant process.

In 2022, a fully blinded electronic voting system was introduced to replace the previous paper-based blinded voting, to facilitate the move to hybrid face-to-face and virtual grant assessment meeting.

During 2023, the research committee reviewed and amended all ANZCA research grant application forms and guidelines which we hope will make the application process easier for all applicants and reviewers, and further improvements are planned from 2024. The contribution of committee members and reviewers are often made in their own time. We would like to express our sincere thanks to all of them, and to the ANZCA Council and CEO of ANZCA for their ongoing commitment to the research that is being led by our fellows and trainees, as a vital contribution to continuous improvement in quality, safety and patient outcomes.

Finally, I would like to thank Professor Alicia Dennis who left the committee in May after six years and Professor David A Scott who is stepping down as a member after 12 years on the committee at the end of 2023. I wish to thank them both for the contributions they have made over many years, and particularly David for his outstanding leadership as committee chair (2018-2022) and his support and mentorship during my first year as committee chair. Both David and Alicia have given substantial time to the committee and their contributions have improved our processes and are greatly appreciated.

Professor Britta Regli-Von Ungern-Sternberg
Chair, ANZCA Research Committee

RESEARCH COMMITTEE MEMBERS:

Professor Britta Regli-Von Ungern-Sternberg, Chair (WA)

Associate Professor Matthew Doane, Deputy Chair (NSW)

Mr Andrew Brookes, community representative (Vic)

Dr Douglas Campbell (NZ)

Professor Matthew Chan (HK)

Professor Andrew Davidson, CTN Chair (Vic)

Professor Alicia Dennis (Vic) (to May 2023)

Professor Victoria Eley (Qld)

Associate Professor Lis Evered (Vic)

Professor Kirsty Forrest (Qld)

Professor Paul Glare, FPM representative (NSW)

Dr Julie Lee (Qld)

Associate Professor Paul Lee-Archer (Qld)

Associate Professor Stuart Marshall (Vic)

Professor Simon Mitchell (NZ)

Professor Philip Peyton (Vic)

Professor Robert Sanders (NSW)

Professor David A Scott (Vic)

Professor Andrew Somogyi (SA)

Associate Professor David Sommerfield (WA)

Professor André van Zundert (Qld)

Dr Chris Cokis, ANZCA President (WA)

Research grants for 2025

ANZCA AND ANZCA FOUNDATION GRANTS PROGRAM

Applications are invited from fellows and registered trainees of ANZCA and FPM for the following research grants and awards for projects related to anaesthesia, perioperative medicine, or pain medicine.

Applicants are asked to carefully read the guidelines, as the ANZCA Research Committee have made a number of amendments and additions to the grant application forms in each grant category.

Grants available for 2025:

- **Academic Enhancement Grant** This grant aims to foster the advancement of these academic disciplines, and help establish, enhance or sustain a research program. All chief investigators must be fellows of ANZCA and/or FPM with an academic appointment.
- **Douglas Joseph Professorship** This prestigious grant is for Fellows of the college making an outstanding contribution to the advancement of the specialty to pursue research in human anaesthesia in Australia, New Zealand, Hong Kong, Malaysia and Singapore.
- **Project Grants** These grants support specific research projects proposed by fellows and trainees. Applicants undertaking a higher degree may apply for scholarship support as part of a project grant.
- **Professional Practice Research Grants (including simulation and education)** These grants are to support high quality research to provide evidence for effective, efficient, safe and equitable professional practices in anaesthesia, perioperative and pain medicine for patients, organisations and staff and include the areas of education, simulation, and strategies for translating and implementing evidence into clinical practice
- **Novice Investigator Grants** Early applications from novice investigators are invited by 14 January for mentoring during the application process. Further details available on the website.
- **Skantha Vallipuram ANZCA Research Scholarship** This scholarship has been established by the family of Dr Vallipuram, FANZCA FFPMANZCA to support a fellow or trainee enrolled in a higher research degree and assist in establishing their research career.
- **Environment and Sustainability Research Grant** This grant is the initiative of a group of anaesthetists and the foundation to encourage and support research exploring the environmental impact of anaesthesia and related products and activities.
- **ANZCA Patrons Emerging Investigators Grant** A dedicated grant to support emerging researchers transitioning from the novice investigator grant level. The grant is named in honour of the foundation patrons who are high-level donors to research.

Full details of the ANZCA grants program and each of the grant categories with the relevant application forms and guides for applicants are available on the college website. Further resources for applicants can be found in the ANZCA library research hub.

The closing date for all grant applications is 5pm AEDT 2 April 2024.

For further information, please contact:
Ms Susan Collins
Research and Administration Coordinator
ANZCA Foundation

research@anzca.edu.au

ANZCA Foundation – year in review

2024 SUBSCRIPTIONS, OPTIONAL DONATIONS, AND INSPIRATIONAL DONORS

Many supporters donate to the foundation with their annual subscription payments, inspiring and helping us continue to support our fellows' and trainees' voluntary work to further improve the quality and accessibility of specialist healthcare.

Our donors support long term advancement, enhancing the science and evidence clinicians need to supplement their extensive training and experience, further reduce adverse perioperative events and improve outcomes and lives for patients.

Through our global development and Indigenous health programs, donors also support dedicated volunteer fellows working in lower income countries in our region and beyond, providing training, education, and access to acutely needed anaesthesia, pain medicine, and perioperative medicine.

The ANZCA Foundation, Foundation Committee, and the Research, Global Development and Indigenous Health Committees convey heartfelt thanks to all our wonderful donors.

GRANTS TO 94 RESEARCH TEAMS SINCE 2022

In the last three years, the ANZCA Foundation has granted $A5.25 million through the ANZCA Research Committee for 94 research projects led by ANZCA and FPM fellows, trainees, and research teams in anaesthesia, pain medicine and perioperative medicine.

These involved 163 ANZCA and FPM fellow and trainee chief investigators, and many more chief and associate investigators from disciplines within and related to perioperative medicine.

The Australia and New Zealand-based work of these dedicated teams is advancing knowledge and supporting clinical practice for all fellows. It adds insights through international peer-reviewed journals, but also provides contextually-validated knowledge and tools to support practice in our countries.

Above from left: Dr Kara Allen, Professor Kate Leslie, Ms Anna Parker; Dr Stan Tay and Dr Lahiru Amaratunge

GLOBAL AND INDIGENOUS HEALTH GRANTS FOR 2024

It was exciting to see nine grant funding applications for health equity projects to start in 2024, received through the ANZCA Policy Unit and approved by the Foundation Committee, based on recommendations from the Global Development and Indigenous Health Committees.

This is the highest number of ANZCA health equity grants made to date, and a healthy increase on the three received when the Health Equity Project Fund (HEPF) grants were first introduced in 2019 to support outreach in global and Indigenous health. A total of 31 HEPF grants have now been provided to date for projects in these important areas.

Six of the applications for 2024 are for global development projects, two are for Indigenous health, and one focusses on gender equity. Further project details will be released after final approval.

DONOR-FUNDED RESEARCH STUDIES HELP CLINICAL TRIALS NETWORK (CTN) SURPASS $68 MILLION

For many years donor and ANZCA Foundation-funded exploratory studies have delivered new insights, but also frequently led to large multicentre studies that improve evidence for better clinical practice and outcomes. ANZCA grants have also supported the career advancement of hundreds of fellow researchers.

At its August 2023 strategic workshop, the ANZCA CTN announced that it has now surpassed $A68 million in peer-reviewed funding for endorsed multicentre randomised clinical trials in the specialties and across perioperative medicine.

Foundation donors have made this possible by supporting ANZCA grants, and a stream of discovery, pilot, and feasibility studies without which many ANZCA CTN-endorsed clinical trials would never have been developed.

These have led to strong contributions from ANZCA and FPM academic anaesthetists and pain medicine physicians to international peer-reviewed literature, evidence for practice, and global recognition.

GOVERNOR PATRON INCREASES GRANT FUNDING

Long-standing Governor Patron Dr Peter Lowe has increased his already generous annual funding of a research grant and a scholarship for emerging investigators working at University of Melbourne-affiliated hospitals. Dr Lowe has kindly increased his annual research grant from $10,000 to $15,000, and the scholarship from $20,000 to $25,000. Dr Lowe will also contribute an additional $10,000 in 2024 to increase support for the ANZCA Clinical Trials Network Pilot Grant Scheme. The foundation greatly appreciates Dr Lowe's support.

Fellows interested in fundraising to establish similar programs to support emerging investigators through their own universities or regions are strongly encouraged and should contact the foundation for assistance.

FOUNDATION EVENTS IN 2023

The foundation saw a welcome return to face-to-face events in 2023.

On 7 May, more than 120 guests attended the ANZCA Foundation Reception at the ANZCA Annual Scientific Meeting, where Research Committee Deputy Chair Dr Matt Doane presented the ANZCA Foundation Named Research Awards. Australian Society for Medical Research Chair and University of Sydney cancer researcher Dr Emily Colvin delivered the keynote address.

A successful professional practice research webinar was held in September with Victoria Brazil, Professor of Emergency Medicine Simulation at Gold Coast Health Service and head of the Bond University Translational Simulation Collaborative, helping build the Professional Practice Research Network.

