



ANZCA
FPM

Bulletin

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

SPRING 2021

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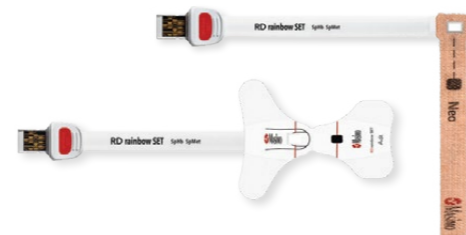


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Get ready for National Anaesthesia Day!



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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Cover: Dr Matthew Drake took on the first full hospital changeover to the new standard neural connectors in Australasia. He brings us a "how-to 101" in this edition.

Photo credit : Dr Grace Chang FANZCA.

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Important leadership e-vote coming

with the Australian Institute of Company Directors, and other learning opportunities that equip councillors to govern such a complex organisation. This long-term investment in its people is a key reason why ANZCA is a professional, measured and reliable organisation, whose advice is respected and valued. As a result, it is influential with decision-makers at all levels.

The normal pathway to the presidency is a planned progression. The council elects the vice-president with the expectation that, subject to performance, that person will become the next president. If the first year goes well, the council will designate the vice-president as the president-elect, to take office at the end of the next AGM.

At this point, there is a vulnerability. A good succession plan for the presidency can be derailed, because the three-year election cycle for councillors and the two-year election cycle for presidents are not aligned with each other. Each councillor's anniversary year for re-election is determined by the year in which they were first elected to the council.

This means that only a councillor re-elected to the council at the same time as being designated president-elect would be secure in office until they had completed the allowable two years as president. Thus a one-year-in-three candidate has a much smoother pathway to the presidency than candidates due for re-election to the council in the other two years of the council's three-year election cycle. That is capricious.

One possible response to the problem is simply, "Let democracy take its course." However, that would fail to acknowledge another important consideration: How attractive is the office of president of ANZCA?

All presidents that I have known have made large sacrifices of income, and have irreversibly rearranged their professional and personal lives, in order to carry out the duties of the president of ANZCA. It is a tribute to their commitment and to the standing of ANZCA that they have been willing to do so. It would be no surprise, however, if good candidates were discouraged by the insecurity caused by this anomaly.

So far, no sitting president or president-elect has lost office as a councillor. Nevertheless, the potential exists, and it would be destabilising if it were to occur.

A RELATIVELY MINOR amendment to the ANZCA constitution will go up for an e-vote by the fellows in the next few weeks. At the risk of causing eyes to glaze over, here is a brief explanation of the reason for it.

ANZCA's fellows elect the councillors. The councillors elect from their ranks the president and vice-president. This is consistent with the principle that an organisation's formal structure should follow the informal flow of information within the organisation¹. The fellows have the local knowledge to inform their opinions of candidates in the states, the territories and in Aotearoa New Zealand. From working closely together in the council and in committees, councillors have the best vantage point from which to inform their opinions about each other's potential for leadership.

For the refreshment of the organisation, each president's time in office is limited to two years – two terms of a year each. Each councillor's time on the council is limited to 12 years – a maximum of four terms of three years each.

This structure provides a good framework for the collective development of the governance qualifications, skills and experience necessary to run the organisation. It also provides a good framework for the continuing task of succession planning.

ANZCA invests in high-quality training and development for its councillors, including the week-long company directors' course

There is no perfect solution but, after carefully examining the alternatives, and after considering legal advice, the council supports the recommended constitutional change as the best way to address the problem. It takes the long view, while incurring little or no risk for the organisation.

The council recommends an amendment that postpones the council re-election date for a sitting president-elect and a sitting president, until after their completion of the allowable two-year term as president. This leaves in place an important check, in the unlikely event of manifestly inadequate performance or (in the worst scenario) bad conduct on the part of a president-elect or president; the council still has the power annually to elect, or not to elect, that person as an office-holder.

A failure to win election by the council as an office-holder would immediately return that person to the three-year election cycle for council membership, and to the judgement of the fellows. The amendment does not extend the maximum number of years that someone can serve on the council. That remains at 12.

The amendment therefore overcomes an anomaly, while adequately safeguarding the best interests of ANZCA and its fellows.

The council recommends the amendment for your approval.

Dr Vanessa Beavis
ANZCA President

1. See, for example, Henry Mintzberg, *The Structuring of Organisations: A Synthesis of Research*, (Prentice-Hall 1979).

“So far, no sitting president or president-elect has lost office as a councillor. Nevertheless, the potential exists, and it would be destabilising if it were to occur.”

Free ANZCA Doctors' Support Program

How to make an appointment:

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

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



HELP IS ALSO AVAILABLE VIA THE Doctors' Health Advisory Service:

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

Managing for the future



RIGHT NOW OUR senior leaders are working with the finance team to finalise our budget for 2022, and it's proving to be quite a challenge in these uncharted times.

In October, the budget will be presented by ANZCA Honorary Treasurer Dr Chris Cokis to our Finance, Audit and Risk Management Committee, chaired by experienced financial advisor to the college, Richard Garvey. It will then be presented to ANZCA Council and the FPM Board for their review and approval.

It is no secret that the past 18 months have been tumultuous from a financial perspective.

The pandemic created great uncertainty and in 2020 senior management worked hard to reduce costs. Major projects, such as the development of a diploma in perioperative medicine, were put on hold, events were cancelled or transferred online, we held off on allocating research grants and travel halted.

There were real concerns that we would be forced to stand down staff but fortunately we were eligible for the Australian government's JobKeeper subsidy for not-for-profit organisations whose revenue dropped at least 15 per cent. Ours dropped by nearly 20 per cent (when government grants were excluded) and we had independent external auditors review our application to ensure compliance with the Federal government guidelines.

Thankfully we were able to retain our staff – mostly working from home – during these very different times so that they could support our fellows and trainees as they focused on their critical roles as frontline clinicians in hospitals.

Our staff supported the quickly formed COVID-19 Clinical Expert Advisory Group which oversaw the development of personal protective equipment (PPE) guidance and curated evidence-based resources in our library.

We ramped up our communications, providing our fellows and trainees with regular, informed updates on the website, via

email and in our publications, and spoke with key government representatives on issues including PPE, fit testing, telehealth and vaccinations.

Senior management worked hard to reduce costs where possible, while at the same time adapting how we normally went about things. The ANZCA Annual Scientific Meeting (ASM), cancelled in 2020, became a virtual event in 2021 along with most of our other educational events in 2020 and 2021.

Our exams staff worked hard amidst ever-changing travel restrictions to hold written exams in a multitude of new locations, sometimes within hospitals because trainees were in locked down areas. This certainly created a huge amount of logistical work but the team pulled it off successfully.

Our 2020 vivas, normally held face-to-face with examiners in either Melbourne (primary candidates) or Sydney (final candidates) had to be held at multiple venues across Australia and New Zealand.

Depending on examiner numbers in each area, some vivas were held face-to-face, some only online and some a hybrid model, adapting to what has unfortunately had to become the new normal. An enormous number of hours were spent by our exams and IT staff and fellows ensuring fair exams could be held using reliable technology while, maintaining the high level of integrity expected of our ANZCA Training Program.

When we came up for air at the end of the year, we were pleased to see a significant unexpected surplus for 2020. This result was boosted by a better-than-expected return on our investments, government grants associated with the FPM Better Pain Management Program and JobKeeper.

While other colleges increased fees for fellows and trainees, we were able to freeze ours in 2020 and 2021, and no increases are planned for 2022.

However, our financial experts have advised us not to bask in the surplus result for too long. The reduction in operating expenditure is only temporary with many of our costs, such as project expenditure and research grants, deferred. We expect 2022 to be a challenging one.

Travel and events are expected to slowly build again, and we hope we will be face-to-face in Perth for our ASM and its satellite events, including the popular Emerging Leaders Conference at Sandalford Estate in the Swan Valley (please see page 82).

There have also been significant additional costs that will flow into 2022 associated with the challenges of maintaining the training program and resuming many other activities and capital projects to strengthen ANZCA's education offerings.

However, I am confident we can continue to manage our assets and resources prudently as we face the ongoing challenges ahead to support our fellows and trainees.

Nigel Fidgeon
ANZCA Chief Executive Officer

Letter to the editor

BREAST SURGERY ISSUE

Like every other anaesthetist, and many other health professionals, I am commonly confronted with the issue of breast surgery patients, without lymphoedema, requesting me to use the contralateral arm, from their previous breast surgery for all invasive procedures such as cannulation or for blood pressure measurement.

The veins on the contralateral arm have often been used for chemotherapy and repeated cannulations, rendering them more difficult to use. But the patients have been indoctrinated in the sacred arm dogma, despite them not having lymphoedema in the arm, and are commonly militant with this viewpoint.

As far as I'm aware there is no evidence published, that in the absence of lymphoedema, that cannulation or blood pressure measurement on the ipsilateral arm has any relevance to developing subsequent lymphoedema.

However, there is much in the literature to refute this unsubstantiated contention. This myth is perpetuated by the breast cancer nurses, who must have tacit support from breast cancer surgeons, despite much publication refuting this redundant ritual.

Could it be time that the college takes up this cause, and possibly puts out a policy statement on the use of ipsilateral breast cancer upper limbs for cannulation or blood pressure measurement, for the sake of all anaesthetists, and our patients, and puts to bed this farce, so that rational practice may be resumed?

Voluntary assisted dying

I applaud Dr Beahan for contributing his eminently sensible ideas to the long overdue voluntary assisted dying acts of Victoria and WA ("Letters" *ANZCA Bulletin*, Winter edition). It certainly is time for anaesthetists to take more interest in this genuine leap forward in the humane management of terminal illness and the completion of life.

The skill sets and pharmacology are, after all, our domain, and anaesthesia input can only be hugely beneficial to this recent valuable addition to our compassion and humanity.

Dr Stuart Skyrme-Jones FANZCA
Anaesthetic Services, Richmond, Victoria



2021 Anaesthesia and Pain Medicine History and Heritage Grant

This annual grant program provides up to \$A5000 to fellows and trainees involved in the research and interpretation of the history of anaesthesia and pain medicine.

Applications close 29 October 2021, with the announcement made 19 November 2021.

For more information, including the application form and guidelines, see the [ANZCA website](#).



COVID-19, research and history covered in media

THE NEW WAVE of COVID-19 cases in Australia and New Zealand since the Winter edition of the *ANZCA Bulletin* has again focused attention on the role of anaesthetists in hospital surge planning and intensive care.

ANZCA President Dr Vanessa Beavis was interviewed by Radio New Zealand's *Morning Report* about the role of anaesthetists if there is a surge of COVID-19 patients into ICUs in New Zealand hospitals. The three-minute segment led the RNZ flagship current affairs program's news hour on 30 August reaching 400,000 people.

Dr Beavis was also interviewed by *stuff.co.nz* on 26 August about a joint statement between ANZCA and six other medical colleges that supported postponing elective surgery during COVID-19 infection surges. NZ fellow Dr Alex Psirides, an ICU specialist in Wellington, wrote an opinion piece published on *stuff.co.nz* on 8 August highlighting concerns that New Zealand does not have enough ICU capacity.

The chair of ANZCA's NSW Regional Committee Associate Professor Nicole Phillips featured in a Nine News Sydney exclusive TV report on 22 August. Associate Professor Phillips explained how many anaesthetists, including at Concord Hospital where she is director of medical services, are on the frontline working in special COVID-19 wards. The report reached an audience of 510,000 people and was also broadcast across 13 regional NSW news bulletins.

The involvement of Australian and New Zealand fellows in COVID-19 medical assistance teams in Fiji attracted broadcast media interest in both countries. NZ fellow Dr Tony Diprose was interviewed on TVNZ on 4 August about the surge in COVID-19 cases in Fiji. TVNZ Breakfast interviewed Dr Diprose from Suva on 4 August. Christchurch fellow Dr Wayne Morriss featured on Radio New Zealand's flagship current affairs program *Morning Report* on 2 July. He spoke about the work he was undertaking in Fiji and also featured on the TVNZ current affairs program *Q and A* on 4 July and again on *Morning Report* on 7 July. As the death toll increased in Fiji, Dr Morriss appeared on TV3's AM program on 8 July forecasting more hospitalisation and a health system under pressure.

Darwin fellow Dr Brian Spain was interviewed for the ABC's 7.30 program on 30 June in his role as leader of the AUSMAT mission to Fiji. Dr Spain, Director of Anaesthesia and Co-Director of Surgery and Critical Care at the Royal Darwin Hospital, headed an eight-member Australian and New Zealand medical team.

The history of anaesthesia featured in several broadcast segments and print and online articles in Australia with the release of Associate Professor Christine Ball's book on Dr Joseph Clover, *The Chloroformist*. Associate Professor Ball featured in a 22-minute interview on the ABC Radio Melbourne Mornings program with Virginia Trioli on 2 August reaching 115,000 listeners. She was also interviewed on ABC Radio Perth and

in a 55 minute segment for the national ABC radio program *Conversations* on ABC Radio National on 9 August, reaching 130,000 listeners.

A 1000-word review appeared in *The Australian* on 24 July, describing it as "...like a successful procedure: you come out from it feeling better than ever". The review reached an audience of 115,000 people. *The Canberra Times* also ran a 450-word review on 17 July which said "The author, herself an anaesthetist at The Alfred hospital in Melbourne, stresses his gentleness and the importance he placed on putting the patient at ease."

WA anaesthetist and researcher Professor Tomás Corcoran was interviewed on ABC Radio Perth on 26 July about the Long-term Outcomes of Lidocaine Infusions for persistent PostOperative Pain (LOLIPOP) study in patients undergoing breast cancer surgery. The ANZCA Clinical Trials Network secured \$A4.5 million from the national Medical Research Future Fund to perform a clinical trial in 4400 patients undergoing breast cancer surgery.

FPM Dean Associate Professor Mick Vagg and FPM fellow Dr Diarmuid McCoy were interviewed for an ABC online article on 10 July about the disparity between pain specialist services in urban areas compared to those offered for residents living in regional, rural and remote areas of Australia. They said despite there being millions of people who suffer from chronic pain across the country, the specialty is under-resourced.

South Australian FANZCA Dr Michael Goldblatt was interviewed on Channel Seven Adelaide on 27 June about how hypnotherapy is helping people overcome their fear of needles, especially those preparing for their COVID-19 vaccinations.

Professor Alan Merry was interviewed by leading New Zealand broadcaster Kim Hill on Radio New Zealand on 26 June about his newest book, *Medication Safety during Anaesthesia and the Perioperative Period*, his retirement as the head of the School of Medicine at the University of Auckland and his work on medical manslaughter.

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

Carolyn Jones
Media Manager, ANZCA



Dr Wilga Kottek
Anaesthetist, VIC

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STP funding to continue

AUSTRALIA

STP forum and new funding agreement

ANZCA hosted a virtual Specialist Training Program (STP) stakeholder forum on 10 June. The forum was originally scheduled as the forerunner to the Rural Special Interest Group meeting in Airlie Beach, Queensland however was switched to an online format due to ongoing COVID-19 travel restrictions.

Thirty-five participants joined the virtual forum including representatives from the Commonwealth Department of Health, other specialist medical colleges, state health services, metropolitan and regional trainings sites, regional training hubs, training hospitals, and universities as well as ANZCA representatives, including four ANZCA councillors, Associate Professor Deborah Wilson, Dr Scott Ma, Dr Michael Jones and Immediate Past President Dr Rod Mitchell.

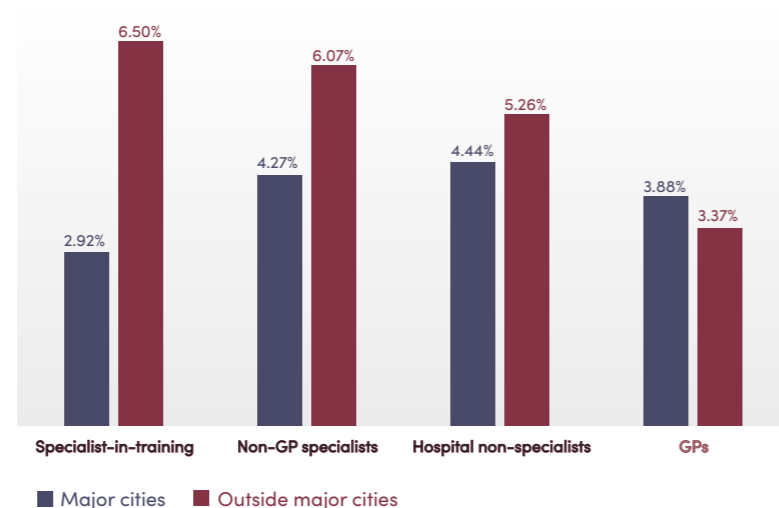
Attendees were provided an update on the STP from Commonwealth Department of Health representatives, discussed important aspects of training such as accreditation, recruitment and selection, trainee welfare, as well as an interactive presentation from the Australian Digital Health Agency.

During July the Department of Health held a number of information sessions with medical colleges regarding ongoing funding of the STP initiative.

At a meeting with ANZCA in late July the department confirmed that all colleges will be invited to participate in a non-competitive tender process for a further four-year STP funding agreement (2022-2025). The grant process will take place during the final quarter of 2021. The college will be required to undertake a review of all posts in 2022 with funding for the 2024-5 period to be informed by the findings of the review.

Further details regarding the review and any changes to the operational framework for the program are still being finalised by the department. The STP team will be in contact with all program training sites in order to commence contract preparation once funding with the Commonwealth has been formalised.

Average annual percentage increase in the number of doctors working outside and inside major cities (between 2013 to 2019).



Evolution of the medical workforce report

In June college staff attended the launch of the latest Melbourne Institute health sector report *The evolution of the medical workforce*.

Utilising data from the Medicine in Australia: Balancing Employment and Life (MABEL) survey, the Commonwealth Department of Health's National Health Workforce Dataset and Services Australia MBS statistics, the report examines recent and longer-term trends in the Australian medical workforce.

The report highlights how doctors have adapted their practice to both the continued expansion in the size of the workforce over the past decades as well as more recently, to the COVID-19 pandemic.

Some of these trends support those identified in the national medical workforce scoping framework released in 2019 – the growth in the size of the medical workforce, the growth of non-GP specialists and a geographic maldistribution of doctors. With regards to the latter, the report does demonstrate some evidence of an increase in the number of doctors working outside of major cities.

While the overall increase is modest – the percentage of all doctors working outside major cities from rose 22 per cent in 2013 to 22.8 per cent in 2019 – the increase has been among trainees and non-GP specialists rather than GPs (see figure below).

The report credits the establishment of training pathways outside metropolitan teaching hospitals, such as those training posts supported by STP, and potentially, increased supply and competition attracting doctors away from major cities. The percentage of GPs outside of major cities areas has actually fallen slightly from 29.2 per cent in 2013 to 28.7 per cent in 2019, although it should be noted that GPs are still significantly more equitably geographically distributed than non-GP specialists.

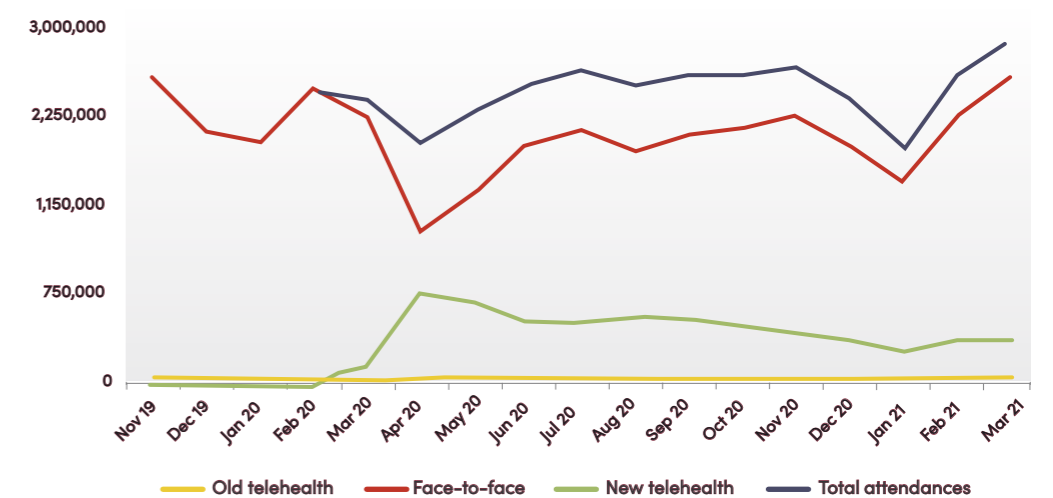
“Medical practitioners have continued to adapt to significant increases in medical workforce supply as well as COVID-19. Increased supply leads to more competition, and the effects of this are beginning to be seen as doctors spill over into rural and regional areas and increasing pressure on fee revenue. But after 20 years, issues such as specialty choice have not been addressed, rural practice needs continued support, and the benefits of telehealth need to be better utilised.”

– *The evolution of the medical workforce report*

Another interesting trend highlighted in the report is the use of telehealth. COVID-19 saw the rapid introduction of new MBS telehealth items and the figure below shows the rapid uptake of telehealth among non-GP specialists and a commensurate fall in face-to-face consultations commencing in March last year.

Following a peak reached in April 2020 however, the use of telehealth has fallen to around 13 per cent of specialist attendances. This is still a significant proportion given that pre-COVID virtually no specialist attendances were via telehealth.

Number of MBS items claimed for specialist attendances, November 2019 to March 2021.



Digital Health Capability Action Plan and My Health Record

In June the college participated in a stakeholder workshop to refine the draft National Digital Health Workforce Capability Action Plan.

The purpose of this plan is to bridge the gap between the current and future states outlined in the National Digital Health Workforce and Education Roadmap and articulate clear roles, responsibilities, timeframes and targets to realise the Roadmap. The Capability Action Plan contains 11 actions across four themes:

- Standards and frameworks.
- Education and training.
- Regulation.
- Collaboration.

Working closely with the Australian Society of Anaesthetists (ASA), the college collaborates with the Australian Digital Health Agency to deliver outcomes aligned with the education and training theme of the Capability Action Plan.

More than 200 anaesthetists recently attended two webinars about My Health Record where Dr Kathy Rainbird, Senior Provider Adoption Lead at the Australian Digital Health Agency, presented updates on the rollout of My Health Record, how to access the system and upload information.

Following a live demonstration, Dr Rainbird led a Q&A session along with a panel including Dr Suzi Nou (ASA President) and Dr Richard Horton (Director of Anaesthesia, Perioperative and Pain Medicine, Western Health). Dr Horton is currently on sabbatical leave and acting as project lead with the Digital Health Branch of the Victorian Department of Health looking at the potential for My Health Record in perioperative medicine.

The large number of anaesthetists participating in the webinars highlights the high level of interest in digital health and the use of tools such as My Health Record to improve safety and quality.

Accessing My Health Record, uploading information and how this fits into established workflows, particularly outside of public hospitals, represents a barrier at present. This is beginning to be addressed as the Digital Health Agency works with more software developers to integrate My Health Record into their products.

Further information for specialists is available at specialist-toolkit.digitalhealth.gov.au.

NEW ZEALAND

Recent updates from the Transition Unit, the body working from inside the prime minister's office to see a smooth changeover to the new health system in the middle of next year, confirm there has been the wide range of sector engagement.

The unit has hosted and attended more than 100 meetings with Māori, sector groups, government agencies and medical colleges.

There has been a specific focus by the Māori Health Authority (MHA) to set up the Iwi Māori Partnership Boards (IMPBs). More than 150 applications have been received for the board of the interim MHA.

The Health Quality and Safety Commission and the Transition Unit have jointly created a framework to capture and represent the consumer voice. "Partners in Care" will oversee the delivery of a national set of expectations, a national consumer forum and a centre of excellence all dedicated to leverage consumer feedback into the design of the new health systems.

Changes to the district health board (DHB) contracts are flagged as a critical piece of the proposed changes. Most DHB contracts will be under Health New Zealand from July 2022. Some contracts that will be under the Māori Health Authority, but decisions on those are still to be made.

SUBMISSIONS

ANZCA 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.

Australia

- Australian Commission on Safety and Quality in Health Care: Delirium clinical care standard.
- National Transport Commission: Assessing fitness to drive.
- Australian Competition and Consumers Commission: Draft determination on application by Honeysuckle Health Pty Ltd and nib health funds limited in respect of the Honeysuckle Health Buying Group.
- National Blood Authority: Draft guidance for the Investigation and Management of Acute Transfusion Reactions.

New Zealand

- Ministry of Health/ Manatū Hauora: Submission on amendments to the schedule of the medicines (Designated Pharmacist Prescribers).
- Accident Compensation Corporation: Pamidronate guidelines for complex regional pain syndrome.
- Accident Compensation Corporation: Facet joint consideration factors.

For a listing of recent submissions visit www.anzca.edu.au/communications/advocacy/submissions. Note that some inquiries and requests for college input are confidential.

What would you do?

Dr Peter Roessler explains ANZCA's professional documents using practical examples. In this edition he addresses sexual harassment.



"HAVE YOU HEARD THE ONE ABOUT ..." is a common lead-in to initiating humour with the usual intention of either defusing stressful situations or to entertain. After all, laughter is said to be the best medicine. Which reminds me, when I hired a gardener to landscape my garden, they said they couldn't help me as my garden was in portrait format.

The challenge for some is in knowing the boundaries of what is acceptable and remaining within them. This is especially so in the case of jokes of a sexual nature or ones that can be viewed as demeaning or intimidating. It is not uncommon to hear comedians telling jokes about their wives or husbands that are disparaging.

At this point it is worth noting that a significant number of successful and stable partnerships, including marriage, originated while at work. Indeed, in my own case, my marriage to my ex-fiancé has lasted 43 years and is still going strong. The issue, however, is in differentiating between welcomed approaches and unwelcome harassment.

In the professional arena, overstepping the boundary is likely to result in some people finding it offensive, which marks one end of the spectrum of sexual harassment. Sadly, complaints of such a nature submitted to the college are not infrequent. They include offensive humour, inappropriate and unwanted physical contact, display of images of a sexual nature, use of various social media platforms in a way not expressly authorised or not for their intended use and at times abuse of the imbalance of power as a means of coercion or adverse influence.

Consider this scenario

You witness a senior male colleague exhibiting inappropriate and sexually suggestive behaviour towards a female trainee and a nurse who are clearly upset by this.

You decide to bring this to the attention of the theatre nurse unit manager (NUM). You find her in the tea room where she is showing two of her nursing friends her downloaded collection of lewd images of males on her phone, while a male technician is present in the tea room.

WHAT WOULD YOU DO?

Bullying, discrimination, and harassment (BDH) are clearly defined both by professional organisations and jurisdictional authorities.

There are also matters such as moral, socially acceptable or ethically appropriate considerations that can also come into play. Harassment is a form of unlawful discrimination characterised by unwelcome behaviour that offends, humiliates, belittles, or intimidates any individual based on their gender, race, disability, or personal characteristics. Breaching these regulations has serious consequences.

Sexual harassment also includes behaviour that is an offence under the criminal law such as physical assault, indecent exposure, sexual assault, stalking, or obscene communications.

The college policy on BDH can be accessed on the college website (www.anzca.edu.au). In addition, the college also has a policy on notifications and processes that can be accessed on the website. As at time of publication these policies are under review.

