ANZCA
FPM

Bulletin

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

SPRING 2023

BEYOND CITY LIMITS

Tasmanian attractions

Vaping dangers
Exploring the risks

Training and education
Primary examiners needed

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Cover image: Dr Lia Freestone (centre) with anaesthesia trainees Dr Chris Etherington (left) and Dr Bing Chang (right) at Royal Hobart Hospital. Photo: Peter Mathew

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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Medical workforce issues a top priority for colleges

"If ANZCA is displaced as the decision maker for overseas trained specialist equivalency we run the risk of having a two-tier system."

Workforce seems to be the issue at the forefront of most health authorities at the moment.

ANZCA and many of its fellows have attended a number of jurisdictional health department summits over the past six months to help provide solutions to the international phenomenon of shortages in the medical workforce.

A significant driver is an increasing elective and planned workload, which in the UK now stands at seven million people with over one in 10 of the population now on a wait list.

Unfortunately determining our specific workforce requirement is hampered by poor and conflicting data. The national workforce strategic plan from 2019 suggests anaesthetists are in over supply but the more recent "Independent Review of Overseas Health Practitioner Regulatory Settings" led by Ms Robyn Kruk AO, targets anaesthetists as a group in short supply.

We know there is a maldistribution of workforce within Australia and New Zealand and there is also a recent trend for fellows, trainees and specialist international medical graduates (SIMGs) to have a more balanced lifestyle and work fewer hours.

Our trainee numbers have increased 8.5 per cent over the last 10 years from 1635 to 1775 compared to population increases in Australia and New Zealand of 13 per cent and 16 per cent respectively. Most of you are probably aware these numbers are largely determined by the capacity to move our trainees through the specialised study unit bottle necks.

OVERSEAS TRAINED SPECIALISTS

There are no easy solutions to the workforce issue but the focus in Australia and New Zealand seems to be around streamlining the process for allowing international medical graduates and nurses to enter and work in Australia.

The Kruk report was commissioned by the Australian government in 2022 with the interim report recommending streamlining overseas applications, changing the English language requirements, removing migration barriers and developing fast track pathways for recognised specialists.

Whilst ANZCA is supportive of some of these changes we feel the decision to determine equivalency of overseas trained specialists should rest with the colleges who are best placed to make this assessment.

ANZCA has a timely, transparent and robust process to assess SIMGs, which is similar for pain medicine and anaesthesia but varies between Australia and New Zealand, where the Medical Council of New Zealand has more autonomy in the decision to award equivalency.

For those SIMGs from countries with similar health systems and found to be substantially comparable after interview, the most common outcome of an SIMG application is for six to 12 months of supervised clinical practice, a performance assessment, continuing professional development compliance and the completion of an Effective Management of Anaesthetic Crises course.

Those SIMGs who are found to be partially comparable are usually required to do the above, plus up to two years of supervision and/or the SIMG examination, which is the viva component of our final exam.

I understand these requirements may seem onerous and expensive but they strike an appropriate balance between maintaining a high standard of specialty care and workforce demands.

Over the past 10 years ANZCA has assessed and awarded FANZCA to 368 SIMGs.

This group of anaesthetists has contributed immensely to our specialty, working in all our communities, but particularly in regional areas and often attaining senior leadership roles in our workplaces and within the college.

Both Australia and New Zealand are reliant on SIMGs with over 30 per cent and 40 per cent respectively in our workforce, but I have some reservations with major changes to our current system.

If ANZCA is displaced as the decision maker for overseas trained specialist equivalency we run the risk of having a two-tier system with FANZCAs working alongside another group of specialist anaesthetists accredited via an alternate pathway. This will have implications for supervision, training and standards.

I also believe there is an inequity around countries "poaching" doctors from where their skill and expertise may be in greater need. Surely our main emphasis should be on training enough doctors, nurses and specialists to manage our own requirements?

VOICE STATEMENT

Thank you to those who have provided feedback to me about the ANZCA Council and FPM Board decision to publish a supportive statement on the Australian referendum for a Voice to Parliament.

I have attempted to respond to all of you and explain why we have made this decision but I understand this is a polarising and personal issue with many views amongst our fellows.

PERIOPERATIVE MEDICINE

The Diploma of Perioperative Medicine (DipPOM) launched as a pilot on 4 September. This has the potential to be one of the most important steps forward for hospital-based medicine in our history.

Even if you're not interested in pursuing a career in perioperative medicine I strongly encourage you to take a look and see the potential in the DipPOM. The statistics around the morbidity and mortality of the perioperative period are a compelling argument for change and gives us a clear direction for moving forward in the most cost-effective manner. This is beneficial for both healthcare costs and patient care.

This year our National Anaesthesia Day on 16 October (see page 5) focused on this important area.

Dr Chris Cokis
ANZCA President

ANZCA President Dr Chris Cokis giving a tour of ANZCA House during a recent ANZCA Trainee Committee (ATC) meeting. From left: Siobhan Lane (ATC member), Anthony Notaras (ATC co-chair), Dr Chris Cokis and Ellen Webber (ANZCA Learning & Innovation Manager).

ANZCA responds to challenging medical landscape

ANZCA continues to cement its role as a leading educational institution of excellence.

On 4 September, the college successfully launched a pilot of the first unit of study in our perioperative medicine qualification with 14 participants taking part and a full roll-out of all units of study scheduled in 2024.

This is an important development that will benefit patients, the medical workforce and the health system.

ANZCA's tripartite rural generalist anaesthesia qualification, developed in partnership with the Royal Australian College of General Practitioners and the Australian College for Rural and Remote Medicine, will have its first graduates at the end of 2023, an important benefit for the health of communities outside metropolitan areas.

At the same time, the college's work with the College of Intensive Care Medicine to develop a dual training pathway is also progressing well and we hope to launch it in 2025. This should also benefit rural and remote communities who sometimes have difficulties attracting specialists.

Meeting the demands from Australian and New Zealand governments for delivery of health services has also been a focus of the college in recent months.

Stemming from these pressures are multiple inquiries, reviews of regulatory settings and scope of practice, the introduction of new roles, funding models and new regulatory settings for international medical graduates seeking to enter Australia and New Zealand.

The college is actively involved in all this activity making multiple submissions and consulting widely with governments and relevant departments.

While quick solutions by governments to workforce challenges is desirable, it is critical that patient safety and standards remain central to any reform processes. They must not be compromised in government efforts to address the challenges of a workforce still suffering the impacts of COVID-19 and its lasting effects, combined with mounting pressures to clear surgical backlogs and overall pressure on our health systems.

ANZCA will continue to advocate for fellows, specialist international medical graduates and trainees in this challenging landscape.

ANZCA's involvement in the Australian government's Specialist Training Program (STP) has been particularly helpful, especially a successful new funding stream ANZCA was able to help facilitate for Tasmania that will extend and develop resources for the delivery of anaesthesia education and training in that state with a focus on simulation-based learning.

These components will strengthen educator capacity and address maldistribution issues of educators and equipment throughout the state.

To further support our Tasmanian community, ANZCA is also establishing its first regional office in Hobart.

The rapidly emerging presence of artificial intelligence (AI) is another challenge for the college which is developing a position on how we will ensure safe and ethical use of AI and its potential impact across so many aspects of the college and our core roles.

We continue to see the commitment and generosity of many fellows and trainees as they volunteer their efforts across the college in roles such as continuing medical education and special interest group events and of course the ANZCA Annual Scientific Meeting and FPM Symposium, next year in Brisbane.

I am sure the remainder of 2023 will continue to be at full pace across all aspects of the college.

Nigel Fidgeon
ANZCA Chief Executive Officer

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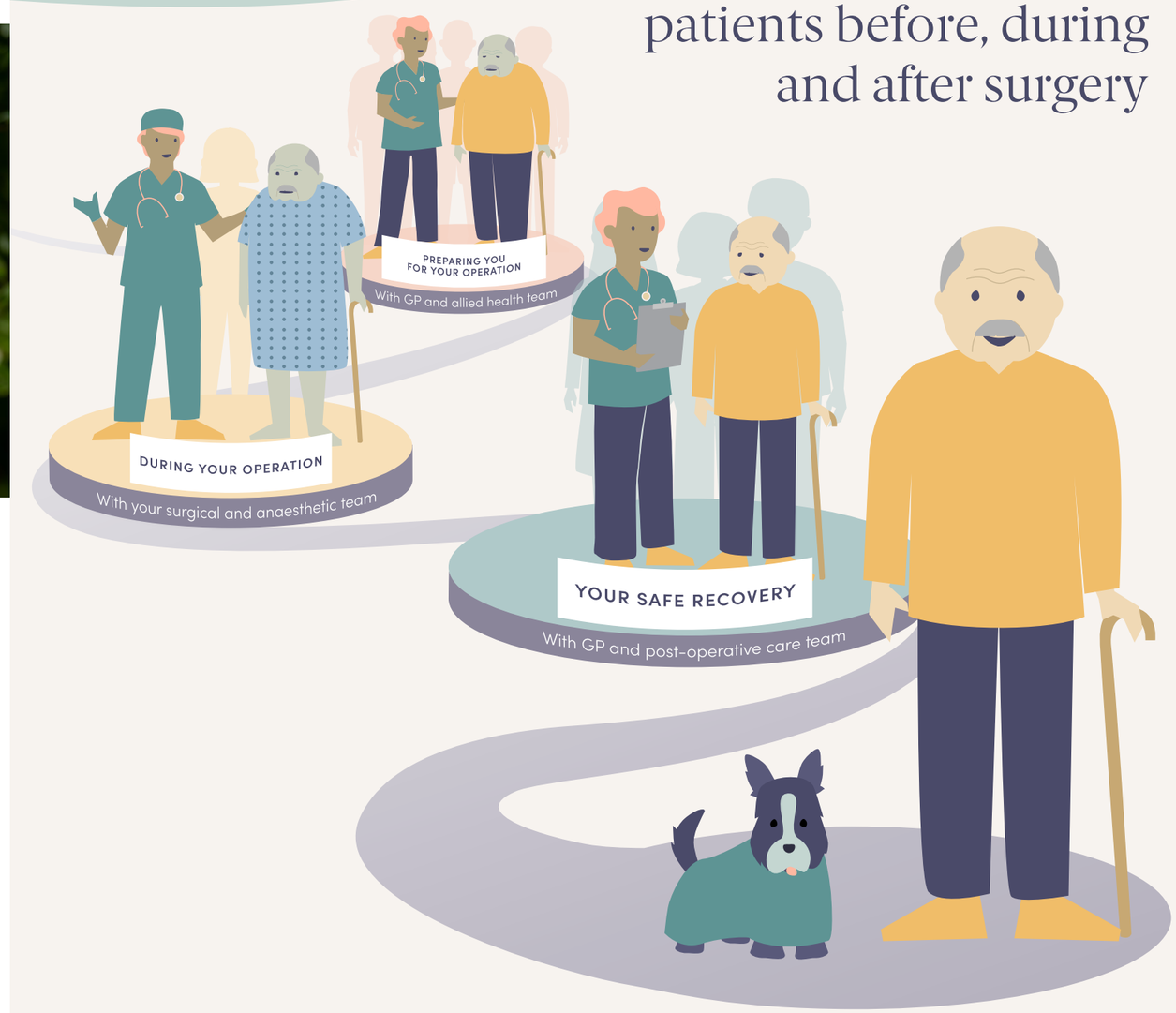
NATIONAL ANAESTHESIA DAY 2023
16 OCTOBER

Anaesthetists – Caring for our sickest patients before, during and after surgery



Find out what we're doing to establish perioperative care in hospitals in Australia and New Zealand. #NAD23

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Letters to the editor

RESPONSE TO PRIDE LETTER

The *ANZCA Bulletin* received several responses to the letter in the Winter edition, "Pride March not part of college's mission or vision".

Some fellows have queried why we published the letter when we have such a strong focus on inclusion and diversity; the *ANZCA Constitution* says we should "advocate on any issue that affects the ability of members to meet their responsibilities to patients and to the community" (clause 1.1.4); our purpose is "to serve our communities by leading high quality care in anaesthesia, perioperative and pain medicine, optimising health and reducing the burden of pain"; we have our 2019 council-approved "Statement on the role of ANZCA in advocating for the health and wellbeing of all people"; and diversity is a focus of the *ANZCA Strategic Plan 2023-2025*.