The foundation was also delighted to host a donor networking evening at ANZCA House on 20 October, including presentations from Associate Professor Jai Darvall and Dr Katrina Pirie on their exciting research, and the important role donors' support has played in their research career advancement.

The foundation hopes to continue to deliver and expand our events program during 2024.

Australian Society of Medical Research (ASMR) **Board and affiliates meeting**

On 1 November the foundation again represented the college at an (ASMR Board and affiliates meeting in Melbourne. ASMR Chair Dr Emily Colvin flagged that inflation, increased costs, and static investment has halved the number of National Health and Medical Research Council (NHMRC) funded grants over the last decade. The ASMR is advocating a doubling of the NHMRC budget to respond to growing health challenges and support more innovative and cost-effective healthcare,and was instrumental in the federal government's doubling of the NHMRC budget from 1999 to 2005 after a federal government Health and Medical Research Strategic Review (the 'Wills Review').

CONTACT & SUPPORT

For queries, contact:

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Susan Collins, research and administration coordinator, scollins@anzca.edu.au

ANZCA Clinical Trials Network:
Karen Goulding, CTN manager, karen.goulding@monash.edu

To donate, please use the 2024 subscriptions form, search 'GiftOptions – ANZCA' in your browser, or scan the QR code.

Thank you to all foundation donors

The ANZCA Foundation is very grateful to all of its patrons, bequestors, and other generous donors for assisting the vital work of fellows and trainees in research, global development, and Aboriginal, Māori, and Torres Strait Islander health.

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ANZCA Clinical Trials Network news

GRANT FUNDING

The ANZCA Clinical Trials Network has now secured more than $A68 million in competitive grant funding to run large multicentre clinical trials and pilot and feasibility studies. A team led by Professor Robert Sanders (above) from the Department of Anaesthetics and the Institute of Academic Surgery, Royal Prince Alfred Hospital, is getting the latest funded DECIDE study under way. The protocol was presented at the CTN workshop which was held in Coogee, NSW in August, for further feedback from delegates. Visit anzca.edu.au/ctn for more information on how you can be involved in this study and other trials.

DECIDE TRIAL: DEXMEDETOMIDINE AND DELIRIUM IN CARDIAC SURGERY

There are over 20,000 cardiac operations conducted in Australia per year, and more than two million worldwide. Postoperative delirium is a common complication of cardiac surgery that affects about 50 per cent of patients. Delirium is distressing, and is associated with prolonged hospital length of stay, loss of independence, increased 10-year mortality, and cognitive decline. It is also associated with neuronal injury, with meta-analyses showing that delirium is associated with a 12-fold increase in the odds of dementia (OR 11.9, 95% CI 7.3-19.6).

Promising data suggest that the α2-agonist dexmedetomidine (DEX) may reduce postoperative delirium. The mechanisms of postoperative delirium include a combination of over-sedation, neuronal injury, blood brain barrier disruption and inflammation. DEX's sedative effect stems from reduced noradrenergic activity producing an arousable sleep-like sedation. DEX acts at neuronal, immune and/or renal adrenoceptors, to transduce organ-protective and anti-inflammatory actions. DEX is neuroprotective in multiple injury models, including cardiopulmonary bypass, preventing neuronal death, blood–brain barrier disruption and inflammation, and the subsequent cognitive impairment.

Recent meta-analyses suggest DEX reduces delirium, length of stay in hospital and death following cardiac surgery. However, meta-analysis of high-quality RCTs suggests there may be benefits but significant heterogeneity leads to uncertainty in the findings (for example, delirium, risk ratio 0.77 95% CI 0.56-1.04).

The DECIDE trial aims to randomise 1100 patients 65 and older undergoing cardiac surgeries with cardiopulmonary bypass to determine whether those who receive DEX will experience: more days free of delirium or coma and alive in the first 14 postoperative days; increased number of days alive and at home in the first 30 postoperative days; and improved cognition at one year.

The trial will be run out of the National Health and Medical Research Council (NHMRC) Clinical Trials Centre. DECIDE is funded by a $A4.1 million grant from the NHMRC Clinical Trials and Cohort Studies scheme adding to the impressive track record of the CTN in securing multimillion dollar grants.

Training and education

Reflections on two decades of ANZCA and FPM education

Director of Professional Affairs FPM Education Dr Melissa Viney is the recipient of the 2023 Steuart Henderson Award which is awarded to a fellow who has demonstrated excellence and provided outstanding contribution, scholarship and mentorship to medical education in the field of anaesthesia and/or pain medicine.

Dr Viney was appointed to her role of DPA, FPM Education in March 2022 having worked as FPM assessor for two years and as a member of the FPM Board.

With a breadth of experience across assessment, curriculum development, specialist international medical graduate (SIMG) processes, support and mentoring she has spent more than 20 years supporting trainees, SIMGs and fellows in their work.

Many of those she has mentored and supported now work as clinicians or researchers with careers in national, international and leadership roles. Her own preferred approach is one-on-one teaching.

In an interview with the *ANZCA Bulletin* Dr Viney candidly admits that she prefers personalised interactions with trainees and fellows because she is not a "front of house" person.

"I'm not one to stand up in front of a group and teach," she explains.

Dr Viney's involvement in education with ANZCA and the faculty began in 2002 with her first role as an ANZCA supervisor of training (SOT). It was in 2005 after she had taken on a role as an FPM SOT at Geelong Hospital, (now University Hospital Geelong) that her first faculty trainee came under her wing – the immediate past FPM Dean and now DPA, FPM Professional Affairs, Associate Professor Mick Vagg.

"No one had really thought much about medical education when I started out as an anaesthetist. In those days clinical training supposedly gave you skills that we now describe as roles in practice. There was actually very little in the way of support but over the years that has changed and there is now a lot more emphasis on the importance of learning and support.

"Having greater oversight of trainees now means we can be alert to any problems they may be having but it also allows them to put their hand up and let us know if they need help," she says.

"Before, it was just about the medicine but now there has been real positive change. When I was an ANZCA trainee I knew of two anaesthesia trainees and a fellow who died by suicide. Now there is a much greater awareness and recognition of the need for a better understanding and awareness of wellbeing and mental health."

In her years of working in education for the faculty – both as a clinician, an assessor and curriculum developer, there has been a noticeable change in the cohort of FPM trainees.

"In the early days of my involvement most of the FPM trainees were anaesthetists with a smattering of trainees from other groups such as surgeons, physicians, psychiatrists and rehabilitation specialists – now there's been a definite shift towards having more GPs and rehabilitation physicians. That's a reflection of what they're dealing with in their own practices particularly with chronic pain and severe trauma patients."

Dr Viney believes the methods of assessment for faculty trainees are evolving over time with less emphasis on knowledge exams and a stronger focus on authentic skills such as communication, understanding and implementing local rules and regulations pertinent to medical practice and using the literature to develop an evidence base that is contextual for a specialist's own clinical practice.

A clinician one day a week at the University Hospital Geelong's pain management unit, she is a strong advocate for stepping out of your comfort zone when, and if, the time is right. Dr Viney encourages fellows with an interest in medical education and mentoring to consider a volunteer role with the faculty and/or college.

"If you need to limit your clinical time for whatever reason then a college role provides fulfilling and rewarding opportunities. You get a different perspective on the college when you are involved in college activities. It has given me opportunities and insights that I wouldn't necessarily have known about and has given me an alternative career path in medicine."

Carolyn Jones
Media Manager, ANZCA

ANZCA farewells Maurice Hennessy

After 12 years, Maurice Hennessy, ANZCA's Learning and Development Facilitator is hanging up his college hat.

Since 2011 when he began delivering the ANZCA Foundation Course he has worked with dozens of trainees and fellows including supervisors of training, specialist international medical graduates, members of the ANZCA Educators Sub-committee (AESC) and participants in the ANZCA Educators Program (AEP) and Emerging Leaders' conferences.

Maurice presented his last AEP in Canberra on 10 November and was farewelled at ANZCA House on 6 December.

During his time at the college the AEP evolved from an eight-module program in 2016 to the current five module program (developed after a review of the program in 2022). The program is now delivered in one and a half days.

Maurice prefers to use "facilitator of learning" rather than "teacher" when describing the AEP's work as he believes the process should focus on the learner, not the teacher. He is also a strong supporter of "feedback conversations".

"As a developer of the clinician facilitator model for the AEP he ensured that each facilitator perform to a consistent standard," says FANZCA Dr Scott Fortey, member of the ANZCA Educators Sub-committee.

"Maurice has always encouraged us to keep the message the same but change the delivery if it wasn't to our style. Such a respectful style encourages our participation. When Maurice says, 'Would you like some feedback?', we always know that it is discussed so that we may be continuously on the improve. He asks the same of himself.

"Thank you, Maurice, from all the thousands of clinicians you have influenced at ANZCA. I'm sure those in Hong Kong and Singapore will also be thanking you."

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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 2024 are now open.

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

Applications close 31 January 2024.

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

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Make sure you're not missing out on important information!

Keep your details up to date on the MyANZCA portal. We use the information on your MyANZCA profile for all of our official communications, including:

Exam updates · Events and courses · Committee vacancies
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So please take a few minutes to check your personal details. It's easy to do, and ensures you won't miss out on important information.

1. Log into anzca.edu.au/portal
2. Click "Update my contact details"
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If you have multiple addresses you can select a preferred mailing address. You may also choose to let us know if you identify as Aboriginal Australian, Torres Strait Islander, Māori or Pacific Islander; and alert us to any dietary requirements.