The following resources may also be helpful:

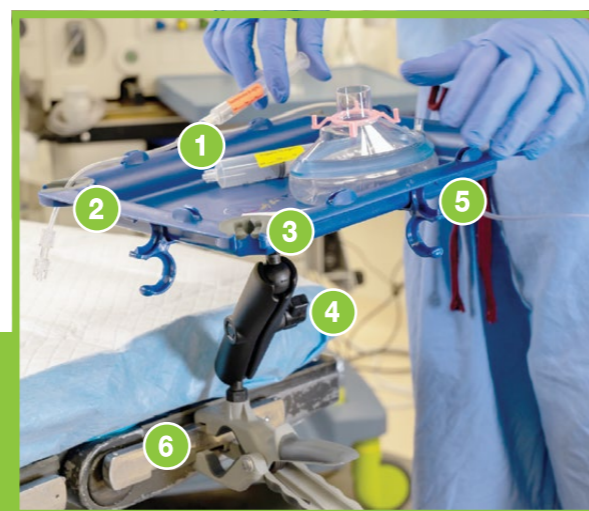
- MBA Good medical practice: a code of conduct for doctors in Australia.
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- MCNZ Conduct and professionalism standards. www.mcnz.org.nz
- ANZCA/FPM Supporting anaesthetists' professionalism and performance: A guide for clinicians. www.anzca.edu.au
- *PS49 Guideline on the health of specialists, specialist international medical graduates, and trainees* (now under review) – updated version.

It is interesting to contemplate the driver behind inappropriate behaviour such as sexual harassment. Is it simply fulfilling a need for self-gratification, or is it abusing a power imbalance? The latter is clearly evident in situations where perpetrators threaten to jeopardise employment and career opportunities or spread rumours about their "prey". This is regarded by the college as reprehensible conduct and total abuse of the power imbalance.

An understanding of these factors may play an important role in terminating the behaviour through providing insight and awareness, followed by targeted education and remediation. This has the benefit of supporting, not the behaviour, but the individual, which if successful will have a beneficial effect on all future interactions.

Eradication of unacceptable behaviour requires:

- Defining the behaviour – definitions are available in the above-mentioned resources.
- Identifying the behaviour when it occurs and calling it out – being an upstander and not a bystander.
- Modifying the behaviour through remedial actions or imposing consequences in situations where behaviour persists despite attempts at remediation.

Success in eliminating sexual harassment, whether it be through remediation or through imposition of consequences, is very much dependent on reporting the behaviour. The problem is that there is a failure to report due to victims not wishing to be identified, either for fear of their jobs or for their wellbeing. Reluctance to come forward in the presence of a power imbalance is understandable – as is the empathy some victims exhibit when considering the impact on the perpetrator. Notwithstanding such considerate empathy, it is important to appreciate that sexual harassment of any one individual is likely to be just one of many instances.

Unfortunately, the college is unable to act on anonymous reports, which is why it is essential that inappropriate behaviour is reported, and complaints are not anonymous. This is clearly articulated in the college's policy. Any such reports to the college are managed with sensitivity, confidentiality and support through the office of the chief executive officer. No personal information of any person reporting such scenarios is disclosed without the prior permission of the notifier.

In fairness, those who inadvertently or unintentionally cross the line need to be made aware of the inappropriateness of their behaviour at the earliest signs and should be provided with the opportunity to adjust their behaviour. Those who are intransigent and persist will continue to have a negative impact on those around them, on the college, and on themselves, in which case alternative and more stringent actions may be imposed.

If we are genuine about wellbeing then we should be prepared to act accordingly. Especially towards victims of sexual harassment in a considerate, supportive, and protective manner.

Dr Peter Roessler
Director of Professional Affairs, Policy

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Applications close 31 January 2022.

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

Lessons from a mass neural connector changeover

On 5 June 2021 the Auckland District Health Board (ADHB) became the first full healthcare facility in New Zealand and Australia to change to the ISO 80369-6 small-bore medical device (neural) connector standard.

Anaesthetist Dr Matt Drake led the complex implementation at Auckland City Hospital, Starship Children's Hospital and the Greenlane Clinical Centre.



Dr Matthew Drake with a neural connector epidural set.
(Photo: Dr Grace Chang)

THE TRANSITION TO neural connectors – with the simultaneous introduction of nearly 70 new products across three centres covering more than 1100 beds – was the largest product change our procurement team had ever undertaken.

Key to its overall success was meticulous planning, strong engagement with staff across the organisation, and rapid response to issues in the weeks following implementation.

We have now established the product supply chain and worked through the various other regulatory issues making it relatively easy for those who follow.

Introducing a system-level safety feature such as neural connectors is undoubtedly of benefit to patients.

Read on and work out if you could drive this in your hospital.

International agreement on safer connectors

The ISO 80369 standard¹, a revision of the ISO 594-1 *conical fittings with a 6 per cent (Luer) taper for syringes, needles and certain other medical equipment*, was published in 2016.

As a registrar in the UK I had taken part in clinical evaluation of some of the spinal needle and syringes that manufacturers were developing to make specific connectors for intrathecal injection. One of my training hospitals had suffered a devastating wrong-route error in obstetrics, after epidural Bupivacaine was administered instead of crystalloid as fluid resuscitation for a postpartum haemorrhage². I was acutely aware of the harm that can result from such errors.

The publication of the ISO 80369 ensures international agreement on the fit, form and function of the six different routes.

- Breathing systems and driving gases.
- Enteral and gastric.
- Urinary collection.
- Limb cuff inflation.
- Neuraxial.
- Intravascular.



Left: Replacing Luer equipment with neural connector items in one of the theatre suites.



Right: Ensuring that neurosurgical-specific items continued to be stocked in the Luer standard.

“Key to its overall success was meticulous planning, strong engagement with staff across the organisation, and rapid response to issues in the weeks following implementation.”

This provides greater assurances of product availability in terms of volume, portfolio diversity and price efficiency.

In early 2019 I approached the then director of anaesthesia at the ADHB and now ANZCA President, Dr Vanessa Beavis, requesting we implement the neural connector standard in the Women's Health Department of Anaesthesia. Dr Beavis agreed on the condition that the implementation was across the whole organisation.

STEP 1: Work out who has what, where, and in what volumes: Find local champions

Each clinical area across the district health board purchases its own portfolio of neural connector-affected items.

It soon became clear that there was no simple way to determine the volumes or locations of all items that would need to be changed over, nor how these items were used clinically. To manage this uncertainty I invited each clinical area in the hospital to nominate a local champion to attend one of three neural connector workshops. A well-connected team support person was key to finding these clinical champions.

At these workshops, I introduced the concept of the new connector standards, invited needle and syringe suppliers to demonstrate their current neural connector offerings, and asked the champions to list the individual items that would need to be changed in their own areas.

Having a local champion in every clinical area proved invaluable. They were a local expert to consult on specific uses of affected items; they helped with arranging education sessions for staff in their area, and they were the conduit to the project team on any post-implementation issues.

STEP 2: Determine the non-neural connector areas

Ideally, all equipment used for neural drug administration should change to the new ISO 80369-6 standard.

However, it quickly became evident from our workshops that because of their length, sharp spinal needles were being used in a great deal of non-neural clinical applications from amniocentesis to aspiration of pleural fluid on the respiratory wards.

We considered having a hybrid approach with neural products changed to neural connectors while still stocking Luer equivalent items for non-neural applications. However, the risk of incompatibility at the point of use was too great. If an incorrect needle is used for a procedure, there is no Luer-neural connector adapter available as this would negate the safety benefits of the ISO-80369 system.

We decided to either change over clinical areas completely or have specific areas that did not change to the new standard.

Interventional radiology remains with the Luer standard, but a single neural connector trolley has been introduced for neural procedures such as nerve root injections and epidural blood patches. Our neurosurgical theatres and the maternofetal medicine procedure room also remain entirely Luer, while the respiratory ward has moved to using neural connector needles and syringes for their pleural aspiration.

STEP 3: Map what you have against what can be supplied

Although we had good engagement from the needle and syringe manufacturers at our initial workshops, at the time many either had no neural connector items in production, or didn't have manufacturing capacity to import them to the New Zealand market.

Even those companies who were producing neural connector items did not have their whole portfolio available. The cost of setting up a supply chain meant there were some items that were not economically viable to import for a single New Zealand DHB.

Our stocktake of items eligible for change to neural connectors ran to nearly 100 individual items.

Not all of these had a direct equivalent in neural connectors, although this was an opportunity to rationalise similar items into one.

Being all-new products, getting samples of items was a slow process. All had to be sourced from Europe. Our epidural, spinal and combined spinal-epidural (CSE) procedure packs took a few iterations to get right.

STEP 4: What additional neural connector items are needed?

There are additional items that are required for transition to a new connector standard.

Some are obvious such as syringes, epidural lines, drawing up needles, caps and stoppers as well as “spares” such as loss of resistance syringes and epidural filters. Others are not immediately obvious like the need to perform epidural blood patches that require a specific cross-standard set.

All these additional items take up space in clinical areas. Part of the change management involved determining which additional items are needed and where. Most neural connector equipment is yellow although the yellow colour is not included in the ISO 80369 standard so this is not consistent across all products or manufacturers.





Identifying, removing and replacing products in theatre stockrooms, and updating the inventory management data for each item. Photo credit: Dionne Lee.



STEP 5: Prepare orders, forecasts and contracts with suppliers

Suppliers need estimates of the expected use of each new item because of lead times for manufacturing and shipping.

Get this wrong and potentially there will be a gap in supply. Order too many and there is a risk the hospital is forced to purchase and write off out-of-date stock if they are the only users of the item.

Replacing like-for-like items were easy to work out from purchased volumes. However, those with reduced consumption, such as spinal needles used in interventional radiology, were more difficult.

Items like syringes, caps and drawing up needles required a “best guess” given the possible numbers of procedures performed each year.

A robust supply chain and buffer stock is imperative to success. You cannot just phone the hospital down the road and borrow some neural connector stock to cover manufacturing or shipping delays.

Our initial requirement was for manufacturers to bring in six months of stock and to hold three months of stock in the country at all times. With more hospitals using neural connectors and a better understanding of the demand, we expect there will not always be a need for such close monitoring.

STEP 6: Revise orders in light of supplier contract negotiations and manufacturing lead times

Steps 1-5 occurred during the second half of 2019, and we were about to place our order in February 2020, for a mid-2020 implementation, when COVID-19 hit. The pandemic hijacked both my time and the resources of our procurement team.

The neural connector project was put on hold until June 2020 and we adjusted our pre-COVID-19 plans:

- Airfreight to New Zealand became expensive and scarce meaning obtaining extra items could take months rather than a couple of weeks. As a result, we increased our initial stock purchase from six to nine months.
- Raw materials shortages, manufacturing shutdowns, and enthusiasm for regional anaesthesia during the pandemic have significantly extended product lead times and increased prices, resulting in some changes to our planned product portfolio.

We placed the order with the suppliers towards the end of 2020, with the expectation that stock would arrive in April 2021.

STEP 7: Staff education

A new small-bore medical device connector standard affects nearly every clinical and medical member of staff in the hospital including nurses, midwives, anaesthetic technicians and pharmacists.

For many, just being aware that a different connector standard will be introduced and the reasons behind the change is sufficient. However, for those doing neural procedures on a regular basis and whose “regular” needle may be changing to a different supplier, a little more in-depth discussion and diplomacy is required to ensure the intention of making clinical care safer is balanced with the potential dissatisfaction with a different “feel” of a new needle.

We had already started educating staff with the intention of a mid-2020 implementation through visits to various department meetings. We repeated these in early 2021 because of the delay.

We supplemented face-to-face presentations and dissemination amongst nurse and technician educator groups with written factsheets, targeted emails to different staff groups, a neural connector intranet page and screensavers.

We aimed for saturation of the neural connector message in the weeks leading up to implementation.

STEP 8: Set an implementation date, run down stocks of Luer items, order sufficient neural connector stock for implementation and plan implementation while clinical work continues

Settling on an implementation date required coordination of all five equipment suppliers, both pharmaceutical suppliers, as well as internal dependencies such as completion of staff education and availability of the product team.

Once we had a provisional implementation date, six weeks after our final consignment of equipment was due to leave Melbourne by sea freight, we began to run down stocks of Luer items that were due to be discontinued. We ordered two months’ supply and found additional space in our clinical stores for nearly 70 new neural connector items.

Regular project meetings continued as detailed plans for swap-out of items in a systematic and coordinated way were finalised.

We planned for a two-day implementation. The first day was for all the theatre complexes across the organisation and the second day was to cover all the other clinical areas in the hospital.

We chose a weekend to ensure availability of all project team staff without distraction from their “business as usual” roles. Key areas such as critical care, all the different operating theatre suites, as well as the adult and children’s emergency departments, were closely involved in determining which neural connector items would be stocked and where.

Three weeks from implementation day, the container ship from Melbourne was delayed. Anxiously I tracked the ship across the Tasman Sea. The journey itself was short but, because of congestion at the Ports of Auckland, the ship anchored in the Waitematā Harbour frustratingly in sight of the hospital.

We set and passed a “drop dead” date of 13 May. The last of the stock finally arrived in the supplier’s warehouse on 19 May and at the hospital stockroom a week later.

The delay meant that our pharmacy was not able to perform stability testing on our in-house chemotherapy syringes ready for launch day. We revised the implementation plan to ensure areas administering chemotherapy could still do so.

Up to that point, our compounding pharmacy had been busy preparing syringes of COVID-19 vaccine so the staff were relieved they had a few more weeks to rehearse the process for preparing these syringes with the new connector standard.

“Our stocktake of items eligible for change to neural connectors ran to nearly 100 individual items.”



A Luer syringe and neural connector epidural needle – both connectors are very similar, but incompatible. Photo credit: Dr Grace Chang

STEP 9: Go live

Implementation started at 7am on Saturday 5 June.

Area-by-area, item-by-item, we painstakingly identified the products to be substituted on the inventory management system, determined minimum/maximum inventory levels for each item, printed shelf labels, picked stock and put it in the clinical areas taking care to count and remove any old stock.

A note stating, “You have been changed to neural connector” with our contact details for any issues was stuck near any new items. We identified procedure trolleys and other areas where affected items may be hiding with the help of the nurse in charge of the ward area, or, in the case of the theatre suites, the anaesthetic technician.

Progress was initially slow. We had filtered all affected items for all areas into a single spreadsheet which we worked on area-by-area. Line-by-line for each clinical area, the inventory team leader would call out the product code; I would then check, find the corresponding code and relay this back for entry on the spreadsheet. We would agree on suitable stock levels for the item and move on to the next.

To complete each area we added additional items as required, such as caps, drawing up needles, and syringes, either as requested by the area, or my “best guess” assessment of their requirements. Finally, this data was exported to the inventory management system and labels printed.

By day two we had got into the swing of things. Outside the emergency departments and department of critical care medicine, the ward areas were much less complex and were completed relatively quickly. Many shared the same template of a couple of spinal needles and a manometer.

Our final area was the children’s operating theatre complex, which we completed just before 10pm.

By doing our implementation over a weekend and starting in the operating theatre areas where most epidurals and other infusion catheters are sited, we largely managed to avoid the problem of patients having epidurals or other neural infusion catheters set up with Luer connectors that became incompatible with the neural connector infusion lines.

STEP 10: Post-implementation review and continue to aim for 100 per cent neural connector

Following implementation there was an initial flurry of queries and unexpected issues.

For example, the Luer lumbar drain sets used in neurosurgery had been kept for their exclusive use. However, it transpired that they preferred using anaesthesia epidural kits so the old Luer epidural packs were brought back.

Initial complaints from clinicians about the different needles quickly changed to quite positive feedback on the quality of the replacement items.

There were a few very low-volume items which two of our suppliers did not deliver in time for our implementation. They were non-essential items so we decided to go ahead.

We are still waiting for the production of a neural connector version of an electronic manometer to allow completion of our neural connector transition in our paediatric hospital. This should arrive by the end of the year. Our ultimate aim is for neurosurgery to change to neural connectors, if these items ever become available.

I can give you detail that is more specific across individual departments, and am happy to field queries if you decide to lead your hospital in the implementation.

Dr Matthew Drake

Specialist Anaesthetist & Service Clinical Director, National Women's Health Department of Anaesthesia, Auckland City Hospital

“Initial complaints from clinicians about the different needles quickly changed to quite positive feedback on the quality of the replacement items.”

Thanks to the project and implementation team – Mr Matt Chappell, Ms Carol Whitfield, Mr Nikolay Golyshev, Mr Rohil Kishore, Mr Ben South, Ms Teresa Iakopo, Ms Rose Martin, Ms Nicola Smith-Guerin, and Dr Nigel Robertson.

References:

1. <https://www.iso.org/standard/50734.html>
2. http://news.bbc.co.uk/2/hi/uk_news/england/wiltshire/7226836.stm

Neural connectors – progress in Australia

The Neural Connector Device Working Group (NCDWG), set up by the Australian Commission on Safety and Quality in Health Care (the Commission) held its first meeting in May. Dr Phoebe Mainland represents ANZCA on the working group.

Made up of peak bodies and state and territory representatives, the NCDWG has been formed to provide guidance and support with national collaboration on the implementation of neural connectors.

Discussions so far have focused on information sharing and supply. Key issues include:

- Introduction of connector devices is dependent on the availability of all components to enable complete set up of an end-to-end procedure.
- Most states and territories are awaiting access to the full range of new devices.
- Clinicians and those responsible for device procurement will need to liaise closely over supply.
- Implementation is irreversible, so the ongoing supply of the range of devices must be reliable.

The NCDWG is working to establish the availability of products in Australia and which end-to-end procedures can be undertaken to guide the changeover from Luer connectors.

The NCDWG encourages pilot sites demonstrating early adoption of ISO80369-6 compliant neural connectors to share their experience.

Sponsors of neural connector devices compliant with ISO80369-6 are requested to share information on neural connector devices via the Medical Terminology Association of Australia.

Other resources which may be of interest include:

Introduction of Connectors to Prevent Misconnection (Neuraxial Anesthesia), Pharmaceuticals and Medical Devices Agency (Japan); Medical Safety Information No.55 August 2018. Available from: www.pmda.go.jp/files/000225311.pdf

Neuraxial Connectors (NRFit®), Overview of Design Changes; Stay Connected/Global Enteral Device Supplier Association (GEDSA). Available from: stayconnected.org/neuraxial-nrfit/

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Perioperative medicine curriculum nearing completion

OUR PERIOPERATIVE MEDICINE diploma continues to take shape with significant work done on our crucial “grandparenting” process. This outlines the proposed requirements and provisions available to practitioners with prior education and/or current practice in perioperative medicine to be eligible for the diploma.

CURRICULUM

Work on the curriculum is aligned to the Perioperative Care Framework and will be completed by the end of the year. Input has been sought from a wide range of anaesthesia and non-anaesthesia specialists involved in perioperative care.

The six areas of study (formerly known as modules) are:

1. Perioperative impact of major disease.
2. Planning for appropriate care.
3. Optimisation.
4. Intraoperative impacts on patient outcomes.
5. Safe recovery in hospital.
6. Discharge planning and rehabilitation.

The first four areas of study have been developed, and the final two are under way.

Each area of study includes a range of pre-reading, suggested online reading packages and face-to-face teaching and a likely period of 1.5 days to apply this knowledge in a clinical setting.

Consideration is being given for the six areas of study to be done over two semesters (three areas of study each) or two modules in three trimesters.

There will also be the option of doing individual areas of study separately as a stand-alone course.

The diploma will be structured in a flexible and accessible format with a combination of online, face-to-face intensives and targeted clinical exposure throughout the six areas of learning. Assessment will be required throughout the course so candidates acquire the requisite knowledge and skills.

GRANDPARENTING

The chair of our Perioperative Medicine Education Group, Dr Joel Symons, and ANZCA Director of Professional Affairs, Dr Maggie Wong have spent considerable time developing the proposed pathways for recognition of the diploma, or the grandparenting document.

We have sought feedback from key stakeholders and this has been incorporated into the draft.

Grandparenting is required to ensure there is a critical mass of perioperative medicine diploma holders to run the proposed qualification.

Our thinking is that there are already a number of leading figures in perioperative medicine throughout Australia and New Zealand who will qualify for the diploma to be decided by an exemption pathway committee (EPC) and then play an important role as our thought leaders and supervisors. A points-based system will operate for those who do not qualify through the EPC and will take into account prior perioperative medicine education and teaching, research and clinical exposure.

The process will be finalised and publicised at least 12 months before the planned launch of the diploma in 2023, to allow everyone with an interest in applying enough time to do so.

Through our consultations we have been made aware of concerns that the diploma will result in some specialties encroaching on others. The purpose of the diploma is not to create a “level playing field” across our specialties.

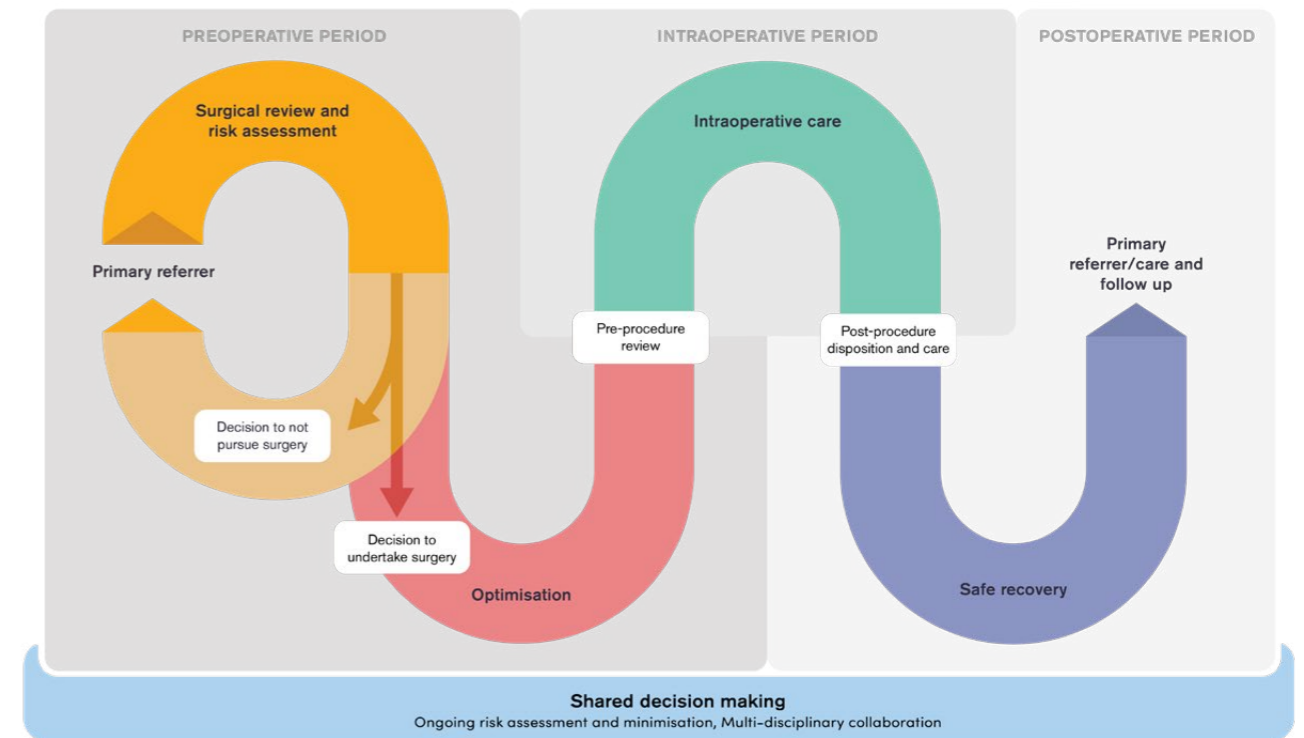
We are not trying to make anaesthetists out of physicians, for example, nor physicians out of anaesthetists. Instead, the diploma will provide our graduates who in their departments/hospital become known as those with the skill set to develop perioperative medical services. They also pursue relationships with other services to effectively work in a multi-disciplinary environment.

They are likely to provide leadership to the Perioperative Care Team (please see below).



The Perioperative Care Framework

From the contemplation of surgery to an optimal outcome



FRAMEWORK

Dr Jeremy Fernando’s Perioperative Care Working Group is applying the finishing touches to our Perioperative Care Framework based on feedback from stakeholders from within ANZCA and from other specialty and craft groups.

The framework maps the patient’s journey from the time surgery is contemplated through to recovery (see diagram).

Feedback has shown an overall appreciation of the attempt to bring together recommendations and principles to help clinicians improve perioperative care and outcomes.

The challenge of delineating roles and responsibilities between the primary referrer, proceduralists and members of the perioperative medical team has been noted and there is recognition that rural and remote areas may not have access to the resources to form a perioperative medical team.

At its September meeting, the Perioperative Medicine Steering Committee fine-tuned some of the definitions of perioperative medicine to delineate roles and responsibilities inside the Perioperative Care Framework, namely:

- Perioperative Care: The multidisciplinary, integrated, personalised care of patients from the moment surgery is contemplated through to an optimal outcome.
- Perioperative Care Team: Includes all the individuals who may be involved in a patient’s perioperative journey. This may include doctors, nurses and other health professionals in hospitals or clinics, as well as family or other carers.

- Perioperative Medicine: The science and practice of optimising patients prior to surgery and minimising the risk of perioperative complications.
- The Perioperative Medical Team: Led by medically qualified specialists, this works collaboratively with the surgical team and other health disciplines, primary care team, family and carers to support safe, effective and efficient care for patients for whom surgery is a potential treatment option.

Once finalised, the framework will be uploaded to the ANZCA website as an interactive graphic.

Dr Sean McManus
Chair, Perioperative Medicine Steering Committee

Colleges collaborate to develop new rural GP anaesthesia qualification

ANZCA SIGNS MOU

A significant milestone in the development of the new diploma of rural generalist anaesthesia was recently achieved with the signing of a memorandum of understanding (MOU) between ANZCA, the Royal Australian College of General Practitioners (RACGP) and the Australian College of Rural and Remote Medicine (ACRRM).

Under the MOU the three colleges agree to work together to establish a diploma that will actively cultivate and maintain the highest principles and standards in the training, practice and ethics of rural generalist anaesthesia.

ANZCA, RACGP and ACRRM have been working towards this goal for the past five years and significant work on the diploma's curriculum has already been completed by a working group of expert clinicians and educators from the three colleges. To be launched in 2023, the aim of the diploma is to provide training to produce rural generalist anaesthesia graduates who can deliver safe anaesthesia and perioperative care in rural and remote settings for:

- Patients classed as ASA 1, 2 and stable 3 undergoing elective surgery.
- Patients requiring emergent surgery.

This includes obstetric and paediatric patients (within scope of practice) and the resuscitation and stabilisation of patients for transfer when required.

Why a diploma of rural generalist anaesthesia?

In some rural and remote regions of Australia, circumstances preclude the referral of certain types of surgery and establishing a specialist anaesthesia practice is not viable.

Recognising the benefits of providing care as close to home as possible, a number of different service models have evolved to provide specialist care to these communities such as outreach program that provide access to visiting medical specialists.

The college recognises the vital role general practitioners with advanced training in anaesthesia also play in many rural and remote communities and is committed to continuing to provide supervision, training and continuing professional development (CPD) opportunities to support them to provide safe and high quality care.

In 1994 ANZCA, RACGP and ACRRM established the Joint Consultative Committee on Anaesthesia (JCCA). Over the past 27 years the JCCA has provided hundreds of rural general practitioners with advanced training in anaesthesia and ensured that the care provided by GP anaesthetists is safe, meets contemporary standards of clinical practice and is

practical and responsive to the needs of rural practitioners and the communities they serve. While there has been continuous improvement of the existing GP anaesthesia program, there is recognition that several issues need to be addressed, including:

- Consistency of anaesthesia training.
- Access to established educational resources to supplement the clinical-based training program.
- Standardised examination and examination processes.
- Linking ongoing CPD to the currency of the qualification.