Others believe the college should not stray from its remit of facilitating training, education, research and setting standards. Our 2021 fellowship survey showed that more than 60 per cent of fellows felt social justice was an important issue for the college. But this also means there's a significant group for whom it is not.

It is our view that we can't ignore those who disagree with ANZCA's stance otherwise we open ourselves to accusations of censorship or pretending those alternative views don't exist and we risk becoming an echo chamber. We have always said we welcome debate.

Clea Hincks
Editor, *ANZCA Bulletin*

Dr Tanya Selak
Medical Editor, *ANZCA Bulletin*

MARDI GRAS ATTENDANCE ALIGNS WELL WITH THE COLLEGE'S STATED PURPOSE

I read with interest the letter from Dr Millist in the most recent *ANZCA Bulletin*.

Therein, Dr Millist decried the official representation of the college at the 2023 Gay and Lesbian Mardi Gras, asserting that such recognition poses a reputational risk by "promoting an activity that has nothing to do with the college's stated mission or vision". Dr Millist also asks, "what other 'woke' causes is the college to be used for...?"

The word "woke" is defined as to be "aware, especially of social problems such as racism and inequality". This contrasts with the incorrect, pejorative definition, paraphrased as "any perspective that does not align with my moral and/or religious views". Given the inferior health outcomes associated with systemic inequality (not just race, but also within sexually and gender-diverse communities), the attendance of ANZCA fellows at Mardi Gras, with official recognition of the same, aligns well with the college's stated purpose, namely: "to serve our communities by leading high quality care in anaesthesia, perioperative and pain medicine, *optimising health* (my emphasis) and reducing the burden of pain". Such attendance highlights the presence of vulnerable groups within our society and the support of the college for these groups.

Dr Millist also asks: "how can the...persons named, claim to be representatives...when there has been no vote of those college members authorising this action on their behalf?" Conspicuously, Dr Millist does not voice similar complaints about the many other decisions which are delegated to council.

Dr Millist may wish to right this perceived injustice by standing for ANZCA Council. This would provide them with input into the decisions taken on behalf of the fellowship about which they feel so strongly. Assuming their convictions are held as tightly as their pen, I look forward to seeing their name on the next ballot paper.

Associate Professor Lachlan F. Miles, FANZCA

PRIDE MARCH VERY MUCH PART OF COLLEGE'S MISSION AND VISION

We were pleased to see the "ANZCA loud and proud for 2023 Mardi Gras parade" article on page 50 of the Autumn 2023 *ANZCA Bulletin*.

ANZCA fellows come from all walks of life and ANZCA must continue to demonstrate inclusivity.

ANZCA is setting standards for pain medicine and anaesthesia for patients regardless of their sexuality.

Bringing visibility to this part of our community that is often subject to discrimination can only bring confidence to our patients, who might otherwise worry about aspects of their health being marginalised or neglected.

This fits clearly with the college's commitment to ending discrimination which it considers an "unacceptable behaviour".

Dr Donald Johnson, FANZCA
Dr Peter Garnett, FANZCA

A REMINDER THAT PROGRESS IS NOT EVENLY DISTRIBUTED

Thank you for publishing Dr Millist's letter expressing his opinions on Mardi Gras in the 2023 Winter *ANZCA Bulletin*.

It is a difficult but important decision to publish prejudicial views without endorsement. It reminds us that progress is not evenly distributed.

I found myself asking, what might life be like if I was the child or grandchild of this person?

For all children there is a prolonged period where neither they, nor their family, are aware of the eventual sexual identity of the child.

Of all the children who grow up immersed in an environment of homophobia, approximately five per cent will discover that they are same sex attracted. The beliefs they have assimilated can be incompatible with their dignity and self-respect. This is a profound cause of preventable harm.

It was found that 24 per cent of suicides in the 12-14 year age bracket were LGBTI in one of the very few studies that attempts to quantify suicide rates in LGBTIQA+ populations (this figure is subject to confounding and errors).

Adults deployed to hostile environments with wrap-around institutional support can develop post-traumatic stress disorder. What happens to a frightened kid living in a homophobic household for years with no safe adult to talk to?

Once a Queer child becomes aware of their identity the apprehension of disapproval, rejection, or abandonment because of their diversity can best be understood as a chronic pervasive threat to life. They are completely dependent upon their family and community for survival.

We need to find ways to connect through compassion and empathy with parents in every community who are motivated by love and care for their children. What would you want to say to a 12-year-old kid contemplating suicide because they've realised that they are gay?

The Orbona Foundation will create a comprehensive public health strategy educating parents from antenatal clinic onwards.

Dr James Allen, MBBS/LLB, FACLM, AFCHSM, FRACGP
Director, The Orbona Foundation
Orbonafoundation.org

NOT THE ROLE OF THE COLLEGE TO ADVOCATE ON POLITICAL OR ETHICAL MATTERS

Dr Warren Millist (Winter 2023 *ANZCA Bulletin)* raises an important matter, further illustrated by the ANZCA president's column in the same issue.

What do Gay Pride, the Voice to Parliament, or same-sex marriage have to do with the safe provision of anaesthetic care to patients in Australia and New Zealand? They are all, of course, important, but individual fellows will have individual views, often firmly and sincerely held. It is not the role of the college to advocate on what are essentially political or ethical matters.

I protested to ANZCA Council when it issued a statement of support for same-sex marriage, not because of my own views but because council should not have done so without polling fellows. My letter was ignored until I followed it up twice. A year after the referendum I finally received a reply, which said the support was from council, not from ANZCA as such. The current president makes the same claim about the Voice referendum.

This attempt to divide council support from the support of ANZCA fellows is dishonest. Statements from council will be understood as reflecting support from the fellows and ANZCA.

It is incumbent on council to stay within its remit, as defined by the *ANZCA Constitution*. To stray from this invites accusations of political activism, and has the potential to destroy the reputation of ANZCA as an independent body responsible for anaesthetic training and practice.

Dr Graham Sharpe ONZM, FANZCA

THOSE WHO MARCHED SHOULD BE APPLAUDED

I was appalled to read a letter by Dr Warren Millist in the 2023 Winter *ANZCA Bulletin* questioning whether participation by three college fellows in the pride in medicine and surgery float at the 2023 Mardi Gras fitted with the college's purpose and vision.

I trained in anaesthesia after coming out as gay and have been a fellow of the college for over 30 years and have always felt accepted and respected as such by the anaesthetic community. Seeing this letter under a headline added by the *Bulletin* was disappointing in the extreme.

To Dr Millist, I recommend he read the college's strategic plan for realisation of its purpose and vision. This includes "encouraging people of diverse backgrounds", "exploring new avenues of engagement across the full spectrum of current and potential members", and "embedding diversity, inclusiveness and equity across all facets of the organisation".

Participation in an event celebrating the diverse LGBTQI communities absolutely fits within these objectives, and importantly identifies people within our anaesthetic community as supportive, accepting and tolerant.

Dr Millist asserts that the doctors participating in the Mardi Gras should have sought approval from other fellows before acting as their representatives. I trust most fellows of the college would be aghast if told others had disallowed a representative on the pride in medicine float.

Dr Millist also questions whether using the college for "political activism" will have consequences for the college's status. Given his letter is about participation in Mardi Gras, I conclude he thinks supporting homosexual people will degrade the status of the college. If this is correct, it is homophobic and insulting to the many fellows of the college, co-workers and patients who identify as LGBTQI.

Those who marched should be applauded for supporting the members of diverse communities and making them welcome in the field of anaesthesia, whose basic tenet is, after all, caring for people.

To the college I ask that such views as Dr Millist's be clearly noted as those of a single person and not college policy.

I will end my letter with the same words with which Dr Millist ended his complaint:

"Let our college stay true to its stated purpose and vision and thus retain its well-deserved status and esteem".

Dr John Wynter, FANZCA

PRIDE IN ANAESTHESIA

I want to celebrate the college and *ANZCA Bulletin* for endorsing and publicising the fellows who represented themselves as members of the college at the Sydney Gay and Lesbian Mardi Gras and WorldPride 2023 *(ANZCA Bulletin* Summer, 2022).

I am proud that our college has been active in avoiding the scandals and disruption caused by bullying and discrimination that have beset some other institutions. I'm proud that our processes for selection, supervision,

assessment and support of trainees and fellows have been developed to promote openness, accountability and equity and to support a diversity of experience and voices. This is the best way to promote the growth of quality anaesthetic practice and the health and happiness of our members and patients.

It is good that the college promotes members' activities in areas such as overseas aid, outreach to disadvantaged communities, awareness of the environmental impact of human activity and anti-discrimination.

As anaesthetists we are charged with the care and protection of people of all sorts, in their most vulnerable times and it is right that the necessary spirit of vigilance, wakefulness and agape (unconditional love) is carried outside the operating theatre and hospital, into the surrounding world in addressing the risks and hazards that face our shared humanity.

I'm thankful for the privilege of working with younger fellows and trainees who express themselves fully and passionately in their personal and professional lives. Contrary to Dr Millist's opinion (*ANZCA Bulletin* Winter 2023), I'm sure that the college can only grow in status and esteem by encountering, engaging with, and reflecting the greater society in which it functions.

Dr Simon Maffey, FANZCA
Brisbane

TEAMWORK IMPORTANT IN AIRWAY MANAGEMENT

We thank Professor Baker and Dr Skyrme-Jones for their comments on the article referencing the recently published Project for Universal Management of Airways (PUMA) international consensus guidelines for preventing unrecognised oesophageal intubation[1]. They both raise interesting comments about the prevention of this rare but catastrophic complication that deserve further clarification.

Professor Baker notes the historical discovery by Dr Brian Pollard (whose obituary he wrote in the same issue) of using a 50ml catheter tipped syringe to exclude oesophageal intubation. Tracheal positioning is supposedly confirmed should 30mls be easily aspirated from the tube[2]. What Dr Pollard described is a variation of the oesophageal detector device, assembled from commonly available equipment.

While the PUMA guidelines suggest use of the oesophageal detector device in appropriate circumstances, they specifically caution against this improvised approach, in favour of using a commercial, purpose-made device. In general, 'MacGyvering' of devices is to be discouraged[3] as it may introduce unforeseen hazards. In this case the reliance on creating an airtight seal between two devices not designed to be connected[4], increases the potential for a falsely reassuring result that precipitates a catastrophic outcome.

We agree with Dr Skyrme-Jones that the team coordinator (typically the airway operator) must be clear and decisive about management interventions during airway management but this does not preclude considering the suggestions of others before reaching these conclusions. Other team members may have information or ideas vital to appropriate management.

Both airway cases that have arguably had the greatest effect on practice in the last 20 years – Elaine Bromiley and Glenda Logsdail – could have been avoided if airway assistants and/or other staff felt able to voice their concerns and be heard. In Elaine Bromiley's case it is clear from testimonies that nursing staff in the room knew what needed to be done (a neck rescue technique) but that their concerns were not acknowledged[5].

Many needless deaths from unrecognised oesophageal intubation continue to occur across the world because of individual, overbearing and irreproachable practitioners wrongly insisting that the tube is correctly placed. The use of a videolaryngoscope and screen that can be seen by all members of the team allows the maintenance of a shared mental model and situation awareness that counteracts an 'inhibitory hierarchical structure'[6] to promote open communication. While ultimate responsibility for the airway lies with the airway operator, this does not diminish the importance of teamwork.

Associate Professor Stu Marshall, FANZCA
Dr Nicholas Chrimes, FANZCA

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NITROUS OXIDE WILL ALWAYS HAVE A PLACE IN MEDICAL PRACTICE

Having spent my whole professional life avoiding controversy I'm slightly anxious about cutting a steak from the current pharmacological sacred cow, in this case the nitrous oxide/greenhouse gas debate.

Two things are for sure. First is that nitrous oxide significantly contributes to global warming, despite only being a fraction of total greenhouse gas emissions. Second is that grassroots programs championed by anaesthetic colleges have emerged both here and in the UK (and possibly others I'm unaware of) that encourage limiting or restricting the use of nitrous oxide for the sole or prime reason of reducing the contribution that that medically used nitrous oxide makes to climate change.