If you're worried that you're not receiving our emails, please check your junk and spam filters and, if necessary, add @anzca.edu.au or @anzca.org.nz to your address book.

And don't forget to follow us on your favourite social media channels for all the latest news, events, and insights into college life.

Join the new Anaesthesia Curriculum Review Sub-committee

We are currently seeking expressions of interest from ANZCA fellows to join a new sub-committee being established in early 2024.

This newly formed sub-committee will directly contribute to the quality improvement and enhancement of the *Anaesthesia Training Program Curriculum*. Aligned with the college's strategic plan, initial priorities include introducing systematic approaches to curriculum review processes and progressing embedment of diversity, equity and inclusion and social determinants of health within the training program.

Joining this sub-committee is a great opportunity to build deeper connections within the college and influence the design and delivery of the training program. Members will proactively engage in identifying, proposing and developing evidence-based enhancements to the anaesthesia training curriculum, including:

- Graduate and program outcomes.
- Learning outcomes.
- The integrated program of assessment.
- Volume of practice requirements.
- Specialised study units.
- Core unit reviews.

WHO WE'RE LOOKING FOR

ANZCA fellows with an interest in education and experience as a supervisor, workplace-based assessments (WBA) assessor, tutor, or examiner are encouraged to apply. We encourage and promote diversity, equal opportunity and regional representation on all our committees, so these factors will also be considered as part of the appointment process.

WHAT'S THE COMMITMENT?

The sub-committee will meet four times a year through a combination of in person (hybrid) and online meetings. Members will contribute actively between meetings to ongoing development of the ANZCA training program.

HOW DO I APPLY?

When applying, please include a letter outlining your reasons for applying and include a brief resume. Applications are due by Friday 2 February 2024, and outcomes will be notified to applicants in early March 2024. Send your application to educationstrategicprojects@anzca.edu.au.

FURTHER INFORMATION

The Curriculum Review Sub-committee is a sub-committee of the Education Development and Evaluation Committee (EDEC). Sub-committee terms of reference, including scope of the work and what is required of members can be requested from the education team.

Membership selection will consider applicants experience with ANZCA education activities and expertise in medical education, training and assessment.

Find out more on our website.

ANZCA
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Steuart Henderson Award

Nominations are being received for the 2024 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 2024.

Successful candidates

Primary fellowship examination

2023.2 Exam

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

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Navid Aminian
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Madelaine Elizabeth Collins Howard
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Thomas Mulckey Yates

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Peggy Xie
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Duncan Peter Hamilton

Queensland

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Keith Prashanth Chandrarajan
Xavier Christopher Conner
Jackson James Cowan
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Samuel Sharif Hanafy
Abbey May Hoswell
Zachary James Lovelady
Timothy Alan Mason
John Michael Parr
Abraham Petrus
Iain Charlie Prew
Jack Peter Righton
Luke James Salmon
Kate Alexandra Taylor
Anuar Turgulov
Mahmoud Ugool
Laura Myfanwy White
Emmie Caroline Millroy Willis
Jacinta Louise Wynne

South Australia

Tegan Lee Asser
Amy Jane Chapman
Tess Madison Chee
Adrian Gasparini
Christine Gayan Li
Brianna Adele Martin
Teodor Florin Mocioaca
Miles Hilton Logan Roberts
Sean Ezekiel Wei Shuen Seow

Tasmania

Ellie Grace Cash
Andrew Nathan Eckhardt
Matthew John Holmes

Victoria

David Edric Barlow
Henry Thomas Beaumont-Kelly
Maddison Kate Bullock
Nathan Jia-Xue Chua
Amanda Dao
Nicholas De Vincentis
Jarron Mitchell Dodds
Lisa Dunne
Alastair Duncan Eadie
Craig Leonard Fisher
Stephanie Rose Gederts
Andrew Girgis
Robert John Greaves
Kate Maree Greentree
Linley Margaret Hayes
Margaret Hezkial
Andrew Stephen Hunter
Carena Euleen Lai
Joel McRae Lawrence
Eva Madeleine Matthews Staindl
Charles Daniel McKay
Daniel Redmond Nagle
Liam Joseph O'Bryan
Emily Clare O'Grady
Bobby Ou Yang
Luke Alastair Perry
Julian William Quigley
Shorsha Bae Kopu Ross
Rebecca Catherine Rowland
Edward Christian Lloyd Seyfort
Nicholle Yau Wen Sim
Karena Jie-Yu So
Brandon John Spina
Samuel Jesse Stephens
Stephen Surace
Owen Nicholas Tomasek
Max-William Ubels
Mayank Vasudeva
Jared Bart Vurens Van Es
Dominic James Walpole
Vanessa Weerasinghe Mudiyansalage
Cliff Ngai Tin Wong
Luke Ling-Song Yang
Harrison Yao
Aun Chian Yeoh
Lauren Jia-Li Yip
Anna Anyun Zeng
Jessica Jing Zhang

Western Australia

Gautam Malhotra
Matthew Shane Parker
Jack William Perkins
Geoffrey David Ryan
Claudia Kerry Nadia Toro
Laura Marguerite Wisniewski
Jessica Jun Yi Zheng

NEW ZEALAND

Hannah Kate Newcombe
Harith Sinan Butrus Awrooj
Mikayla Jo Barnett
Alexandra Mary Beggs
Gabrielle Suzanna Britton
Annelise Nicole Brown
John Choi
Charlie Davies
Jean-Prieur du Plessis
Charlotte Michaela Dumble
Caleb Ngai-Hin Fung
Himesh Natwar Gosai
Andrew Zinzan Harris
Kevin Mark Hart
Barnabas Ranen Hyland
Holly Anne Lorraine Johnstone
Christopher Mark King
Mohamad Atif Mohd Slim
Elliot Marshall Page
Alina Yurevna Savastyuk
Jong Woo Shin
Louise Alice Thomas
Kristyan Andrew Urlich
Thisura Chandula Wijeweera
Antony Xie

MERIT CERTIFICATES

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

Stephen Surace, Victoria

Geoffrey David Ryan, Western Australia

Samuel Jesse Stephens, Victoria

Julian William Quigley, Victoria

Jackson James Cowan, Queensland

Liam Joseph O'Bryan, Victoria

Renton Prize

The Court of Examiners recommended that the Renton Prize for the half year ended 31 December 2023 be awarded to:

Annelise Nicole Brown, NZ

"I am part of the central training scheme in NZ, based at Nelson hospital for the year as the only registrar.

I studied in Otago, and started my postgraduate work in Nelson followed by postgraduate year 2 in a remote hospital in Zambia.

I was introduced to anaesthesia as a house officer in Nelson and I have had the privilege of pursuing it as a specialty since.

I have been extremely well supported by the anaesthesia team here and I am pleased to be able to share in the success with the staff.

It is a great relief to have the exams behind me and I am enjoying spending more time in the mountains and outdoors. "

The Court of Examiners recommended that the Renton Prize for the half year ended 31 December 2022 be awarded to:

Henry Thomas Beaumont-Kelly, Vic

"I grew up in a small coastal Victorian town before moving to Melbourne for university. I graduated in 2019 and began working at The Alfred hospital. I enjoyed anaesthesia as both a medical student and junior resident, and I am fortunate to now be in my first year of training.

I'm sure everyone who has sat the primary would agree that it is a protracted experience that would be almost impossible to do alone. I owe huge thanks to all the Alfred team, particularly Ben and Lisen, for their teaching, motivation and support. I'm incredibly lucky to have had the encouragement and perspective of my friends and family who helped me to maintain some degree of exam-life balance. Most importantly, I am beyond grateful for the support and understanding of my partner Hannah, who single-handedly kept our lives running this year.

Post-exam I've enjoyed doing anything other than sitting at a desk, and I'm looking forward to a summer of hiking, cycling, and swimming."

Image opposite page: Court of Examiners for the primary fellowship examination.