In 2015 the three colleges commenced discussions to develop a diploma for rural generalist anaesthesia to replace the JCCA to ensure rural generalist anaesthesia training aligns with contemporary medical education and Australian Medical Council standards.

Who can undertake the diploma?

The Diploma of Rural Generalist Anaesthesia will primarily be available to rural generalist registrars seeking formal training and certification in anaesthesia who are enrolled in the fellowship of the ACRRM training program and/or the RACGP fellowship of advanced rural general practice training program.

The diploma may also be applicable to those who have gained fellowship with ACRRM or RACGP in the rural pathway and wish to gain an additional qualification in anaesthesia in the rural setting.

What will the curriculum look like?

The diploma is based on the ANZCA anaesthetic training curriculum and includes three key components: rural generalist roles in practice, clinical fundamentals and specialised study units. The curriculum aims to:

- Articulate the scope of practice required by a rural generalist anaesthetist including breadth and depth of knowledge, range of skills and professional behaviours necessary for safe and high quality patient care.
- Guide supervisors and other specialists involved in the training program with respect to suitable learning experiences for trainees.
- Foster trainees' self-directed learning by providing clear requirements and tools to facilitate their achievement.
- Promote regular and productive interaction between trainees and supervisors, through formative workplace-based assessments and constructive feedback.
- Provide consistency of standards and outcomes across different training settings.
- Provide a framework to inform the scope of continuing professional development activities for RGAs.

ANZCA is responsible for the clinical standards in the diploma curriculum, while ACRRM and RACGP are responsible for standards and requirements for their respective rural generalist fellowship programs.

Next steps

Development of the diploma curriculum is in its final stages. The next 18 months will focus on creating regulations and handbooks, recognition of prior learning, developing resources to support supervisors with the new curriculum and assessments, and accrediting training sites.

A frequently asked questions page is now available on the college website at www.anzca.edu.au/education-training/diploma-of-rural-generalist-anaesthesia/drga-faqs.

The college thanks ANZCA's Immediate Past President Dr Rod Mitchell for his tireless contributions to date. Thanks also to the curriculum working group under the leadership of curriculum design consultant Jodie Atkins and the expert advice of members

including Dr Kirsty Forrest, Dr Kevin Hartley and Dr Lindy Roberts from ANZCA, Dr Pete Gilchrist and Dr James Ware from RACGP, Dr Neil Beaton from ACRRM as well as staff from the three colleges.

We look forward to our first intake of trainees in 2023 and improving access to safe and high quality anaesthesia services for Australians living in our rural communities.

Associate Professor Deborah Wilson

Acting Chair, Tripartite Committee of Rural Generalist Anaesthesia



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New CPD standard: Our approach

THE MEDICAL BOARD of Australia (MBA) has released its new continuing professional development (CPD) registration standard which is effective from 1 January 2023.

The ANZCA and FPM CPD Committee and team have been eagerly awaiting the final version of this standard, released on 30 July 2021, after years of stakeholders' workshops, consultations and consideration about how proposals may influence our 2014 ANZCA and FPM CPD program and online CPD portfolio system. This comes as Pillar 1: Strengthen CPD of the MBA's Professional performance framework (framework).

We continue to discuss the new CPD standard, framework and its final versions, acknowledging a large portion of the work towards reaching many of the new requirements had been achieved in previous years through launching the current CPD program.

We trust you find this article informative, as we recognise this impacts not only our 6500 fellows and CPD participants but also the whole Australian medical community. We are keen to maintain transparent communications with our members, and will continue to provide regular updates as new information becomes available through our college publications and website news items.



Professional Performance Framework

Strengthened continuing professional development	Active assurance of safe practice	Strengthened assessment and management of practitioners with multiple substantiated complaints	Guidance to support practitioners	Collaborations to foster a positive culture
<ul style="list-style-type: none"> All doctors to have a CPD home CPD to be relevant to scope of practice CPD to be based on personal professional development plans 50 hours CPD per year, a mix of: <ul style="list-style-type: none"> performance review outcome measurement, and educational activities. CPD home to report to the Board where medical practitioners have not completed their CPD program requirements. 	<ul style="list-style-type: none"> Board to identify risks to patient safety and define the principles for screening those at risk Increasing age is a known risk factor: <ul style="list-style-type: none"> peer review and health checks for doctors who provide clinical care aged 70 and three yearly after that Board will not receive the results of peer review and health screening unless there is a serious risk to patients. Professional isolation is a known risk factor: <ul style="list-style-type: none"> education on how to identify and manage this risk increasing peer-based CPD for professionally isolated practitioners. 	<ul style="list-style-type: none"> Board to strengthen its assessment and management of practitioners with multiple substantiated complaints Board to require practitioners with multiple substantiated complaints to participate in formal peer review. 	<ul style="list-style-type: none"> Board to continue to develop and publish clear, relevant and contemporary professional standards including: <ul style="list-style-type: none"> revise <i>Good medical practice: A code of conduct for doctors in Australia</i> refine existing and develop new registration standards issue other guidance as required. 	<ul style="list-style-type: none"> Promote a culture of medicine that is focused on patient safety Work in partnership with the profession to reshape the culture of medicine and build a culture of respect Encourage doctors to: <ul style="list-style-type: none"> commit to reflective practice and lifelong learning take care of their own health and wellbeing support their colleagues. Work with relevant agencies to promote individual practitioners accessing their data to support practice review and measuring outcomes.

MBA's framework, CPD registration standard and our CPD program

PROFESSIONAL PERFORMANCE FRAMEWORK

Released in late 2017, the proposed framework provides a new foundational national perspective for CPD. Its aim is to ensure that medical practitioners in Australia practice safely and with competence throughout their professional lives.

The intention of the framework is to build on existing initiatives and our CPD program although we've been reassured we were already in good standing. This was supported through our inclusion of many of the items that will now become an MBA requirement such as Practice evaluation and Knowledge and skills activities, the CPD Plan and triennial evaluation and the online CPD portfolio.

Stakeholder workshops and consultations have included representation from the Australian Health Practitioner Regulation Agency, Australian Medical Council, Australia Medical Association, other specialist colleges, health complaints commissioners, government representatives and medical indemnity insurers with discussions over many years to work through any issues or concerns with the structure and implementation of the framework.

This large consultation, and pandemic priorities, has brought out delays as to when the expected final version would be provided by the medical board and how it differed from initial consultations.

Following its release, work required to ensure our CPD program complies with all aspects of the framework will start, with the vision of delivering an updated CPD standard/program/portfolio.

The framework includes five pillars, with pillar one, "Strengthened continuing professional development" the key focus of the revised MBA's new CPD standard.

CPD REGISTRATION STANDARD

This new CPD registration standard requires all medical practitioners in each calendar to:

- Meet the requirements of a CPD program of an accredited CPD home, of which ANZCA is accredited for anaesthesia and pain medicine.
- Develop a written annual professional development plan.
- Complete a minimum of 50 hours per year of CPD activities that are relevant to their scope of practice and individual professional development needs.
- Allocate a minimum 50 hours per year between the following types of CPD activities:
 - At least 12.5 hours (25 per cent of the minimum) in educational activities.
 - At least 25 hours (50 per cent of the minimum) in activities focused on reviewing performance and measuring outcomes, with a minimum of five hours for each category.
 - The remaining 12.5 hours (25 per cent of the minimum), and any CPD activities over the 50-hour minimum across any of these types of CPD activity.

- Self-evaluate your CPD activity at the end of the year as you prepare your professional development plans are prepared for the next year.
- Retain records of your annual CPD activity for audit by their CPD home and the board for three years after the end of each one-year cycle.

Additionally, two important items from the standard that influence our unique program to highlight are:

- CPD programs can be a points-based program if the activities can be translated to hours for the purpose of the practitioner meeting this standard and for auditing activities.
- CPD programs can be longer than one year (such as trienniums) provided they include annual requirements that meet the board's standard.



OUR CPD PROGRAM

Over the past few years, we have provided updates on the impending formal process to review the CPD program and ANZCA CPD standard.

These discussions continue, with the commencement of the formal process to review the CPD program following the MBA's final documentation and implementation date. The CPD program and standard had been due for review since 2019, five years after implementation, with the intention to align with the MBA proposed framework and Medical Council of New Zealand's recertification documents. This will also now look to align with the college's Lifelong Learning project.

A CPD program review project group will be established, with the timelines and scope largely governed by the release of this finalised CPD standard. The decision was aimed at minimising disruptions to our members and to ensure clarity with our direction.

We have been actively engaging with both regulators' bodies and other college representatives, in preparation to start our own formal CPD program review project and share any lessons learnt and areas to avoid.

We are confident that adjustments needed to be made will ensure the continued success of our highly regarded program.

WHAT DOES THIS MEAN FOR CPD PARTICIPANTS?

There are no confirmed changes to the CPD standard or portfolio at this time. As the college establishes the CPD review project group and reviews the released documentation, the group will identify recommendations to reach these new standards and seek respective committee approvals.

We ask that all CPD participants continue to update their CPD portfolio to ensure they are best prepared if any changes are needed to be made.

The changes required to meet the MBA's CPD registration standard will be communicated to all CPD participants and maintain the lengthy implementation to the MBA's effective January 2023 date.

We appreciate the uniqueness of our triennial cycle, and respect these changes may raise concerns for participants on meeting their requirements. It is our priority to continue to provide regular communications as new information is available, and ask that all CPD participants keep up to date with regular college publications.

Further information can be found on the MBA website:

- Revised CPD registration standards – www.medicalboard.gov.au/Registration-Standards.aspx
- Professional performance framework – www.medicalboard.gov.au/registration/professional-performance-framework.aspx

2021 VERIFICATION OF CPD ACTIVITIES (AUDIT) SELECTION

We are preparing to conduct a 2021 annual CPD verification (audit) with selection and notification planned from September 2021.

We appreciate as specialists the stressful encounters you experience day to day, especially during the COVID-19 pandemic. To support you, and to help alleviate some of the stress that may come with the CPD audit process, we have provided a breakdown of our processes and answered commonly asked questions.

We encourage those selected or interested in our verification process to view our website news item – www.anzca.edu.au/news/cpd-news/annual-cpd-verification-your-questions-answered.

ARE YOU ENROLLED IN THE 2019-21 CPD TRIENNIUM?

With the 2019-21 triennium in its final few months, we encourage the 1219 CPD participants in this cohort to start updating their CPD portfolios and completing any outstanding CPD activities by the 31 December 2021 final submission date.

Over the coming months, we will begin sending our regular reminder emails. These contain information specific to each individual, outlining what is remaining to successfully complete your CPD triennium.

We recognise the challenges faced during the outbreak of the COVID-19 pandemic, and the disruption to usual channels of completing your CPD. In support, we have put together some motivating stats and an assortment of resources that we recommend you review on our website news item – www.anzca.edu.au/news/cpd-news/end-of-triennium-could-we-really-be-on-track-to-do.

If you have any concerns in with meeting your CPD requirements or about the verification process, please do not hesitate to contact the CPD team at cpd@anzca.edu.au as soon as possible to discuss your options.

Quantra delivers 'sniper attack' to deal with critical bleeding

"Without viscoelastic testing, I would have treated this patient with shotgun therapy...now I use the Quantra for sniper attacks on hypocoagulability", cardiac surgeon Dr Pierre R. Tibi on open heart surgery protocols at Yavapai Regional Medical Centre, Arizona, US



Acute perioperative situations demand fast action on whether to transfuse critically bleeding patients. Patient blood management must therefore be a multi-disciplinary effort aimed at improving patient outcomes.

Comprehensive diagnostic panel

The QPlus cartridge provides a comprehensive diagnostic panel with six parameters - clot times with and without heparinase (CT and CTH), clot stiffness (CS) and fibrinogen contribution to clot stiffness (FCS). Two unique parameters are then automatically calculated: clot time ratio (CTR), and platelet contribution to clot stiffness (PCS). Unlike some other systems, clot stiffness parameters can be used while patients are on bypass. The QStat cartridge provides an additional parameter, the Clot Stability to Lysis (CSL), a quantitative analysis of fibrinolysis.

Clinical studies indicate high precision, generally strong correlation with standard laboratory assays, good concordance with the clinical presentation and high negative predictive value for thrombocytopenia.

A recent study identified potential cut-off values for the FCS and PCS parameters for use in place of, or alongside, lab-based fibrinogen and platelet thresholds to guide transfusion decisions.

Pioneering use of ultrasound

For the first time in viscoelastic testing, Quantra uses ultrasound technology to measure the dynamic changes as a clot

forms. Unlike classic systems, the Quantra cartridge is fully enclosed, with no need for pipetting. This minimises the risk of blood exposure.

Also, there are no moving parts to come into contact with the blood and potentially disrupt clot formation, increasing sensitivity to early clot formation and to the soft clots often linked to bleeding.

Those Patient Blood Management (PBM) programs that integrate viscoelastic testing deliver better clinical decision-making, cost savings and optimal patient care. Data from the Quantra has enabled the development of more simplified treatment algorithms to apply targeted therapy in the management of bleeding patients.

New Quantra POC Solution website

Visit www.quantrapocsolution.com, the new website dedicated exclusively to Quantra. Find out exactly what singles out this innovative, viscoelastic testing system - from results' delivery within 15 minutes to the expanding bibliography of Quantra-related clinical studies.

For more information or to request a demo, email info@au.stago.com or call 1800 4 Stago (1800 4 78246) for Australia or 0508 4 Stago (0508 4 78246) for New Zealand.



With a fully enclosed cartridge, Quantra needs no manual pipetting

In less than 15 minutes, the Quantra haemostasis analyser and QPlus cartridge provide critical information about clotting time and the quality of any formed clot. You can read the results the moment they appear on the screen, without needing to decipher complex curves. Data can also be shared remotely with the blood bank, clinical colleagues or laboratory via the Quantra Desktop Remote Viewer.

Quantra is the first viscoelastic testing device to provide direct quantification of the Platelet Contribution to Clot Stiffness (PCS), measuring clot elasticity, rather than amplitude. This accounts for both platelet count and platelets' ability to aggregate, contract, and contribute to clot strengthening. The Quantra can measure the evolving clot stiffness without any manipulation or disruption to the clot.



Easy-to-interpret, intuitive dials display



Diagnostica Stago, a global leader in haemostasis and thrombosis, expanded into point-of-care with the acquisition of HemoSonic.

References on request

Anaesthesia and
having a baby —

Get ready for National Anaesthesia Day!

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

This year's theme is "Anaesthesia and having a baby".

As usual, we've sent posters and other resources to participating hospitals in late September. We'll also be launching a new animated patient information video on the day, designed to guide conversations between patients and healthcare professionals, and to provide reassurance and advice to pregnant women about the

safety of anaesthesia before, during, and after having a baby. We'll be running a social media campaign across Twitter, Facebook and Instagram using the hashtag #NAD21.

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



Get in touch

Contact communications@anzca.edu.au in Australia or communications@anzca.org.nz in New Zealand to find out more and keep watching our website for updates!

ANZELA-QI shows the benefits of national standards

After hip fractures, emergency laparotomies are the most common procedure associated with perioperative mortality. A two-year pilot collaborative project involving anaesthetists and surgeons highlights the benefit of national quality care hospital standards for emergency abdominal (surgical) procedures to reduce mortality and length of hospital stay for patients.

THE REPORT OF the Australian and New Zealand Emergency Laparotomy Audit-Quality Improvement (ANZELA-QI) pilot study found the quality of patient care improved in hospitals where eight key compliance standards were used for patients undergoing emergency laparotomy in their hospitals.

One of the key care standards identified involves recording a preoperative risk assessment – which drives other key compliance standards such as timely access to theatre – the presence of a specialist anaesthetist and surgeon for patients with predicted mortality risk > 5 per cent, and direct admission to a critical care unit when predicted mortality risk exceeds 10 per cent.

Data was collected monthly from 24 participating Australian hospitals and 2886 patients (representing 11 per cent of all emergency laparotomies performed in Australian hospitals). The data was then used to provide timely feedback to each participating site, allowing them to assess their performance against evidence-based indicators of care and to drive quality improvement processes across the hospital.

"The overall in-hospital mortality was 7.1 per cent (2.3 per cent–13.5 per cent) and average length of stay 15.5 (8.6–22.7) days. Both significantly declined over the course of the pilot program. Preoperative risk assessment (overall 45 per cent) improved almost three-fold during the study. Only 60 per cent had timely access to theatre and only 70 per cent with a predicted mortality risk of > 10 per cent were admitted to critical care," the report says.

"These ANZELA-QI results suggest that the care standards directly controlled by individual surgeons and anaesthetists have largely been achieved. Further improvements will require organisational or systemic changes."

Specialist anaesthetist Dr Ed O'Loughlin, an ANZELA-QI working party member with Mr James Aitken, a Western Australian colorectal surgeon, said the study was significant as it was the first Australian quality improvement project to measure the care and outcomes of Australian patients undergoing an emergency laparotomy against international benchmark standards.

The pilot study was established with seed funding from ANZCA and the Royal Australasian College of Surgeons and was supported by a collaboration of anaesthetists, surgeons and other doctors across Australia and New Zealand.

"We hope that we can learn from the hospitals that have done well using the quality care standards and apply them more broadly to improve the care of Australian patients undergoing an emergency laparotomy," Dr O'Loughlin said.

"We found that patient care can be improved with participation in a national clinical quality registry (CQR) standard of care. There are fewer complications for patients so we can save lives and reduce health costs. We hope this can be endorsed and supported by health officials and government."

Dr O'Loughlin said more than 60 Australian hospitals had expressed interest in participating in the project that had national ethics approval. The final number of 24 hospitals participating in the project highlights the challenges of the lack of an overarching and simple governance framework for clinical quality registries.

"By publishing the findings we're hoping that other hospitals will be able to use this approach and improve outcomes for their patients. By just participating, hospitals have demonstrated improvement. We have shown that patient outcomes do improve by providing data and audit feedback. It's not a wonder drug but it's the wonder effect."

We would like to thank the anaesthetists involved in the project on the working party and all anaesthetists and others, including support staff, working at the ANZELA sites.

ANZELA-QI working party

Dr Jill Van Acker, FANZCA
Dr Ben Griffiths, FRCA
Dr Ed O'Loughlin, FANZCA

ANZELA-QI sites

Albany Hospital	Mt Gambier And Districts Health Service
Albury Wodonga Health	Nepean Hospital
Alfred Health	Port Macquarie Base Hospital
Armidale Rural Referral Hospital	Rockhampton Base Hospital
Ballarat Health Service	Royal Adelaide Hospital
Barwon Health (University Hospital Geelong)	Royal Darwin Hospital
Fiona Stanley Hospital	Royal Hobart Hospital
Gold Coast University Hospital	Royal Perth Hospital
Latrobe Regional Hospital	Sir Charles Gairdner Hospital
Logan Hospital	St John Of God Midland Public and Private Hospitals
Mackay Base Hospital	St Vincent's Hospital, Melbourne
Mater Hospital (South Brisbane)	Western Health

Reflections on the analysis of cardiovascular incidents reported to WebAIRS

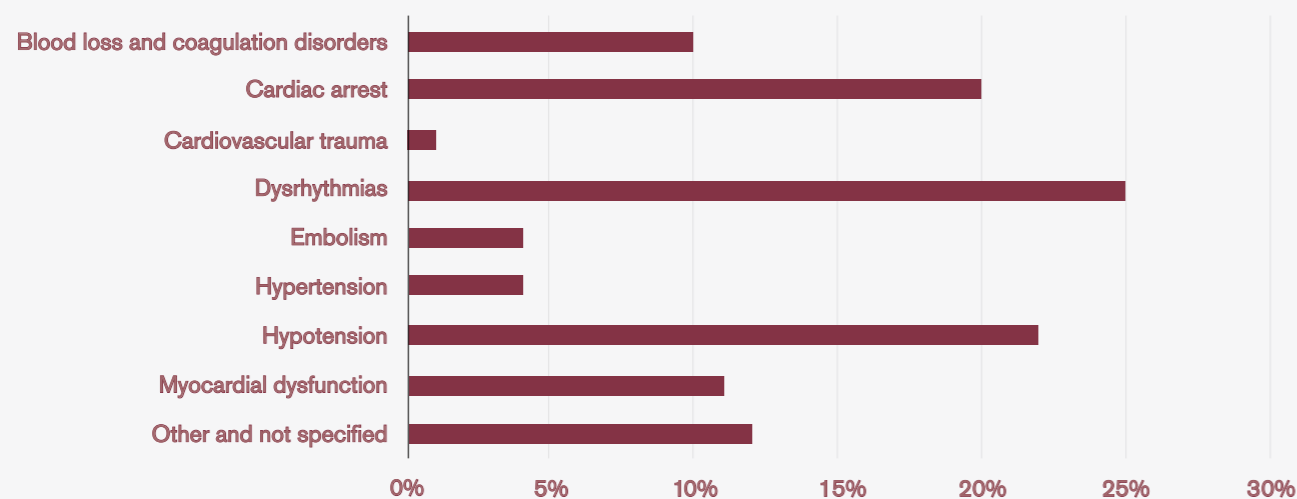
WebAIRS has reached another milestone with more than 9000 reports submitted, and as of August 2021 the first 8000 reports have been cleansed and finalised. In this edition of the Bulletin, an overview of WebAIRS reports involving the cardiovascular system will be discussed.

Cardiovascular incidents accounted for almost 17 per cent of the reports. The categories of cardiovascular incidents reported are grouped into the following sub-categories: blood pressure 26 per cent (including hypertension four per cent and hypotension 22 per cent), blood loss and coagulation disorders 10 per cent, cardiac arrest 20 per cent, cardiovascular trauma one per cent (unintentional surgical events), dysrhythmias 25 per cent, embolism four per cent, myocardial dysfunction 11 per cent and other miscellaneous events 12 per cent.

In the *Bulletin* Winter 2021 edition, we created a bowtie diagram to help understand the effects of incidents involving infrastructure and system factors. In the analysis of the cardiovascular incidents, however, the nature of incident sub-categories for the cardiovascular incidents makes it difficult to create a unifying bowtie diagram. There is a great deal of interplay between the sub-categories. These sub-categories would be all worthy of a diagram of their own, and ANZTADC plans to release online versions of these diagrams based upon the WebAIRS data.

Incident main categories	% of reports
Assessment/documentation	5%
Infrastructure/system	5%
Medication	18%
Respiratory/airway	31%
Cardiovascular	17%
Neurological	6%
Other organ	2%
Medical device/equipment	12%
Miscellaneous/other	8%
Not specified	2%
Total	106%

Figure 1. Sub-categories of cardiovascular incidents within the first 8000 WebAIRS reports (The total shown is greater than 100 per cent as it is possible to have more than one incident per report).



Many, but not all incidents in this main category, are associated with patient risk factors, some are related to the task being performed, and there are some related to either caregiver or system factors, which could all be appropriately listed in the hazards column of the diagram.

However, the methods to trap errors or manage incidents that occur are very dependent on the type of incident that occurred. Each of these sub-categories would require different management strategies and, in some instances, more than one sub-category would be involved such as blood loss and hypotension, or dysrhythmia leading to cardiac arrest. In some cases, it might be difficult to know the precise cause.

For instance, hypotension might be due to anaesthesia, which is common but could also be due to occult bleeding, myocardial dysfunction, hypovolaemia, or a variety of other causes that might occur during anaesthesia for various procedures.

A sub-analysis of the incident categories might give more answers to how to manage these events successfully and could assist in developing specifically targeted cognitive aids. In the meantime, emergency management manuals have been published in Australia^{1,2} and worldwide^{3,4}, which describe in detail how to manage the most frequent cardiovascular incidents.

Readers are invited to contact ANZTADC (anztadc@anzca.edu.au) if they wish to make their own analyses of WebAIRS cardiovascular events in any sub-category.

Are you contributing to quality anaesthesia? Visit the WebAIRS website to register or email anztadc@anzca.edu.au.

ANZTADC Case Report Writing Group

ANZTADC thanks all WebAIRS users for their contributions to the WebAIRS database

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My social media journey

Many in the social media community know Wollongong anaesthetist and ANZCA councillor Dr Tanya Selak as @GongGasGirl. An avid Twitter user, she describes how the benefits of social media outweigh the bad.

Multi-tasking: Dr Tanya Selak live tweets during ANZCA's Virtual ASM while watching her children ice skate in Wollongong.

HOW IT ALL STARTED

I am originally from New Zealand and my husband and I settled in Wollongong, New South Wales after some time training in London. I started consultant practice when our first child was a few months old, and we quickly had two more.

I found myself in the fog of having a young family and navigating the workplace as a new consultant with no onsite family support. When our three children were a little older, I was able to breathe a little and attended my first conference in years – “Social Media and Critical Care (SMACC)”.

It was there I was introduced to a whole new world beyond those in my real life. I was intrigued – I could be a mother, an anaesthetist, a head of department and use platforms to connect with others in our specialty and other professions across the world.

LIKE IT OR LOATHE IT, IT'S BIG AND IT'S NOT GOING ANYWHERE

Social media is ubiquitous in our professional and personal lives. The impact is astonishing and difficult to overstate. \$US138 billion worldwide is generated in advertising revenue across all social media platforms.

In New Zealand and Australia, 80 per cent of the total population is on social media, with the average internet user spending 1 ¾ hours on platforms every day (see www.statista.com).

SAFETY

Despite all the benefits, there are dangers online. We must follow the social media policies of our employers, the Australian Health Practitioner Regulation Agency (AHPRA), the New Zealand Medical Council and ANZCA.

These documents are not intended to be pernicious. Instead they are designed to help protect us, our patients, and our organisations from harm. They can have subtle differences, but in essence they set a standard where doctors are expected to demonstrate the same professional behaviours as in real life.

I find the 12-word Mayo Clinic social media policy the easiest to follow and it encompasses most of the points of the others; “Don't Lie, Don't Pry, Don't Cheat, Can't Delete, Don't Steal, Don't Reveal” (socialmedia.mayoclinic.org).

In particular we need to remember that all is public (even on some social media sites such as Facebook where there is a perception of privacy, screenshots are used more often than we think), we must fiercely protect patient confidentiality, not engage when providing direct clinical care and have respectful discussions.

WHY I TWEET

Hippocrates would probably be on Twitter, and so should we. His belief was that knowledge sharing was fundamental to the advancement of science and medicine (see www.mja.com.au/journal/2020/213/11/hippocrates-would-be-twitter).

Social media allows us to be curators and disseminators of accurate information in addition to producers of it. Experts present on social media and cover every aspect of anaesthesia and medicine more broadly – science, research, teaching, learning, wellbeing and advocacy. They share their expertise so generously, and I learn so much.

I started engaging by live-tweeting conferences. This involves taking presentation notes in real time directly into Twitter. It allows others at the conference and at home to engage with the content. It is also beneficial to the speaker and the conference as amplification occurs via the conference hashtag.

Live-tweeting is an easy way to find like-minded people and serve others in a low risk way. Now with online conferences, barriers to access are even lower, especially for those from low- and middle-income countries. It now seems quaint to wait at the letterbox for scientific journals to arrive with content created months or even years earlier.

Colleagues across all specialties help me keep up to date with latest research. Anyone can contribute to the discussion, allowing a deeper understanding of the topic from diverse workplaces. No invitation is required, there is no fee and all can participate respectfully.