Numerous sources tell us the same thing: that by far and away the major contributor of nitrous oxide in the atmosphere comes from agricultural farming fertiliser (78 per cent) followed by combustion and industry (seven per cent each) and then manure management and transport (four per cent each)[1]. Trying to find the contribution of medical nitrous oxide in all this is rather tricky, but there is a very thin slice of the pie chart that says "other" and is generally reckoned at about two per cent of the total. One estimate is that clinical sources of nitrous oxide form only one per cent of total human contribution to the atmosphere, which contributes less than 0.05 per cent to the greenhouse effect, or 0.1 per cent of the whole of global warming[2].

In some ways, victory has already been achieved – nitrous oxide use is but a fraction of what it used to be. Twenty years ago, the nitrous rotameter and the oxygen were usually turned on at the same time, yet a straw poll I conducted with a group of trainees last week suggested they would rather give their patients cat food than the stuff in the blue cylinder! The various journal articles questioning the future of nitrous oxide[3] as well as the results of the first ENIGMA trial seem to have had the desired effect.

Nitrous oxide will always have a place in medical practice. In some circumstances anaesthetic outcomes may be enhanced by its judicious use: paediatric induction and maintenance being an example. There is also renewed interest in the agent as a possible means to reduce pain and in studies that are just emerging, to treat mood disorders[4].

While reducing waste of nitrous oxide is a worthy and long overdue endeavour[5], I do query whether the environmental impact of medical nitrous oxide is being overstated, and I am not the first to do so.

In some ways, controlling anaesthetic usage of nitrous oxide can be seen as sort of "low hanging fruit" of global warming and climate change, as it seems most people are on board with the idea and, through the implementation of personal or hospital-based restrictions of nitrous oxide use, quite rapid, quantifiable and meaningful results can be obtained[6].

However, whether all this reduction, admirable though it may be, will have any measurable impact on reducing global nitrous oxide emissions, when compared against the 200 million metric tonnes of nitrogen containing (and hence nitrous oxide producing) fertiliser used annually[7] is hard to establish.

It seems a lot of effort for a very small reward.

Professor Ross MacPherson, FANZCA
Department of Anaesthesia and Pain Management
Royal North Shore Hospital, Sydney

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SUGAMMADEX ARTICLE ADDS TO MYTHS ON DRUG'S IMPACT ON CONTRACEPTIVES

We read the safety and quality article calling for more counselling about contraceptive effectiveness after sugammadex with interest (Winter *ANZCA Bulletin* 2023 p40)[1]. We feel that the article adds to the myths surrounding the potential impact of sugammadex on hormonal contraceptives.

As suggested in the article, it is theoretically possible for sugammadex to encapsulate steroid molecules such as female hormones. The drug company warns of a potential reduction in the action of progesterone that should be covered by the patient taking precautions as if they had missed a dose of their contraceptive[2]. However, the article does not stress that this information is based on pharmacokinetic modelling only. The only study to address this question in real patients undergoing real operations was published by our group earlier year[3].

Dr Marroquin-Harris and Dr Olesnicky quote the results of the study but have misinterpreted them.

The decrease that was found in oestrogen levels would biologically protect against ovulation. The decrease in progesterone levels at four hours was not significant and did not reach the amount of decrease projected in the modelling. Therefore our study did not find any evidence to support the proposition that sugammadex might threaten contraceptive efficacy.

We understand that one small study will not immediately change practice and that drug companies will be reluctant to reduce any level of advice that has potentially expensive consequences.

However, we do hope that anaesthetists will seek out and apply evidence when considering clinical practice, rather than propagating theoretical risks without any supporting evidence.

Dr Natalie Smith, FANZCA
Dr Tamblyn Devoy M.B.B.S.
Wollongong Hospital, NSW

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

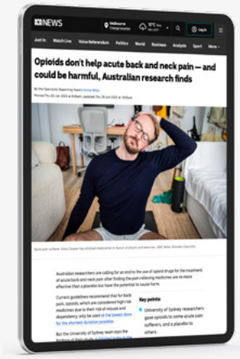
ANZCA and FPM media coverage

Highlights since the Winter *ANZCA Bulletin* include:

FPM responds to new opioid study report

(ABC.NET.AU 29 JUNE, THE AGE 29 JUNE)

ABC online and *The Age* featured a response from the faculty to an Australian randomised placebo-controlled trial on the use of opioids for acute neck and back pain. The University of Sydney's authors concluded that opioids are ineffective and should not be recommended.



FPM's Director of Professional Affairs Associate Professor Mick Vagg told the ABC the study was not "anywhere near strong enough" to prompt a change in guidelines, and that opioids still had a place as long as they were used judiciously and for a short period of time.

Opioid overdose - dangerously addictive, overused and often ineffective

(THE POST, 22 JULY)

FPM New Zealand National Committee member Dr Tipu Aamir spoke to *The Post* about the nature of pain and the risks of opioid dependence.

"People end up on a very high dose of opiates, where their pain levels are still 8, 9 or 10 out of 10," Dr Aamir explained. "People are now dependent on them. They've developed physical tolerance. And they have significant side effects. Their function is actually deteriorating."

He also touched on the shortage of specialist pain doctors in New Zealand saying New Zealand should have about 50 specialist pain doctors.The article noted that "when he checked a few years ago there were 19."

Unravelling the mystery of anaesthesia

(RADIO 3AW MELBOURNE, 7 SEPTEMBER)

ANZCA's Vice-President Professor David Story was interviewed on Radio 3AW Melbourne's afternoon program on 7 September about anaesthesia and how it works.

In a 10-minute segment Professor Story explained that even after 150 years it's not quite clear how some anaesthetic drugs work. "We know that some of our drugs have certain effects and we know how to deal with that. Anaesthesia in Australia is incredibly safe. And one of the reasons is that anaesthetists are highly trained medical specialists who understand what they're doing with these drugs and how they affect people and how it affects individuals, whether they're younger or older."

The segment reached 70,000 listeners and several listeners rang in to the program to describe their own experiences of anaesthesia.

The evolution of chloroform and other anaesthetics

(ABC RADIO OVERNIGHTS, 4 SEPTEMBER)

Fellow Dr Chris Ball, an anaesthetist at Melbourne's Alfred Hospital, was interviewed on ABC Radio's *Overnights* program on 4 September. Dr Ball discussed her book *The Chloroformist* and the history of anaesthesia in a 40 minute segment that was syndicated to more than 50 ABC radio stations across Australia.

Several callers rang in and texted during the program to reveal their own experiences of anaesthesia including allergies and how they dealt with their recovery after their operations.

The segment reached more than 100,000 listeners across Australia.

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

ANZCA and government

New training pathway targets rural workforce

AUSTRALIA

Victoria is leading a new approach to address workforce maldistribution.

There has been significant change and development in the anaesthesia training landscape across regional Victoria since the *ANZCA Bulletin* launched its Beyond City Limits series in December 2019 with a feature article on the specialty at Goulburn Valley Health in Shepparton (on page 27 see our latest instalment on Tasmania).

Dr Helen Roberts, the Director of Anaesthetics at Goulburn Valley Health, said she hoped trainees exposed to working and living in a regional town would see the benefits and opportunities afforded there and return later as consultants.

Four years on, Dr Roberts and Dr Greg Henderson, Director of Anaesthesia at Grampians Health Ballarat, have been instrumental in developing the Victorian Regional Anaesthesia Training Network (VRTN). The VRTN is a pathway for four years of ANZCA-accredited anaesthesia training that is co-ordinated across a network of regional hospitals. Its establishment has been supported with funding from both the Victorian and Commonwealth governments.

Dr Henderson and Dr Roberts acknowledge that establishing a "reverse" style training network where trainees rotate from the country to the city, rather than the traditional city to country, has been a steep learning curve.

Ongoing participation in the VRTN is just one of the ways ANZCA continues to engage with the state and territory departments of health, the Australian Department of Health and Aged Care (which funds the Specialist Training Program), regional training hubs, health settings and other colleges to actively address the priority areas of the National Medical Workforce Strategy – namely tackling maldistribution and undersupply in the specialist medical workforce to meet community need.

The VRTN enables 70-80 per cent of training to occur in non-metropolitan health settings. The balance of training needs to be completed in metropolitan tertiary hospitals to meet volume of practice requirements for high complexity surgery. Provisional fellow positions are not included in this pathway – trainees are encouraged to get extra skills in areas such as paediatrics, obstetrics, or trauma that will be valuable when they return as FANZCAs.

Recruitment is via the statewide Victorian Anaesthetic Training Scheme process – with applicants able to opt in for the VRTN pathway. This ensures applicants have the requisite standard of clinical background and academic capacity to undertake ANZCA training.

The training network continues to grow year on year. The first cohort of VRTN trainees started in 2021 and some of this group will be undertaking their provisional fellowship at a regional hospital in 2024.

"The goals of the VRTN (are) to recruit and retain anaesthetists to non-metropolitan Victorian hospitals, in large part by providing a positive rural training experience."

There are 13 ANZCA registrars across the VRTN, with five first-year trainees joining the rotation for the 2024 hospital education year. Dr John Hay (Goulburn Valley Health) is the rotational supervisor for the VRTN, overseeing the allocation of trainees across the network's accredited training sites.

Both Goulburn Valley Health Shepparton and Grampians Health Ballarat received STP-funded training positions in 2021.

Two Commonwealth-supported Integrated Rural Training Pipeline (IRTP) positions were added to this network at the start of the 2023 hospital employment year. Smaller regional hospitals such as Mildura Base Hospital and South West Healthcare Warrnambool recently achieved ANZCA training accreditation for the first time and joined the VRTN. Both Mildura and Warrnambool were also successful in their application for a spot on the Department of Health and Aged Care's Specialist Training Program (STP) reserve list this year, meaning these hospitals may have the opportunity to join the program in the future should additional funding become available.

The Victorian government-funded Victorian Medical Specialist Training (VMST) program has been key to the establishment of the VRTN. The VMST provides funding to health services to expand high quality medical specialist training opportunities in priority locations and specialties.

The 2021 VMST funding round identified rural and regional anaesthesia as an area of need, which coincided with the goals of the VRTN – to recruit and retain anaesthetists to non-metropolitan Victorian hospitals, in large part by providing a positive rural training experience.

Dr Roberts and Dr Henderson were successful in their 2020 VMST application and secured salary support for multiple VRTN training positions for 2021-2025.

Additional infrastructure and non-clinical coordination time is being delivered to the VRTN via a two-year Commonwealth STP support project. This project is being rolled out in 2023-24 and provides IT equipment, licenses, remote supervision, and structured trainee welfare activities to ensure every health setting in the network has equal resources and capacity.

NEW ZEALAND

New Zealand's health reforms have been under way for just over a year.

Establishment of top-level teams and merging of shared services are slowly being worked through, while essential IT infrastructure, especially related to a national payroll, service performance reporting and shared patient records, is still under development.

The Pae Ora legislation mandated the development of six national strategies within the first year: The New Zealand Health Strategy, Pae Tū: Hauora Māori Strategy, Te Mana Ola: The Pacific Health Strategy, The Women's Health Strategy, The Health of Disabled People Strategy, and The Rural Health Strategy. All have now been released.

The launch of the NZ Health Charter, and the establishment of regionally organised shared services (called Localities), and service-led National Clinical Networks is underway.

While new commissioning of community services by Te Aka Whai Ora (the Māori Health Authority) is progressing, there has so far been less obvious change for hospital-based services apart from a concerted drive to clear surgical waiting lists via the Planned Care Taskforce.

Pain services have initially been identified as a national service but de-prioritised for implementation. The Faculty of Pain Medicine (New Zealand) is advocating strongly for pain services to instead be provided via a clinical network led by specialist pain medicine physicians.

As the general election draws closer, health spokespeople from the National and ACT parties have both signalled that should they reclaim the government benches, many of these changes will be reversed and the focus on health equity will reduce.

After a reported rise in youth vaping in New Zealand, legislation is now in place banning the sale of disposable vapes, preventing new vape stores from opening near schools and colleges, limiting the sale of child-friendly flavours, and requiring new child-safety mechanisms on nicotine-containing devices. The new regulations build on protections introduced in 2020, including banning sales to under-18s and prohibiting vape advertising and sponsorship.

Vaping is also the focus of a review of *PG12(POM) Guideline on smoking as related to the perioperative period*. The PG12(POM) professional document will be included as an appendix to *PG07(A) Guideline on pre-anaesthesia consultation and patient preparation* (see page 21).