Final fellowship examination

2023.2 Exam

One hundred and thirty-one candidates successfully completed the final fellowship examination:

AUSTRALIA

Australian Capital Territory

Brandon James Kirsten Barks
Tarun Sharma

New South Wales

Cheyne Bester
Jarrod Brady
Hannah Eilish Braithwaite
Bradley Robert Bridge
Dennise Angela Castaneda
Abishana Gnaneswaran
Mark Roland Grivas
Sukhi Manjunatha Hegde
Mary Hoang
Riddhi Piyush Joshi
Ho-Kyung Kim
James Chan Hee Kim
Sarah Xin Kong
Mari Koyanagi
Austin Yong-Sheng Lee
Tanya Manolios
Andrew David John McKeown
Alexander Thomas Mende
Michael Christopher Millett
Grant William Moore
Stephanie Joseph Naim
Fiona Elizabeth Pearce
Morgan Olivia Pengelly
Brian Pereira
Paul Hoang Nguyen Pham
Yusra Parvaiz Qamar
Haydn Robert Sawtell
Ravi Senegal Shankar
Claire Mary Ellen Smyth
Adam Avram Sonnabend
Erika Strazdins
Loran Varlie Towell
Hannah Tracey Watson
Rosie Ann Watters
Yao Lin Yang
Xinmei Yao
Kylie Jun Ting Zhong

Northern Territory

Emma Louise Jill Zorab

Queensland

Justin Azzopardi
Simon Ali-Akba Robert Baker Jones
Andrew Brendon Michael Bond
Kyle Mathew Dailey
Taissa Irene Groch
Dat Khuong Huynh
Dayal Gamunu Jayawardena
Antony Ji
John Bernard Jones
Rafid Shahriyar Karim
Daniel Kwanwoo Kim
Geraldine Wen Bin Kong
Sei Nishimura
Amy Elizabeth O'Sullivan
Gowri Manohari Ravichandran
Alexander Ramsay Lyndhurst Robinson
Fiona Ruth Ryan
Veeranjit Singh
Kevin James Twomey
Michelle Dahlia Wartski

South Australia

Naomi Eve Abbt
Mendel See Hok Au
Vishnu Bhardwa
Alexander Dai Ishimaru Dean
Alyssa Jane Gardner
Arvind Jothin
Sam Douglas Kirchner
Courtney Ellen Lloyd
Michaela Malek
Angela Alex Mathew
Ravindran Samuel Nathan
Christopher James Stanton
James Paul Turnbull

Tasmania

Lisa Christina Allen
Bing Hui Chang
Alexander James Head Lewis

Victoria

Katarina Arandjelovic
Jason Robert Bishop
Macushla Clare Byrne
Arno Crous
Lisa Christine Marstrand Dahl
Lauren Jane De Koning
Alexandra Louise Drucker
Leonie Madeline Harold
Damian Joseph Graham Johnson
Kelly Anne Jones
Kirsten Sarah Long
Nicholas William Blake Lower
Andrei Melnik
Emma Louise Paxton
John Robert Elliott Pearson
Callum James Robinson
Danushka Tharindri Seneviratne
Bernard Liyang Shan
Meghan Kate Shaw
Andrew Seong Kiat Tan
Jin Sern Toh
Haipeng Wang

Western Australia

Susannah Maria Lyes
Kim James Maher
Rosalind Elizabeth Maris
Rebecca Francisca Ruth Wood
Jacob Daniel Woodward

NEW ZEALAND

Aliya Arslanova
Dhir Madhav Bhattacharya
Aislinn Sarah Brown
Rebecca Grace Buckley
Daniel Ching-Hsuan Chiou
Richard John Hanlon
Matthew James Barraclough Hill
Nicholas Ivan Instone
Dayle Andrew Keown
Suhyun Kim
Catherine Anne Liddle
Vernon Alexander McGeoch
Eilidh Gladys Menzies
Jessica Murphy
Varun Nanda
Chinmay Pandit
Thomas Kevin Macintosh Scott
Millie Settle
Vimu Matthews Sinhalage
Sean Smyth
Bhavan Srikumar
Peninatautele Maria Taimalelagi
Leo Taylor Urquhart
George Paterson Wallace
Kailun Wang
Katherine Joan Wauchop
Lewis Hamish Wixon

SIMG EXAMINATION

One candidate successfully completed the specialist international medical graduate examination:

Ahamed Lafir Aliyar, Tasmania

MERIT CERTIFICATES

Merit certificates were awarded to:

Varun Nanda, New Zealand
Chinmay Pandit, New Zealand

Image above: Court of Examiners for the final fellowship examination.

Cecil Gray Prize

The Court of Examiners recommended that the Cecil Gray Prize for the half year ended 31 December 2023 be awarded to:

Meghan Kate Shaw, Vic

"I am an ATY1 and lucky to have the privilege of training through the North West Training Scheme in Melbourne.

This year I have rotated through the Royal Melbourne (where I have done the majority of my training), the Royal Children's, and the Mercy Hospital for Women. I have been extremely well supported by each department and am very grateful to both formal and informal mentors and my supervisors of training.

At home, my wonderful husband Ben has been an amazing source of encouragement and practical support. It is great to have the exams behind me and I am enjoying spending more time with family and close friends"

No Cecil Gray Prize was awarded for the half year ended 30 June 2023.

Faculty of Pain Medicine

Faculty recognises benefits of locally focused advocacy

I would like to start by thanking Dr Irina Hollington and Dr Sharon Keripin for organising such a successful FPM Spring Meeting in Adelaide. The venue for the conference and the stunning location of Penfolds Estate for the conference dinner worked beautifully and with local presenters the structure and content ran perfectly.

One colleague called it the best FPM Spring Meeting they had attended. The work has already begun for the next meeting in Auckland in October 2024, but a high bar has been set.

We held the faculty's first regional forum at the meeting, an initiative from the chair of the Professional Standards Committee (PSC) to create an opportunity to discuss local issues and examine how the national and regional FPM committees interact and work with the FPM Board.

There was good discussion at the forum and we ran out of time long before we ran out of comments and discussion. There seems to be a general concern that in the public sector our colleagues are struggling with waiting times and the inability to grow services to match the demand – a situation common across both countries.

These issues can't be resolved in a *Bulletin* message but what we must do is ensure that our internal structures enable us to best advocate for better services across Australia and New Zealand.

Under our current structure, regional committees report to and sit on the PSC. The New Zealand National Committee reports to the FPM Board but also sits on PSC. The purpose of this arrangement was to give the regional committees input into professional standards and to create a reporting line that did not exist or function before.

Unfortunately, this has not worked out as we had hoped with the result that the PSC does not always reach quorum and local issues, if raised, are not resolved. As a result we are working to introduce a different process for 2024 which will involve a restructure of PSC that focuses more on professional standards and documents, with the regions all reporting to the FPM Board.

Each regional committee and the NZ National Committee will have a designated board member who will be responsible for working closely with the regional chairs to ensure that any local issues are brought before the FPM board/executive/dean/executive director as appropriate. We are also planning to have part of each board meeting dedicated to discussing regional issues and inviting the regional chairs to these discussions on a rotational basis.

These changes won't fix the challenges in our healthcare services, but the starting point is to ensure we hear what the issues are and to create locally focused advocacy.

The faculty has commenced a comprehensive review of its hospital accreditation processes which will continue into 2024. The review builds on work already done to strengthen our processes and will implement conditions set by the Australian Medical Council and Medical Council of New Zealand.

One of the aims for 2024 will be to introduce annual monitoring of units. This process will include data from the Training ePortfolio and will be designed in consultation with our accredited units.

The concepts we are considering involve separating quality service provision from the learning environment and creating professional standards to align with our accreditation standards. The creation of these professional standards will become the major focus of the reformed PSC with a focus on defining who we are and how we work.

I was part of an interesting discussion with our paediatric pain colleagues about how the faculty could support them. The key issues raised concerned paediatric pain and where it sits in the curriculum, setting professional/clinical care standards and considering how we can support the training of future specialists.

Spring is over and summer is now here. I hope you all stay safe.

Dr Kieran Davis
FPM Dean

2023 FPM fellowship examination

Twenty-seven candidates were invited to the oral section of the fellowship examination, following the written exam on 14 September. The viva voce examination was held at the Royal Melbourne Hospital on Saturday 11 November.

The faculty acknowledges the examiners' tremendous contribution in delivering the examination and the support offered by supervisors and fellows in preparing candidates.

A merit award was achieved by:

- Dr Jonathan Ramachenderan (WA)

The candidates who successfully completed the fellowship examination are listed below:

AUSTRALIA

Australian Capital Territory
Dr Richard Arnold
Dr Jayanti Gajra

New South Wales
Dr Chantelle Berenger
Dr Nazmeen Shameem
Dr Ben Tassie
Dr Michael Zhao

Queensland
Dr Nitin Chaudhary
Dr Larissa Cowley
Dr Emily Farrell
Dr Tina Moriarty

South Australia
Dr Meredith Daff
Dr Kin Lau
Dr Chong Han Lim

Victoria
Dr Rao Fu
Dr Sophia Grobler

Western Australia
Dr Yusuf Mamoojee
Dr Reshad Mirnour
Dr Jonathan Ramachenderan
Dr Charanya Sridharan

NEW ZEALAND

Dr Sebastian Ang
Dr David Boothman-Burrell
Dr Ashveer Dunpath
Dr Kushlin Higgie

HONG KONG

Dr Kin Ho Aaron Lee

NEW FELLOWS

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

- Dr Sibella Bentley, FRACP, FFPMANZCA (NSW)
- Dr Yuen Ting Vivian Cheung, FHKCA (Anaesthesiology), FFPMANZCA (Hong Kong)
- Dr Nathan Flint, FANZCA, FFPMANZCA (NSW)
- Dr Ashkan Khakpour Saebi, FAFRM (RACP), FFPMANZCA (NSW)
- Dr Christopher Turnbull, FRANZCP, FFPMANZCA (New Zealand)

We congratulate the following doctor on their admission to FPM fellowship through completion of the specialist international medical graduate (SIMG) pathway:

- Dr Kwun Tung Ng, FANZCA, FFPMANZCA (VIC)

Images from left: Merit award recipient Dr Jonathan Ramachenderan (right) with Chair of the Examinations Committee, Dr Charles Brooker.

Panel of examiners 2023

The deans from left: Dr Kieran Davis (current dean), Dr Milton Cohen AM, Associate Professor Mick Vagg, Dr Roger Goucke AM, Dr Penny Briscoe AM, Dr David Jones, Dr Chris Hayes and Associate Professor Brendan Moore.