I admire our hardworking researchers. It can be a difficult and lengthy process to secure funding, ethics and to finally get to publication, with much of their work completed after hours. However, there is a tsunami of new papers and work can be lost in the noise. Social media expert Mari Smith says “content is King, but dissemination is Queen, and she rules the house”.

Social media can be used creatively to move scientific content to bedside clinicians using tools such as podcasts, infographics and tweetchats.

Sir Mark Walport, the former UK Chief Scientist said “Science isn't finished until it's communicated”.

TWEETING IN A PANDEMIC

Many of us have been sharing educational content and public health messages on social media throughout the pandemic.

Those who were affected early, generously shared their lessons allowing others to use the time to learn and be prepared.

It was on Twitter that I learnt about pandemic fit-testing, N95s, donning and doffing, simulation, treatment and lessons from previous pandemics. I shared this information with colleagues, and it helped inform local strategy. Those of us who weren't yet affected with cases, sent messages of support and solidarity to those dealing with cases, wishing we could help.

“Hippocrates would probably be on Twitter, and so should we. His belief was that knowledge sharing was fundamental to the advancement of science and medicine.”

We willed them on as they resiliently kept working even when exhausted and overwhelmed with death. Social media has allowed doctors to use their voice to advocate for improved protection of healthcare workers. We are able to “leverage social media in public health outbreaks to bring attention to topics of importance” (Leibowitz et al WJEM 2021).

IT WOULD BE FUNNY, IF IT WASN'T SO DANGEROUS

In addition to being able to weather storms on social media with the help of my community, I believe that we shouldn't be bullied offline.

Communication of accurate information is too important to healthcare and society, particularly during a pandemic, and we can all play a small part. “Disinformation has become a direct threat to public health,” said Imran Ahmed CEO of the Centre for Countering Digital Hate (CCDH).

The anti-vaxx industry has a well-funded targeted campaign to spread misinformation about the safety of COVID-19 vaccines. Social media enables the recruitment and indoctrination of ordinary people using sophisticated tactics which stoke fear and mistrust.

We see the effects of this in our own workplaces where a minority of healthcare workers including doctors and nurses decline vaccination. Social media content can give the appearance of widespread vaccination hesitancy, that it is common.

However, the CCDH and Anti-Vax Watch's joint report found that up to two-thirds of anti-vaccine content on social media sites is tied to 12 individuals or organisations, the so called “disinformation dozen”.





Dr Tanya Selak on screen during the 2021 ANZCA Annual General Meeting.

“The anti-vaxx industry has a well-funded targeted campaign to spread misinformation about the safety of COVID-19 vaccines.”

Some hire large teams to create content and to coordinate attacks on those who support public health messages, with their own agendas. Unfortunately, most of these 12 are still on the platforms despite violating policies. US President Joe Biden has said publicly they are killing people.

The CCDH quite rightly urges social media giants to take action.

New Zealander of the Year Dr Siouxsie Wiles has spoken in the *NZ Herald* about her experience of social media abuse in response to communicating pandemic science.

SOCIAL MEDIA COMPLICATIONS

Even when we follow guidelines, it is to be expected that sooner or later social media difficulties will occur. It is inevitable whether or not we engage.

There will always be some who do not like what we say, or how we practice, and they can post negative content about us without our knowledge or permission. Surgeons experience this routinely on patient satisfaction sites and they have limited right of reply.

Instead of advocating abstinence, we should instead learn how to wisely manage social media just like we learn clinical skills – indications (when to engage), contraindications (when not to engage), complication management and when to call for help. There should be no moral shame when this occurs, just like we don't think poorly of someone whose patient suffers

anaphylaxis. We institute a management plan and later reflect, analyse, discuss with peers and change technique if necessary.

If you find yourself bullied online, please don't deal with it alone. There are many ready willing and able to provide support. The bullies aim to make the target ashamed and fearful in order to silence them.

Instead, seek support and wise counsel from trusted sources. Marketers in crisis management say that if we have made a mis-step that we should fight fear with fact, apologise and correct if a mistake has been made and try to take disputes offline if needed.

Do not hesitate to block offensive accounts and report bullying and abuse. eSafety.com.au and netsafe.org.nz have useful resources.

CHANGE IS SCARY, NOT CHANGING IS SCARIER STILL

Rear Admiral Grace Hopper said: “The most dangerous phrase in the English language is ‘we’ve always done it this way’.”

Even though the internet can be a cesspit, we should not respond with abstinence. If we don't participate, the void will be filled by others, some of whom do not have good intentions.

Anaesthetists have many valuable insights to share about anaesthesia, medicine and society. We are large in number and we are highly trusted by our communities. We can shape healthcare and society positively when we move beyond our anaesthesia machines.

We are stronger together.

Dr Tanya Selak, FANZCA (aka @GongGasGirl)
ANZCA Councillor
Wollongong, NSW

That time I went viral...



“Hey there's lots of crazy/inept nurses and doctors. FYI.”

“She deleted it because she was virtue signaling and knew it.”

“Always them crazy eyes”

“I clean myself with hydrochloric acid after shopping. You know, just to be sure.”

“She needs a mental health time out”

“Clown”

“I told her she should immediately resign and burn her degree and license and find a job outside of the medical profession. Hope she did just that.”

“Anaesthetists are supposed to make people numb. She sort of succeeded but not in the way she wanted.”

It all started with a trip to Woolworths.

As we entered our fifth week of lockdown with the outbreak escalating, I tweeted about vaccination, and created a series of education tweets with the title “I'm a vaccinated anaesthetist and this is how I shop for my family”.

My messages echoed those of NSW Premier Gladys Berejiklian, Chief Health Officer Kerry Chant, and Health Minister Brad Hazzard: Shop only when you need to, wear a mask, sanitise and QR code on entry and exit, physically distance, shop with purpose, limit time inside.

For the first two days, the feedback was positive with the usual interesting exchange of information. There were helpful contributions from others such as how those with disabilities in locked-down Sydney could get home delivery priority, where delays were five days in some areas.

Unfortunately, my tweets were then picked up by large anti-vaccination accounts in the US and the UK.

They encouraged their hundreds of thousands of followers to attack me. The mob duly followed orders. There was a tsunami of nasty tweets – that I was ruled by fear, that I was their masked unhinged oppressor, that I needed psychiatric help, that I should be deregistered, with a few threatening gendered violence.

I went to sleep on Monday night with the tweet having 300,000 impressions and largely positive commentary.

By the morning the tone had changed and there were 3 million impressions which were rapidly rising. I elected to deactivate my account to stop the activity.

The mob then celebrated that they had bullied me into silence.

For days I was trending, at up to 1400 tweets per hour.

I went viral across the world and was ridiculed in thousands of memes.

I GET BY WITH A LITTLE HELP FROM MY FRIENDS

Most would probably expect me to say that this was a traumatic experience, and the only logical response from a reasonable person with a busy work and family life would be to avoid social media forever, to pipe down, avoid all this trouble, get back to my anaesthesia machine and childcare and domestic duties.

It was indeed extremely unpleasant, however, I was able to brush it off after a brief hiatus and continue.

I found strength from the outpouring of kindness from many places. In addition to my real life support crew of family and friends, total strangers risked abuse themselves by defending me, Twitter friends who I've never met in real life reached out via intermediaries, colleagues I have collaborated with checked up on me, cheered me up and shared their own stories of social media bullying.

Many reported abusive tweets resulting in the suspension of many accounts. Organisations I am associated with including my workplaces were not calling for my expulsion, instead they checked on my welfare and strongly supported me in practical ways. In particular, my fellow ANZCA councillors and ANZCA senior management were so incredibly kind and wise, offering practical support and advice.

I won't ever forget those who quietly (and loudly) sat with me in the rubble.

How we are guided



ANZCA's Executive Director of Professional Affairs (DPA) Dr Leona Wilson looks at how our regulatory bodies handle codes of conduct issues on both sides of the Tasman.

"I will not conform to your ridiculous moral standards and your expectation of what a doctor should or should not say."

"I didn't go to med school for six years and gain entry to the (ANZ college's registrar training scheme) to let some anonymous moron call me a nurse and fake doctor. My qualifications are as genuine as your stupidity."

"I can just as easily condemn your mother for a whore (if the situation warranted it) as I can save your life or even hers."

These comments came from one doctor on an online forum that led to a disciplinary case in 2019.

While this may not be unusual for some of the nastier parts of the social medical landscape, it is not what the public expect from doctors who are treating them or their families now or may in the future. So how do we know what is expected of us?

Both our regulators, the Medical Board of Australia (MBA) and Medical Council of New Zealand (MCNZ) have codes of conduct, both named *Good Medical Practice*. Then there are specific statements on matters with more detailed advice. The MBA code has fewer associated statements than the MCNZ.

An example is cultural safety: MCNZ has the "Statement on cultural safety" which has an associated data report and four further statements on aspects of cultural safety. The MBA has put this in the main code.

The codes "make explicit the standards of ethical and professional conduct expected of doctors by their professional peers and the community". For almost all of us, these will read simply like "common sense" and sit well with our concept of how a doctor behaves.

Our college has these statements incorporated into the curriculums and professional documents for those of particular relevance to anaesthesia and pain medicine. While these may not be page-turning reading, they are worth using as references on what is expected of us.

So, what can we learn about social media use?

Both MBA and MCNZ have specific statements on this, as does the college. They are titled respectively "Social media: How to meet your obligations under the national law" and "Statement on use of the internet and electronic communication" and "Social media policy".

The MBA statement includes: "Where relevant, national boards may consider social media use in your private life (even where there is no identifiable link to you as a registered health practitioner) if it raises concerns about your fitness to hold registration". The relevant New Zealand standard includes "Be careful when sharing information using social media platforms where it can be accessed by members of the public. Do not disclose information about yourself that might undermine your relationship with patients, or that might identify and cause distress to colleagues, patients and their families."

Another example of a breach of the code has been a New Zealand consultant who lied about a patient's care to the patient's legally appointed carer. They alleged another member of the health care team had made the decision about care not them, in an attempt to cover up what they had actually done. The consultant then compounded that deception by directing the registrars working with them to not document what they had said to the carer.

"Only approximately 0.07 per cent of medical practitioners are referred to a disciplinary tribunal or similar (in Australia and New Zealand) per year but they are the tip of the iceberg."

This behaviour breaches multiple parts of the code, including the need to be honest, the need to respect medical colleagues and other health professionals, the need to act as a positive role model for team members, and the need to maintain clear and accurate medical records. The doctor was found to have committed professional misconduct, and conditions were placed on their medical registration. These remain at the time of this article.

The above examples may appear extreme (only approximately 0.07 per cent of medical practitioners are referred to a disciplinary tribunal or similar in each country per year), but they are the tip of the iceberg and have been taken from publicly available information on disciplinary processes in Australia and New Zealand.

Central to both codes is the need for doctors to respect their patients and to behave ethically to earn and hold their patients' trust. While they have a different style and headings, they cover very similar areas. These are applied to the practice of anaesthesia and pain medicine in the curriculums and the *Supporting anaesthetists' professionalism and performance – a guide for clinicians*.

You may be curious as to what happened to the doctor at the beginning of this story. He was easily identified from his posts. He was tried in front of the Health Practitioners Tribunal, reprimanded, suspended from the medical register for a short



period, and conditions were imposed on his registration requiring him to undertake education on ethical behaviour and communications, especially in the use of social media. His current registration status on the Australian Health Practitioner Regulation Agency (AHPRA) remains "suspended" as the *Bulletin* went to print.

Dr Leona Wilson FANZCA
Executive Director of Professional Affairs (DPA), ANZCA

Thanks to Dr Jo Sutherland, associate professor with the NSW Rural Medical School, for her input.

TABLE 1

Medical Board of Australia	Medical Council of New Zealand
Professionalism	Professionalism
Providing good care	Caring for patients
Working with patients	Acting honestly and ethically
Respectful culture	Respecting patients
Working with healthcare professionals	Working in partnership with patient and colleagues
Working within the healthcare system	
Maintaining professional performance	Accepting obligations to maintain and improve standards
Patient safety and minimising risks	
Professional behaviour	
Ensuring doctor's health	
Teaching, supervising and assessing	
Undertaking research	



International military deployments a way of life for decorated anaesthetist Colonel Susan Winter

AFTER COLONEL SUSAN (SU) WINTER returned to Australia in 1995 from Rwanda, her first overseas deployment as a medical specialist with the Army Reserve, there was little in the way of structured debriefings for personnel.

Then, in contrast to the support now provided after military deployments, she recalls “the debrief was a cab charge from the airport. You were expected to just get on with it”.

Since that deployment to Rwanda the decorated ANZCA and College of Intensive Care Medicine fellow has been involved in many Australian and international conflict and humanitarian missions including Afghanistan, Iraq, East Timor, the Solomon Islands and as one of the first responders just hours after the 2002 Bali bombing which killed 202 people.

Colonel Winter's service as an army reservist was recognised in this year's Queen's Birthday Honours list with a Medal of the Order of Australia (OAM) in the Military Division for her “meritorious service as a specialist anaesthetist and intensivist on

multiple overseas deployments and specialist medical advisor to the 2nd General Health Battalion, 3rd Health Support Battalion and Army Health Services”.

In 2003 she received the Conspicuous Service Cross (CSC) in recognition of her role as a specialist medical officer to Operation Bali Assist, the Australian Defence Force (ADF) evacuation of injured Australians and foreign nationals after the 2002 Bali bombing. That operation involved the triage, stabilisation and evacuation of 66 critically ill patients from Bali to Darwin over 21 hours. The patients were flown to Royal Darwin Hospital and then transferred for treatment to other Australian hospitals.

Reflecting on her years of army reservist service as an anaesthetist and intensivist with the *ANZCA Bulletin*, Colonel Winter explained how until earlier this year she was spending several hours a week teaching registrars at The Alfred hospital in Melbourne.

Opposite: Colonel Winter (centre) Director of Clinical Services at the Taji Military Complex Iraq 20 km north of Baghdad in 2017. (Photo: supplied)

Below: Colonel Su Winter at The Alfred in 2019.

Colonel Winter was diagnosed with motor neurone disease (MND) early in 2019 but she was able to continue to practise as an anaesthetist and intensivist for several months. She formally retired from clinical practice in July.

Colonel Winter grew up in Tasmania where her father, a Vietnam War veteran, was an army reservist. Not long after she had started her medical degree in Hobart she too decided to join. After graduation she moved to Launceston for her internship and later Sydney where she began her anaesthesia training at North Shore Hospital, continuing at Westmead Hospital and with the aeromedical retrieval service CareFlight.

“I had gone to a dinner in Sydney after my primary exam and met a reserve officer with an army medical unit who offered me the chance of working with a reserve medical battalion so when I received my fellowship in early 1995 I joined and then was sent to Rwanda as my first deployment,” she explains. (The ADF committed more than 300 personnel including a medical support force as part of the United Nations Assistance Mission for Rwanda.)

“At that time I was the Australian mission's only female specialist in Rwanda. There were a few other female doctors including Wing Commander Alex Douglas (profiled in the June 2018 *ANZCA Bulletin*) who later trained as an anaesthetist. In those days specialists were reservists and we were there for six week rotations. When I returned from Rwanda I was quite unsettled and the only person I could talk to about it was Alex so we would often catch up over coffee as a way of supporting each other.”

“While I was in Rwanda I looked after a baby in ICU for 24 hours who had been brought in with a perforated anus. The surgeon I was working with operated on the baby but unfortunately the baby died some weeks later. It was the first operation for me in a third world environment and it was confronting looking after the baby in an operating theatre in the main private hospital in Kigali. I spent much of the night ventilating the baby by hand-bagging and that was the reason I chose paediatric anaesthesia when I continued my training back in Perth.”

After her Rwanda deployment Colonel Winter moved to Perth so she could complete her paediatric anaesthesia fellowship and then returned to Sydney and Liverpool Hospital.

Between 1997 and 1999 she was deployed to Bougainville as part of a specialist surgical team and later with the International Force East Timor (INTERFET), a multinational mission led by Australia to stabilise the country in 1999. Several short-term stints on the Australian hospital ship HMAS Manoora during unrest in the Solomon Islands followed and her daughter Madeleine was born in Sydney in 2001 where she was living with her then partner, now husband, Brigadier John-Paul Ouvrier.

In 2002 the family were living in Darwin where John-Paul had been posted and Colonel Winter was working at Royal Darwin Hospital doing occasional shifts as an anaesthetist and an intensivist in ICU. When the phone rang early on that Sunday morning in early October she knew that she was about to head off again.

“The Bali bombing had just happened and the army rang asking me to organise a medical team to fly to Denpasar airport. I rounded up my mates and equipment and we joined the defence flight in Adelaide that had left from Sydney and then flew to Denpasar. Time was



crucial because of the victims' injuries and burns. As the first medical responder team we set up a triage staging facility at the airport. We had to look after everyone on the tarmac for a few hours until the next flight came in and this involved putting in drips, pain relief and doing basic burns resuscitation. I returned to Darwin on the first medical flight with 22 patients and then the rest of the patients came back over the next 24 hours."

"It was this response that ultimately led to the National Critical Care and Trauma Response Centre being established and the Australian Medical Assistance Teams. All the lessons we learnt from the 2002 response we again used as part of our response for the next Bali bombing in 2005."

When her husband was transferred from Darwin to Melbourne in 2004 Colonel Winter continued with her intensivist training at The Alfred before moving to Townsville with her family for another army posting. It was while working as a senior medical officer with an army brigade there that she was deployed to Afghanistan in 2007-08. She was posted for four months in a Dutch military hospital in Tarin Kowt in Oruzgan province in southern Afghanistan as part of Australia's mission with the NATO International Security Assistance Force.

"In deployments such as Afghanistan and East Timor we were allowed to provide humanitarian aid to the local community. I looked after a baby in ICU in Afghanistan one night. The hospital had been destroyed and I was at the base. Often the local Afghanis would arrive seeking help from us and one night a baby was bought in with bronchiolitis (a common lung infection in young children and babies). The baby improved after I put her on a BiPAP machine and that was another turning point for me as I realised then that I wanted to continue with my ICU training."

After Afghanistan she moved with her family to Canberra where her husband had been posted to the Australian Defence College and she completed her ICU training there before they moved again to Darwin, returning to Melbourne in 2011.

"My brain still works even if my legs don't... Life is now a bit more stressful than it was and the only problem with motor neurone disease is there is no treatment."

"Looking back now I realise I had quite a weird CV and getting a hospital job in Melbourne was difficult at first. I worked in Wagga Wagga as a visiting medical officer anaesthetist for a while where I worked for about 10 days a month doing paediatric anaesthesia and I really enjoyed it. I had a break from deployments from 2011-2014 and then in 2016-17 I was asked if I was interested in taking on medical roles in Iraq."

Colonel Winter spent three months with US forces as an anaesthetist and intensivist at the US military base at Baghdad airport in 2016 and in 2017 worked as an anaesthetist as director of clinical services at Camp Taji, the joint international coalition forces base north of Baghdad.

"In the early days of my deployments we were giving humanitarian aid to the local civilians but that later changed and security became more of an issue. In Afghanistan and Iraq the local conditions became more confronting and dangerous and the medical rules of engagement were very different as we were only allowed to look after contractors and coalition troops."

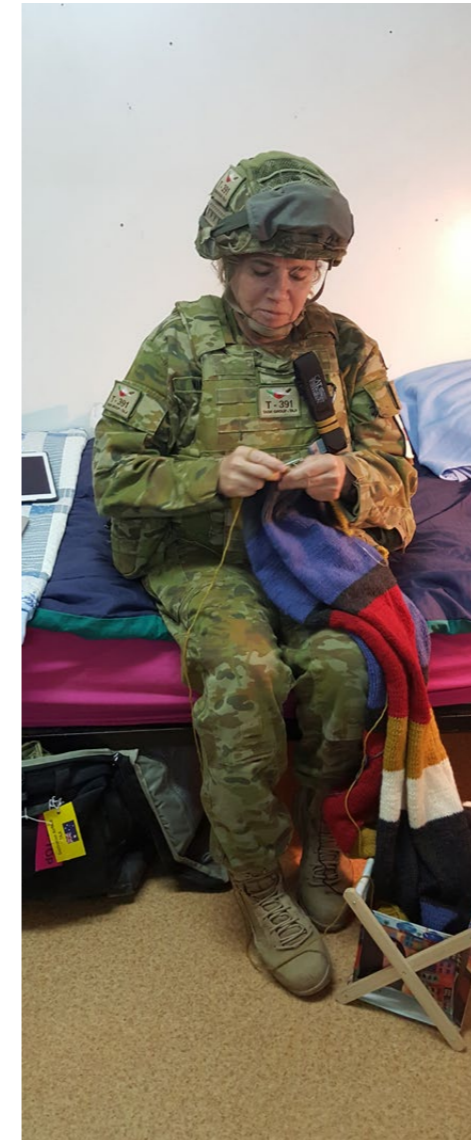
Colonel Winter nominates advances in technology and communications as having the most impact on clinical practice in deployments in her nearly 30 years of service.



Colonel Winter in her "mess dress" in 2018.



The then Major Winter with Captain Richard Crompvoets treat an infant in the intensive care unit in the Australian ward of Kigali central Hospital in Rwanda.



Colonel Winter taking a well-earned break in Iraq in 2017.

"We had to take text books with us to Rwanda whereas in Iraq we just had phones and googled everything. I can remember ringing home from Rwanda and a phone call cost something like \$10 a minute and there was always a huge queue. In Afghanistan we had a community phone system and a decent internet service.

"Bedside ultrasound and the advent of portable monitoring such as oximetry has changed a lot of our practices. Now we can use ultrasound for diagnostic and procedural things. The advent of ultrasound, wireless communication and quick access to information are the things that have changed. As long as the electricity doesn't give out or you run out of battery life you can do just about anything. Blood supplies are also now much more robust than they were 25 years ago.

"I could have conference calls with medical teams in Australia while in Iraq. The fundamental principles of looking after people though is no different. I remember in Taji in Iraq I was working with an American surgeon who hadn't done an open appendectomy before. He had done everything with a laparoscope so we had to do a bit of a YouTube search. The procedure went well!"

Until she retired Colonel Winter was teaching intensivist registrars at The Alfred in a combination of Zoom and face-face-face presentations.

"My brain still works even if my legs don't. I worked in a wheelchair to the end of February and I'm now retired. Now I'm in a wheelchair all the time though I have a motorised scooter and that gives me some independence. Life is now a bit more stressful than it was and the only problem with MND is there is no treatment. I was 56 when I was diagnosed and we had all these great plans about what we were going to do including many more skiing trips."

Colonel Winter says she was honoured to be awarded the OAM in recognition of her military service.

"I am quite humbled by it because everything I've done really has been by accident. The ADF missions really started up when I was young and single so I could leave at short-term notice, getting a phone call on the Thursday and then arriving somewhere for a deployment on the Saturday.

"Having a very supportive extended family meant I could be deployed to Afghanistan when my daughter was six years old and then to Iraq when she was 15 so I have been very lucky to be able to do this."

But despite her years of often confronting military medical service in international conflict zones there is one overseas "mission" that makes her smile.

She was just one of four Australian defence representatives – and the only woman – selected to carry the Australian flag at the Queen Mother's one hundredth birthday celebration parade in London in 2000.

"Senior defence health officers wanted a decorated Australian doctor to carry the flag because the Queen Mother was patron of the Royal Australian Army Medical Corps. I had three medals so we were flown to London and trained for the parade with the Welsh Guards and Queen Alexandra's Royal Army Nursing Corps. I was really honored to be part of the parade," she says.

"It was the ultimate in tokenism at the time. A female reservist doctor with medals!"

Carolyn Jones
Media Manager, ANZCA

"The advent of ultrasound, wireless communication and quick access to information... have changed. As long as the electricity doesn't give out or you run out of battery life you can do just about anything."

Investigating Māori experiences of anaesthesia in the perioperative setting

Dr Courtney Thomas is a Christchurch-based anaesthetist who is completing a doctoral thesis investigating Māori patients' experiences of anaesthesia in the perioperative setting. As part of this work, she hopes to produce a framework to guide recommendations for improving future practice and to assist anaesthetists in Aotearoa New Zealand with practical information that may enhance their communication with Māori patients.

She is supervised by Professor Jenny Weller and Dr Jamie-Lee Rahiri from the University of Auckland.

IT IS WELL ESTABLISHED that disparities for Māori continue to exist in almost all aspects of the health system including access to care, health outcomes, rates of disability and disease, and life expectancy. To be Māori in and of itself is not a risk factor but, as a consequence of decisions made by society on major factors like health care funding, welfare and tax policy, inequities are perpetuated for Māori (Carr, 2012).

The Perioperative Mortality Review Committee (POMRC) continues to highlight inequities for Māori in the perioperative setting. A recent report stated that ethnicity and socioeconomic status should not influence outcomes after surgery (POMRC 2017). POMRC recommend a role for qualitative and quantitative research to investigate Māori experiences of care within the hospital setting and for surgical staff to undertake training on Te Tiriti and cultural safety.

The Australian Medical Council and the Medical Council of New Zealand have echoed these sentiments in recent years calling for a greater focus on Indigenous health outcomes (AMC, 2017). This is also recognised in ANZCA's Indigenous Health Strategy that incorporates equity in access and outcomes, culturally responsive care and provision of safe and high-quality care within its key principles (ANZCA, 2018).

As part of my research, I am conducting surveys and interviews with Māori patients from Auckland and Christchurch about their anaesthesia experiences. Participant recruitment is more than halfway completed and I have obtained the following early insights:

- Patients have generally been motivated to take part, to share their experiences and to contribute towards the overall aim of the research.
- Some have voiced concern at "not being Māori enough" or fulfilling stereotypes of what society thinks it means to be Māori. They have needed reassurance about the importance and relevance of their contributions. Attributing value or validity judgements according to a proportion-based assessment of an individual's genealogy is not a Māori concept. It is actively rejected in my research. I am interested in the experiences of ALL Māori and it has been a challenging journey at times ensuring the *Kaupapa Māori research methodology* (research methods that are culturally appropriate and acceptable to Māori) underpinning this thesis is enacted in a culturally safe and appropriate manner in an otherwise mainstream environment.



Dr Courtney Thomas

This is one patient's reflection on their perioperative journey:

PREADMISSION CLINIC

"It almost felt like I was ... number seven for the day and it was like a procedural type of way of engaging with me, rather than a customised way of engaging and there being ... genuine and authentic connection with the patient and the clinician."

PREOPERATIVE PERIOD

"There was a lot that I didn't understand... It was a very complex korero (talk)... The things that were explained to me were premised on the idea of it being explained to someone who already had the understanding of an anaesthetic process... I don't know how to explain it but I felt really hori [whakamā (ashamed)]... talking with her and I felt dumb... it just disconnected me from that discussion."

POSTOPERATIVE PERIOD

"I suppose the way that I felt my experience was, was that it was like a pākehā experience and the premise was that all patients have that experience, and that's not a life experience I share and it's not my personal narrative."

My supervisors and I recently completed a systematic review investigating Māori experiences of acute hospital care in New Zealand. We identified multiple barriers within clinical, organisational and structural levels of care. Culturally unsafe practice combined with a lack of Māori representation and inequitable access to care culminated in significant, multi-faceted barriers to care (Thomas et al, 2021).

Proposed interventions include building cultural safety in response to each of the barriers identified such as cultural safety training for clinical staff, system/service/provider level reprioritisation of Māori health needs and health system, and policy level changes that improve access to and uptake of quality hospital services for Māori.