Safer opioid prescription

The Misuse of Drugs Regulations 1977 have been amended to address concerns with controlled drug prescribing regulations.

This reduces the maximum limit (period of supply) for all opioid prescriptions from three months to one month. The limit applies to medical practitioners, nurse practitioners, dentists, midwives, designated nurse prescribers and designated pharmacist prescribers.

For Class B opioids (such as fentanyl, morphine, oxycodone, and methadone) this restores the maximum limit to what it was before December 2022, and means prescribers will only be able to issue one month's worth of opioids on a prescription.

The new regulations take effect in October.

Cultural safety

Cultural safety is now at the forefront of medical education in Australia and New Zealand.

Revised standards for medical school programs include a strong focus on cultural safety in all aspects of medical education. The standards have been endorsed in a joint statement by the Australian Indigenous Doctors' Association, Te ORA, Australian Medical Council, New Zealand Medical Council, Medical Board of Australia, Leaders in Indigenous Medical Education (LIME) Network, and Medical Deans Australia and New Zealand.

SUBMISSIONS

The college prepares submissions and makes representations to government and other stakeholders on a range of policy initiatives and inquiries, many of these in response to requests for college feedback and input.

Our submissions to public inquiries are available on the college website following the inquiry closing date. Note that some inquiries and requests for college input are confidential. For a listing of recent submissions visit www.anzca.edu.au/safety-advocacy/advocacy.

Australia

Australian Bureau of Statistics: Australian and New Zealand Standard Classification of Occupations review.

Department of Health and Aged Care: Consultation on the national health and climate strategy

Department of Health and Aged Care: Spinal cord stimulators – post-listing review.

National Cabinet: Independent review of overseas health practitioner regulatory settings – interim report.

New South Wales State Insurance Regulatory Authority: Draft Australian clinical guidelines for health professionals managing people with whiplash-associated disorders, fourth edition.

New Zealand

Medical Council of New Zealand/ Te Kaunihera Rata o Aotearoa: Medical Certification.

Medical Council of New Zealand/ Te Kaunihera Rata o Aotearoa: Updated Telehealth statement.

Statistics New Zealand/Tatauranga Aotearoa: Consultation on the New Zealand Health Survey.

Medical Council of New Zealand/ Te Kaunihera Rata o Aotearoa: Physician Associate Credentialling

Medical Sciences Council / Te Kaunihera Pūtaiao Hauora Aotearoa: Perioperative Practitioner (AT) name and scope consultation.

Anaesthetic technicians shortage highlights workforce pressures

A shortage of anaesthetic technicians is putting pressure on surgical lists and adding to treatment delays in New Zealand – and a change to the profession's main training pathway is causing further concerns.

ANZCA New Zealand National Committee Chair, Dr Graham Roper, says some of the shortage is attributed to poor retention with problems associated with a lack of career progression, recognition of skills, and workplace entitlements when compared to other health care professionals.

"We lose people from the workforce if they don't feel valued, not only by people that work alongside them, but in terms of financial value, support for ongoing training, and opportunities for career progression.

"It's a niche workforce, it's not publicised as a career when you leave school. It's a bit like anaesthesia is to medical students among other medical specialties, it's a bit hidden – they don't come across it when they walk in the hospital or go to the wards."

However, Dr Roper says anaesthetic technicians are important and highly valued members of the anaesthesia workforce.

"Without them, our ability to deliver safe anaesthesia is gone. We can't ensure safety without a highly trained assistant."

Concerns also exist over a change in anaesthetic technician training from an on-the-job apprenticeship diploma model to a new Bachelor of Health Science (Perioperative Practice) degree, offered by Auckland University of Technology.

The clinical hours under the new degree fall short of the ANZCA *PS08(A) Position statement on the assistant for the anaesthetist*, and graduates will enter the workforce with less clinical experience and less exposure to the theatre team than those employed in training hospitals during the diploma program.

"The main concern is exposure to clinical hours during the training and what we see as the relatively practical, on-the-job apprenticeship style training that they've had in the past. There used to be about 2000 hours of clinical exposure and that's down to about 1000 now," Dr Roper says.

Dr Roper is also worried about a lack of visibility around the pipeline of degree students who might go on to become anaesthetic technicians.

"We may not have had enough people coming through the diploma, but at least we knew what those numbers were and where people were working, so we had some forecasting ability. We don't have good data on the numbers completing the degree, because during that first year you can move into different specialty areas."

The new degree is also more expensive for potential students. To help alleviate this issue, scholarships are being offered and some smaller hospitals are offering on-site accommodation for students on work placements.

Dr Roper says the degree program has some potential long-term benefits for anaesthetic technicians. It provides a tertiary degree to set graduates on an equal footing with other health professionals, builds a workforce with a clearer identity, and provides opportunities for anaesthetic technicians to examine and extend their role.

"The training for anaesthetic technicians needed revising to become contemporary, support extended roles in healthcare settings, and ensure this highly valued workforce is appropriately recognised within the workplace.

"Anaesthesia technicians are our colleagues. We'll continue to work collaboratively to address concerns with the new degree program, and guarantee that well trained, highly skilled practitioners are with us in theatre caring for our community."

Reon Suddaby
Senior Communications Advisor
New Zealand, ANZCA

Nominations for ANZCA Council Awards are now open

Award Title	Criteria	Eligibility
Robert Orton Medal	The highest award the college can bestow on its fellows. It recognises distinguished service to anaesthesia, perioperative medicine and/or pain medicine.	Fellows of the college.
ANZCA Medal	Recognises major contributions by fellows to the status of anaesthesia, intensive care, pain medicine or related specialties.	Fellows of the college.
ANZCA Council Citation	Awarded to an ANZCA fellow in recognition of significant contribution to a college project or ongoing college activities.	Fellows of the college.
ANZCA Recognition	Recognises significant contributions at a regional level to anaesthesia, perioperative medicine and/or pain medicine.	Fellows, trainees and SIMGs of the college.
ANZCA Star	Awarded in recognition of those who make extraordinary and critically important contributions (clinical or non-clinical) in times of major disaster, conflict or in other circumstances outside the college.	Fellow, trainee, SIMG of the college or department.

It's time to recognise the members of our college who make a difference to anaesthesia and pain medicine, with nominations for the 2023 ANZCA Council Awards now open.

ANZCA has a suite of awards that have been expanded to recognise the achievements and contributions of our fellows, trainees, specialist international medical graduates (SIMGs) and departments. The awards are a chance for our members to celebrate the contributions and outstanding achievements of individuals within their departments or communities.

For more information on the nomination process and selection criteria, visit the college website via www.anzca.edu.au/councilawards

ENTRIES CLOSE ON THURSDAY 30 NOVEMBER 2023

The Award recipients will be announced at the 2024 College ceremony in Brisbane as part of the 2024 ANZCA Annual Scientific Meeting on Saturday 4 May.

If you require assistance, please contact the membership services unit at membership@anzca.edu.au

Professional documents

What would you do?

Dr Peter Roessler explains professional documents using practical examples. In this edition he examines ANZCA standards.

Did something go wrong?

"IS THERE ANY REASON THAT YOU FAILED TO ADHERE TO THE ANZCA STANDARDS?"

This is one of the questions anaesthetists dread being asked, and which go to the core of the college's professional documents.

What would you do if you were asked this question? Yes, I know, it depends on the setting.

There are subtleties and nuances in this line of questioning that need to be understood by both the interrogator and the respondent.

There continues to be confusion between terms such as standards, policies, and guidelines such that they are often used interchangeably.

What's in a name?

Only everything! Much of the angst accompanying the above question can be alleviated as a result of a clear understanding of the different types of documents.

The college is internationally acknowledged for the excellent quality of diplomates it produces through its outstanding training program. It is responsible for setting standards, which it has done for its trainees, and which are articulated in the curriculum. These standards are benchmarks of performance that must be met or exceeded, as evaluated by the satisfactory performance in the comprehensive assessments in order to be granted fellowship.

Standards are not mandatory unless mandated by a regulatory body or as part of the authority an educational body such as our college has in setting its internal regulations. In this instance, the college has the authority to mandate that trainees meet the standards to be awarded the diploma.

But what about the college's qualified diplomates? What standards apply to us?

Until very recently the college's professional documents were viewed as standards. While college guidelines (professional documents) contribute to standardisation with the aim of achieving quality and consistency in outcomes, they are not of themselves standards, although the two are closely related. To help picture this association, we can look at the manufacturing world, where products are expected to meet whatever quality standard is applicable to a particular item. The consistency and quality is predetermined by standardising the manufacturing process. This may be varied to some degree without affecting the quality; however, if the quality falls outside accepted limits, then it triggers inquiries as to whether the standardised process was followed, and if so, whether the process needs to be reviewed.

Of course, one can't compare anaesthesia where the starting materials are so varied, to manufacturing where the ingredients are known and can be tightly controlled. This partly explains the necessity for ensuring flexibility in our guidelines and avoid being prescriptive.

In recognition of the absence of defined standards, a set of standards has been developed for anaesthesia and are published on the ANZCA website *Anaesthesia standards*. A separate set of standards is being developed for perioperative medicine (currently out for consultation and for which all feedback is welcome). These serve as benchmarks against which performance can be gauged.

The original question above, now has relevant context. The only reason for concern is failure to meet the benchmark. Although the authorities do refer to our professional documents, it is not whether there has been a failure to adhere to each and every recommendation contained within any guidelines but rather the failure to meet the benchmark.

Guidelines are advisory documents but essential for guiding evidence-based best practice. Where evidence is lacking, then there is a reliance on consensus with all its flaws and limitations. Guidelines are designed to steer performance towards meeting or exceeding applicable benchmarks. They are not intended to be prescriptive nor serve as a manual of training. They can be identified by their prefix *PG* denoting professional guideline or *PS* denoting position statement, an explanation of which can be found on the website.

It may be helpful in putting this together to consider an analogy within the realm of wellbeing. Maintaining a level of fitness is known to have beneficial effects on health. Fitness may involve cardio exercises and/or resistance training. The specifics for each area of exercise will be determined by many factors. For example, cardio exercises will be determined by individual needs and demands but may consist of walking, jogging or cycling. Similarly, resistance exercises will vary depending on goals/needs and may include a range of exercises with weights or elastic resistances.

In terms of standards and guidelines, the standard is represented by the level of fitness however determined and benchmarked, while the guideline is represented by the recommendations for specific activities to be undertaken for cardio fitness and muscle strength. The details of specific

exercises for each recommendation are based on the individual's needs and circumstances.

It is hard to avoid mentioning the Matilda's recent World Cup participation where the standard to be met is to score more goals than their opponents, while the guidelines include the game plan, team tactics, and team formation 4-4-2 depending on player availability and opponent style. The activity of any individual will be determined by the specific circumstances being faced at any particular point in the game.

Finally, organisational governance demands productivity and performance, structure, and order to optimise efficiency and effectiveness. To achieve this entails the development of rules and regulations that direct actions and behaviour. This is where policies come into effect. Policy documents reflect any organisation's by-laws and internal regulations, which if not complied with, may result in consequences.

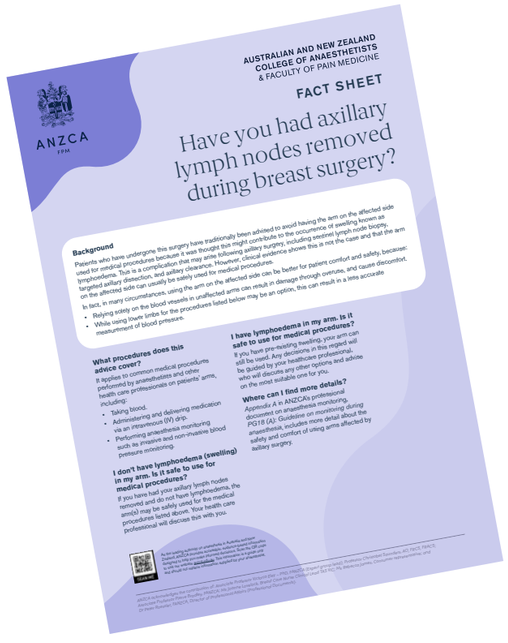
ANZCA/FPM have regulations covering matters pertaining to staff of the college, training, professionalism, and continuing professional development from which policies have been drafted. Policy documents are mandatory, drawing on regulations and address corporate matters such as bullying, harassment and discrimination as well as professional issues.