25 YEARS
FACULTY OF PAIN MEDICINE
ANZCA

25-YEAR ANNIVERSARY

The Faculty of Pain Medicine's 25-year anniversary was celebrated in style at the 2023 Spring Meeting in Adelaide complemented by a celebratory dinner at Penfolds Magill Estate. Our trainees and new fellows were inspired by pain medicine trailblazers who created a world-leading medical specialty.

FPM fellows contributed to an online exhibition, available at the Geoffrey Kaye Museum of Anaesthetic History website, which focuses on four key themes: Beginnings, defining the specialty, impact and influence, and the future. Commemorative glassware specially designed by Mon Verre for the anniversary is still available for purchase.
Two oral histories from faculty foundation fellows have been released as part of the museum's FPM 25-year anniversary online exhibition. In these, Dr Gretel Davidson speaks with Dr Penelope Briscoe AM and Professor Pamela Macintyre about their careers in pain medicine and how FPM has evolved over the past 25 years. These bite-sized interviews provide an excellent insight into the profession as well as the impacts on patients and where the specialty is heading.

SPRING MEETING

2023 FPM Spring Meeting Co-convenors Dr Irina Hollington and Dr Sharon Keripin welcomed nearly 135 faculty members from Australia, New Zealand, and Hong Kong to Adelaide from 6-8 October 2023 for the meeting theme "From Silver Lining to Silver Anniversary". Delegates enjoyed a variety of sessions and enjoyed the networking and exchange of ideas.

The first female dean of the faculty, Dr Penny Briscoe AM opened the meeting by reflecting on the early days of pain medicine in Australia and how the faculty emerged almost accidentally, yet boldly, from a group of passionate doctors. She encouraged all fellows and trainees to engage in their faculty, expand their professional friendships, and be role models for the next generation, explaining "you get more out of it than you put in".

FPM Dean Dr Kieran Davis gave an overview of how much the faculty has achieved as an organisation and how it can be proud of its track record. The new fellow board member Dr Amrita Prasad set out an ambitious vision for the next 25 years.

The program covered diverse topics, with many delegates surprised at how some of the less traditional topics flowed on to contemporary clinical pain medicine practice. The highlights included sessions on the role of AI in chronic pain medicine, setting up an acute pain unit from scratch, how providing high-value chronic pain care can be a driver towards reducing costs in emergency departments and "Closing the gap" in First Nations people.

PROFESSIONAL DOCUMENTS

The pilot period for *PG13(PM) Guideline on return to pain medicine practice for specialist pain medicine physicians* (including its background paper *PG13 (PM) BP*) and *PS14 (PM) Statement on the responsibility for co-prescription of oral and intrathecal opioids* closed in October. The FPM Board approved the final versions of these documents, now available on the website.

We are seeking expressions of interest for FPM fellows to contribute to the development of three new professional documents:

- The role of telehealth in pain medicine practice (either position statement or clinical care standards).
- Defining the scope of practice of specialist pain medicine physicians (position statement).
- Clinical care standard for pain management programs

Contact fpm@anzca.edu.au to register your interest

INTRODUCING THE FPM RESEARCH NETWORK

The FPM Research Network (FPMRN) is an initiative of the FPM Research Committee. Inspired by the success of the ANZCA Clinical Trials Network, the purpose of the FPMRN is to enable fellows to contribute to the evidence base that guides safe and effective practice in pain medicine.

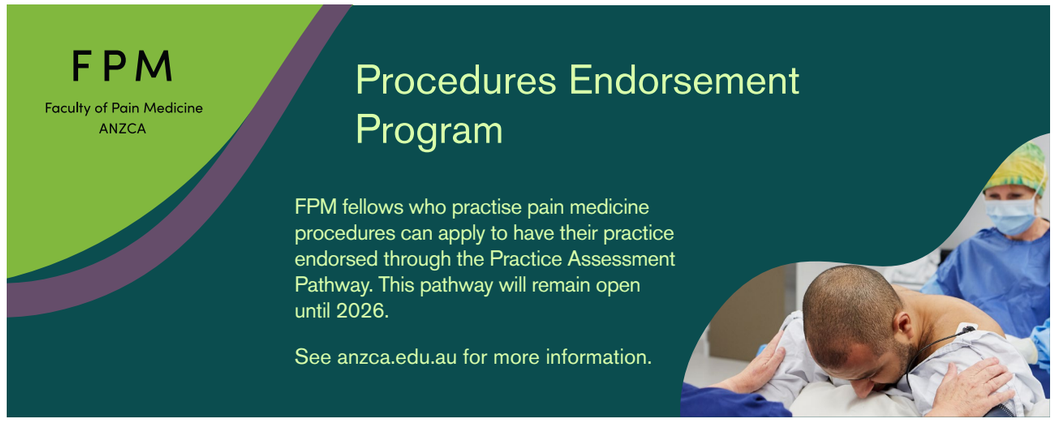
A leadership group was established in late 2021 to determine the feasibility of an FPM Research Network, and to develop a proposal to put to the FPM Board. Board approval was formally obtained in December 2022. A soft launch of the network was held at the 2022 FPM Spring Meeting.

The FPMRN Working Group (Professor Paul Glare, Dr Martine O'Neill, Professor Andrew Somogyi, Associate Professor Damien Finniss and Associate Professor Matt Doane) has been meeting every two months this year to finalise the governance of the FPM Research Network Leadership Group and progress the research action plan with online roundtables and research workshops. A series of webinars and FPM research workshops are planned for next year with workshops to be held at the 2024 ANZCA Annual Scientific Meeting in Brisbane and the 2024 FPM Spring Meeting in Auckland.

We now want fellows to get involved so we can increase our research capability by improving fellows' research knowledge and skills, especially for trainees and new fellows. The network will also increase its research capacity by raising awareness about pain research, identifying pain research priorities, and increasing infrastructure through grant writing success.

How will we know if the FPM Research Network is successful? We will measure fellowship engagement, confidence of fellows to undertake research, and standard research metrics, such as grants submitted, grants success, amounts awarded, publications (number, impact), presentations, implementation, policy, consumer involvement.

For information on the FPM Research Network Leadership Group please contact Paul Glare paul.glare@sydney.edu.au, or Nikki Frescos nfrescos@anzca.edu.au.



Hong Kong pain unit accreditation

Just as the super-typhoon Saola and phenomenal rainstorms wreaked havoc across Hong Kong, Dr Winnie Hong and Dr Melissa Viney arrived on the island to undertake pain unit accreditation visits of the four Hong Kong training units at the Pamela Youde Nethersole, United Christian, Queen Elizabeth and Queen Mary hospitals.

The reviewers were welcomed at a dinner before a busy week reviewing the training facilities and interviewing personnel involved in pain medicine training in Hong Kong. While the Hong Kong College of Anesthesiologists has its own Faculty of Pain Medicine, training and qualification in the ANZCA FPM program remains popular, with the faculty having 11 trainees in the program.

Despite a severe shortage of medical, nursing and allied healthcare staff across Hong Kong, the reviewers were impressed with the enthusiasm and commitment to excellence in patient care and training. Each of the hospitals offered novel opportunities for trainees in pain medicine.

The Pamela Youde Nethersole hospital has a chaplaincy program incorporated into the pain program and, both it and the United Christian Hospital, had Chinese medicine practices – variously Qigong and tai chi – delivered in their programs, in keeping with cultural beliefs.

The Queen Elizabeth Hospital has very impressive facilities including its own operating theatre and recovery room, based on those at the Sir Charles Gairdner Hospital in Perth, and a state-of-the-art, island-wide referral program for occupational therapy where virtual reality and 3D printing were integrated into patient care.

The pain management unit at the Queen Mary Hospital is a major academic centre associated with the Chinese University of Hong Kong. There is an active research facility where the reviewers were hosted and introduced to several of the PhD and student researchers.

At the end of the week, after visiting the research facilities, Dr Hong spoke to members of the pain community in Hong Kong about pain management for burns patients, and the reviewers were again hosted to a superb banquet meal.

Dr Melissa Viney, FANZCA, FFPMANZCA DPA (FPM Education)

From front left: Dr Melissa Viney and Dr Winnie Hong with the Queen Mary Hospital team.

Beyond medicine: A humbling exchange in Papua New Guinea

Dr Emma Panigas is a recipient of the 2023 ANZCA Global Development Committee Trainee Scholarship which supports final year ANZCA trainees to accompany a visiting team on an overseas clinical or educational/teaching visit. This is her account of her recent visit to Papua New Guinea.

Despite being Australia's closest neighbouring country, with mainlands separated by a mere 150 kilometres, I knew little about Papua New Guinea other than its reputation as a world-class scuba diving destination.

This started to change when, as a resident I spent a day in theatre with an anaesthetist passionate about global health, Dr Yasmin Endlich, where she regaled me with wild stories from her life-changing annual visits to the country.

These trips involved a combination of medical education, mentorship and support, while soaking in culture and making new friends (and of course a bit of diving). It ticked all my boxes; I had to go on one of these trips.

PNG HEALTH OVERVIEW

PNG has a population of about 12 million people, but as the largest Pacific country by land mass, more than 80 per cent live in rural villages scattered throughout the mainland's mountainous highlands and across more than 300 remote islands. This poses a multitude of issues that affect access to healthcare – huge geographical separation, lack of infrastructure, severe medical workforce shortages (there are only 602 doctors for the entire country), lack of resources with widespread shortages of drugs and consumables, and limited opportunities for training, education and upskilling.