Multilevel interventions are needed to address the inequitable care and disparate outcomes afforded to Māori in our health system in New Zealand. Qualitative research will allow us to consider how to translate these findings into the sub-specialty care setting such as anaesthesia, where our practice might be adjusted or redesigned to facilitate cultural safety and contribute towards equitable health outcomes for Māori patients.

Dr Courtney Thomas FANZCA
Specialist anaesthetist, Christchurch Public Hospital

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New Zealander elected president of world body

FIVE OUT OF seven billion people do not have access to safe and affordable anaesthesia and surgical care when needed. New Zealand fellow Dr Wayne Morriss, the new co-president of the World Federation of Societies of Anaesthesiologists (WFSA), says it is an issue of equity.

“We need to address equity issues in Australia and New Zealand, but we are also part of the global community and we can’t ignore inequity around the world.”

For this Christchurch-based doctor, fighting for better access to safe anaesthesia is inextricably linked with efforts to improve patient safety and wellbeing worldwide. For a long time, the World Health Organization and some governments have not seen surgery and anaesthesia as a priority and one article called surgery “the neglected step child of global health”. Dr Morriss quotes an anaesthesia colleague: “If surgery is the neglected step child, anaesthesia is his invisible friend.” There is a lot of work to do.

Dr Morriss became president of the WSFA alongside Professor Adrian Gelb from the US in late 2020 in online elections with a record 115 out of the 150 societies voting. He is currently president-elect and will take over the reins in July 2022 however, the pair are working as a tag team. It is busy.

The past 20 years have paved the way for Dr Morriss to head the world body. The journey began in 2000 when he and his family moved to Fiji. He worked for two years as a senior lecturer in anaesthesia and physiology at the Fiji School of Medicine in Suva. Living and working in Fiji gave him insight into the anaesthesia issues in a country with limited health resources. After moving to Christchurch, he continued to do clinical and teaching work in the Pacific and further afield. He found that issues are similar in countries all around the world, and workforce is key. “We need to increase the workforce and create capacity by helping develop leaders and teachers.”

Doctors in New Zealand and Australia are often unaware of the gap between healthcare in high-income countries (HICs) and low- and middle-income countries (LMICs). “We think we have an average healthcare system but internationally we are held up as best practice.” Seventy-five per cent of the world’s population live in countries with very limited resources and healthcare access and outcomes are correspondingly poor.

At a global level, significant progress has been made during the past few years. In 2015, member states of the World Health Organization unanimously approved a resolution to strengthen emergency and essential surgical and anaesthesia care as a component of universal health coverage. It has provided “much-needed impetus to efforts to improve the quality, accessibility and safety of surgical, obstetric and anaesthesia care at the global




level” according to WHO. The WFSA needs to keep reminding governments of their commitment according to Dr Morriss.

The past year has been tough for the WFSA and anaesthetists worldwide. “In many countries, anaesthesiologists have been at the forefront of the fight against COVID-19 – in emergency departments, intensive care units and operating theatres.”

Patients still require surgical care during a pandemic and many of our overseas colleagues have been working very hard and also facing the real risk of catching COVID-19. Dr Morriss has spoken at a couple of overseas online conferences which began with a minute’s silence to acknowledge colleagues lost to the disease.

Out of the trauma of the COVID-19 pandemic, there is now a greater understanding of the role of anaesthetists in healthcare systems. In April 2020, an anaesthesiologist appeared on the front page of TIME magazine. “We must continue to tell governments and the public about the work we are doing and argue for greater resources and protection of the workforce.”

Workforce shortages and lack of equipment and medications are particularly acute in poorer countries. Even the basics may be unavailable:



May 7

“Medical oxygen should not be a luxury & yet oxygen is 5X costlier in Africa than in Europe— Interesting article. Support the #unitingforOxygen appeal and get oxygen concentrators where they’re needed”

@ConversationUK

The WFSA recently launched the Uniting for Oxygen Appeal and this has struck a chord with many colleagues around the

world. “The WFSA is very grateful for a donation from ANZCA which will help us to provide much-needed oxygen concentrators and other basic equipment to several hospitals in Africa,” said Dr Morriss.

Dr Morriss is looking forward to the World Congress of Anaesthesiologists, originally planned as a face-to-face meeting in Prague, Czech Republic in 2020, but now a fully virtual congress on 1-5 September 2021 (wca2021.org).

“The 2021 WCA promises to be a unique global event, with more engagement from around the world than ever before.”

Dr Morriss hopes that many Australians and New Zealanders will take part.

“We are all part of the global anaesthesia community and it is a great to be part of an organization that is making a difference worldwide.”

Adele Broadbent
Communications Manager, NZ



Earlier this year the WFSA launched a new and improved online learning resource as part of its mission to share high-quality and up-to-date education resources to improve anaesthesia knowledge and practices.

The new online learning resources encompass a bespoke and searchable virtual library containing improved Anaesthesia Tutorial of the Week (ATOTW) and Update in Anaesthesia (UIA) pages.

What it is all about – the personal story

The WFSA has a global imperative to make safe anaesthesia universally accessible and to improve patient care around the world. Building capacity is part of that work as this story illustrates.

Fijian Dr Luke Nasedra was doing postgraduate training in anaesthesia (Masters in Medicine in Anaesthesia) when Dr Morriss started work in Fiji in 2000. Dr Morriss taught him in the medical school as well as in the operating theatres. Dr Nasedra finished his training at the end of the 2001.

Dr Morriss says he kept on bumping into Dr Nasedra during clinical and teaching visits. “We taught together on Primary Trauma Care and Essential Pain Management courses, and I saw him at Pacific Society of Anaesthetists’ meetings. He climbed the ranks in Fiji and is now the head of anaesthesia for the country. When I saw him after Tropical Cyclone Winston in February 2016, he was heading the medical response to the disaster”.

Throughout July this year the two friends worked closely together. Dr Nasedra headed the Fiji Emergency Medical Team while Dr Morriss was on the Australia New Zealand Medical Assistance Team (ANZMAT) working on the COVID-19 response.





Left to right: Dr Akuila Naqasima (anaesthetist), Dr Anis Ta'eed (renal physician), Dr Wayne Morriss (anaesthetist), Ben Schmidt (logistician), Dr Rajeev Patel (urologist).

COVID-19 update from the UK and Fiji

In the UK at the time of publication there have been nearly eight million confirmed cases of COVID-19 with 136,208 deaths. In Fiji there have been more than 50,000 confirmed cases of COVID-19 with 592 deaths. The health systems in both countries are a world apart but have groaned with lack of capacity.

In both these parts of the globe, ANZCA fellows are working on the frontline. The *Bulletin* brings you a snapshot of how they are doing and what they are facing.



“The big driver for that change is the vaccination program, which is providing effective protection from serious illness.”

New Zealander Dr Roger Hall (OBE), FANZCA, FRCA, FFICM, who was recently honoured for his work as medical director at the Royal Papworth Hospital and his role in the COVID-19 response in the east of England, brings us up-to-date with the latest from the UK.

We are now well into the third wave of the coronavirus (COVID-19) pandemic in the UK, but thankfully it looks significantly different from waves one (March to May 2020) and two (January and February 2021).

The big driver for that change is the vaccination program, which is providing effective protection from serious illness. At the time of writing, 77 per cent of adults in the UK have had both doses of the COVID-19 vaccine and nearly 90 per cent have had at least one dose.

Even though transmission increased through the summer months, as the restrictions were eased and then lifted, the comparative hospitalisation rate and death rate has remained much lower than previous outbreaks.

We are now in a position where COVID-19 is not going away; the numbers remain steady but are bobbing along at a lower number. For example, at Royal Papworth Hospital we had more COVID admissions in July than any of the previous five months, but fewer than 10 per cent of what we had at the peak in January. This is still placing a demand on our services. About 30 per cent of our critical care beds are occupied by coronavirus patients, and the number of ECMO patients – those most seriously ill and in severe respiratory failure – is much higher than would be the case in a “normal” summer. The vast majority of these patients (more than 80 per cent) are unvaccinated.

This has undoubtedly had an impact on the other heart and lung services we provide. Thankfully we have not had to redeploy staff during this third wave and have also been able to maintain our elective workload and emergency and urgent care pathways.



“What followed was the highest per capita incidence of COVID-19 in the world.”

In Fiji, five Australian and New Zealand fellows have been involved in combined Australian and New Zealand Medical Assistance team missions. Dr Brian Spain (Royal Darwin Hospital) sets the scene.

An island nation remotely located in the South Pacific, Fiji had managed to avoid the waves of COVID-19 that had swept the globe through 2020.

Following a small “blip” in early 2020, the public health system had managed to eliminate COVID-19 until a leak from their Nadi-based hotel quarantine system in April 2021 of the Delta variant. Through a “super-spreader” event, the virus spread across to the capital Suva and in late May was found to have infected staff and patients in the Colonial War Memorial Hospital (CWMH), the main tertiary referral hospital for the whole country. What followed was the highest per capita incidence of COVID-19 in the world.

Services at CWMH were substantially reduced from early June, with a focus on COVID-19 only. The Fijian Emergency Medical Assistance Team (FEMAT) set up a field facility in a sporting complex in Suva for non-COVID health services and the Fijian Government requested assistance from Australia with various aspects of their health response.

Australian aid through the Department of Foreign Affairs and Trade (DFAT) had already donated large numbers of vaccinations. An Australian Medical Assistance Team (AUSMAT) was mobilised to assist with infection prevention and control (IPC), public health and reconfiguring CWMH patient flows to allow return to broader tertiary services including expected large numbers of critically-ill patients with COVID-19.

The mission team leader for the AUSMAT Alpha team and I led a combined Australian and New Zealand Medical Assistance Team (ANZMAT) that spent four weeks in country from 20 June 2021. Members included IPC nurses, an infectious disease specialist, a public health physician and FANZCA Dr Wayne Morriss (Christchurch) who provided expert advice on reconfiguring operating theatre and critical care services as well as reviewing oxygen services and supply chains for personal protective equipment (PPE).

In conjunction with the Fijian Ministry of Health and Medical Services (MHMS) the team recommended to continue the IPC support and further enhance critical care and operating theatre services via the subsequent ANZMAT Bravo and Charlie teams which deployed for a further four weeks each.



Dr Brian Spain and the ANZMAT team advising on operating theatres at the main hospital in Fiji.



Dr Wayne Morriss with the theatre team on the day after Fiji beat New Zealand for gold in the rugby 7s in Tokyo.



Dr Rob Ray (Ballarat West Hospital, Victoria) describes his six weeks in the second Australian and New Zealand Medical Assistance Team (ANZMAT) in Fiji along with other ANZCA fellows, team leader Dr Dan Holmes (Sunshine Coast University Hospital, Queensland) and Dr Tony Diprose (Hastings Hospital in New Zealand).

You might ask what it is like to be figuratively parachuted into another country to help in a pandemic-related disaster. For me it is like *A Tale of Two Cities* – Dickensian in a different way.

I can describe my recent experience at Suva's main hospital, the Colonial War Memorial Hospital (CWMH), and the intensive care unit (ICU) as "It was the best of times, it was the worst of times."

My best times:

- Working with great teammates at the Australian and New Zealand Medical Assistance Team (ANZMAT). As the second medical team into this South Pacific nation, we were part of a complex and multi-disciplinary effort with a whole lot of expertise and logistics behind it. Being at the sharp end of that is an awesome responsibility and privilege, as is being able to work alongside our Fijian colleagues, sharing problems and solutions, and seeing reward for effort, theirs mainly of course, but ours also.
- Leaving our Fijian colleagues feeling they were able to start to deliver normal ICU care again.

My worst times:

- Caesarean sections to save babies when the mum is suffering severe COVID-19, with both the mother and father knowing the mum will probably not survive.
- Patients dying without any family around.
- Consoling colleagues who have discovered that the code we just went to was a near relative.
- "Unavoidable" bad outcomes, knowing that we could have done better in normal circumstances.

Prior to going, I was concerned I was not going to be up for the task. Frankly, one never fully is. ANZMAT puts lot of time and effort into teaching already experienced professionals how to deploy and prepare for working in challenging and unstable environments.

However, in my clinical roles over the last few weeks, I was able to reach into my fellowship training, the teachings of my mentors and colleagues and my continuing medical education to find help that I did not consciously know I had.

Maybe that is the reason that the collective noun for the professional organisation we share is called a "fellowship".

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EPM goes online

Essential Pain Management (EPM) developer Associate Professor Roger Goucke explains how COVID-19 has been the catalyst for the rollout of online training courses for the program.

EPM WAS DEVELOPED by ANZCA fellows Dr Wayne Morriss and myself in response to a request from colleagues in Papua New Guinea who wanted to support doctors and other health professionals in understanding and providing effective pain management.

Following initial piloting in 2010, EPM was further developed with the assistance of ANZCA and is supported by the World Federation of Societies of Anaesthesiologists, the International Association for the Study of Pain, the Australian Society of Anaesthetists and the Royal College of Anaesthetists. EPM workshops have now been delivered in more than 60 countries around the world.

EPM has traditionally been taught face-to-face as a full day workshop, however this has not been possible in most parts of the world due to the COVID-19 pandemic. The dramatic spread of the virus around the world and subsequent lockdowns and travel restrictions has led us to explore alternative ways of teaching. While the first online EPM program was developed by Dr Linda Huggins at the University of Auckland in 2014, the need to continue to deliver pain management training in the “COVID-normal” era has acted as a catalyst to develop modified training programs that can be delivered online in an effective and engaging manner.

Our initial thoughts were that much of the didactic PowerPoint style teaching might be possible either with pre-reading and the use of an online module. However, we know from participant

feedback that the most positive comments come from the interactive case discussions. This led us to ask how do we meet this need in our current COVID-19 era? We began exploring the use of Zoom meetings and how we could utilise some of that platform’s features such as polls, whiteboards, screenshare and breakout rooms. To explore the concept of delivering EPM via Zoom a number of sessions were held with our EPM friends, colleagues and instructors to test different formats.

Led by the indefatigable Dr Carolina Haylock-Loor, past president of the Honduran Society for Anaesthesiology, the first virtual EPM workshop “Resuscitation and pain”, was held on 30 May 2020 for 24 medical students from several Latin American countries. Seven Latin American EPM instructors participated in the workshop which lasted five-and-a-half hours. To keep people engaged and stimulated there were several breaks for tea and coffee, stretching, “brain gym” and even some dancing to local Latin American rhythms!

Since then our Central and South American colleagues have been busy running virtual EPM courses in Spanish across a number of countries over the past year ranging from shorter “EPM Lite” courses to full-day workshops for medical students, doctors and other healthcare providers involved in pain management.

In August 2020, two half-day online EPM workshops were delivered to 31 doctors and nurses from the Chinese General Hospital and Medical Center in Manila, led by Dr Jocelyn Que, and in January this year a train-the-trainer workshop was held for 17 instructors across Latin America.

In June, two half-day online EPM workshops were conducted in Da Nang, Vietnam. This was the first time EPM has been facilitated in Da Nang, with previous face-to-face workshops having been held in Hanoi and Ho Chi Minh City. More than 30 healthcare providers from different specialties participated including anaesthetists, oncologists, rehabilitation physicians and anaesthesia nurses. In addition to seven course instructors, it was great to also have the participation of Professor Nguyen Van Chuong, President of the Hanoi Society for Pain, and Dr Nguyen Thi Thanh Huyen, Head of the Department of Rehabilitation at Hanoi Medical University Hospital.

In addition to modifying the EPM program to make it more amenable to an online delivery format, we have also been working with Interplast and Praxhub to develop a standalone online interactive version of EPM. Interplast is an Australian-based non-government organisation that is improving health outcomes in the Asia-Pacific region through a range of programs that includes provision of free clinical care (plastic and reconstructive surgery and related services) and the development and delivery of free education to locally-based healthcare professionals. Praxhub is a health-technology company focused on the distribution of education to a global community of healthcare professionals and has been working with Interplast for the past two years to develop and deliver online education for Interplast’s partners across the Asia Pacific.



Medical students from around Latin America participate in the first EPM virtual workshop in May 2020.

With support from the World Federation of Societies of Anaesthetists (WFSA), the Australian Society of Anaesthetists, the International Association for the Study of Pain and the Northern Hospital, EPM online was recently launched at the WFSA World Congress of Anaesthesiologists. The course is run through the Praxhub platform so users will just need to register for Praxhub to access the course, but this process is quick, easy and free.

In addition to covering the tools to recognise, assess and treat pain, the EPM online course provides participants with a series of cases using videos to demonstrate the use of EPM in patients with acute trauma and postoperative pain, cancer pain and chronic non-cancer pain.

For further information on the EPM program or to access EPM online, please visit www.essentialpainmanagement.org.

Associate Professor Roger Goucke AM, FANZCA, FFPMANZCA WFSA/ANZCA Essential Pain Management Steering Committee Chair



WHAT IS ESSENTIAL PAIN MANAGEMENT?

Essential Pain Management (EPM) is a short, easily deliverable and cost-effective training program designed to improve pain management worldwide. EPM provides a systematic approach for managing patients in pain and also a system for teaching others about pain management.

EPM aims to:

- Improve pain knowledge.
- Teach health workers to Recognise, Assess and Treat pain (the "RAT" approach).
- Address pain management barriers.
- Train local health workers to teach EPM.

EPM is cost effective, multidisciplinary and encourages early handover of teaching to local instructors. It is designed for any health worker who comes in contact with patients who have pain. The RAT approach can be applied to all types of pain and can be used by all types of health workers including doctors, nurses, clinic workers and pharmacists.

There are two EPM Programs – Standard EPM and EPM Lite.

Standard EPM comprises two parts to the EPM program – the EPM workshop and the EPM instructor workshop. Typically, a "one day, half day, one day" course structure is utilised. Day one is the EPM Workshop, a program of interactive lectures and group discussions. Participants learn the basics of pain management, apply the RAT approach during case discussions and problem-solve pain management barriers. Day two is the EPM Instructor Workshop, a half-day program designed to provide the EPM Workshop participants with the knowledge and skills to become EPM instructors. Participants learn the basics of adult learning, practise teaching skills and plan their own EPM workshops. On day three, the EPM Instructor Workshop is followed by one day workshops taught by the new instructors with the help of the visiting team.

EPM Lite is designed for medical and nursing students and is a modified version of the one day workshop. The program can be delivered in four to five hours and covers the basics of pain management as well as how to use the RAT approach.



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Key dates

- Program available – 19 November 2021
- ASM Registrations open – 26 November 2021
- Abstract submissions close – 16 January 2022
- Abstract notification to authors – early March 2022
- FPM Symposium – 29 April 2022
- ANZCA ASM – 29 April – 3 May 2022

Faculty of Pain Medicine

Focus on research and leadership key for our advocacy



A major philosophical challenge is that increasingly, health services view pain services as a purely chronic non-malignant pain service.

A comprehensive pain unit which encompasses acute, sub-acute, chronic and palliative pain is the gold standard but services are increasingly unwilling to contemplate such a bold vision.

Pain units which are part of an anaesthesia department continue to tie pain medicine appointments to provision of anaesthesia services, effectively discriminating against pain medicine specialists who are not anaesthetists. Many public sector services complain that it is difficult to attract FPM fellows to work there, while simultaneously dramatically restricting their ability to provide high-quality care.

In these circumstances, who could blame fellows for choosing to work in an environment where their full range of skills can be utilised, and the moral injury of being forced to provide inadequate care can be avoided?

The inaugural meeting of the Primary Pathway Working Group will be commencing work before the end of the year.

In the current environment, there is no rush to radically change the current pathway to fellowship but our feedback from junior doctors and medical students is that many of them feel the current structure is a barrier to their participation. This is especially so, given that the majority of medical schools in Australia are graduate-entry, and therefore new junior doctors are older, and have more commitments than was the case when the majority of new graduates were undergraduates.

Major new developments in the faculty's support for research are under way, with FPM leading the discussions to establish a high-level national alliance to strive for substantial long-term government and philanthropic investment.

Internally, the Research and Innovation Committee is also seeking to establish a supportive network of mentors and collaborators to advance the development of individual projects or researchers.

As we enter the major assessment season, with the written and clinical fellowship exams approaching, I wish all our trainees every good luck, and I hope your efforts are rewarded with progression through the program.

I would like to acknowledge the efforts of the Examination Committee in being flexible and rigorous in delivering a high-quality assessment pathway under very challenging circumstances.

Associate Professor Michael Vagg
Dean, Faculty of Pain Medicine

Despite the ongoing restrictions and frustrations of the pandemic, the faculty is continuing to develop work which advances its strategic mission.

The Therapeutic Goods Administration (TGA) grant for provision of free licenses to undertake the Better Pain Management (BPM) program ended up exceeding the target of 10,000 licenses. This was a major source of unexpected revenue for the college, and a significant development in enabling faculty intellectual property to become part of institutional continuing professional development (CPD) and some undergraduate training programs in non-medical disciplines. The planned uplift project should ensure the ongoing relevance and viability of the modules into the future.

Our other major strategic government-funded project, regarding health practitioner education in pain, has reached an advanced stage of consultation with a large range of stakeholders and provides a really exciting framework for ensuring that we are well-positioned to provide leadership in pain education across disciplines and to our medical colleagues.

We continue to seek high-level meetings with politicians, bureaucrats and health service administrators to advocate on behalf of setting concrete strategic goals in alignment with the National Strategic Action Plan for jurisdictions, as well as trying to ensure that the service provision priorities of health services do not compromise the standards of our training or best practice.

The challenges in this respect come on several fronts, from the philosophical to the pragmatic.

2022 FPM Board election

THE CALL FOR nominations for the 2022 board election will be circulated in October 2021. FPM fellows will be invited to forward nominations for three elected vacancies on the board. To allow for the transition of the composition of the board as outlined in the revised by-law 1 (Faculty Board, in addition one position will be designated as “co-opted” leading up to the 2022 FPM Annual General Meeting). The co-option process allows the board to ensure it has the skills and diversity required to progress its ambitious strategic goals.

If a ballot is required for the elected positions, this will take place in January 2022. The faculty uses the information on your MyANZCA profile for all official communications, so please take this opportunity to ensure that your contact details are up to date.

Prospective candidates are reminded that while there are no formal prerequisites for election or appointment other than being a fellow in good standing, the demands of leadership and governance that fall upon board members require a time commitment that should be planned for in between meetings as well as around board meetings.

Interested fellows who wish to nominate are encouraged to discuss the time and level of commitment required with existing board members so they understand their potential responsibilities if elected or appointed.

The procedures endorsement program update

The procedures endorsement program pilot launched in early 2021. There are six endorsees currently undertaking the Supervised Clinical Experience Pathway and five accredited procedural supervisors who offer work-place based training in New South Wales (Prince of Wales Hospital and Sydney Spine and Pain); Queensland (Axxon Pain Medicine); Victoria (Pain Matrix Geelong) and Hong Kong (Queen Mary Hospital). This small number of endorsees and accredited supervisors has allowed modifications and refinement to the program as required, based on feedback. Given the continued and invaluable feedback received by the accredited supervisors, the program is due to transition to the ongoing governance structure shortly. With this in mind, we are currently endorsing further accredited procedural supervisors to expand the program and from 2022 the Practice Assessment Pathway will open for those fellows with established experience in pain medicine procedures who want to seek faculty endorsement in at least one recognised pain medicine procedure.

Further updates will be provided and we encourage you to look out for them in our e-newsletters.

New professional document

In 2016 the faculty published “Proposal for a practice guideline: Low dose ketamine infusion in the management of chronic non-cancer pain”. This document has now been revised into a position statement that describes where the faculty stands on this issue – it is not prescriptive nor binding.

PS12(PM) Position statement on the use of ketamine in the management of chronic non-cancer pain reflects both the unsettled state of the literature in this arena and the fact that such practice is “off-label” in Australia and New Zealand. This document is not a guideline for the use of ketamine in chronic non-cancer pain but offers guidance, based on the literature and expert consensus, in order to inform the judgement of practitioners and to promote safety and quality for their patients.

This position statement is being piloted and will be reviewed again in December 2021. We welcome feedback during this time.

Professor Michael Cousins biography launched

A biography about pain medicine pioneer and founding dean of the Faculty of Pain Medicine, Professor Michael Cousins AO, has been released.



Breaking through the pain barrier: The extraordinary life of Dr Michael J. Cousins explores the way historic events shaped Professor Cousins and how he in turn shaped international pain research, treatment and policy.

Professor Cousins was a councillor with ANZCA from 1995 through to 2006, and elected president in 2004. He was a member of the FPM Board from 1998 to 2004 and the inaugural Dean of the Faculty from 1999 to 2002. Major initiatives during his presidency include overhauling governance processes, a new focus on perioperative medicine, a new emphasis on quality and safety, involvement of prominent community leaders on the ANZCA Foundation Board, and a major research fundraising drive. As a councillor, he was strongly involved in the development and implementation of the Faculty of Pain Medicine, in 1998.

Breaking through the pain barrier by Gabriella Kelly-Davies is available for purchase online through Hawkeye Books at: hawkeyebooks.com.au

NEW FELLOWS

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

- Dr Christina Cheng, FANZCA, FHKCA, FPPMANZCA (Hong Kong).
- Dr Ilamurugu Kaliaperumal, FANZCA, FPPMANZCA (Qld).
- Dr Joanna Lee, FRACS, FPPMANZCA (NSW).
- Dr Zoe Vella, FANZCA, FPPMANZCA (Qld).

We also congratulate the following doctor on their admission to FPM fellowship by completing the specialist international medical graduate (SIMG) process:

- Dr Rajib Dutta, FANZCA, FPPMANZCA (NSW).

We also congratulate the following doctor on their admission to FPM fellowship via the election to fellowship pathway:

- Associate Professor Damien Finnis, FANZCA, FPPMANZCA (NSW).

TRAINING UNIT ACCREDITATION

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

- Middlemore Hospital (New Zealand).
- Pain Specialists Australia (Vic).
- Pamela Youde Nethersole Eastern Hospital (Hong Kong).
- Precision Brain, Spine and Pain (Vic).
- Royal Brisbane and Women’s Hospital (Qld).
- Townsville Hospital (Qld).
- Westmead Hospital (NSW).

FPM ANZCA

2021 FPM and HKCA Virtual Spring Meeting

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Mana whakatipu*

Anaesthesia leader and advocate Professor Alan Merry retires

PROFESSOR ALAN MERRY has retired as deputy dean of the Faculty of Medical and Health Sciences at the University of Auckland. He is heralded as a world leader in anaesthesia.

Some of his achievements include being the establishment chair of the board of New Zealand's Health Quality and Safety Commission for 10 years. Professor Merry was also on the ANZCA Council for 11 years and the World Federation of Societies of Anaesthesiologists for eight. He is a director of Lifebox.

Dr Merry co-founded and co-chaired the New Zealand Medical Law Reform Group, whose advocacy contributed to the Crimes Amendment Act 1997. He also led the Safe Anaesthesia Group of the World Health Organization's (WHO's) Safe Surgery Saves Lives global challenge, which led to the promulgation of the WHO Safe Surgery Checklist.

His research has focused on the quality and safety of healthcare, notably in the context of the interprofessional teams who deliver surgical care to patients, and on the management of acute and chronic pain. These interests are reflected in over 200 peer-reviewed journal articles and book chapters, and in four co-authored books.

He is the subject of an ANZCA oral history due out later this year. To acknowledge his retirement, the *Bulletin* asked him a few questions about his career.

What has surprised you about your career in anaesthesia, patient safety and academia? What was very unexpected?

It was all a bit unexpected.