There are many factors that contribute to the enhancement and ongoing improvement in quality of patient care. In the professional documents arena these include the means for gauging performance against applicable benchmarks (how am I doing?) and recommendations/suggestions to guide performance (how should I do this?)

For anaesthetists it is helpful to be aware of the standards as benchmarks that should be met, or better still, exceeded, and to appreciate the important role of our guidelines in providing advice towards reaching those standards.

Dr Peter Roessler FANZCA
Director of Professional Affairs (Professional Documents)

Axillary lymph node removal – patient information campaign



Earlier this year, ANZCA updated its advice on intravenous access and blood pressure monitoring in patients who have had previous surgery involving removal of axillary lymph nodes, advising patients and practitioners that the arm on the affected side can usually be safely used for medical procedures.

This important development was the result of a review of "Appendix 1 – Intravenous access and blood pressure monitoring in patients with previous axillary nodal dissection 2023" of ANZCA's professional document on anaesthesia monitoring, *PG18 (A)*.

The college undertook a patient information campaign, developing web-based information including a patient fact sheet (see www.anzca.edu.au/patient-information/anaesthesia-information-for-patients-and-carers).

The college wrote to about 20 organisations (nursing, cancer, consumer, physiotherapy and medical) in Australia and New Zealand to encourage them to communicate the revised guidelines with both practitioners and patients.

We provided them with digital assets for a social media campaign. A media release issued during the ANZCA Annual Scientific Meeting in May resulted in an article that featured in the *Herald Sun, Gold Coast Bulletin, Townsville Bulletin* and *Northern Territory News* reaching an estimated 750,000 readers.

Professor Victoria Eley, the expert group lead, also pre-recorded a webinar on behalf of the group comprising Professor Christobel Saunders, AO, FRCS, FRACS, Associate Professor Pierre Bradley, FANZCA, Ms Joanne Lovelock, McGrath Breast Care Nurse Clinical Lead, Ms Rebecca James, consumer representative and Dr Peter Roessler, FANZCA, ANZCA Director of Professional Affairs.

Seeing through the vaping haze

A focus on vaping is part of a review of professional document *PG12* on perioperative smoking which will become a new appendix to professional document *PG07* on pre-anaesthesia consultation. It is due to be piloted soon.

"A 'witch's brew' of sweet-flavoured toxins, dressed up in candy-coloured packaging."

The perioperative use of e-cigarettes is increasingly common.

Due to a lack of sufficient data, it has been difficult to know whether we should congratulate our vaping patients for choosing the less risky path of nicotine addiction or admonish them for exposing delicate airway tissues to a "witch's brew" of sweet-flavoured toxins, dressed up in candy-coloured packaging.

Cigarettes are the deadliest consumer product ever developed by humankind, killing half of all its regular users, yet it took decades to elucidate the health harms fully. Fortunately, research on the impact of vaping devices is growing, and there is an increasing body of literature to help perioperative clinicians see through the e-cigarette haze.

The first devices that aerosolised nicotine solutions into vapours were invented in China in 2003. Several "generations" of e-cigarette devices have since evolved, and currently, refillable tank devices or more environmentally harmful disposable cartridges dominate the market. E-liquids typically contain nicotine, flavours and a base of glycerol or propylene glycol. When heated, both propylene glycol and glycerol form thermal degradation products, including carcinogenic formaldehyde and acetaldehyde. Acrolein, acetone, propylene oxide and allyl alcohol are also detectable. Heavy metals may be present in low concentrations.

Popular e-liquid flavours include caramel popcorn, blueberry bubblegum, watermelon and lemon pie. Some flavourants, including diacetyl and cinnamaldehyde, are especially toxic and deemed acceptable for inhalation based solely on their safety profile for oral ingestion. Although limited *in-vivo* evidence exists for pulmonary harm from flavourants, *in-vitro* evidence indicates cytotoxicity and immune system impacts from inhalation. No pharmaceutical company has ever produced an asthma aerosol filled with fun fruit flavours, which could be why.

Nicotine is the addictive component of e-liquids, and modern devices deliver the chemical more efficiently. The rate of rise of plasma nicotine is similar for electronic as conventional cigarettes, but the peak and total nicotine intake is generally lower from a single e-cigarette puff. However, while a single tobacco stick provides a smoker with eight-10 puffs, a single vape cartridge offers up to 6000 puffs. Observational studies show that typical vapers consume 500 puffs daily from their devices, five times the number of puffs taken by regular tobacco users. Some vapers have found them as difficult to quit as cigarettes, if not more so.

E-cigarettes are particularly prevalent in New Zealand, with the *2021-22 New Zealand Health Survey* finding that current use has almost doubled since 2019/20, from 5.3 per cent to 10.3 per cent. The 2021 *Vaping in New Zealand Youth Survey* found that nearly 20 per cent of secondary school students reported vaping at least daily. The increase in youth e-cigarette use since 2019/20 was much more significant than the decrease in smoking prevalence, implying that the overall usage of nicotine products is increasing. There is evidence that e-cigarettes are a gateway to youth smoking. A recent systematic review indicated that adolescent e-cigarette users have three to five times the risk of becoming future smokers than those never using e-cigarettes.

Australia has taken a hard line on vaping by officially banning recreational use while leaving the door open for those wanting to quit smoking through vaping by obtaining vapes from pharmacies with a medical prescription. Neither Australia nor New Zealand have e-cigarette products registered as therapeutic goods, but these so-called "unapproved medicines" may still be purchased without being assessed for safety, quality or efficacy. Before the ban, Australian e-cigarette use had grown from 1.2 per cent of all adults (2016) to 2.5 per cent (2019), with the highest prevalence in the 18-24-year-old age group.

The effects of the ban on stymying the growth of e-cigarette sales remain to be seen, and unless New Zealand joins Australia with similar restrictions, a fascinating natural experiment has been set for vaping outcomes. Critics of the Australian approach state that access to a less harmful nicotine product is severely restricted, while cigarettes remain available almost 24/7 at supermarkets, corner stores and service stations.

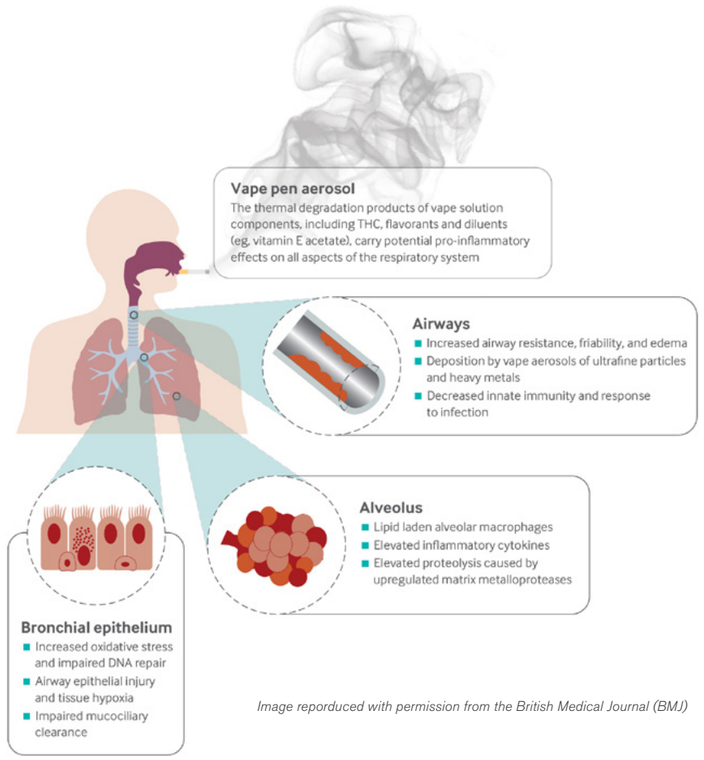


Image reporduced with permission from the British Medical Journal (BMJ)

In the UK, e-cigarettes are officially viewed as a disruptive technology capable of achieving public health benefits by transitioning smokers to less harmful alternatives.

UK health organisations, including Public Health England, have stated that e-cigarettes are unlikely to present more than five per cent of the health risks of cigarette smoking. This claim has been amplified and rebroadcast worldwide, often by those with commercial e-cigarette interests. Still, the basis for that statement was an opinion arising from a two-day meeting of a small expert group, including some with potential conflicts of interest. Regarding the significant message of the Public Health England e-cigarette report, a *Lancet* editorial cuttingly stated that it was on an "extraordinarily flimsy foundation".

There are insufficient studies recommending e-cigarettes as a smoking cessation tool in a perioperative setting. However, there is growing evidence from non-surgical trials that nicotine-containing e-cigarettes are valuable in assisting smoking cessation, even compared to pharmacological nicotine replacement therapy (NRT).

A Cochrane report of studies showed that for every 100 people using nicotine e-cigarettes to stop smoking, eight to 12 might successfully stop, compared with only six of 100 people using NRT, seven of 100 using e-cigarettes without nicotine, or four of 100 people having no support or behavioural support only.

However, of the six included studies randomising e-cigarettes against NRT, most weight (40.7 per cent) was given to the study by Hajek et al. in which 80 per cent of those randomised to e-cigarettes were still using them at the 52-week endpoint. Stopping smoking often meant swapping one nicotine addiction for another (nine per cent of the NRT group were still using NRT at 52 weeks), so any overall health benefits would depend on outcomes from the evolving knowledge on long-term vaping harms. The only other positive study for e-cigarettes (vs. NRT) forming part of the Cochrane report had a similarly high rate of ongoing vaping by the study's end (47 per cent).

VAPING – KEY POINTS

- Patients should be asked about smoking and vaping, with further questioning on cardiorespiratory function for those with affirmative responses.
- Vapour exposure causes several adverse effects, including cytotoxic and inflammatory changes to respiratory tissues, negative consequences to cardiovascular function and appears to impair wound healing. Cessation for as long as possible before surgery is recommended.
- Pharmacological preparations of nicotine replacement therapy (NRT) remain first-line smoking cessation therapies and are safer than vaping.
- There is insufficient evidence to recommend that smokers switch to vaping before surgery.
- Nicotine-addicted e-cigarette users may require pharmacological NRT to prevent withdrawal symptoms if ceasing before surgery.

Associate Professor Ashley Webb, FANZCA
Peninsula Health, Victoria

Dr Trent Cutts, FANZCA
Taranaki Base Hospital, NZ

Most recent evidence incorporated into pain prof doc

Treatment of pain is core to the practices of anaesthetists and pain medicine specialists, and an essential component of patient care. The provision of such a service needs to address both safety with mitigation of risks and quality aiming for optimal return of functional activity. A review of *PS41: Position statement on acute pain management* was undertaken using these supporting principles.

The current version addresses all forms of acute pain including non-procedural/surgical pain and spans both anaesthesia and pain medicine. The ultimate aim is to ensure that doctors can use the framework that has been developed to advance the quality of acute pain management. It brought together eminent experts from pain medicine and anaesthesia ensuring that the most recent evidence was considered and from varied and diverse perspectives.

During the review an important concept emerged acknowledging that the sensible goal in management of acute pain is to strive for good functional recovery as opposed to "no pain" given that attempts to achieve this with opioid medications introduces increased risk of opioid-related adverse effects including opioid induced ventilatory impairment (OIVI).

Pain perceptions, which are modified by patient attitudes and beliefs can be influenced by education, and setting the expectation of achieving good functional recovery, which can positively influence the outcome of acute pain management.

The framework for acute pain management focuses on education and its role in advancing quality care; assessment of analgesic efficacy; monitoring for potential adverse effects that may be associated with treatment accompanied by instructions for timely management should an adverse effect arise; the range of pharmacological therapies and their interactions; delivery of effective pain management within the varied settings and circumstances; and finally, considerations of quality assurance.

Terms relating to duration of action of opioids, such as long-acting, slow-release, sustained-release and modified-release (MR) have been used interchangeably in various publications resulting in confusion.

Consequently, it is necessary to differentiate between long-acting opioid medications that have long durations of action due to their pharmacokinetic and pharmacodynamic properties from those whose actions are prolonged due to the MR formulation of the medication, which extends their duration of action.

In past clinical practice MR opioids were commonly prescribed for treatment of acute pain. The review undertaken for *PS41* revealed a lack of robust evidence suggesting a significant difference in analgesic efficacy between MR and immediate release (IR) opioids.