According to the World Health Organization (WHO), the current life expectancy at birth is almost 20 years lower than Australia at 65.4 years, and for every 1000 births in PNG as many as nine mothers and 24 newborn babies die.

There are 33 specialist anaesthetists and 27 trainees working across nine of the provincial hospitals. The remaining provincial and district hospitals are staffed by anaesthetic scientific officers (ASOs), who have completed a one year course at the University of PNG and provide more than 90 per cent of all anaesthesia in the country. They also run their hospital's intensive care unit.

PURPOSE OF THE TRIP

Nearly seven years after that day in theatre, in my final year of anaesthesia training, I was incredibly fortunate to have been granted the ANZCA Global Development Committee Trainee Scholarship to help fund my trip to PNG. I joined Dr Endlich, Dr Christine Huxtable, Dr Jessica Lim and medical student Sarah Endlich for the Society of Anaesthetists of PNG 36th Annual Scientific Meeting (SAPNG ASM) in Port Moresby in early September.

Our trip was initially planned for Kimbe in West New Britain province to attend both the SAPNG ASM and the 57th Annual Medical Symposium, however due to significant tribal conflict, the conferences had to be moved to Port Moresby. The new dates for the medical symposium unfortunately clashed with our travel schedule, and while we were very disappointed to miss it, it highlighted the flexibility, perseverance and dedication to education shown by the medical workforce of PNG.

The theme for this year's SAPNG ASM was "Cancer – The role of the anaesthetist and intensivist." This was particularly topical as improving cancer outcomes is one of the objectives of the PNG National Health Plan for 2021-2030. Conference convenor Dr Michelle Masta, PNG specialist anaesthetist, invited us to each give a presentation, and having recently completed my airway fellowship at the Royal Adelaide Hospital, I discussed "The impact of radiotherapy for head and neck cancer on the airway."

The cultural practice of chewing betel nut has resulted in PNG having the world's highest rate of oral cancer, which, due to a lack of accessible treatment coupled with late presentation, is a source of significant morbidity and mortality. PNG has had limited and unreliable access to radiotherapy over the years, with the last treatment given in 2017, however this will soon change with the construction of a new national cancer centre in Port Moresby.

From left: Dr Yasmin Endlich, Dr Emma Panigas and Dr Sarah Endlich.

Over the course of the conference, we instructed workshops on difficult airway, regional anaesthesia, basic life support and advanced life support and pain management. These workshops were very kindly supported by Storz, represented by PNG veteran Jayne Thompson, who provided CMAC and fibreoptic scopes, and Sonosite, who provided ultrasound machines. These workshops were greatly appreciated and provided a unique opportunity to collaborate, share experiences and form new friendships.

MY EXPERIENCE

While the purpose of the trip was to support the SAPNG through medical education and sharing my own experience, I learnt just as much from the PNG anaesthetists and ASOs. It was unbelievably sobering to hear their audit data and stories about the realities of day-to-day life in PNG. Equally, I was moved by the resilience and dedication of this small group of anaesthetists and ASOs who work extremely hard each day to improve their conditions and creatively overcome a multitude of barriers to provide care to their patients. One anaesthetist cheerfully recounted a story where she and her team recently went by small boat to a remote island to perform life-saving surgery on a patient in the moonlight under a tree where, among her already challenging anaesthetic duties, she also had to drive the foot-pump for the surgical suction!

They seek out every available training and education opportunity, which was evident in their skills and knowledge in managing some truly astonishing cases with such limited resources (imagine successfully anaesthetising an infant with unquantified cyanotic heart disease for emergency surgery without a working blood pressure cuff). It was particularly noticeable how supportive and encouraging they were to their trainees, and the atmosphere at the conference was incredibly collegiate. There was a clear mutual respect and recognition of the contribution of each person to the health service, as well as an admirable humility – often attributing their successes to God rather than their own skill and bravery.

MY REFLECTIONS

I have gained a greater awareness of health inequalities in low- and middle-income countries, as well as a deeper understanding of the nuances, complexities, and barriers to improving global access to healthcare through foreign medical aid. A lack of robust medical record-keeping hinders the ability to perform research and audits to improve care and guide resource allocation. The massive cultural diversity, with more than 800 distinct languages and 1000 ethnic groups each with strongly embedded cultural belief systems, inhibits healthcare unification, and a typically colonial "one-size-fits-all" model doesn't work. Unreliable access to basic needs such as water, roads and electricity, creates obstacles both for people trying to access healthcare and for those trying to provide it. Constant exposure to danger from tribal warfare, natural disasters and communicable diseases hampers the efforts of those who provide healthcare and try to make meaningful change in an already vulnerable country.

Tackling these many challenges every day, this small group of anaesthetists, ASOs and other health workers use resourcefulness, dedication and resilience to drive the advancement of anaesthesia in PNG. Witnessing their extraordinary clinical skill, optimism in the face of great adversity, and continued commitment to their patients has left me deeply inspired.

I am so grateful for the experience, opportunities and new friends that this visit to PNG has provided. We're already planning the next trip where we hope to continue to collaborate to provide ongoing support and expansion of these programs into the future. Plus, I still need to go for that dive...

Dr Emma Panigas
Anaesthesia trainee, South Australia

ANAESTHESIA EXAMS IN PNG

Exams for the Higher Postgraduate Diploma of Paediatric and Obstetric Anaesthesiology were held at the School of Medicine and Health Sciences (*SMHS*) at the University of Papua New Guinea (UPNG) and Port Moresby General Hospital (PMGH).

Writtens (short answer questions and multiple choice questions) were held on 9 and 10 November and vivas, short and long cases were held on 13-14 November. Dr Yasmin Endlich (Adelaide), Dr Anna Loughnan (Melbourne) and Dr Michael Cooper (Sydney) were the external examiners as required by UPNG.

It has been 10 years since the first higher postgraduate diploma in anaesthesiology was awarded in PNG to Dr Arvin Karu (cardiothoracic anaesthesia).

These higher postgraduate diplomas in medicine are quite unique to PNG and do not exist in Australia or New Zealand. These subspecialist qualifications are incredibly valuable in a resource poor country and the successful candidates become a valuable national resource in that subspecialty. They provide guidance and advice for difficult cases around the country, training of future specialists, recommendations for advanced care of patients and work clinically at the level 7 National Referral Hospital (Port Moresby General Hospital) in the capital.

Two candidates sat and passed the Higher Postgraduate Diploma in Paediatric Anaesthesia – **Dr Pauline Wake and Dr Keno Temo.**

One candidate sat and passed the Higher Postgraduate Diploma in Obstetric Anaesthesia – **Dr Lisa Akelisi-Yockopua.**

Two of the candidates have been the first PNG anaesthetists to hold World Federation of Societies of Anesthesiologists (WFSA) fellowships: Dr Wake Dr Wake undertook paediatric anaesthesia in Vellore, India and Dr Akelisi-Yockopua undertook obstetric anaesthesia in Kuala Lumpur.

Dr Michael Cooper, AM, FANZCA
Adjunct Professor of Anaesthesiology, SMHS, UPNG

The examiners and candidates. From left: Dr Michelle Masta (facilitator SMHS), Dr Lisa Akelisi-Yockopua, Dr Yasmin Endlich, Associate Professor Michael Cooper, Dr Anna Loughnan, Dr Pauline Wake and Dr Keno Temo.

Health equity projects fund

The ANZCA Health Equity Projects Fund supports college activities in global development, Indigenous health and other health equity priorities.

It is a competitive grant process open to all ANZCA and FPM fellows, for projects that support the aims and activities of the Indigenous Health Committee, Global Development Committee and other health equity priorities of the college.

2024 RECIPIENTS

Dr Mark Trembath, Brisbane
Management of Anaesthetic Crises in Papua New Guinea: Simulation Based Crises Resource Management
Deliver crises resource management training in the mould of Effective Management of Anaesthetic Crises (EMAC) (modified to local requirements) to anaesthesia trainees and anaesthesia assistants at Port Moresby General Hospital over two to three days.

Dr Nilru Vitharana, Sydney
Pacific Paediatric Anaesthesia In-situ Teams Course – Pacific PAINTS: Timor-Leste
Deliver the Pacific Paediatric Anaesthesia In-situ Teams Course (Pacific PAINTS) – a half-day course that covers the principles of resuscitation and management of the critically unwell child and common anaesthetic emergencies in a simulated environment, in Timor-Leste

Dr Megan Walmsley, Darwin
Anaesthesia registrar teaching and anaesthesia consultant upskilling in Timor-Leste
Provide educational support for the anaesthesia consultants and registrars in Timor-Leste. The educational format will be tutorials, case discussion and simulations. The Timorese anaesthesia team have requested topics focusing on anaesthesia crisis management.

Dr Megan Walmsley, Darwin
Anaesthesia registrar teaching and clinical supervision in Samoa
Provide two weeks of in person academic support for the MMED anaesthesia program (catch up tutorials, exam preparation, work based assessments such as mini-clinical evaluation exercises and direct observation of practical skills) and in-theatre clinical supervision for two trainees completing their Fiji National University MMED training in Samoa.