I didn't set out to be an anaesthetist. Actually, I intended to be a psychiatrist, and that interest is why I became involved with

“I am very proud that ANZCA has become a leading light among medical colleges, and also one of the few that has genuinely attempted to embrace its binational identity.”

chronic pain. However, I sort of fell into a senior house officer (SHO) anaesthesia position and found that I enjoyed it. I then thought I might become a GP anaesthetist in a small town, and that getting a fellowship in anaesthesia would be a good idea for doing that (this was before GPs had their own fellowships).

I went to Green Lane as a registrar and fell in love with cardiac anaesthesia, just because everything was monitored and you could really see the physiological responses to various influences, including our medications.

In those days, the difference in monitoring between cardiac and other specialties was much greater than today. In the general surgical theatres at Green Lane the only monitoring was a finger on the pulse, an eye on the colour of mucous membranes and a manual blood pressure cuff (and of course these are still very effective monitors).

I actually made myself unpopular by pointing out this discrepancy and asking for an ECG monitor. Dr Eve Seelye (the clinical director) finally dragged an old cathode ray oscilloscope out of a cupboard for me to use! It literally had a single dot that sort of danced across the screen.

The fact that she subsequently allowed me to get a job as a “tutor specialist”, and then as consultant at Green Lane, is probably the most surprising thing about my career.

What has surprised you about anaesthetists, anaesthesia and the breadth of anaesthesia?

The changes in the specialty since I began in 1978 are astonishing.

The depth of and breadth of expertise, the increased adoption of technology (notably ultrasound) and the total engagement with patient-centred care and everything that goes with that has been extraordinary.

This has been matched by the impressively increased involvement of anaesthetists in the leadership of hospitals and healthcare more generally. In New Zealand at least, we have shed any vestiges of being a Cinderella specialty, or “just technicians”. However, this has not really surprised me. I was always surrounded by role models who were highly patient-centred and who were also leaders in every sense, even in the 70s and 80s. Dr Eve Seelye is just one example, and Dr Mike James is another.

What are you most proud of?

I am very proud of our college and the New Zealand Society of Anaesthetists (NZSA), and of all that we have collectively done to advance the standard of perioperative patient care in New Zealand.

I remember that some older anaesthetists, including ones I respected, opposed breaking away from the surgeons, saying we would never make it on our own. I was very enthusiastic about the move. I am very proud that ANZCA has become a leading

light among medical colleges, and also one of the few that has genuinely attempted to embrace its binational identity.

The engagement of New Zealand anaesthetists in the work of ANZCA has been particularly impressive (at one stage Kiwis chaired half of ANZCA's committees) and of course Dr Leona Wilson was ANZCA's first female president (starting a substantial trend).

I am particularly proud of our training program. It is clearly based on sound pedagogy and fairness rather than on controlling the market place. The role of NZSA in supporting the specialty has also been critical – and the division of priorities between the two organisations has been inspired.

Finally, the contribution of anaesthetists to teamwork in the operating room has been particularly impressive. In this regard, I would like to acknowledge the amazing contribution of Dr Jenny Weller, Dr Kaylene Henderson and many others (including surgeons and nurses) through the NetworkZ program.

What is something you wish you had seen already during your career?

I think the global gap in anaesthesia services is distressing. I would have liked to see greater progress towards ensuring that all patients everywhere can receive safe anaesthesia.

Hand-in-hand with this is the need for all anaesthesia providers to have respected and adequately remunerated careers. In that regard, it would be hard to beat New Zealand and Australia.

Can you crystal gaze 30 years into the future and predict what the college and specialty should look like?

The current momentum is great, but I think we do need to keep a reasonable focus on research within the specialty. I believe we can give better support to young anaesthetists who have a research interest to help them fulfil their potential. Research is not for everyone but it is one of the keys to progress in any medical discipline.

Like Australia, New Zealand has a strong cadre of anaesthesia researchers, but they are rather skewed in their age group. If I compare other specialties, I think there is a challenge here that we need to recognise. I think it goes hand-in-hand with the challenges of equity and life/work balance, in all their guises. It is hard for young anaesthetists (and indeed young doctors more generally) to do everything that is asked of them.

We need our specialty to continue to be a professional home in which all doctors can find a meaningful career while still having lives that include families and other activities.

A thriving and diverse specialty is the key to the provision of great patient care.

Adele Broadbent
Communications Manager NZ, ANZCA

**Mana whakatipu* – power and status accrued through talented leadership

“Research is not for everyone but it is one of the keys to progress in any medical discipline.”

ANZCA Lifelong Learning project

The college is embarking on a significant information technology-based project to update the electronic platforms utilised with the education space.

THIS PROJECT IS a multi-year, multiphase process that will see the refresh of many of the platforms that fellows, trainees, and specialist international medical graduates (SIMGs) engage with. The Lifelong Learning project is part of the college's Information and Communications Technology strategy and aims to improve the user experience for all those who engage with college activities.

The platforms being refreshed include:

- Training Portfolio System (TPS).
- Exam Management System (EMS).
- Continuing Professional Development Portfolio (CPD).
- Learning Management System (LMS – currently referred to as Networks).
- Training Site Accreditation System (TSA).

A project team has been working on phase one of the project to develop a sound understanding of the educational platforms in relation to how they are used and what is needed in the future to create an improved technology environment.

The team has engaged with fellows, trainees and SIMGs that use these platforms to identify current issues and create a clearer understanding of what the future state is. Staff within the college have also assisted in identifying areas for improvement to create an experience for college users and identify how system improvements may assist in data entry and monitoring.

The college will move away from the purpose built boutique systems that are currently in place which are nearing their end of life and move toward a structure of utilising external vendors that will partner with the college to provide systems that meet the college's needs. It is anticipated that these systems will decrease issues with multiple credentials to log on and data entered will flow across systems syncing periodically without manual intervention.

It is also expected that the platforms adopted will allow for improved experiences on mobile devices and will move towards the ability to submit information into systems such as the TPS from a mobile device with greater ease.

Having developed the requirements for each platform the college has now entered into a tender process with identified vendors who will submit their proposals. A robust selection process will include evaluation, interview and demonstration to staff and representatives from the fellowship, trainees, and SIMGs. This process will take place in late 2021 and be finalised

in 2022. As result, it is expected that a schedule for refresh and implementation will see a number of platforms change commencing in 2023.

This project is a significant undertaking by the college to further enhance the experience of fellows, trainees and SIMGs. One of the core functions of ANZCA is to provide high quality education and training in anaesthesia and pain medicine. The introduction of an improved education technology experience will assist in the provision of high-quality learning opportunities and the ability to track and monitor training progress.

This project will complement other technology initiatives within the college that will automate and enhance current paper-based systems in anaesthesia, pain medicine, diving and hyperbaric medicine and future offerings in perioperative medicine and rural generalist anaesthesia.

Recent changes from regulatory authorities, such as those for continuing professional development (CPD), from the Medical Board of Australian have highlighted the continued need to develop the capacity of the college in monitoring and evaluation. The changes required in CPD will be part of the new platforms and it is anticipated will be available for the commencement of the 2023 CPD year.

Throughout the next 12 months there will be many opportunities for members of the ANZCA and FPM community to engage in working with the college in creating an online education environment that will not only meet the immediate needs but be flexible to evolve and develop with the needs of the broader college.

Associate Professor Robert O'Brien
Executive Director, Education and Research, ANZCA

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Scan the QR code to download the app.

The above outcomes are based on comparisons against procedures utilising anaesthesia without depth-of-anaesthesia monitoring. The BIS™ monitoring system should not be used as the sole basis for diagnosis or therapy and is intended only as an adjunct in patient assessment. Reliance on the BIS™ system alone for anaesthetic management is not recommended.

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Medtronic

Self matters

As the pandemic again challenges our health services and communities, this edition's piece is a timely reminder of support resources on the pandemic kindness movement (PKM) website – www.aci.health.nsw.gov.au/covid-19/kindness – not only for basic needs like sleep, but also on managing lockdown fatigue, quarantine, own mental health and assisting colleagues. I'm grateful to Professor Jane Munro, paediatric rheumatologist at the Royal Children's Hospital Melbourne, for her captivating piece reflecting her leadership and the power of social media for good. While the PKM was founded in Australia, many of the resources are applicable to all trainees, fellows and specialist international medical graduates, where-ever you are located.

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

Dr Lindy Roberts AM

Director of Professional Affairs (Education)



IT WAS ONLY 20 months ago that the Pandemic Kindness Movement (PKM) came about with an idea, a bit of luck, social media on fire and people with huge hearts.

It took off in March 2020 right when Australia's healthcare workers were starting to feel the effects of COVID-19 on our shores. All the healthcare workers I knew were in a state of frenzied preparation.

Many reported feeling rising levels of anxiety and were concerned we may soon encounter what we had been doomscrolling for weeks on our social media and news feeds from Wuhan, Bergamo and New York.

There were long days filled with moving to telehealth, physically altering our clinics, helping staff to work offsite, changing theatre practices, pivoting, learning via webinars at all times of the day and night.

It was an exhausting and heady time of rapid change and innovation: of huge collaboration – where bureaucracy

actually asked “how can we help?” and often let clinicians lead the way. Resources were made available and changes occurred quickly but always on a background of uncertainty and imperfect systems.

By mid-March 2020, many healthcare workers talked about feeling like they were standing on the beach having watched the waves go all the way out, knowing it meant a tsunami was about to come back in to hit them, but being unable to leave. This was causing huge anxiety, and a variety of responses.

Almost no one was sleeping normally. Think back to what you were like at that time. Some people withdrew, many threw themselves into activity, learning and advocacy, others (many!) just tried to keep their heads above water.

Clinicians were seeking basic information about how to best support themselves. Leaders were struggling to know how to lead and support their teams during a crisis.

There was a lot of discussion about what could be done to support Australian healthcare workers if this potential tsunami of COVID-19 was to follow.

After a WhatsApp group chat with senior medical staff was renamed Pandemic Kindness, on a Saturday night I put up posts on Twitter, LinkedIn and various medical Facebook groups. I awoke Sunday morning to my own social media tsunami!



March 2020 – LinkedIn post

“I've been chatting with some colleagues around Melbourne as well as friends in the community who know the hard yards many of the healthcare care system team are going to be under this year - ED, ICU, wards, anaesthetics, cleaners, ward clerks, you name it...and I just wonder for some of us who might be more ambulatory or for some of my friends and community who are not medical or in healthcare but want to support those in the hospitals and GPs and have ideas and contacts and who might be able to help me with inspiration and coordination while we are in the Bunker Down Phase...I know in Italy and China things got and are very tough. Current predictions in Australia is a lot of our health workforce will be infected in coming months.

I'm thinking:

- Basic needs: food, water, coffee
- Hangry trolleys
- Toiletries at work
- Sleep: beds, linen, getting safely home
- Access to supports
- Deliveries of food, meals, supplies, toiletries, help for pets.

Awash with offers of all sorts of kindnesses that included donations (money, mattresses, toiletries, food, accommodation for healthcare workers around Australia), influence and connection from politicians, CEOs, business leaders, entrepreneurs and government leaders, and many hundreds of doctors and healthcare workers (particularly psychiatrists and psychiatry registrars).

This led to a whirlwind of connections and brainstorming. There were a few sliding door moments and a touch of serendipity and within 72 hours the Pandemic Kindness Movement was born.

We came together as clinicians with expertise in doctors' health and wellbeing from a range of backgrounds - anaesthesia, psychiatry, emergency and retrieval medicine, paediatrics, medical administration and coaching. The leadership group of Dr Tracey Tay, Dr Kym Jenkins, Dr Shahina Braganza, Dr Sam Bendall, Dr Lynne McKinlay, and Dr Mary Freer remains.

Their commitment to supporting healthcare workers, changing cultures and spreading kindness is inspiring. It has been an absolute joy and privilege to work with them. We were fortunate to partner with the NSW Agency for Clinical Innovation (led in 2020), Safer Care Victoria (in 2021), the Commission on Excellence and Innovation in Health (SA) and Queensland Health.

It's hard to reflect back, but in March 2020 there were many health services scrambling to provide even basic information about fatigue management, how to decontaminate yourself after a shift, how to manage your anxiety, or how to lead your team through a crisis.

Landing on what was needed and not duplicative was both difficult and easy. There was a desperate need at the time for diverse and high-quality information, which was carefully curated and relevant at the different phases of the pandemic.

We took the view we are all in the same storm all around the world, but our experiences are different, our access to resources and leadership and care are different, so it's the same storm but a different boat, or no boat or no life jacket even.

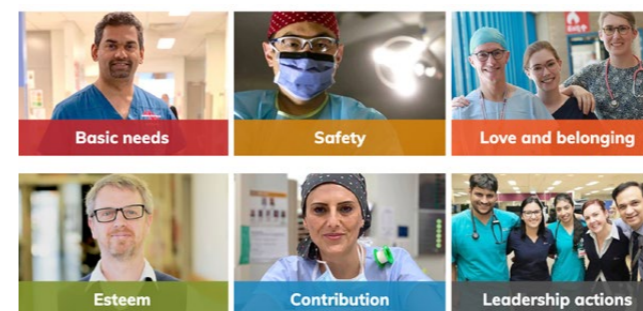
We based the Pandemic Kindness Movement model on Abraham Maslow's hierarchy of needs, with a few modifications. The pyramid (see page 73 of the Winter edition of the *ANZCA Bulletin*) representing these needs was adapted to reflect the potential challenges of the pandemic on the health workforce. In particular, effective leadership was seen as critical at all levels of the pyramid and was an additional “layer” represented in our model along the side.

The movement has curated respected, evidence-informed resources and links to valuable services to support the wellbeing of the health workforce. We track the usage data by Australian states and territories and refresh the resources depending upon what is needed.

The aim of the movement is to provide health workers with easy access to curated resources to enable them to access the support they need. The pyramid is divided into the different needs: basic needs, safety, love and belonging, esteem, contribution and leadership actions. By mid-2020 we were able to collaborate with and add in specific resources for Indigenous health workers.

The Pandemic Kindness Movement is a clinician-led project, created by clinicians across Australia, working together to support all health workers during the COVID-19 pandemic.

Associate Professor Jane Munro
Founder, Pandemic Kindness Movement



An image of the PKM website landing page.

“The aim of the movement is to provide health workers with easy access to curated resources to enable them to access the support they need.”

We love to hear from clinicians and healthcare workers: if you have a question or would like to provide feedback or suggest resources to include on the Pandemic Kindness Movement webpages, please email: ACI-kindness@health.nsw.gov.au, jane.munro@rch.org.au and on Twitter @drjanemunro

ANZCA's doctors' health and wellbeing resources

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

This is an independent counselling and coaching service available via the helpline, online live chat, the app and face-to-face meetings. It provides support for a variety of work-related and personal problems that may be affecting work or home life. The Aboriginal and Torres Strait Islander Peoples Helpline is also available on 1300 287 432.

Go to www.anzca.edu.au/about-us/doctors-health-and-wellbeing.

Emergency contacts

- Your GP
 - Doctors Health Advisory Service
 - Lifeline 13 11 14
 - ANZCA Doctors' Support Program (see above)
- Australia: 1300 687 327
New Zealand: 0800 666 367.

A case for the reusable scrub hat



Dr Ann Lee (left) and Dr Jessica Hegedus in their own scrub hats

THERE IS A growing consensus across healthcare organisations that we need to reduce our collective carbon footprint and minimise the significant impacts of climate change on human health.

In Australia, the healthcare sector is estimated to account for 7 per cent of national CO2 emissions^{1,2,3}.

Operating theatres are particularly resource intensive areas, requiring large amounts of energy and consumable products^{1,2} and contribute to approximately 20-30 per cent of hospital waste, largely due to single use items such as disposable hats and packaging^{1,2}.

The amount of waste generated by the healthcare sector has further increased in the COVID-19 pandemic era, with the increased use of single use personal protective equipment⁴.

ANZCA and the Royal Australasian College of Surgeons (RACS) are committed to reducing the health impact of climate change^{1,2,5} and single use medical items have a significant carbon footprint from production to disposal. Therefore, ANZCA advocates for the consideration of reusable items where possible to reduce the environmental and financial impact of anaesthesia, in a manner that maintains patient care and safety^{1,2}.

Reusable scrub hats are being increasingly embraced by staff for environmental reasons, along with reasons of personal expression and attempts to improve team dynamics (for example, embroidered scrub hats that allow team members to identify each other).

However, there is a common perception that reusable scrub hats are less effective than disposable, single-use options in reducing the risk of surgical site infections (SSIs), and it is not uncommon to hear of institutions that mandate against their use for this reason.

Here, we consider the comparative evidence regarding the risk of SSIs with cloth versus disposable scrub hats in an attempt to balance their environmental and cost benefits with concerns about patient safety.

Scrub caps are worn by all theatre staff with the intention of reducing SSIs by preventing the spread of microbial organisms⁶.

Surgical site infections are associated with a high level of morbidity and mortality⁷, and it is therefore essential to adopt evidence-based approaches to minimising their prevalence. Interestingly, there is only limited evidence that head coverings reduce SSIs, with some research even suggesting that scrub caps do not significantly reduce rates of SSIs in non-scrubbed theatre staff^{7,8}.

When scrub hats are worn, there is little evidence to suggest any benefit in the use of disposable hats to reduce SSIs. One study recreated a surgical procedure in a simulated, dynamic operating theatre (OT) environment and compared disposable bouffant, disposable skull caps and laundered, cloth skull caps.

They assessed the fabrics for permeability, pore size and particle transmission and sampled the OT environment for airborne particulate and microbial contaminants. There was no difference between cloth and disposable skull caps in terms of microbial and particulate shed and interestingly, they found that disposable bouffant hats were inferior to cloth scrub hats⁹.

Other studies have reported no reduction in SSIs within large institutions that have mandated the use of disposable bouffant hats over other options^{10,11}.

Taken together, there is no convincing evidence that disposable scrub hats are more effective than freshly laundered and lint-free hats in reducing the risk of SSIs in both scrubbed and unscrubbed OT staff.

It is becoming increasingly evident that human health is contingent on environmental health and reducing the environmental impact of the healthcare sector will benefit our patients³. It is therefore essential we make environmentally sustainable choices, while ensuring patient care and safety is upheld.

The choice of scrub hat has not been demonstrated to have any impact on risk of SSIs and we therefore advocate that reusable, freshly laundered and lint free hats are embraced as one way we can reduce the impact of our practice. Please engage with your institutions if reusable scrub hats are currently not sanctioned for use, otherwise get shopping!

Dr Ann Lee
Critical Care SRMO, St George Hospital, Sydney

Dr Jessica Hegedus
Anaesthetist, Wollongong Hospital and member, ANZCA Environmental Sustainability Working Group

***ANZCA's next steps in supporting environmental sustainability.**

The Environmental Sustainability Working Group (ESWG) has now been disbanded and has delivered its final report to the Professional Affairs Executive Committee (available on the website).

In line with the college's commitment to environmental sustainability, ANZCA Council has approved the working group's recommendation to establish a new Environmental Sustainability Network (ESN). The purpose of the ESN is to advocate, collaborate and promote initiatives and projects related to environmental sustainability within anaesthesia, perioperative and pain medicine, positioning ANZCA as a proactive leader and advocate in this area. More information on how fellows, trainees and SIMGs can become involved will be available soon in the E-Newsletter and on the website.

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What's new in the library?

GETTING TO THE BASICS

Did you know that you can access ANZCA library full-text just about anywhere? Or that you can access any article free-of-cost? Or that there's a bunch of apps that will make keeping up-to-date easier?

Are you new to ANZCA and not sure where to start when using the ANZCA library or what services are available? Or an experienced user looking to get more out of the ANZCA library?

Here's a rundown of some of the pages/guides that we've put together to assist:

- The library orientation page: A good place to start for any user unfamiliar with the ANZCA library and what services/resources are available. Caters to all users including trainees, fellows, educators and CPD participants. Google "anzca library orientation".
- Anaesthesia essentials: Core resources for anaesthetists – key journals, the latest cutting-edge articles, key e-books including the top 50 "most-used", specialist collections, apps and podcasts, and websites of interest. Google "anzca anesthesia essentials".
- Pain medicine essentials: Core resources for pain medicine specialists – key journals and the latest ground-breaking articles, key books and e-books, relevant databases, and apps and podcasts. Google "anzca library pain essentials".
- Access anywhere: You can access ANZCA library full-text resources via Google Scholar, PubMed, Wikipedia or just about anywhere a DOI appears. Google "anzca library help".

UPDATE TO LIBRARY DISCOVERY SERVICE

The ANZCA library discovery service recently received a major upgrade with the main interface being completely overhauled.

New features include a modernised interface with an updated look and feel;

search results now highlighting the search terms used; updates to the additional editions/formats display; and item records displaying linkable MeSH terms and incorporating a new Access & Request Options panel which allows for quicker access to online, print and document delivery options.

Users who experience any issues, are advised to empty their browser cache and delete their cookies. For more information, see the Library Help page: <https://libguides.anzca.edu.au/help> for further details.

LIBRARY STATISTICS

The library has recently reported its mid-year statistics. After a big year for journals in 2020 – thanks COVID – here are just a few of the highlights for 2021 so far:

- 62 literature searches performed.
- 528 books lent.
- 885 document delivery requests processed (average turnaround: 1.4 days).
- 71,211 discovery service searches performed.
- 74,017 articles downloaded.
- 89,953 e-book chapters downloaded.
- 102,039 library guides pages viewed.
- 152,000 library website hits.
- 162,248 items viewed from AIRR (institutional repository).

NEW CHRONIC PAIN LIBRARY GUIDE

The library recently launched a new Chronic Pain library guide.

The guide has been designed to help pain medicine specialists locate relevant resources on chronic pain, including those available through the ANZCA library. The guide brings together a wide variety of resources, including key documents, websites, journals, articles of interest and a number of e-books (including the new Preoperative Optimization of the Chronic Pain Patient: Enhanced Recovery Before Surgery).

Google "ANZCA library guides" to access.

RESEARCH CONSULTATION SERVICE

The new Research Consultation Service was launched in April as part of a 12-month pilot program. The main component of the service was the introduction of a part-time research librarian who undertakes literature searches for fellows, trainees, and staff, as well as providing support and guidance for research-related queries.

Below are some examples of recent queries Research Librarian Kathryn Rough has been assisting with:

- An emerging researcher asking what is a H-Index and how do I find out if I have one?
- Searching for evidence around a new educational program.
- Performing literature searches – one recent search involved finding materials on an ethical dilemma component for a trainee presentation.
- Performing one-on-one database searching training via Zoom for an interstate fellow.
- Searching for the most-cited paper in Anaesthesia, covering the years 2018-2021.
- Discussion and advice via Zoom with fellow on Systematic Review processes.

For further details – including full contact details – about the research consultation service, visit the webpage www.anzca.edu.au/library/research-consultation-service or Google "anzca research consultation".

COVIDENCE – THE TOOL FOR SYSTEMATIC REVIEWS

ANZCA Library has recently extended the trial for Covidence until 30 June 2022.

We recommend anyone interested in undertaking a systematic review, check out Covidence for better SR management.

Covidence is a web-based tool that improves healthcare evidence synthesis by improving the efficiency and experience of creating and maintaining systematic reviews.

Learn more via the ANZCA Covidence library guide: libguides.anzca.edu.au/covidence or contact the research consultation service: researchconsultation@anzca.edu.au.

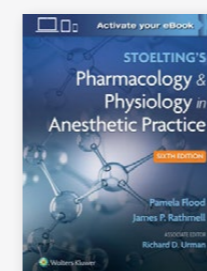
New books

A complete list of new books can be found at:

<https://libguides.anzca.edu.au/latest/>

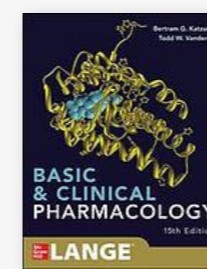
NEW EXAM BOOKS

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



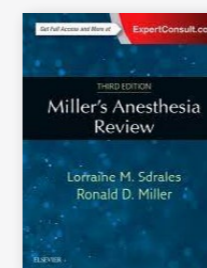
Stoelting's pharmacology & physiology in anesthetic practice, 6e

Flood P, Rathmell JP, Urman RD [eds]. Philadelphia: Wolters Kluwer, [2022].



Basic & Clinical Pharmacology, 15e

Katzung BG, Vanderah TW [eds]. New York: McGraw-Hill, 2021.

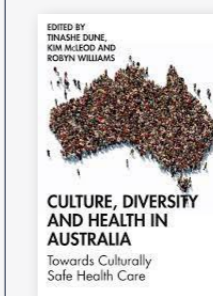


Miller's anesthesia review, 3e [print only]

Sdrales LM, Miller RD [eds]. Philadelphia, PA: Elsevier, [2018].

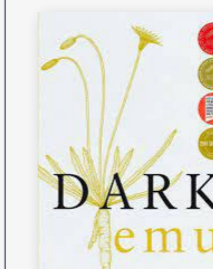
INDIGENOUS HEALTH

A number of new titles have been added to the Indigenous Health collection: libguides.anzca.edu.au/indigenous



Culture, diversity and health in Australia: towards culturally safe health care

Dune T, McLeod K, Williams R [eds]. Milton: Taylor & Francis Group, 2021.



Dark emu: Aboriginal Australia and the birth of agriculture

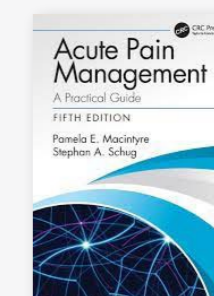
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Indigenous knowledge systems and research methodologies: local solutions and global opportunities

Huaman ES, Martin ND [eds]. Toronto; Vancouver: Canadian Scholars, 2020.

NEW EBOOKS



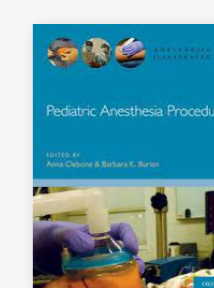
Acute pain management: a practical guide, 5e

Macintyre PE, Schug SA. Boca Raton: CRC Press, 2021.



Oxford textbook of anaesthesia in the obese patient

Sinha AC [ed]. Oxford: Oxford University Press, 2021.



Pediatric anesthesia procedures

Clebone A, Burian B [eds]. New York: Oxford University Press, 2020.

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

Sydney fellow wins education award



Dr Adam Rehak was awarded the 2021 Stuart Henderson Award in May for his contribution to medical education in anaesthesia. Dr Robert Marr, Deputy Chair ANZCA Educators Sub-Committee, met Adam to discuss his achievements.

ADAM IS A Staff Specialist at Royal North Shore Hospital (RNSH) and The Sydney Clinical Skills and Simulation Centre (SCSSC). He was the centre's supervisor of EMAC from 2007-18 and continues to be a lead instructor and a member of the EMAC sub-committee since 2014. He has also run and developed numerous crisis resource management courses for anaesthetists, other doctors and the multidisciplinary team. He is on the executive of the Airway SIG and has authored numerous papers and guidelines on airway management and management of human factors.

What led you to an interest in medical education?

Serendipity. I had moved to Sydney to work as a fellow at RNSH and was given the simulation centre portfolio. I loved the simulation teaching and really loved the centre staff who were highly motivated people, who loved what they were doing. It was infectious to work in that environment. It takes me a long time to develop into a role and I get bored very easily, so having a role that wasn't just giving anaesthetics has been part of the key to my longevity. I just wanted to keep doing this! I'm only now realising the mistakes I was making 10 years ago, whereas others would have run in, mastered it and left after five years. That slow learning has meant that I'm not bored and I have no need to move on. I'm still challenged by medical education and simulation education in particular.

What difficulties have you faced when advocating for medical education?