However, interpersonal variation in pharmacokinetics and response to opioids make predicting a dose of long-acting opioid and titration in an opioid naïve person impossible, rendering them less effective than IR opioids.

"Modified-release opioids resulted in a higher risk of opioid-related adverse effects including OIVI and persist post-discharge opioid use."

Furthermore, in comparison with IR opioids, MR opioids resulted in a higher risk of opioid-related adverse effects including OIVI and persistent post-discharge opioid use (PPOU).

Hence the recommendation to avoid the routine prescription of MR opioids in the absence of demonstrable specific benefit, monitoring, and a cessation plan.

This recommendation is in line with that from the Australian Commission on Safety and Quality in Health Care Opioid Analgesic Stewardship standards released in 2022.

Appendix 1 on analgesic stewardship to support the position statement is a well-considered and constructed section that presents stewardship concepts ranging from pre-admission, during admission, and post-discharge.

It addresses the multifactorial contributors to pain perception and the range of varied medications and techniques applicable to managing acute pain. The importance of multidisciplinary engagement with the special centralised role of GPs is also stressed.

Patient and carer education with regard to expectations are wisely promoted along with risk mitigation and harm mitigation strategies.

The importance of opioid stewardship is highlighted in acknowledgement of the potential significant complications such as OIVI, PPOU, and risks of opioid misuse and diversion.

The review has been a collaborative one involving members of the Document Development Group (DDG) contributing from a diverse range of experience and perspectives.

I would like to thank Professor Pam Macintyre for her tireless leadership and expertise in leading this review as well as all members of the DDG, the expert group, and members of the Safety and Quality Committee, all of whom have contributed to the final product that will serve as a highly useful resource.

PS41 can be found at www.anzca.edu.au/safety-advocacy/standards-of-practice/policies,-statements,-and-guidelines.

Dr Peter Roessler
ANZCA Director of Professional Affairs
(Professional Documents)

New look ANZCA and FPM CPD Committee

In July, five new members joined the ANZCA and FPM CPD Committee. The ANZCA and FPM CPD Committee oversees the structure and operations of the CPD program and standard including participation and compliance. It also undertakes continuous quality improvement, making program enhancements in relation to international, bi-national and regulatory developments and feedback from relevant stakeholders..

The committee's new make-up provides a great opportunity to build from the excellent experience of long-standing members, with new members adding diversity through their varied expertise – across private practice, pain management, clinical support roles, and rural/regional positions.

NEW CPD COMMITTEE

Dr Debra Devonshire (Vic) – Chair

Dr Sarah Green (NSW) – Deputy Chair

Dr Peter Roessler (Vic) – Director of Professional Affairs (Policy)

Dr Yvonne Murray (NZ) – FPM CPD Officer

Prof Pamela Macintyre (SA) – FPM rep

Dr Michelle Castro (NSW)

Dr Michael Barlev (NZ)

Dr Chris Cokis (WA) – president (ex-officio

New members:

Dr Scott Ma (SA) – Chair, PAEC

Dr Vicki Cohen (WA)

Dr Babitha Kudakandira Basappa (Qld)

Dr Andrea Kattula (Vic)

Dr Genevieve Goulding (Qld)

UPDATE YOUR CPD PORTFOLIO

If you have an active online CPD portfolio, you will need to update it before the end of the year (31 December). With over 7000 fellows and other CPD participants needing to update their CPD portfolios to meet requirements by then, it's the largest CPD cohort to go through the end of CPD cycle process.

This is the end of our staged transition process to move all fellows and other CPD participants from triennial CPD programs with three different cohorts and submission dates to one updated annual program.

There are several helpful resources available through:

Learn@ANZCA the college's online learning portal which hosts a wide range of free online courses and resources to support your personal and professional development.

The professional development hub, designed for ANZCA and FPM CPD program participants and any medical professionals interested in keeping up to date with current research in the area of anaesthesia and pain medicine, including those resources available through the ANZCA Library.

The ANZCA Wellbeing SIG Library Guide for those interested in locating resources relevant to the general wellbeing of medical practitioners. It includes several resources to support completion of the Knowledge and skills "Wellbeing CPD education sessions" activity.

2022 – 2024 TRIENNIUM

We developed a bespoke CPD portfolio support document to support those in this cohort, as we appreciate the challenges that the annual CPD program transition has created. The support document clarifies amendments that have been made to your online CPD portfolio to reflect your reduced requirements and provides other helpful resources.

2023 ANNUAL PROGRAM

We've put together case studies, guidance, and support resources to help you understand how to meet your requirements under the annual CPD program.

Check out the "how can I meet my requirements" dedicated CPD webpages for a calendar breakdown of the new annual 2023 ANZCA and FPM CPD program.

There is also a new 5-minute support video to help navigate the updated online CPD portfolio.

ENTERING DATA INTO THE CPD PORTFOLIO

From time to time, fellows and other CPD participants reach out to the CPD team for clarification on how much evidence to upload in their CPD portfolio. To reassure all CPD participants, information you enter in your CPD portfolio is to only verify participation in the completed CPD activity.

For example, when providing evidence for patient experience surveys, multi-source feedback (MsF), and peer review of practice, you should upload the relevant CPD verification form and do not need to submit the feedback forms or collation forms.

Please also remember that collecting information about patients has privacy implications and only de-identified information should be routinely stored in your CPD portfolio.

THE CPD TEAM IS ON HAND TO HELP

To support the end of CPD cycle process, the CPD team will be sending regular communications to help you successfully update your CPD portfolio and complete your CPD requirements. Our goal is to smoothly transition everyone to the updated annual CPD program from 1 January 2024. We hope these targeted emails are helpful to outline any remaining CPD activities and suggested resources.

We enjoy hearing from our fellows and other CPD participants and are delighted to provide support via emails and phone calls. We appreciate it can be hard to balance completing CPD with other commitments and are happy to organise a time to go through your CPD portfolio with you.

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

CPD REVIEW PROJECT

The CPD Committee and CPD review project group (CPD-RPG) are progressing several initiatives to further enhance the ANZCA and FPM CPD Program to meet your needs.

NEW CPD ACTIVITIES

Following a detailed gap analysis and consultation process, the CPD Committee is considering the following 11 new activities for inclusion in the CPD program from 1 January 2024:

- Two emergency response activities.
- Two knowledge & skills activities.
- Four practice evaluation – measuring outcomes activities.
- Four practice evaluation – reviewing performance activities.

We hope that these additional activity offerings will help you to meet the updated annual hours-based requirements. Once approved by the CPD committee, guidelines for each activity will be added to the CPD handbook.

REFERENCE GROUPS

The CPD-RPG established two reference groups to ensure the perspectives of those who practice without direct patient care and private practitioners were considered in the CPD review. Both reference groups have now concluded their activities and shared recommendations with the CPD committee. We would like to thank all members who volunteered their time and provided valuable insights.

A key further outcome of the practice without direct patient care reference group is a toolkit to help fellows and other CPD participants identify relevant CPD activities for clinical support roles (including education, management, governance, and research). We are finalising this toolkit as a CPD handbook appendix and library guide.

COMMUNICATIONS

We'll be sharing several CPD related communications before the end of the year to support everyone's transition to the annual program and introduce our new CPD activities.

Self matters

The inspiration of others

This regular column explores doctors' health by highlighting practical ways to support anaesthetists' and pain specialists' wellbeing. This edition looks at what and who inspired one ANZCA trainee to pursue her passion for supporting colleagues' wellbeing, and what she has learnt along the way.

Our profession is inherently a team sport – fellow clinicians in our theatres, clinics and broader workplaces; our contemporaries from medical school, training and specialist practice; and other more senior and junior colleagues. A few of these stand out – sadly and disappointingly, those who treat us poorly, but also those who are memorable for good reason – the inspirational, the courageous, the steadfast, the outspoken, and those who challenge us to think outside current constraints to consider greater possibilities. Many of these become role models and, some, mentors.

It's a great privilege to introduce this edition's piece by Dr Jess Barry, wellbeing provisional fellow in Sydney. My thanks to Dr Tanya Selak for suggesting I get in contact with Dr Barry. It has been inspiring to me as I watched her hone her narrative about how she became interested in the wellbeing of those around her. I trust you also gain inspiration from her piece and that it encourages you to reflect on those who have positively changed the course of your professional life, even if they are unaware of their influence on you.

While working on this column I could not help but reflect on my truly inspirational mentor and friend, FANZCA Dr Ann Newton (1955-2008).

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

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

TO ALL THE WOMEN WHO'VE COME BEFORE

When it was suggested that I should write a piece for the *ANZCA Bulletin*, my imposter syndrome flared. I am not an expert on wellness or wellbeing or welfare. Though I am the inaugural "wellbeing fellow" at my hospital – it's mostly through friendship, mentorship, and a little bit of luck that I am.

How did I get here, and how can we help trainees and each other?

Please allow me to explain...

It started with a loss

When I became an anaesthesia registrar, my support network in medicine largely disappeared. My closest friends had left medicine, left the state, or both. I thought I'd try to make my own support network of sorts. This started with a bunch of junior medical officers (JMOs) sharing food and talking about bad things that had happened at work. We were continually surprised that we had such common experiences but starkly different ways of dealing with how they affected us. Now, with the help of a few dedicated trainees from critical care specialties, we call it ADAPT (All Doctors Are People Too), and we run small group discussion and debrief peer support sessions throughout the year at Auburn, Westmead, and Royal Prince Alfred hospitals in Sydney.

The existence of this program has implicit reliance on the circumstances in which it was created: in the safe space of the Auburn anaesthesia department with the support of Dr Alpha Tung, an unassuming leader and informal mentor to all her "ducklings". She demonstrated to me the importance of integrity. She also advised me to classify my concerns into groups: things you can control / things you can influence / things you can neither control nor influence, and to divide energy accordingly. This provided a work-life balancing routine that remains useful, especially when tasks are piling up and become overwhelming.

Progress, but definitely not perfection

With some new friends, a bit of experience, and a new job in Western Sydney to carry me through my training, I felt well equipped for what lay ahead. First thing I did, though, was fail the primary exam. Both then and now I recognise that this was not the end of the world - but it still happens to many of us while we are just starting our careers, wanting to prove ourselves. Self-confidence and self-worth can take a hit.

Cue Dr Robyn Alleyn with whom I already had an established mentorship. She reassured me and encouraged me to continue to work hard, because life has ups and downs, and it's okay to need support sometimes. I should just accept the help and pay it back later when my circumstances allow. Robyn stresses the importance of fiercely defending yourself. Not in argument or debate, but rather for the maintenance of mental health and life outside of medicine. We discussed that if I was to protect my own welfare, then collaborative work to protect and improve the welfare of everyone within the healthcare system follows, because we're in it together, and we can't do it alone.

"Representation matters. It makes a world of difference if you can see a little bit of yourself in the good people you try to emulate."

Of course, this is much easier said than done. Even at the best of times, positive change in the public healthcare system seems to take multiple attempts to achieve even the smallest things. Especially when, from a JMO perspective, the system appears reluctant to admit its mistakes. We weren't privy to a report written following an independent investigation into the wellbeing of JMOs in Western Sydney, though it did connect me with yet another inspirational woman, Dr Jo Hely, whose work to help others is ongoing regardless.

We should continue, and we should be patient – after all, how do you eat an elephant?

All you can do is ask

During my training I noticed wellbeing committees popping up within hospital departments, often reliant on participants' own time. I thought that it might be beneficial to formalise a wellbeing role with dedicated clinical support time to make improvements.

As luck would have it one of my previous supervisors of training, Associate Professor Nicole Phillips, had recently become head of the Royal Prince Alfred Hospital (RPAH) anaesthesia department in the Sydney Local Health District – coincidentally the same district which employs Australia's first Chief Medical Wellness Officer, Dr Bethan Richards. Ready for a new challenge: this was it.

After we accepted our jobs, new provisional fellows were asked how they would like to contribute to the department in their clinical support time, with several options provided. I thought why not ask for something different? The first thing about asking is: I suggest you have to be okay with hearing "no". There's been a big movement recently about saying "no" – in the context of setting boundaries and self-preservation. However, if you are being encouraged to *say* "no", then you also need to be okay with *hearing* it. There will be more time, more opportunities and different ways to move forward. Luckily for me, it turned out I was in the right place at the right time, with the right people involved – and they said yes!