Dr Adam Mossenson, Perth
Vital Anaesthesia Simulation Training (VAST) implementation in Mongolia
Offer the VAST facilitator course to six to eight Mongolian anaesthesia leads who have demonstrated interest in medical education and who are conversant in English. They will be mentored in applying these skills in a subsequent abbreviated VAST Course for multi-disciplinary healthcare providers. Following training, translation of VAST materials into Mongolian will commence. We also plan to offer VAST Wellbeing, a one-day program to improve wellbeing and reduce burnout for healthcare providers in low-resource settings.

Dr Moira Rush, Melbourne
Building Pain Management Capacity Across the Pacific Region
Support for an additional anaesthetist to join Interplast plastic and reconstructive surgical and training programs to Samoa, Kiribati and the Solomon Islands to deliver pain management training to local anaesthetic and nursing personnel in each country.

Dr Shaktivel Palanivel, Ballarat
Interplast Indonesia Anaesthetic Training Placement
Two Indonesian anaesthetists from the Dr Soetomo Hospital in Surabaya to undertake a four week observational placement at Ballarat Base Hospital at the Royal Children's Hospital, and attend the ANZCA Annual Scientific Meeting.

Dr Arihia Waaka, Rotorua
Trust questionnaire
Research to gauge the trust that patients have in the health system, Māori compared to non- Māori. It is hypothesised that Māori will have a low trust in the health system, and that non- Māori will have a much higher trust in the health system.

Dr Tanya Farrell, Perth
Promoting advancement, coaching and empowerment for gender equity in anaesthesia and pain medicine (PACE-GAPM).
Establish the research component of the Australian and New Zealand Women's Empowerment and Leadership Initiative (WELI) program, particularly the baseline survey, by building a REDCap database and linkage from the website.

From left: Dr Shyamal Narayan (registrar), Dr Raymond Vuniwa (consultant), and Dr Lisepa Daulako (head of department and president of the Pacific Society of Anaesthetists) participate in the Pacific PAINTs Course held at Lautoka Hospital, Fiji in August 2023. The course was facilitated by FANZCA Dr Sally Wharton (far right, of the Children's Hospital at Westmead) alongside Dr Karthik Mudliar (anaesthesia consultant, Lautoka Hospital) who took this photo.

Library news

REVAMPED JOURNALS PAGE

Did you know that the library subscribes to more than 1100 full-text journals? Or that you can access our entire journal collection on your mobile device and tablet using our BrowZine app? Or that our dedicated journals page provides access to all our key medical, anaesthesia, pain medicine, intensive care, emergency medicine, and medical education journals.

If so, you may have noticed the Journals page getting a little cluttered of late as the number of listed titles expanded.

In an effort to make the page easier to navigate, we've redesigned it with collapsible sections to allow for quicker navigation between journal group listings. With the touch of a button, you can then "toggle" open the desired group and access your preferred journal.

The changes have been optimised for mobile and tablet access and should significantly reduce the amount of scrolling required to access your preferred journals.

NEW ZEALAND RESOURCES UPDATE

The ANZCA Library Manager recently attended the 2023 New Zealand National Committee (NZNC) meeting held in Dunedin to report on the progress on updates to resourcing for NZ-based trainees and fellows in the past 12 months:

- Twenty-two new books have been added to the NZ collection (20 of which were trainee-related titles).
- Includes *ANZCA Primary Exam Companion, Essential Pharmacology for the ANZCA Primary Exam* and *West's Respiratory Physiology: The Essentials, 11e*.
- NZ physical loans have risen 300 per cent – three quarters of which were loans to trainees.
- The new Anaesthesia Training Resources guide – which received key support from the NZTC following the 2022 NZNC meeting – has recently become the college's most-used resource guide, amassing 7000+ views since its launch in June 2023.

ACE ANAESTHESIA CONTINUING EDUCATION

UPDATED SIG-RELATED LIBRARY GUIDES

Did you know that ANZCA library maintains library guides for all the Anaesthesia Continuing Education (ACE) Special Interest Groups (SIGs)? These guides even have their own "hub" and can be accessed using the following link: https://libguides.anzca.edu.au/sig-hub.

The library is currently in the midst of revamping the content of these guides, working directly with representatives from the SIG committees. Content changes include new articles, books, podcasts, multimedia, website links and other applicable resources. Our most recently updated guides include:

- Diving & hyperbaric medicine
- History of anaesthesia
- Intensive care medicine
- Leadership and management

We've also updated our ENT, head & neck (renamed from ENT) guide, significantly expanding its scope and content. Check out the complete list of guides available on our library guides home page.

LATEST AUDIODIGEST PODCASTS

Need a way to keep up-to-date on the run? AudioDigest provides instant online and mobile access to 260+ accredited anaesthesiology, pain medicine and critical care audio lectures presented by experts from leading institutions, bringing clinicians a convenient continuing medical education (CME/CE) experience. Each lecture includes objectives, pre-test Q&A, summary and readings, post-test Q&A, evaluation. **Free registration required.**

The newest lectures include:

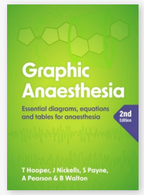
- Hot Button Topics in Trauma Anesthesiology (14 Dec 2023).
- Perioperative Anesthetic Implications for the Care of an Aging Adult (7 Dec 2023).
- Pain Management for Patients with Cancer (21 Nov 2023).
- Acquired Coagulation Defects and How to Manage Them (21 Nov 2023).
- Perioperative Nerve Injury During Regional and Neuraxial Anesthesia (14 Nov 2023).
- The Choice of Anesthetic Technique and Effects on Cancer Outcomes (14 Nov 2023).

Latest books

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

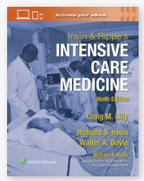
NEW TRAINING BOOKS

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

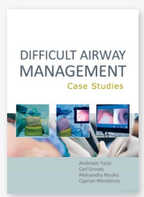


Graphic anaesthesia: Essential diagrams, equations and tables for anaesthesia, 2e
Hooper T, Nickells J, Payne S, Pearson A, Walton B.. Banbury: Scion Publishing, 2023.

Anesthesia oral board review: knocking out the boards, 2e
Lovich-Sapola JA, ed. Cambridge, United Kingdom; New York, NY: Cambridge University Press, 2023.



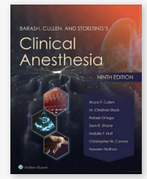
Irwin & Rippe's Intensive Care Medicine, 9e
Lilly CM, Kelly WF, Irwin RS, Boyle WA [eds]. Philadelphia, PA: Lippincott Williams & Wilkins, [2024].



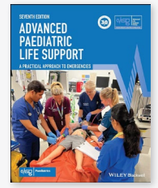
Difficult Airway Management: Case Studies
Yasin A, Groves C, Reszka A, Mendonca C. United Kingdom: TFM Publishing Limited, 2023.

NEW BOOKS FOR LOAN

Books can be requested via the ANZCA Library discovery service: https://libguides.anzca.edu.au/borrowing



Barash, Cullen, and Stoelting's Clinical Anesthesia, 9e
Cullen BF [ed]. Philadelphia, PA: Wolters Kluwer, [2024].

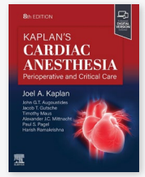


Advanced Paediatric Life Support: A Practical Approach to Emergencies, 7e
Smith S [ed]. Hoboken, NJ: John Wiley & Sons, 2023.

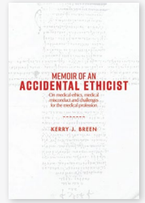
Safety As We Watch: Anaesthesia in Ireland 1847-1998
Warde D, Tracey J, Cahill J. Dublin, Ireland: Eastwood Books, 2022.

Letters from Spring Street: "24 Years of Surgical Recollections"; Short Stories of Surgical Interest Covering Events and Personalities in the Surgical Domain.
Behan F. Canberra, ACT: National Library of Australia; 2023.
Kindly donated by the author.

NEW EBOOKS



Kaplan's Cardiac Anesthesia: Perioperative and Critical Care, 8e
Kaplan JA, Augoustides JGT, Gutsche JT, Maus T, Mittnacht AJC, Pagel PS, Ramakrishna H [eds]. Philadelphia, PA: Elsevier, [2024].



Memoir of an Accidental Ethicist On Medical Ethics, Medical Misconduct and Challenges for the Medical Profession
Breen KJ. Melbourne: Australian Scholarly Publishing Pty Ltd, 2018.

Quick Hits for Pediatric Emergency Medicine, 2e
Zeretzke-Bien CM, Swan TB [eds]. Cham, Switzerland: Springer; 2023.

Remediation in Medical Education: A Mid-Course Correction, 2e
Kalet A, Chou CL. Cham: Springer International Publishing; 2023. doi:10.1007/978-3-031-32404-8

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Patricia Margaret Coyle RSCJ AO

1929 – 2023

In early October Patricia Coyle died in the Mount St Joseph's Home at Randwick after a prolonged period of ill health. She was born in Sydney as the only daughter, with two younger brothers, to Charles Coyle and Hazel (née Bayliss) on 27 October 1929, and died just before her 96th birthday.