Medical education has become compartmentalised as something you do for CPD, or in isolation from your day-to-day work. We still haven't got past this attitude that when you finish your vocational training that you are the perfect well rounded, prepared clinician. We all understand that that is a fallacy, but we still see CPD as a tick box exercise rather than really engaging with this idea of career-long learners, with the idea that I'm going to learn as much as I'm going to work. That's been a complete

battle for a long time to integrate what we do in the sim centre and medical education in general, into a clinical setting. We need to be going down a translational path with medical education to ensure that it translates into our everyday clinical roles and that's not happening at the moment.

What has been your most interesting role in medical education to date?

My most interesting role is getting more involved with training the trainers and trying to unpack and rebuild how we teach into understandable, manageable and deliverable messages. It's a real challenge. Understanding what has worked and not worked in the delivery of education, the role of delivery of education and how you support and scaffold others in their delivery has been really interesting.

What education projects are you working on at the moment?

We've had a bunch of talented junior staff who have been producing cognitive aids for the different anaesthetic subspecialties, and making them fit for purpose. We are building educational activity around the aids – not just to educate others – but to validate their use clinically. We would like to test them to illustrate any performance gaps within our hospital and use the research to show a need for education in these areas and how care can be improved. We've been fortunate to have established links with lead educators for Qantas pilots. We're now developing a human factors in critical care course, which utilises their flight simulator, to educate participants in a unique way.

Where would you like to see medical education at ANZCA in the future?

I'd like to see medical education not just something that stands alone, but being part of the design of the workflow of the hospital to allow continuous education in the theatre environment. I'd love to see that simulation centres no longer be the primary place of delivery for Crisis Resource Management education, and they become more the train the trainer locations with occasional attendance at bigger sessions with regular education in your own hospital.

What advice would you give to a trainee interested in a career in medical education?

Look for the ability to develop and run lower fidelity workshops and training sessions within their operating theatre, to anaesthetists or anaesthetic nurses, or mixed groups. For example, airway training to critical care teams. Think outside the simulation centre and incorporate elements of simulation in your training.

How do you feel about being awarded the Stuart Henderson Award?

I'm in shock. I look at people's dedication and the sacrifice they make. I never think of myself like that because I enjoy what I do. Most gratifying was that my colleague nominated me, which means the work I provide has made a difference. It's been more than just a fun ride for me. It's rubbing off on other people too.

2022 Stuart Henderson Award

For more information, eligibility criteria and the nomination process please visit our website:

www.anzca.edu.au/about-us/our-culture/recognising-excellence/stuart-henderson-award.

Helping realise philanthropic goals

RECENTLY I'VE AGAIN had the privilege of talking to members about how to make real and lasting impacts in their areas of interest, by planning significant philanthropic contributions through the foundation.

The foundation provides a philanthropic service to anyone wanting to help make advances in anaesthesia, pain and perioperative medicine, for better health outcomes for patients and families, and to support the professional capacity, academic contributions and health and wellbeing of healthcare professionals.

I'm often asked what options are available through the foundation. This article is an introduction to some of those options. There are some general initial questions that all donors should consider in planned philanthropy.

What is my timeframe?

It is important to identify whether your goal is to give to make a difference in the short to medium term, or to create a long-term or even perpetual source of funds to support an area of interest.

Larger short- to medium-term gifts can support particular grants or projects that deliver outcomes in the current or following few years. Whether the gift itself is a one off or made over several instalments, the projects supported can still deliver lasting impacts.

To create a longer-term stream of income that sustainably funds a cause or activity, making a donation into the foundation's investment fund is an ideal vehicle. Managed by JB Were, the fund consistently delivers strong returns. Investment income from large gifts can be tracked and distributed by the foundation to create benefits for the work it supports over many future decades.

To generate meaningful income, investment gifts for long-term benefit need to be larger amounts, as the funding generated for projects depends on investment returns, while the capital is retained in the fund. Such a gift may either be made in the short term, generating taxation benefits, or by planning the provision of a long-term bequest gift in a will.

How much do I want to contribute?

Any amount can be donated via the foundation, and all gifts are important. The impact made generally increases with the size of gift, depending on good targeting, and funding and project and management. Individual gifts tied to specific activities or new programs generally require larger amounts, while smaller gifts for existing programs can also be effective, when combined with many gifts of similar size.

Do I want to create recognition or a memorial?

The foundation can create lasting appropriate recognition of individual donors, specific larger gifts, bequests, or family members or colleagues in whose honour a gift is made. An important part of gift planning is considering whether you prefer to remain anonymous, would like your giving recognised as an incentive to others, or to memorialise a loved family member or esteemed colleague.

The foundation can help donors in this process, and many types of recognition are available. Opportunities include named grants, awards and scholarships, our website, events, donor board, publications and presentations.

What cause do I want to target?

Some donors give valuable, flexible funding for the foundation's capacity to support work across anaesthesia, pain and perioperative medicine. Others prefer to target a special interest. Examples include pain medicine, clinical trial pilot studies, a sub-specialty, a type of research or education, global or Indigenous health, the environment, emerging researchers, or professional practice research.

It is important that within any area targeted there is likely to be significant and relevant work undertaken by ANZCA fellows, trainees and staff, and that the area aligns with the college and foundation's mission.

Examples of existing and new targeted giving options

Named research awards

Creating named research awards, scholarships and grants is one of our more

popular giving options. The foundation's named awards recognise donors, bequestors, colleagues or family members, and are awarded to appropriate fellows' or trainees' projects by the ANZCA Research Committee.

Patrons Emerging Investigator Award

This new award will help a talented emerging researcher progress their research career, funded with support from the foundation's highly-valued patrons, who pledge annual giving of \$1000 or more. By becoming a patron you can help reach the target of \$70,000 needed for this exciting new grant.

Global Safer Surgery Fund

The Global Safer Surgery Fund donations provide modest but strategic contributions for health activities in developing countries, seeking to leverage large improvements in areas of great need. Its most recent contribution supported the obstetric arm of the benchmark African Surgical Outcomes Study.

Environment and Sustainability Research Award

This new donor-funded award will be advertised in December 2021 for granting in early 2023. Donations to help make this an annual award can be made via our donation webpage (search "GiftOptions – ANZCA").

Thank you to all of our wonderful donors for helping the foundation to continue to support the inspiring work of our fellows and trainees.

Rob Packer

General Manager, ANZCA Foundation

Foundation name change

To reflect the foundation's role in supporting research and education in anaesthesia, pain medicine, perioperative medicine, global health equity, and Indigenous health, ANZCA Council has re-named the ANZCA Research Foundation the ANZCA Foundation.

Contact the ANZCA Foundation

To donate online, search "GiftOptions – ANZCA" in your browser.

For general queries, contact:

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

ANZCA research grant program queries can be directed to Susan Collins, Research and Administration Co-ordinator, scollins@anzca.edu.au.

Nuffield Chair of Anaesthetics appointed



Professor Robert Sanders

PROFESSOR ROBERT SANDERS (BSc MBBS PhD FRCA DABA FANZCA) an anaesthetist who is recognised as a leader in neuroscience research, is the fourth anaesthetist to be appointed the Nuffield Chair of Anaesthetics at the University of Sydney.

Professor Sanders was appointed from the University of Wisconsin where he was an Assistant Professor in Anaesthesiology. During his five year appointment there his research focused on the mechanisms behind delirium and cognitive decline. Other research interests included the changes in sensory perception and consciousness under anaesthesia.

He attracted \$A8 million in National Institutes of Health (US) research funding and was awarded the American Society of Anesthesiologists' 2020 James E. Cottrell Presidential Scholar Award in recognition of his outstanding work in anaesthesia and translational research. The citation for the award which is bestowed annually noted that "his research is vast and diverse and, in its entirety, has significantly improved the understanding of how anaesthesia impacts the brain."

In 2020, Professor Sanders was also awarded the prestigious Macintosh Professorship by the Royal College of Anaesthetists.

Professor Sanders, arrived in Sydney in June last year with his wife Dr Helen Manning, an obstetrician and gynaecologist, and their three children. As head of the discipline of anaesthetics at the University of Sydney, he divides his time between clinical work at the Royal Prince Alfred Hospital, and doing research, teaching, and supervising PhD and post-doctoral students.

Professor Sanders trained in medicine at Imperial College London after completing a BSc in Neuroscience (First Class Honours). At Imperial College London, he also completed his PhD studying the neuroimmune actions of sedatives.

Professor Sanders has specialist qualifications in anaesthesia from the UK, US, Australia and New Zealand.

Professor Sanders' recent research findings include:

- identifying that five per cent of people wake up after intubation¹.
- that current anaesthetic monitors are poor at detecting these events².
- that a surgery is associated with a cognitive impact that on average is equivalent to five months of aging³.
- that postoperative delirium is associated with neuronal injury⁴.

Asked to comment on his future research directions, Professor Sanders' said that "we will seek to understand two key mechanisms: First, the mechanisms of anaesthesia, how we become unaware of our sensory world, and secondly, how perioperative care may lead to delirium and cognitive decline in vulnerable individuals. Armed with this information, we will be able to design clinical trials that lead to advances for our patients."

References

1. Sanders RD, et al. Incidence of Connected Consciousness after Tracheal Intubation: A Prospective, International, Multicenter Cohort Study of the Isolated Forearm Technique. *Anesthesiology* 2017;126:214-22.
2. Gaskell AL, et al. Frontal alpha-delta EEG does not preclude volitional response during anaesthesia: prospective cohort study of the isolated forearm technique. *Br J Anaesth* 2017;119:664-73.
3. Krause BM, et al. Association between major surgical admissions and the cognitive trajectory: 19 year follow-up of Whitehall II cohort study. *BMJ* 2019;366:14466.
4. Casey CP, et al. Postoperative delirium is associated with increased plasma neurofilament light. *Brain* 2019;143:47-54.

The CTN virtual workshop takes the cake!

THE 2021 ANZCA Clinical Trials Network (CTN) Strategic Research Virtual Workshop was held on 6-7 August 2021.

More than 180 delegates registered to attend, making it the largest meeting in the history of the CTN to date. Originally planned as a face-to-face workshop in Brisbane, the workshop was adapted to a fully virtual meeting due to the uncertainty of COVID-19.

Workshop convenor, Dr David Highton, the CTN team and ANZCA Events team were given the challenge of reimagining the program in the weeks leading up to the meeting. The successful adaptation of the workshop to a virtual format would not have been possible without the careful contingency planning in early preparation stages.

The core aim of this workshop is to troubleshoot research protocols for studies which may lead to large funded clinical trials. Eleven proposals were presented by emerging and senior investigators who sought feedback on key issues. Every year we invite a keynote statistician to provide invaluable input into the design of the new proposals. This year we were delighted to have the statistical expertise of Associate Professor Kristen Gibbons from The University of Queensland, who also delivered an engaging keynote presentation on trial monitoring.

Day one of the meeting opened with keynote presentations from Professor Kerrie Mengersen and Professor Jed Duff, both from Queensland University of Technology (QUT). Professor Mengersen and Professor Duff challenged the minds of delegates with thought-provoking presentations on Bayesian statistics and implementation science respectively. Dr Amy Gaskell (NZ) then discussed the importance of directed acyclic graphs in clinical trials. Day one was wrapped up with a "Getting started in CTN" research workshop, featuring panellists from sites across Australia sharing advice on how to become a sustainable research department.

Day two, also known as "Super Saturday", opened with a "Beyond PADDI" panel with delegates hearing first-hand late breaking results of the PADDI Post-operative Nausea and Vomiting, Sleep and Bayesian sub-studies from Professor Tomas Corcoran (WA), Dr Richard Halliwell (NSW) and Professor Timothy Houle (Boston, US). Later on Professor Andrew Davidson (Vic), Dr Jennifer Reilly (Vic) and Dr Derryn Gargiulo (NZ) shared their advice on how to run more cost effective and efficient trials. Day two concluded with information sessions on the LOLIPOP and TRICS-IV trials led by Professor Tomas Corcoran and Professor David A Scott respectively. These trials are the latest success stories of the CTN to secure major grant funding.

Overall the workshop exceeded expectations of many members and facilitated key networking opportunities delegates would normally have in-person. Delegates were given the opportunity to engage with presenters and connect with other delegates through the online Q&A portal, Delegate app and virtual networking sessions. Delegates also joined the conversation on Twitter, with a record of 1.655 million impressions!

The "Come Together Now" watch party pack got the party started and excitement levels were high leading up to the inaugural trial cake bake off which saw Mayumi Ueoka from The Alfred hospital take the win with her impressive ITACS creation! While still on a sugar high, delegates enjoyed key lessons on running clinical trials from principal investigators.

The CTN trivia left delegates pondering the history of CTN, trials and the many talents of the CTN Executive. Some delegates were also lucky enough to join with colleagues and attend one of the watch parties in Hamilton New Zealand, Adelaide and Perth.

Another highlight for 2021 was the largest attendance of Queensland delegates, a 160 per cent increase on previous years. A meeting of this scale and calibre would not have been possible without the expertise of our AV partner, Wallfly, and the detailed contingency plans in place. Special thanks to our speakers for their time, flexibility and understanding of the necessary changes required due to COVID-19.

Thank you also to all our registered delegates, chairs and co-chairs, as well as the CTN, ANZCA Events and Communications teams. The CTN Executive wishes to extend a special thank you to Dr David Highton, Wallfly and teams tasked with the challenges of a continuously changing format and ultimately responsible for the success of the meeting.

Karen Goulding
CTN Manager

Majella Coco
ANZCA Events Officer



Delegates from New Zealand: Seema Vinish, Gay Mans, Jonathan Termaat, Margie McKellow, Timothy Short, Carolyn Deng, Davina McAllister, Leanda Ritchie, Helen Houston, Sue Olliff



Sophie Wallace, Mayumi Ueoka and Paul Myles from Alfred Health

HemoSphere Advanced Monitoring Platform

Edwards Lifesciences offers you a comprehensive solution to ensure better patient care

Swan-Ganz Catheter
Providing a comprehensive haemodynamic profile for flow, pressure as well as oxygen delivery and consumption in the OR and ICU.

Swan-Ganz CCombo Catheters
Providing continuous monitoring of haemodynamic pressures, continuous cardiac output, mixed venous oxygen saturation (SvO2), and continuous end-diastolic volume (EDV).

ForeSight Tissue Oximetry Sensor
Recommended for cardiac, vascular and orthopaedic procedures, such as beach chair shoulder surgery.

FloTrac Sensor
Recommended for high-risk patients that have an arterial line in place. Commonly used in major abdominal surgery, complex orthopaedic surgery and many other complex procedures where Goal-Directed Therapy and ERAS are adopted.

Acumen IQ Sensor with HPI software
Offers predictive clinical decision software reflecting rapid physiological changes in patient status. Recommended for patients at risk for AKI and intraoperative hypotension.^{1,2,3}



Aotearoa New Zealand ASM: It is all about Whakaora (To Heal)

AS THE BULLETIN goes to print, the COVID-19 outbreak and lockdowns are adding further challenges for the organising committee of the Aotearoa New Zealand Annual Scientific Meeting (ASM) in Ōtautahi, Christchurch scheduled for 27-30 October. The big news is that the meeting will go ahead on the planned dates but will be fully virtual.

The scientific program looks stimulating and engaging with top-flight international and local speakers, all of whom have remained committed to the meeting throughout these difficult times. "Amazing as it seems, our international and Australian speakers had already accepted their invitations and had topics penciled in before anyone had even thought of a global pandemic," says scientific co-convener Dr Veronica Gin.

The theme for the meeting is appropriate for our time – Whakaora (To Heal): Our patients, Ourselves, Our City, Our Planet. The theme is thoughtfully reflected in the program, and the organising committee has curated the scientific program and workshops with a real breadth of expertise and topics. It will challenge anaesthetists to care for their patients more effectively – to look after themselves and each other, and to consider the wider community and the world we live in.

Early bird registration has been extended until 3 October with registrations tracking for 300.

You can check out the program but some highlights to give you a taster include:

- Professor Dan Sessler from The Cleveland Clinic, looking at big data and how it may inform anaesthesia practice and perioperative care.
- Professor Carol Peden (UK and Chicago) describing progress of the multi-year quality improvement program for patients requiring emergency abdominal surgery.
- Associate Professor Ross Kennedy from the University of Otago on reducing anaesthetic gas use, the impact on climate change and collaboration with GE Healthcare.
- And Dr Daniel Hartwell, also from Christchurch, inventor of the Hartwell Simulator, and poser of the question "Should simulation be the start to, well, everything?"

References

1. Salmasi, V., Maheshwari, K., Yang, G., Mascha, E.J., Singh, A., Sessler, D.I., & Kurz, A. (2017). Relationship between intraoperative hypotension, defined by either reduction from baseline or absolute thresholds, and acute kidney injury and myocardial injury. *Anesthesiology*, 126(1), 47-65. 2. Sun, L.Y., Wijesundera, D.N., Tait, G.A., & Beattie, W.S. (2015). Association of Intraoperative Hypotension with Acute Kidney Injury after Elective non-cardiac Surgery. *Anesthesiology*, 123(3), 515-523. 3. Walsh, M., Devereaux, P.J., Garg, A.X., Kurz, A., Turan, A., Rodseth, R.N., Cywinski, J., Thabane, L., & Sessler, D.I. (2013). Relationship between Intraoperative Mean Arterial Pressure and Clinical Outcomes after non-cardiac Surgery. *Anesthesiology*, 119(3), 507-515.

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A new group in New Zealand: PAIA (Pasifika Anaesthetists in Aotearoa)

Several Pasifika anaesthetists have formed a new group to help address the inadequate numbers of Pasifika people in the specialty in New Zealand.



PAIA (PASIFIKA ANAESTHETISTS IN AOTEAROA) says Pasifika people make up 0.3 per cent of the anaesthesia workforce and that is not nearly enough. Spokesperson Satualafa'alagilagi Dr Leinani Aiono-Le Tagaloa says that figure should be closer to 7.4 per cent to mirror the population of the country.

"As Pasifika anaesthetists, we are passionate about supporting young Pasifika students to complete medical school (an area of concern at present) and be encouraged to consider specialist training, particularly in the field of anaesthesia," says Dr Aiono-Le Tagaloa.

Dr Aiono-Le Tagaloa says research clearly shows that there is a huge gap between Pasifika and non-Pasifika ethnic groups when it comes to access to healthcare. "Pasifika continue to be overrepresented with chronic health conditions. Our goal is to look at ways we can provide solutions to these problems, particularly in perioperative care and improvement of outcomes post-surgery."

However, PAIA is also interested in contributing to advancing the anaesthesia workforce in the wider Pacific region by assisting with training and continuing professional development.

PAIA is reaching out to all those who identify as having Pacific origin, and having their roots in the islands of the Pacific, but are resident within Aotearoa New Zealand and call it home. "We would welcome our Pacific colleagues who live and work in Australia to join our efforts, recognising that the Pasifika diaspora extends to include Australia, but have been focussing our initial efforts on Aotearoa New Zealand," says Dr Aiono-Le Tagaloa.

"We are talking with ANZCA about support as we engage with the government to be a voice for the advancement of the Pacific workforce in specialty training. We are the first specialist college to form a Pasifika association. As such we are perfectly positioned to be a template for other specialist colleges to follow in this area," she says.

"Ultimately we would like to see recognition of the unique placement of Australia and New Zealand within the Pacific Ocean, and the rich contribution of the Pacific peoples to the culture and economy of both lands."

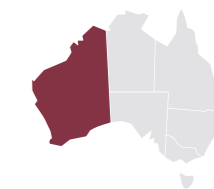
PAIA is working on a memorandum of understanding with the Pasifika Medical Association and have asked for their support as they have expertise in representing Pasifika interests within New Zealand.

"Our heart and our highest aspiration would be to see Pacific people as a fully integrated, respected and recognised part of our community," says Dr Aiono-Le Tagaloa. "We want to give of the riches of our cultures and way of life to the anaesthesia community and the wider community of Aotearoa, and indeed of Australasia. We want to remove the barriers of second-class citizenship and systemic racism that inhibit the ingress of Pasifika peoples to positions of leadership and their ability to contribute their unique perspective for the betterment of healthcare provision.

"To use that oft-quoted pictograph for inequity, we would say don't give us a box – remove the fence!"

**"As Pasifika anaesthetists,
we are passionate about
supporting young Pasifika
students to complete
medical school."**

Western Australia



2022 WA RATP TRAINEE SELECTIONS

In Western Australia, the WA Rotational Anaesthesia Training Program (RATP) undertakes its annual trainee selection process in late August each year. Anaesthesia remains a very popular career choice in WA, and competition is fierce for the highly prized positions in this very successful, statewide training scheme. To that end, a rigorous and intensive selection process is undertaken each year to select the most suitable candidates to become anaesthesia trainees and future anaesthetists.

Approximately 120 candidates apply to the WA RATP selection process each year. The written application includes a CV, a statement addressing selection criteria and references. From this written submission, between 40 and 45 candidates are shortlisted and invited to progress to the next stage of the process.

Over three days at the end of August, candidates attend in person for their selection day, where a range of selection modalities are used to assess different aspects of the selection criteria. A combination of face-to-face interviews, a presentation and two simulation stations allow candidates to demonstrate their skills and their strengths in multiple ways.

This multimodal approach has now been used in WA for 11 years. The interview is designed to elicit medical knowledge

and clinical expertise, in addition to personal insights and reflection. The presentation component is intended to assess the candidates' ability to summarise complex information in a succinct manner under time pressure. The simulations are particularly powerful at elucidating non-technical skills, such as decision making, leadership, teamwork, communication skills and performance under pressure.

Results from the written submission, the interview, the presentation and the simulations all form part of the final selection scoring, with between 10 and 20 candidates successfully appointed to the WA RATP each year.

While this annual process is effort-intensive and time-consuming, it is recognised that this selection process is a crucial undertaking for the future of our specialty. And that a highly robust and rigorous selection process such as this, is essential to recruit the most suitable candidates to our training program.

This process uses numerous consultant anaesthetists and simulation fellows each year. Our thanks go to all the individuals as well as the departments who support the process each year.

Selection committee:

- Co-chair: Dr Kevin Hartley (Joondalup Health Campus)
- Co-chair: Dr Anna Hayward (Joondalup Health Campus)
- Dr Jay Bruce (Fiona Stanley Hospital)
- Dr Shedlayah Dhuny (St John of God Midland)
- Dr Steve Myles (Sir Charles Gairdner Hospital)
- Dr Angela Palumbo (Sir Charles Gairdner Hospital)
- Dr Mark Williams (Fiona Stanley Hospital)
- Dr Bojan Bozic (Sir Charles Gairdner Hospital)

- Dr Melissa Gildenhuys (St John of God Midland)
- Dr Cat Goddard (Sir Charles Gairdner Hospital)
- Dr Grace Ho (Joondalup Health Campus)
- Dr Rebecca Kelly (Joondalup Health Campus)
- Dr Nicole Khangure (Joondalup Health Campus)
- Dr Carl Lee (Joondalup Health Campus)
- Dr Hamish Mace (Fiona Stanley Hospital)
- Dr Volker Mitteregger (Fiona Stanley Hospital)
- Dr Merlin Nicholas (Joondalup Health Campus)
- Dr Natasha de Silva (Joondalup Health Campus)

- Dr Reza Feizerfan (Royal Perth Hospital, Sir Charles Gairdner Hospital)
- Dr Ian Fleming (Royal Perth Hospital)
- Dr Chris Gibson (Perth Children's Hospital)
- Dr Simon Hellings (Sir Charles Gairdner Hospital)
- Dr Steve Lamb (Sir Charles Gairdner Hospital)
- Dr Emelyn Lee (King Edward Memorial Hospital, Sir Charles Gairdner Hospital)
- Dr Belinda Lowe (Sir Charles Gairdner Hospital)
- Dr Claire McTernan (Fiona Stanley Hospital)
- Dr Michele Moore (Fiona Stanley Hospital)
- Dr Christine Ong (Fiona Stanley Hospital)
- Dr Nicolas Prophet (Rockingham General Hospital)
- Dr Tania Rogerson (Sir Charles Gairdner Hospital)
- Dr Phil Russell (St John of God Hospital Subiaco)
- Dr Tania Strickland (Armadale Health Service)

- Dr Sam Bonnington (Royal Perth Hospital)
- Dr JY Chong (Fiona Stanley Hospital)
- Dr Alicia Cullingford (Royal Perth Hospital)
- Dr Falk-Hendrik Droste (Royal Perth Hospital)
- Ms Candice Elliott (Sir Charles Gairdner Hospital)
- Ms Jill Kemp (Sir Charles Gairdner Hospital)
- Dr Kunal Lund (Sir Charles Gairdner Hospital)
- Dr Sneha Neppalli (King Edward Memorial Hospital)
- Dr Lip Ng (King Edward Memorial Hospital)
- Dr Grant O'Brien (Fiona Stanley Hospital)
- Dr Kate O'Hare (Sir Charles Gairdner Hospital)
- Dr Barrie Robertson (Sir Charles Gairdner Hospital)
- Dr Darren Sherwin (Sir Charles Gairdner Hospital)
- Dr Archana Shrivastha (Fiona Stanley Hospital)
- Dr Hannah Smyth (Sir Charles Gairdner Hospital)
- Dr Tamsyn Williams (Armadale Health Service)
- Dr Kahina Wotton-Hamrioui (King Edward Memorial Hospital)

Thank you to those involved with the process this year:

Interviews and presentations

- Co-ordinators – Dr Anna Hayward (Joondalup Health Campus) and Dr Rebecca Kelly (Joondalup Health Campus)
- Dr Annie Carlton (Fiona Stanley Hospital)
- Dr Jakob Chakera (Sir Charles Gairdner Hospital, Joondalup Health Campus)
- Dr Neil Collins (Joondalup Health Campus)
- Dr Ian Fleming (Royal Perth Hospital)

Simulations

- Coordinator – Dr Angela Palumbo (Sir Charles Gairdner Hospital)
- Consultant anaesthetist assessors
- Dr Lisa Alarcon (Fiona Stanley Hospital)
- Dr Bojan Bozic (Sir Charles Gairdner Hospital)
- Dr Kevin Chan (King Edward Memorial Hospital, St John of God Hospital Midland)
- Dr Natasha de Silva (King Edward Memorial Hospital, Royal Perth Hospital)

Simulation assistants

- Dr Marlena Bartmanska (Fiona Stanley Hospital)

South Australia and Northern Territory



FPM CONTINUING MEDICAL EDUCATION

The June CME was presented by Associate Professor Anne Burke, Network Lead, Statewide Chronic Pain Clinical Network. She gave an informative presentation about the network's role which has been established to work on improving the provision of integrated multidisciplinary care for people with chronic pain. The evening was well attended by FPM members and allied health professionals.

PART ZERO COURSE

The SA part zero course was held on 24 July and transitioned to Zoom at the last minute due to the SA COVID lockdown. Participants included eight new trainees and 11 presenters.

Clockwise from above: Dr Graham Wright and Dr Gary Clothier; Dr Irina Hollington and Dr Matthew Green; Dr Tim Semple, Dr Anne Burke and Dr Michelle Harris.



PRIMARY EXAM REFRESHER COURSE

The SA primary exam refresher course was held from 28 June to 2 July at the SA ANZCA office. Once again, the outstanding efforts from the convenors, Dr Gary Tham and Dr Adelaide Schumann, was invaluable. We would like to thank all the presenters for their contribution in delivering another successful program.

Convenors Dr Gary Tham and Dr Adelaide Schumann with course delegates.