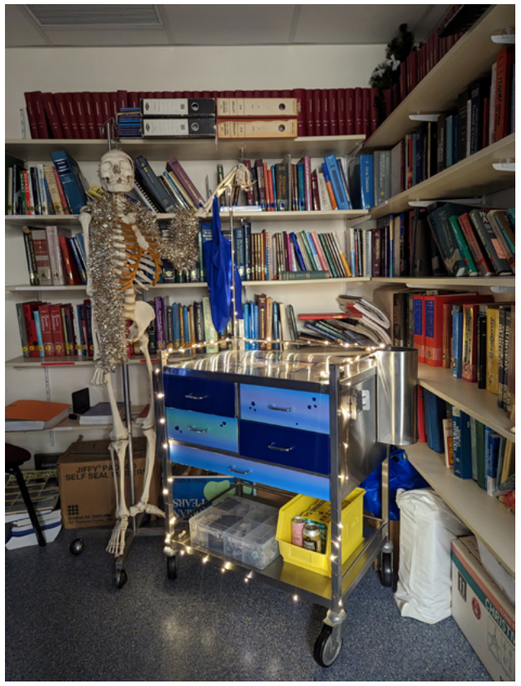


Image 1: Photo of the SOS Trolley

Where to from here?

First, it has to be about the "little things". That's how we can bring people together and build momentum. And we should adopt a practical approach. Sometimes it's "simple" things that make a big difference – access to leave, access to *lunch*, access to support after adverse events.

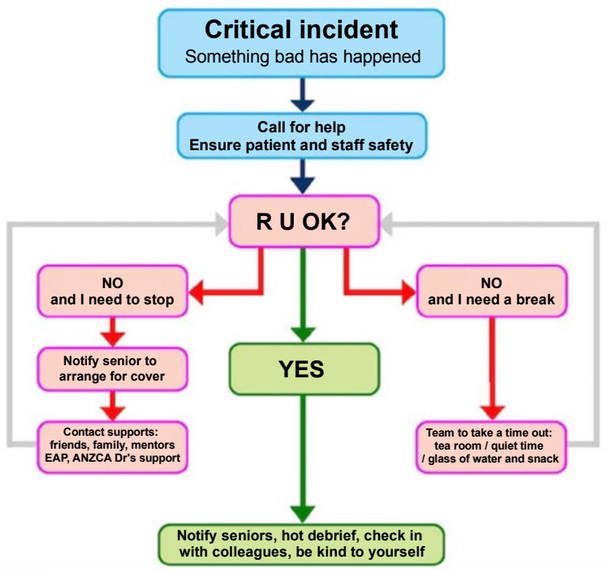
At RPAH we have repurposed a used Morgan trolley to create a staff resuscitation trolley: the "SOS trolley" ("Snacks and Occupational Supports") (image 1). It's stocked with breakfasts, snacks, socks, and personal care items. The trolley has a department-specific resuscitation algorithm to guide staff to supports and resources following adverse events (image 2).

We have a department-wide collaborative Spotify playlist for music in theatre (thanks largely to Dr Tanya Selak). We are working on creating a safe and comfortable space for staff to relax in the department. Our social calendar is refilling with semi-regular and inter-departmental events.

I hope that by fostering a sense of community and camaraderie it will be easier to look after ourselves and each other. If staff feel valued by their institution, respected, and considered, this could reduce absenteeism and burnout, and I suspect improvements in patient care would follow.

Nicole also talks about "getting women on walls". Our historic department – the first anaesthesia department in Australia – is furnished with portraits of those who came before us... mostly older, white, men. While I am thankful that they built the foundations of our department, our specialty has changed. Representation matters. It makes a world of difference if you can see a little bit of yourself in the good

Advanced Life Support for Anaesthetic Trainees



HELP: from where?
> Duty Anaesthetist
> Other doctors in the hospital: anaesthesia / ICU / ED
> On site provisional fellow
> On call consultants
> Trusted mentors and friends
> SOTs / head of department
> Medical indemnity (later if required)

HOT DEBRIEF
> ANZCA toolkit: 5-15mins, immediately post event, confidential and private, no judgement, be respectful
> RESET:
Recall: what happened?
Emotions: how are you feeling?
Success: what went well?
Evolve: what can we learn?
Take away: what will you take away from this?

IMPORTANT POINTS
> Document in patient medical record
> Keep notes of events and concerns for your own later reference and escalation as appropriate
> Handover events and tasks if ongoing
> It's OK to not be OK

EXTRAS
> Allocate responsibility for family communication / SCIDUA / coroners

THE AFTERMATH
> Cold debrief: can be organised by seniors
> Discuss with mentors / incident report / QA or AIMS
> Look after yourself
> See your GP if required
> External resources: 5 free confidential sessions for clinicians at Black Dog clinic available via TEN (The Essential Network for Health Professionals)

Image 2: Modified ALS algorithm

people you try to emulate, while we all try to make things just a little bit better for those who come after us.

Looking back, it's clear that all those mentioned, and many, many more, have certainly helped me. I am exceptionally grateful to them, to all the women who have come before me, and to everyone who continues to support and encourage equity, diversity and wellbeing in medicine.

I hope I can "pay it forward", and I hope I can encourage others to do the same.

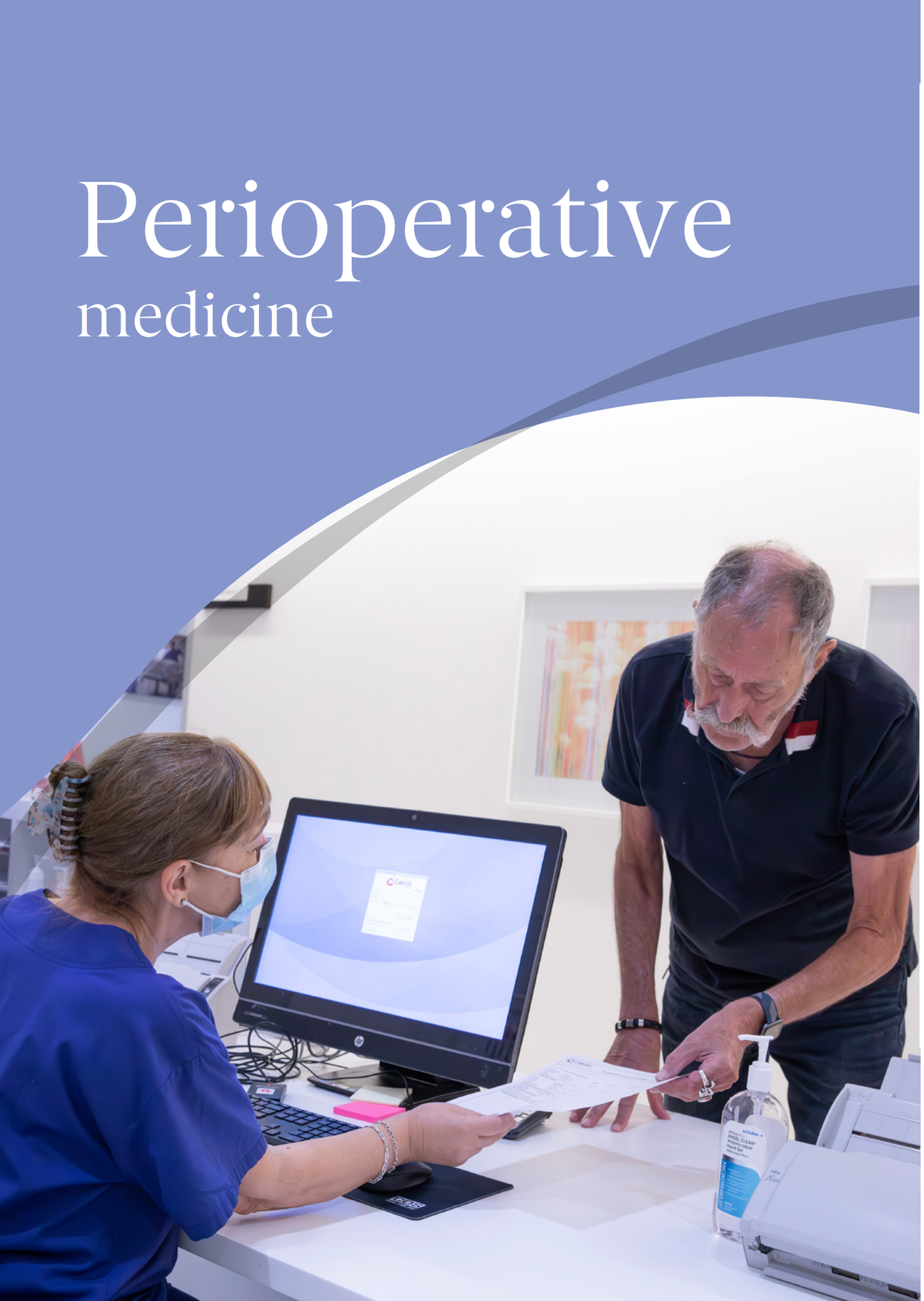
Dr Jess Barry
Provisional fellow in anaesthesia,
Royal Prince Alfred Hospital,
Sydney, NSW

References and further reading:

1. Black Dog Institute: Workplace wellbeing fact sheet, 2022 Direct link: https://www.blackdoginstitute.org.au/wp-content/uploads/2022/06/Workplace-wellbeing-fact-sheet.pdf
2. Aiken LH et al; Physician and Nurse Well-Being and Preferred Interventions to Address Burnout in Hospital Practice: Factors Associated with Turnover, Outcomes, and Patient Safety. *JAMA Health Forum* 2023;4(7):e231809.
3. ANZCA Critical Incident Debriefing Toolkit, 2021. Direct link: https://libguides.anzca.edu.au/criticalincident

Correction: In the Winter ANZCA Bulletin 2023 Self Matters column ANZCA and FPM CPD wellbeing activities (page 25), the research question being addressed by Ms Nadja Kaye was inadvertently omitted. It was 'What CPD wellbeing activities are CPD participants undertaking to develop a greater understanding of their own health and wellbeing?'.

Perioperative
medicine



First candidates commence pilot

An exciting milestone was achieved on 4 September for the many fellows – from ANZCA and our stakeholder colleges – and staff who have worked over so many years to get our qualification in perioperative medicine up and running.

On that day, 14 candidates from nine hospitals across Australia and New Zealand started the pilot of unit of study 1 of our Diploma of Perioperative Medicine.

Over 10 weeks they will complete 20 online modules, attend a workshop in October and undergo 40 hours of perioperative clinical immersion at one of the participating hospitals – the Prince of Wales and John Hunter hospitals in NSW, The Alfred and the Austin hospitals in Victoria, the Auckland and Christchurch hospitals in New Zealand, as well as the Mater in Queensland, the Royal Adelaide Hospital in SA and Fiona Stanley hospital in WA.

SHARED MENTAL MODEL

A principal aim of the DipPOM is for every (already highly specialised) participant to share the same mental model of perioperative medicine, which is why participants need to do every aspect of the program, even when it is very familiar to them.

This important aspect of our diploma means all perioperative medicine clinicians will provide a consistent service that is collaborative and provides seamless communication which ultimately enhances the quality of care we provide.

The diploma builds knowledge and skills across six core units of study, with participants engaging in weekly clinical experiences that link with the online learning content and assessments.

By completing a range of online, in-person and clinical learning activities and assessments, graduates of the diploma will be equipped to deliver excellence in perioperative care that align with the principles outlined in the ANZCA Perioperative Care Framework.

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

HOSPITALS AND PARTICIPANTS

From 2024 additional hospitals will be added to the nine across Australia and New Zealand already hosting the diploma. More will be added as diploma participant numbers grow in the years that follow.

Expressions of interest were sought until early October from hospitals with established perioperative services who could host all six units of study in 2024.

Once we have finalised which hospitals will be hosting the diploma for 2024, we will be recruiting participants when enrolments for trimester 1 (starting in February 2024) open on 20 November.

We will be actively encouraging physicians, surgeons and intensivists from nominated host hospitals to apply to do the diploma in 2024. We are also considering the requirements for general practitioner participation in the diploma.

More detail on dates and fees for our DipPOM in 2024 can be found on the ANZCA website.