Patricia left school at 15 for office work at a dairy food manufacturer with evening study (accounting and comptometry) transferring after two years to laboratory work with the same employer, then after a further three years she transferred to Royal North Shore Hospital Laboratories. In 1952 she matriculated and enrolled at university having studied privately while working as a laboratory technician.

Patricia was admitted to Sydney University medical school, living in Sancta Sophia College, and graduated BSc (Med) Hons 1959 and MBBS 1960. She completed her Internship at Royal Prince Alfred Hospital (RPAH), and in 1961 she entered the Society of the Sacred Heart of Jesus, professing in Rome on 2 July 1969. Patricia never spoke about what had motivated her to enter the society and avoided any queries on the topic. At that time it was not possible in the society to practise medicine so Patricia began teaching in secondary schools (Rose Bay, Sydney and Baradene College, Auckland).

In 1969-70 Patricia studied for her Diploma of Pastoral Theology at the University of Montreal, Canada. Her religious society suggested that she train as an anaesthetist to enable her to carry out missionary medical work in Africa for the society. This specialisation occurred in Auckland and Sydney (FFARACS 1978). Following 18 months staff specialist experience, mainly in intensive care at Lidcombe Hospital, she completed a six-month course for the DipTropMed (School of Tropical Medicine, Antwerp, Belgium) in 1981, and moved to Kampala, Uganda, as consultant anaesthetist for Mission Hospitals (1983-84) and later, senior lecturer in anaesthesia at Makerere University (1985-89) where she established the Diploma of Anaesthesia and degree of Master of Medicine (Anaesthetics).

Much of her time in Kampala was during the Ugandan Bush War (1980-86). When the postgraduate degrees were established Patricia retired, leaving the first graduates she had trained in charge of anaesthesia. In 1992, after a refresher year in anaesthetics at Concord Hospital in Sydney, she spent a year as Associate Professor at the Addis Ababa University, Ethiopia. This was the first year following the Ethiopian Civil War of 1974-91 and Ethiopia was still relatively unstable.

Patricia considered that she was not able to improve either the teaching or clinical activities and left Addis Ababa after the year. More missionary work followed in 1992-93 at Red Cross hospitals on the Thai-Cambodian border (Khao-I-Dang) and in Quetta, Pakistan, before she returned to Sydney in 1994. Later, she worked as a part-time medical officer in emergency medicine at RPAH, Balmain and Sydney hospitals. In 1997 she returned to northern Uganda for a six-month term as an anaesthetist, and later a brief cameo as a Médecins Sans Frontières anaesthetist in East Timor (November 1999 to January 2000).

She had been elected an Anaesthetic Consultant Emerita to RPAH in August 1995. During her "retirement years" she made return visits to lecture and run courses in anaesthesia in Kampala and Nairobi, where she was revered for her excellent teaching and her expertise in paediatric and obstetric anaesthesia particularly in relatively primitive conditions.

Following her experience of wars in both Africa and Asia Patricia became a passionate opponent of land mines, joining the Campaign to Ban Landmines (CBL), as she had seen all too often the appalling destruction the mines had inflicted, often on innocent civilians. During her debilitating final illness when she knew she was failing she arranged for a trusted friend to take on her passionate support of CBL and opposition to land mines.

Patricia's experience in Africa made her an expert in Third World anaesthesia for which she was recognised by the Association of Anaesthetists of Great Britain and Ireland with the Pask Certificate of Honour (1984), and fellowship of the Faculty of Anaesthetists of the Royal College of Surgeons (FFARCS) by election (1988) which later became fellowship of the Royal College of Anaesthetists (FRCA). She also became an editor for the World Federation of Societies of Anesthesiologists' (WFSA) electronic publishing.

Patricia was an extremely humble person who never pushed herself forward, and often had to be coaxed to contribute her experience to clinical discussions, which were invariably succinct and completely relevant contributions. Her faith was a major sustaining joy but she never evangelised, though she was always very pleased and happy to discuss her faith and how it might help others in difficult situations.

Sadly, her last years were marred by dementia. She will be remembered by all who knew her professionally as an excellent anaesthetist who devoted much of her professional life to missionary and anaesthetic work in the developing world.

In the 2001 Australian Queen's Birthday Honours Patricia was awarded an Officer of the Order of Australia (AO) for service to the community, particularly humanitarian aid overseas, as a medical practitioner in the field of anaesthesia, and through the Catholic Church.

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

Dr Sandra Taylor, FANZCA
Retired consultant anaesthetist
Armidale, NSW

Reference

1. Coyle P. Anaesthesia in the Developing World. *Australasian Anaesthesia*. Ed J Keneally ANZCA: Melbourne 1994; 201-204.

Image courtesy of Kincoppal-Rose Bay School of the Sacred Heart, Sydney

David Henry McConnel OAM

1939 – 2023

Dr David McConnel, a former president of the Australian Society of Anaesthetists (ASA) and former board member of the Faculty of Anaesthetists, Royal Australasian College of Surgeons, (FARACS) and former ANZCA councillor, died recently in Brisbane on 4 November.

David was a well-known and popular anaesthetist who had contributed greatly to his specialty and to professional medical organisations during his active life in Brisbane. Over the past few years his activities had been restricted by increasing mobility issues following two major spinal operations, generalised osteoarthritis and cardiac conditions. He experienced a short and rapid decline in his health in the last few weeks of his life.

David and his younger brother, Frederick Baron McConnel (also a medical graduate), were the sons of Frederick Jordan McConnel and his second wife Thelma (née Rand). David was born in Toowoomba on 22 April 1939.

David attended Bulimba, Dutton Park and Junction Park state schools and Brisbane State High School. He graduated MBBS from the University of Queensland in April 1963. Following graduation he was a resident medical officer at Cairns Base Hospital for three years where he met Cecil Dixon who inspired him to become an anaesthetist.

David met his wife Audrey (née Edwards) at a wedding in 1960. They didn't see each other again until 1962 when David was a final year student at the Princess Alexandra Hospital where Audrey was a surgical registrar. David was appointed to the Cairns Base Hospital as a resident in 1963. They married in Brisbane in July 1964. In January 1965, Audrey was invited to take the position of surgical registrar at Cairns Base Hospital completing her training under Superintendent Dr Ivan Lester. They returned to Brisbane so David could train in anaesthesia at the Royal Brisbane Hospital (1966-67).

In January 1968, David and Audrey travelled to the UK during which time David obtained his fellowship of the Faculty of Anaesthesia, Royal College of Surgeons (FFARCS) at the London Hospital. After leaving London, he took a position as staff specialist at the Groote Schuur Hospital, Cape Town, before returning to Brisbane in 1970 and into private practice with the Narcosia Anaesthetic Group. He was elected to fellowship of FARACS and commenced visiting specialist positions at the Brisbane Children's Hospital (1970-74), the Royal Brisbane Hospital (1970-2004 as anaesthetist – Jamieson Neurosurgical Unit), and later the Princess Alexandra Hospital (1995-2004).

His contributions to teaching were recognised in 1994 when he was appointed as a clinical associate professor in the Department of Surgery, The University of Queensland. David retired from clinical practice in 2013.

In 1974 David began his long involvement with the FARACS and later ANZCA when he was elected to the Queensland Regional Committee. Over the years he was Continuing Education Officer (1975-80) and chair of the Regional Committee (1980-83), a panel of examiners member (1976-88) and chair (1986-88), chair of the Workforce Committee (1992-96), and on many other committees. He was a board member and councillor (1984-96) where he was on the Council Committee which designed ANZCA's Coat of Arms.

He was also heavily involved with the Australian Society of Anaesthetists (ASA) as a member from 1967, Queensland chair (1975-77), federal executive (1975-82) and federal president (1978-80). His presidential address was published in 1981[1].

David devoted much time to other medical professional organisations. He was a long-time member of Queensland's medical defence organisations in their various iterations from Medical Protection Society through to Avant, particularly as a member of their cases committees from 1984-2013, and as a director of UMP/Avant (2003-10). He was made a life member of the Medico-Legal Society of Queensland for his contributions as secretary (1984-86), vice-president (1987-90) and president (1990-92).

David was flamboyant and always most elegantly attired with large silk pocket handkerchiefs adding the finishing touch to his tailored suit coats. He loved good food, wine and conversation. Audrey and David shared a love of fine art and opera – paintings, ceramics and sculptures adorn their home – with a collection of Australian art that spans across their 59 years of marriage. David was a keen double bass player first while at university, on occasion playing with the well-known Varsity Five and often played jazz at college and ASA meetings.

In June 2003 David was awarded both an ANZCA Citation and the ANZCA Medal. He was awarded the Medal of the Order of Australia (OAM) in the 2012 Queen's Birthday Honours with a citation for "service to medicine, particularly as an anaesthetist, through a range of executive and professional roles" .

David is survived by Audrey, his brother Fred (and his family), his three children Anthony, Pip and Victoria, his daughter-in-law Anka, son-in-law Chris and his grandchildren, Phoebe, Henry and Alex to whom we send our sincere condolences.

We shall all miss David's infectious zest for life. He stood tall – larger than life.

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

Dr Peter Livingstone OAM
Retired consultant anaesthetist
Brisbane
Inaugural president, ANZCA

**Acknowledgement to the McConnel family for aspects of this obituary.*

Reference:

1. McConnel DH. ASA Presidential Address 1980 – The Queensland Presidents. *Anaesthesia & Intensive Care* 1981; 9: 70-75

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