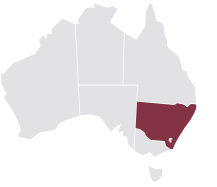
Australian Capital Territory



EVENING PRESENTATION ON HIGH PERFORMANCE UNDER PRESSURE

We are delighted to welcome Associate Professor Brian Burns to Canberra to give an evening presentation on high performance teams and culture, and performance under pressure. The evening presentation is open to ACT trainees, fellows, and non-members including ANU medical students. Associate Professor Burns is an emergency physician (Northern Beaches Hospital and Royal North Shore Hospital), retrieval specialist and director of research (Greater Sydney Area HEMS), and trauma director (Orange Health Service, NSW) as well as being a fantastic and engaging speaker. It's going to be a great evening! The presentation will take place on Wednesday 10 November 2021 from 6pm. Registration is now open and numbers will be capped at the venue COVID limit. Please register early to avoid missing out on this terrific presentation.

New South Wales



WELCOME TO THE TEAM

Earlier this year we welcomed event co-ordinator Jessica Home and course co-ordinator Loma Saythavy to the team. Jessica will be looking after the NSW ACE Winter Meeting, the NSW ACE Spring Meeting, the NSW ACE Anatomy Workshop and supporting the NSW ACE CME committee and NSW office activities. Loma will be looking after the upcoming primary exam refresher course, final exam refresher course, introduction to anaesthesia and supporting the NSW trainee committee.

PRIMARY EXAM REFRESHER COURSE

NSW delivered our first virtual primary exam refresher course from 5-9 July. This success was orchestrated by the course convener, Dr David Fahey and Melbourne course co-ordinator, Cathy O'Brien. Forty-six trainees and six presenters participated in the week-long course. The NSW team would like to thank Dr David Fahey and Cathy O'Brien for their effort and support in delivering this course during lockdown.

INTRODUCTION TO ANAESTHESIA TRAINING PROGRAM

The introduction to anaesthesia training program is specifically aimed at basic trainees in their first year of training or those doctors about to take up training positions in 2022. The course covers many topics, from how to deal with clinical errors, to what to expect in anaesthesia training and

how to look after your own wellbeing, all delivered in a short and informal format.

The session has been such a great success in previous years that many departments have made it compulsory for new trainees. Flyers will be sent to anaesthesia departments across the state shortly.

Date: Saturday 13 November 2021
Venue: Online via Zoom
Fee: Free

Application closing date: Friday 5 November 2021

For further information and to register your interest email nswcourses@anzca.edu.au.

NSW PRIMARY EXAM REFRESHER COURSE

This is a full-time revision course, run on a lecture/interactive tutorial basis and is most suitable for candidates sitting in 2022 March primary written exams. The number of participants for the course will be limited. Preference will be given to those candidates who will be sitting the primary examination in the first part of 2022. Late applications will be considered only if vacancies exist.

Date: Monday 29 November – Friday 3 December 2021

Venue: Northside Conference Centre, Corner Oxley Street and Pole Lane, Crows Nest, NSW

Fee: \$A660 including GST

Applications closing date: 15 November 2021. For further information and to register your interest email nswcourses@anzca.edu.au.

NSW FINAL EXAM REFRESHER COURSE

The course is a full-time revision course, run on a lecture/interactive tutorial basis and is open to candidates presenting for their final fellowship examination in 2022. The number of participants for the course will be limited. Preference will be given to those candidates who will be sitting for their final fellowship examination in the first part of 2022. Late applications will be considered only if vacancies exist.

Date: Monday 6 December – Friday 10 December 2021

Venue: Northside Conference Centre, Corner Oxley Street and Pole Lane, Crows Nest, NSW

Fee: \$A825 including GST

Applications closing date: Monday 22 November 2021

For further information and to register your interest email nswcourses@anzca.edu.au.

SAVE THESE DATES!

- NSW Spring Meeting Leura – Saturday 20 and Sunday 21 November 2021
- NSW ACE Anatomy Workshop Sydney – Saturday 27 November 2021
- NSW ACE Winter Meeting Hilton Sydney – Saturday 18 June 2022

Tasmania



A TRUE WINTER MEETING

On a wet day with cold southerly winds blowing, 20 Tasmanians and one from Western Australia braved the conditions to gather at Barnbougle, Bridport in the north east of Tasmania on Saturday 21 August.

It's a stunning location overlooking the windswept dunes and the wilds of Bass Strait and is listed as one of the top 10 links courses in the world.

Sadly a lot of the delegates from Sydney, Melbourne and Queensland couldn't attend due to border closures with a few from South Australia unable to attend due to flight cancellations. All three interstate speakers were also unable to attend in person.

Due to the unpredictability of the internet at the venue, the speakers prepared their presentations through Wallfly and followed up their presentations with Zoom question and answer sessions.

The remainder of the meeting was face-to-face presentations and at the end of the day, a lively panel discussion that examined the key topics of the meeting, namely paediatric anaesthesia and the environment and anaesthesia.

The convenor of the meeting, Dr Sam Walker was very pleased with the meeting and was grateful for the input of all the speakers, including pre-recorded virtual speakers, Associate Professor Justin Skowno, Associate Professor Forbes McGain and MDA speaker Gae Nuttal as well as Tasmanian speakers Dr Tom Mohler and Dr Ruth Matters who also joined the panel with Dr Simon Morphett, Dr Stephanie Cruice and Associate Professor Deborah Wilson. Dr Walker was impressed with the quality of the presentations and thoroughly enjoyed the thoughtful and considered panel session.

Pre-dinner drinks overlooking Bass Strait, followed by a delicious three course meal completed a relaxed, informal and informative day.



From left: Dr Tom Mohler (standing right at the front) and Associate Professor Forbes McGain (on the screen); panel session – moderator Dr Greg Bulman and panel members Dr Simon Morphett, Dr Tom Mohler, Dr Ruth Matters, Dr Stephanie Cruice, Associate Professor Deborah Wilson; Dr Ryan Hughes, Dr Kate Wearne, Dr Rowena Lawson, Dr Dane Blackford.

TASMANIAN ANNUAL SCIENTIFIC MEETING

Head south for an exciting summer meeting next year! Hobart will be hosting the Tasmanian Annual Scientific Meeting over 26 and 27 February 2022. Over two days we will be "Making connections" through a day of lectures and a day of workshops, exploring the realms of airway management, perioperative medicine and pain management.

Keynote speakers Professor Bernhard Riedel from the Peter MacCallum Cancer Centre, Professor Reny Segal from the Royal Melbourne Hospital and Dr Suyin Tan from Nepean Hospital, Sydney will be sharing their wisdom along with local speakers. Our local speakers will be providing insights into Tasmanian challenges in airway and perioperative management, and sharing updates in regional progress.

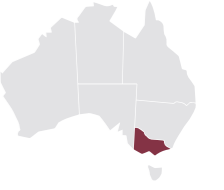
The new venue, the Grand Chancellor Hotel will ensure a spacious, COVID safe but social environment, and our social function, a cocktail style affair enjoying water views, will be held at the renowned Aloft Restaurant.

Please note the date in your calendar. Numbers will be limited due to COVID restrictions. Registrations will open in November 2021.

The annual Trainee Day will again be preceding the meeting on Friday 25 February 2022 at Hadley's Orient Hotel.



Victoria



RECENT COURSES

Since April, Victoria has held five exam preparation courses, welcoming 255 trainees across Australia and New Zealand. These courses included: Primary VIVA practice nights (April and May), Final VIVA practice nights (May), Primary refresher (May), Final refresher (July) and Final anatomy (July).

Trainees tuned into 52 speakers covering 54 specialised topics across the final refresher, anatomy and primary refresher programs. Some of the topics included: Neuromuscular junction and blockers, pain medicine, pharmacokinetics, acid base physiology, anaesthesia for eye surgery, ethics, law and professional issues, anatomy of the heart and lungs and, anaesthesia for thoracic surgery, just to name a few.

In his pain medicine session, Dr Charles Kim reviewed research around pain versus nociception, neural pathways, clinical picture, pain assessment, as part of the final refresher course. Drawing on his extensive experience and review, Dr Kim discussed case studies and evidence around many topics including: whether acute hyperalgesia is associated with chronic postoperative pain and examining induction and maintenance of central sensitization after surgery may be prevented by a low-dose infusion of the NMDA-receptor antagonist Ketamine. It was encouraging to see the high level of engagement among the trainees attending the live session.

Despite the cancellations of face-to-face learning and in turn networking opportunities, for now, the college appreciates all the feedback received from trainees, presenters, and fellows during the pandemic. In light of this, we have taken an excerpt from an email received by one of our trainee's attending the primary exam refresher course in Melbourne, this year.

"I think the zoom platform worked well and in fact had many advantages over face to face (not requiring travel time, allowing quick revision during breaks, allowing people outside of Sydney to still attend). I know this opinion was shared by quite a few of the participants this week".

ATTENTION TRAINEES

If you have any queries or concerns that you would like to discuss with a member of the Victorian Trainee Committee you are welcome to contact them direct via their private email vicanaestheticregistrars@gmail.com.

UPCOMING COURSES AND EVENTS

Victorian registrars' scientific meeting
12 November 2021, 1-6pm

At the Victorian Registrars' Scientific meeting, the regional committee encourages you to submit an abstract in one of the following categories: Scientific research project or audit. To participate please send in an abstract of 250 words in either category, and/or you can register to attend to support your colleagues online.

Exam preparation courses

Final VIVA practice nights
4, 6, 11 and 13 October

Primary refresher course
15 to 26 November, weekdays only

Quality Assurance Meeting – virtual

Your Pain Management toolkit: an update on what's available for the complex pain patient
Saturday 16 October, 1pm to 5pm

FPM VRC CME evening meeting – virtual

The evidence for the use of Ketamine in Chronic Pain
Thursday 25 November, 7.30pm to 9pm

Please contact the secretariat on +61 3 8517 5313 or via email vic@anzca.edu.au should you have any queries and/or to express interest in attending either of our courses/events.

Queensland



FINAL EXAM REFRESHER COURSE

The final exam refresher course was held at the ANZCA Queensland regional office from 26-30 July, with 24 candidates attending in person, and eight virtually via Zoom. This week-long interactive course covered a variety of short answer and multiple-choice tips, a short answer mock exam, and other lecture sessions. We would like to offer our sincere thanks to the convenor Dr Stuart Blain, and course presenters for their time and commitment to this course.

Dr Christopher Futter presenting "Vascular anaesthesia" to Queensland trainees.

Rural SIG meeting 2021

A trainee's experience

THE RURAL SPECIAL Interest Group (SIG) conference was the event of the year on the Mackay Base Hospital Anaesthetic department calendar. The three-day event took place from 11-13 June at the idyllic Coral Sea Resort in Airlie Beach, Queensland and for the first time was held in association with the Mackay Anaesthetic Community (MAC). As a first-year trainee in Mackay, I was excited to be able to attend a national conference that I had heard so many great things about.

Last year's conference had to be cancelled due to the COVID lockdowns, and the uncertainty continued in the lead up to the 2021 event. A snap lockdown in Melbourne only one week out from the conference prevented many of the Victorian delegates from attending in person. Despite this, the event organisers were able to change the event format in a short time to include virtual presentations and online Q&A sessions, making it an all-inclusive success.

Over the three days the conference was completely jam packed with academic workshops, insightful lectures as well as many networking and social activities in the heart of the Whitsundays, demonstrating the best that Airlie Beach has to offer.

There were more than a dozen high calibre speakers from across Australia who were able to draw on their clinical experience in anaesthesia and rural medicine to deliver thought-provoking lectures. Many of the presentations had strong clinical focus, which I felt I could apply to my everyday practice. I really enjoyed the talk on "Designing better anaesthetic emergencies" by Associate Professor Stuart Marshall and the "Top 10 tips for pain management" by Dr James Jarman from Perth. Dr Andrew Cronin, who has spent time working with NASA, discussed

aeromedical anaesthesia and answered everyone's burning question... just how exactly do you intubate a patient in zero gravity?

The academic workshops were also a great feature of the conference and provided a fantastic hands-on and interactive learning experience. Delegates had the opportunity to learn thromboelastometry interpretation, perform ultrasound guided nerve blocks, or participate in Can't Intubate Can't Oxygenate (CICO) emergency scenarios.

A great conference wouldn't be complete without a stellar line up of social events and the 2021 Rural SIG meeting was no exception. It kicked off on Friday evening with a cocktail reception on the jetty overlooking the stunning Coral Sea Marina. The Saturday afternoon activities then demonstrated just how great winter is in tropical North Queensland. Delegates were able to face off in a beach volleyball tournament or set sail on a sunset cruise through the Whitsunday Islands. Early morning yoga and photography workshops were the other optional activities attended by delegates and their families. A gala dinner topped it all off in a spectacular fashion.

The final session of the conference gave junior doctors the opportunity to showcase their research projects. The relaxed setting was great for first time presenters to receive quality feedback from senior colleagues, while improving their CV.

Overall, the conference was a massive success, and as a trainee I relished the opportunity to attend a face-to-face event in the current COVID pandemic. The academic program was outstanding, and the social activities were even better.

Preparations are underway for the next year's annual Mackay anaesthesia conference in June 2022 at Airlie Beach. I would highly recommend this meeting to any junior doctor, whether they are a current trainee or considering training in anaesthesia. I would be keen to attend the Rural SIG meeting again next year and eagerly waiting for the announcement of the dates and location.

Dr Timothy Gilmour
Anaesthesia Registrar, Mackay Base Hospital

Dr Gilmour would like to acknowledge the meeting convenor, Dr Suresh Singaravelu and meeting co-ordinator, Kirsty O'Connor, ANZCA, for their support in the preparation of this article.

The 10th Australian and New Zealand virtual Symposium of Perioperative Medicine

Collaborating against complications

THE PERIOPERATIVE MEDICINE SIG ran their 10th Australian and New Zealand Symposium of Perioperative Medicine "Perioperative care: Collaborating against complications" on the 13-14 August 2021 as a virtual event, following on from a successful one-day virtual event in 2020. It was delivered by co-convenors Dr Rajni Lal (geriatrician, New South Wales) and Dr Nicola Broadbent (anaesthetist, New Zealand) on behalf of the Perioperative Medicine SIG executive who were all working tirelessly both prior to and during the event to ensure a high-quality symposium was delivered. The meeting was held in association with the Internal Medicine Society of Australia and New Zealand. We had 416 registered virtual delegates and the event was ably supported by the SIG events team led by Kirsty O'Connor. The delegates include anaesthetists, physicians, geriatricians, surgeons, intensivists and other various specialities.

Virtual meetings present different challenges to in-person events including engagement of the attendees who spend a prolonged amount of time in front of a screen. Each session we had talks followed by a moderated live question and answer (Q&A) session with the session presenters. We received a steady stream of questions from the virtual universe demonstrating many of our delegates were actively engaged in our journey.

As Covid-19 continues to affect us, work is still going on in perioperative medicine. This year's meeting focussed on two important issues in the field of perioperative medicine: complications and collaborative care.

Several local and international speakers spoke on a variety of topics related to the theme.

We explored quality improvement work in the United Kingdom, Australia and New Zealand including the lessons from the UK National Emergency Laparotomy audit (NELA), The Australian and New Zealand Emergency Laparotomy Audit – Quality Improvement (ANZELA-QI) and local surgical data from the American College of Surgeons National Surgical Quality Improvement Program (NSQIP) and had an excellent presentation on the NZ Health Quality and Safety Commission project; Te māwhenga tūroro: the National Patient Deterioration programme. The logistics of getting perioperative services funded and implemented was considered in both local and international contexts.

Speakers delivered pragmatic and engaging presentations on a number of specific complications. We also had an excellent but confronting description of the UK experience of Covid-19 by Professor Rupert Pearse, a well-known intensivist and researcher in perioperative outcomes.



Adjunct Associate Professor Colin McArthur, Dr Nicola Broadbent (co-convenor), Dr Rajni Lal (co-convenor), Dr Puneet Ranote and Associate Professor Arthur Richardson

On the collaboration front, there were thought-provoking presentations and a Q&A discussion on our relationships with primary care and aged care. The meeting closed with a presentation by ANZCA President Dr Vanessa Beavis outlining the current work and progress on the collaborative development of the perioperative medicine diploma in Australasia, of interest to many in the audience.

You can still register for the meeting to get access to all pre-recorded presentations and live question and answers sessions.

We look forward to seeing you at our planned hybrid Perioperative Medicine SIG meeting in the last quarter of 2022.

Dr Nicola Broadbent and Dr Rajni Lal
Co-Convenors

ELC
2022

Reflect Evolve Achieve

26-28 April 2022
Sandalford Estate
Swan Valley WA

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ANZCA
FPM

Are you an emerging leader in anaesthesia or pain medicine?
Do you want to enhance your leadership within your workplace?
Are you within five years* of fellowship?

Then the ELC 2022 is for you!

Applications are invited from fellows in all training regions to attend the 2022 Emerging Leaders Conference (ELC) at Sandalford Estate, Swan Valley. To be eligible, fellows must be within five years* of fellowship on Friday 29 October 2021 and attending a minimum of two days of the the 2022 ANZCA Annual Scientific Meeting (ASM). Selection will be undertaken by the regional and national committees and the Faculty of Pain Medicine. Fellows who were in their last year of eligibility to apply to attend in 2021 are invited to apply to attend the 2022 ELC. Fellows who were invited to attend the 2021 ELC but couldn't make it can apply for special consideration.

Situated on the banks of the scenic Swan River, Sandalford Estate provides the perfect escape from Perth's busy streets to meet likeminded people, discuss ideas, and enhance your leadership capabilities.

The college and faculty are investing in their future leaders by covering the costs of this conference. The applicant is responsible for the cost of travel to and from the ELC, and the ASM registration fee and associated costs. We welcome and encourage parents with newborns and their support person. Unfortunately, family members including small children, are not otherwise permitted to attend due to the immersive nature of the conference.

How to apply:

Applications are now open! If you wish to apply, please submit a selection criteria application form (found on the [2022 ELC webpage](#)), accompanied by your curriculum vitae, to Majella Coco by Friday 29 October 2021. Successful applicants will be notified in early December.

*Taking into account career disruption.

*The college understands career disruption may be for a variety of reasons, such as parental leave, illness, or time taken to care for a dependent. In support of our member's ongoing learning, education and participation in this conference, time taken for any of these reasons is not included in the five year * requirement.*

For further information:

Majella Coco, Events Officer, ANZCA
+61 3 9510 6299 | events@anzca.edu.au

Michael Alan Boquest

1964-2021

MICHAEL BOQUEST WAS an extremely hard-working anaesthetist who never learned to say the word "no". He was always prepared to take on a difficult case, assist a colleague or come back after hours to provide emergency anaesthesia services. In this regard he remains an inspiration for us all. Clinical anaesthesia is not only required during daylight hours, and it is not only about routine care. Michael was all about dealing with the "messy stuff" in between.

Michael was the eldest of three boys born to Lorna and Alan in the northern suburbs of a burgeoning Melbourne. He led his brothers Paul and Andrew on some wild sailing and other adventures in his formative years. Michael graduated from Ivanhoe Grammar in 1981 and then had to make his first difficult choice; to commence an officer cadetship at Duntroon or accept a place in medicine at Monash University. He chose the latter and graduated (Hons) in 1987. Michael worked as a doctor in general practice, psychiatry registrar and medical officer across regional Australia, Palmerston New Zealand as well as metropolitan Melbourne. Michael enjoyed the "adventure" of anaesthesia and joined the training program at The Alfred (1994), obtaining his FANZCA in 2000.

Michael was always an early adopter of new technology. He gained proficiency in TOE and ultrasound and was involved in several workshops through ANZCA and the ASA to share his knowledge and passion with his colleagues. He also taught the respiratory physiology lectures to the part one candidates for some time. Michael also served on the ASA Victorian regional committee advocating, supporting, and representing his colleagues. Recently during the COVID 19 crisis, Michael collaborated to establish a contingent ICU to deal with the potential overflow of critically ill patients. Michael was very generous with his time.

Michael was very courageous. He participated in tours of duty during the first Gulf War as a reservist naval officer. Perhaps through this military experience, Michael developed an appetite and capacity to deal with difficult situations. Right up until his last week with us, Michael was in theatre until very late dealing with complex, unwell patients requiring surgery.

Michael was also very active outside of theatre. He was an avid sailor and recently returned from sailing the Whitsunday Islands. In recent years Michael discovered the sport of boxing. Like everything Michael did, he threw himself into boxing wholeheartedly, perhaps even obsessively. He trained hard and completed several fights, even drawing and winning some. Michael enjoyed being in "the zone", travelling through regional Victoria in his recently refurbished Harley Davidson motorcycle. Michael was a member of the Medicolegal Society of Victoria and often shared an opinion about the cases presented. Michael was an amateur astronomer and often attended the opera with his family and friends.



Anyone who spent time with Michael, knows he was always up for a chat. He had that genuine capacity to live in the present rather than worry about the future or the past. Consequently, many registrars received quality teaching in theatre and several anaesthetic nurses, surgeons and colleagues will miss his humorous anecdotes.

But no one will miss him more than his three beautiful daughters Katarina, Eloise and Gabby. Michael had many passions and interests in life and by far the greatest was spending time with his girls. He taught them to love life, to be active and participate in everything life had to offer and to always question everything. That is his legacy. Always ask why? Together with their mother Angela, Michael provided the girls a nurturing environment and showed them what love is.

Michael was a colourful character who embraced life. He lived every moment completely, passionately, and purposefully. He was grateful for the present and made the most of any situation. Next time someone asks you something, think of Michael Boquest and just say "yes". Just do it!

Dr Antonio Grossi FANZCA
Victoria

William Murray Ross

1983 – 2021



“We can all learn from and celebrate Will for his well-rounded life and devotion to those around him”

DR WILL ROSS was a gifted and talented ANZCA trainee whose life was tragically cut short in May this year.

After completing his VCE at Carey Baptist Grammar School in 2001, Will spent a year studying a Diploma of Chinese at the Beijing International Studies University before commencing his medical degree at the University of Melbourne. He undertook his intern year at Royal Melbourne Hospital before commencing anaesthesia training in 2012. He will be remembered for his wit, humour, charm and kindness with patients and colleagues alike at the Austin Hospital, the Mercy Hospital for Women, the Royal Children's Hospital, Bendigo Base Hospital and the Royal Melbourne Hospital.

Will had a fiercely intelligent and inquisitive mind. He was interested in everything around him and everyone he met. He had a habit of being well-informed about nearly any given subject of conversation, regardless of whether it pertained to science, economics, music, politics or history. He acquired fluency in Mandarin and was a champion debater at a national level. He had a passion for musical theatre and the arts, and was well on his way to obtaining his private pilot's licence. Will also had a reputation as being somewhat of an activist, agitating for positive culture changes in hospitals and was a champion for progressive social causes. He was never afraid of speaking up against inequality and injustice.

Will was awarded the Cecil Gray Prize in 2014 for his outstanding performance in the ANZCA final fellowship examination. This was no surprise to those of us who attended various exam prep courses with him, where he would not shy away from discussing contentious or challenging topics with the lecturers. The rest of us would watch on in confusion (seriously doubting whether such minutiae would be examinable content), but all the same enjoying the schadenfreude spectacle of having a subject matter expert being cross-examined by perennially well-informed Will.

Will leaves behind his two-year-old daughter Daisy, his partner Emily, parents Nadine and David and sister Eloise. We are poignantly reminded by his death at such a young age that being a doctor places many demands on us, and that it can be far too easy to defer life and become preoccupied with clinical service KPIs, pedantic specialty exams and getting that next stepping-stone non-tenured job. We can all learn from and celebrate Will for his well-rounded life and devotion to those around him, for his interest in exploring and understanding the world, for his amassed library of political biographies, historical texts and musical theatre scores, and his ability to have a conversation with anybody about anything.

We shall all miss you terribly Will, and those of us whose lives you touched will always be grateful for having known you.

Dr Karl Ruhl FANZCA MBBS
Royal Melbourne Hospital, Victoria



The Alfred ICU 2022 Education Calendar

The Event Calendar for 2022 is not yet on sale due to COVID-19 restrictions.

Please email our team at icuevents@alfred.org.au with your name, mobile number and company to be placed on our mailing list for updates.

Alternatively, you can check for updates at www.alfredicu.org.au/courses.

We are unable to take waitlist bookings for events not yet on sale.

Events coming in 2022....

16th Alfred Advanced Mechanical Ventilation Conference plus Waveforms Workshop and Physiotherapy Seminar



The full day AAMVC conference will feature special International and Local experts and will return virtually in 2022. The AAMVC conference will be preceded by the one day hands on Ventilator Waveforms Workshop and followed by the virtual Physiotherapy Multi-Disciplinary Seminar

Advanced Life Support (ALS2) Provider Course & Recertification Course

Two-day Australian Resuscitation Council (ARC) accredited adult life support provider training in advanced cardiac arrest & medical emergency management for Doctors, Nurses and Paramedics The Alfred also hosts a one day recertification course for those holding a current ALS2 qualification annually.

Basic Assessment & Support in Intensive Care (BASIC)

Two day introduction course for medical staff to intensive care and the care of the critically ill.

Bronchoscopy for Critical Care



One day interactive & simulation based course covering fibre optic intubation, massive pulmonary haemorrhage, bronchial lavage, foreign body removal and safe bronchoscopy in critically ill patients

The Critically Ill Airway (CIA) Course

An interactive 'hands on' simulation-based course designed to develop a safe, flexible approach to the unique challenges of airway management in critically ill patients. Topics include difficult airway management & optional percutaneous tracheostomy training. Cancelled registrants for 2020 CIA will receive priority booking for 2022.

Critical Care Ultrasound Course (CCU)

One day ASUM accredited course in the use of critical care ultrasound through practical sessions with models. Topics include chest US, abdominal US including eFAST and aortic aneurysm & DVT screening.

Critical Care Echocardiography & Advanced Echocardiography Courses

Two day ASUM accredited course with an emphasis on echo guided management of the critically ill. Favourable faculty:participant ratio 1:2 providing ample hands on experience using live models & Heartworks simulators.

ICU Adult ECMO Course & Cannulation



Two day course for Doctors, Nurses & Perfusionists covering ECMO support of cardiac and respiratory failure. Optional third day for cannulation training available to doctors and medical perfusionists.

Emergency Neurological Life Support (ENLS) Course

Two day course with hands on interactive simulation scenarios for Doctors, Nurses and Allied Health who encounter patients in the critical first hours of a neurological emergency.

Victorian Primary Examination Course for CICM

One day course for prospective candidates for the CICM Primary Exam to develop exam technique.

For More Information Contact: ICU Events

Ph:+61 3 9076 5404

E: icuevents@alfred.org.au

* Please note dates/event format may be subject to change



Pump	CO2 mmHg	ENCO2 mmHg	FIO2
PUMP-01
PUMP-02	3000	2125	500
PUMP-03	300	128	30
PUMP-04

P 5 2 7
Patient: Julie Davis



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¹ McGrath S et al. *J Patient Saf.* 2020 14 Mar. DOI: 10.1097/PTS.0000000000000696. ² McGrath S et al. *The Joint Commission Journal on Quality and Patient Safety.* 2016 Jul;42(7):293-302. ³ Taenzer A et al. *Anesthesia Patient Safety Foundation Newsletter.* Spring-Summer 2012. ⁴ Estimate: Masimo data on file. ⁵ Published clinical studies on pulse oximetry and the benefits of Masimo SET[®] can be found on our website at <http://www.masimo.com>. Comparative studies include independent and objective studies which are comprised of abstracts presented at scientific meetings and peer-reviewed journal articles. *The use of the trademark Patient SafetyNet is under license from University HealthSystem Consortium.

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