LEADERS IN PERIOPERATIVE MEDICINE

By late September, we had received 315 applications for the DipPOM via the recognition pathway.

Of those, 217 have been approved by our Recognition Pathways Working Group chaired by ANZCA Immediate Past President Dr Vanessa Beavis. More information has been requested from 24 applicants and four have been found not to be eligible.

Amongst the DipPOM holders, there are 139 anaesthetists, 41 physicians, 29 intensivists, four surgeons, three specialist pain medicine physicians, and one rural and remote medicine specialist.

We have so far trained 23 DipPOM holders to be supervisors. A workshop was held at ANZCA House in July.

Attendees at the first supervisor's workshop in July at ANZCA House.

Dr Joel Symons presents at the first supervisors workshop at ANZCA House in July.

We are also grateful to the 50 DipPOM holders who are writing the diploma online content guided by the DipPOM Content and Assessment Working Group chaired by Dr Joel Symons.

The POM Content and Resource Review Working Group is tasked with the annual review and update of the recommendations, resources, currency of reference links and addition of new evidence with the continuing growth of POM around the world. It has now met four times.

Applications for the recognition pathway process close on 1 December 2023. GP applicants will have an extension while we finalise the criteria for this group.

KEY DOCUMENTS

Several key perioperative medicine documents have been approved by ANZCA Council and have now three been published.

These are:

- Diploma of Perioperative Medicine Handbook
- Diploma of Perioperative Medicine Course Curriculum
- Regulation 45: Education program leading to a Diploma in Perioperative Medicine
- Standards for Perioperative Medicine

The curriculum, handbook and regulation are out for further consultation and the standards consultation feedback is now being collated. The standards will be uploaded to the website soon.

PERIOPERATIVE MEDICINE EVENTS

It was good to see a number of you at Professor Guy Ludbrook's Post Operative Complications Summit II in Adelaide in July (see opposite page).

Coming up on 16 October is ANZCA National Anaesthesia Day (see page 5) where we will explain perioperative medicine to the community under the theme, "Anaesthetists: Caring for our sickest patients before, during and after surgery".

Also happening soon is the 2023 Australia-Asia-Pacific ERAS+ conference in Melbourne from 26-29 October and the Perioperative Medicine Special Interest Group meeting to be held in Brisbane from 23-25 November.

We hope to see you there.

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

DIPPOM - KEY DATES

DipPOM pilot – 4 September-17 November 2023
Pilot participants' workshop – 21 October

Trimester 1 – 12 February-28 April 2024
Enrolment period – 20 November 2023-21 January 2024
Supervisor workshop – 23 November 2023
Participants' workshop – 9-10 March

Trimester 2 – 27 May – 11 August 2024
Enrolment period – 19 February-28 April
Participants' workshop – 20-21 July

Trimester 3 – 16 September – 1 December 2024
Enrolment period – 10 June-18 August
Participants' workshop – 16-17 November

Supervisor introductory workshops will be held in November 2023, and in March, June and November in 2024.

Second summit seeks to progress perioperative medicine

Professor David Story presents at the summit.

Increasing demand for care and budgetary challenges are impacting on the ability of patients to get timely access to surgery, while complications and postoperative requirements are increasing.

However, recent and ongoing work in perioperative care has shown us that a lot can be done to address this issue, in particular, interventions that improve better outcomes for patients and the health system.

In July, Adelaide perioperative medicine leader Professor Guy Ludbrook, supported by Professor Tarik Sammour and Professor David Watters, hosted "The Hidden Pandemic of Postoperative Complications: Summit II" to address some of these issues.

It attracted attendees from professional colleges and organisations, quality and safety organisations, public and private healthcare insurers and providers, academic institutions, and consumer groups.

The summit series, which followed the first in 2020, began with a workshop and a tour of the Advanced Recovery Room Care (ARRC) facility at Royal Adelaide Hospital before being formally opened by SA Health Minister Chris Picton the next day.

Facilitated by Dr Norman Swan, the summit had a range of invited speakers including representatives from ANZCA, the Consumers Health Forum of Australia, the Victorian Perioperative Consultative Council, primary care, the Australian Medical Association, the Agency for Clinical Innovation (NSW), the Peter MacCallum Cancer Centre, University of NSW, the Australian Commission on Safety and Quality in Health Care, University of Southampton, CALHN, Private Healthcare Australia, SaferCare Victoria, NT Health, nGAGE Talent (UK), and Edwards Lifesciences.

They provided views on an ideal state for the health system, the gaps, and what might be needed to close these. The task of developing action plans was handed over to a series of focus groups on the final day.

Several key messages and suggestions were generated by the summit:

- Concern about the size and scope of the challenge was universally expressed and there were calls for a national taskforce(s) and an independent expert group to address the issue.
- System approaches were important in underpinning the solutions.
- Good data and information is essential.
- Information technology is a key component.
- A set of comprehensive perioperative standards is a priority.
- There needs to be a focus on specific activities, early postoperative care and the provision of clear evidence-based guidelines for decision makers.

Professor Ludbrook, Professor Sammour and Professor Watters are preparing a summit report to be published in the peer-reviewed literature this year. This will provide a clear summary of a range of options available to decision makers, including the development of a national taskforce to deliver on those options.

Low calorie diet clinics an effective tool in perioperative care

Queensland's Logan Hospital has a dietitian led, preoperative Very Low Calorie Diet (VLCD) clinic for non-bariatric surgery patients. Sally Griffin, an accredited dietitian and PhD candidate designed and implemented the clinic which has now been introduced to multiple hospitals and has attracted international attention. Her research focus is on perioperative care for patients with complex obesity, and she is passionate about the integral role of dietitians in this specialist area. Here she explains how preoperative weight loss and VLCDs can improve patient outcomes.

Obesity is a significant risk factor for surgical complications, leading to longer hospital stays, increased infection rates, and higher healthcare costs. Significant obesity and associated co-morbidities, such as obstructive sleep apnoea, can complicate the administration of anaesthesia through increased cardiovascular strain, difficult airway management, and reduced lung function.

Recently, there has been growing interest in the use of preoperative weight loss interventions to optimise, or "prehabilitate" patients for elective, non-bariatric surgery, particularly in the context rising obesity rates. Among these interventions, the use of very low calorie diets (VLCD) have shown to be an effective and safe method for achieving significant weight loss and improving co-morbidities in a short period (two-12 weeks) before surgery.

VLCDs are defined as calorie-restricted diets that provide ≤800 kilocalories per day and are usually rich in protein and low in carbohydrates and fats. These diets are best administered under dietitian and medical supervision and are designed to induce rapid weight loss while maintaining muscle mass. The rationale behind using VLCDs for preoperative weight loss lies in the potential to reduce surgical risks associated with obesity, such as compromised respiratory function, impaired wound healing, and cardiovascular complications.

Few studies have investigated the effectiveness of VLCDs in *non-bariatric* surgical settings, despite the multitude of research on bariatric surgery. One study was undertaken to examine the impact of dietitian led VLCD on preoperative weight loss for gynaecology, general, colorectal and orthopaedic surgery. The results of this study indicated that a preoperative dietitian led VLCD Clinic achieved clinically significant weight loss, sufficient weight loss to facilitate elective surgery for most patients, and the approach was feasible, highly valued by patients and surgeons, and resulted in perceived surgical benefits, including shorter and easier surgeries [1].

The use of VLCDs as a preoperative weight loss strategy has also been shown to improve surgical access in patients with excess visceral and pelvic adipose tissue. For instance, gynaecological and urological surgeries can be particularly challenging when patients have increased adiposity in the pelvic region, and positioning these patients can be more difficult due to their body size and can increase pressure on the airway. By effectively reducing pelvic fat mass through VLCD, we can potentially benefit from easier airway management, surgical visualisation, and ease of critical structure identification.

Furthermore, weight loss can improve anaesthesia response in surgery by reducing the physiological stress on the cardiovascular and respiratory systems. A lower body weight and decreased adipose tissue can lead to more predictable drug dosing, and reduced risks of anaesthesia-related complications, ultimately enhancing patient safety during surgery.

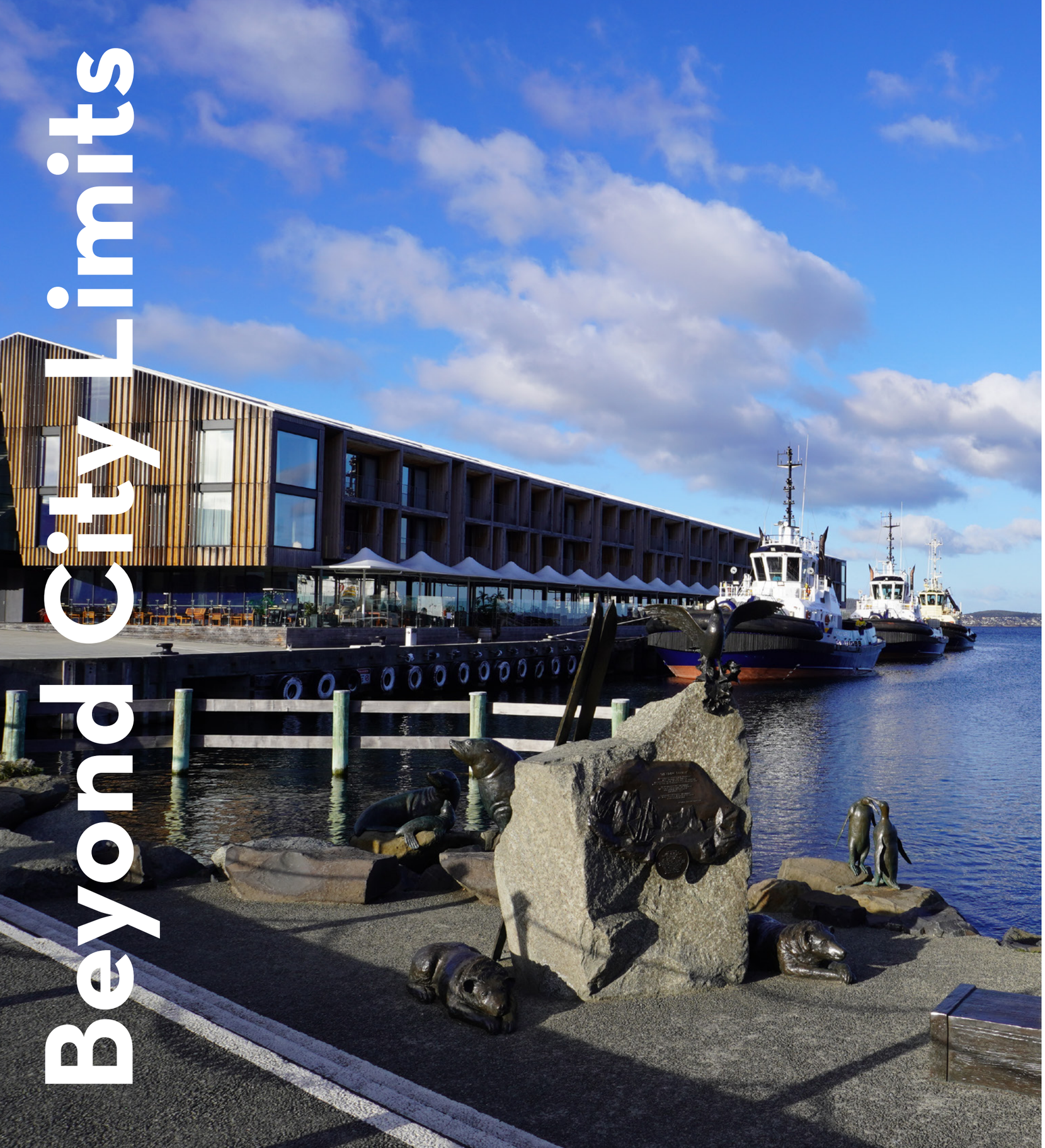
In conclusion, preoperative weight loss using VLCDs presents a promising strategy for optimising surgical outcomes in non-bariatric surgery patients. The significant reductions in body weight without compromising lean body mass, improvement of obstructive sleep apnoea, and potential benefits in improving surgical access in specific procedures indicate the potential efficacy of dietitian led VLCD interventions.

However, larger well-designed randomised controlled trials are warranted to further investigate the impact on outcomes of elective surgery. With continued research and integration of evidence based VLCDs, surgeons, anaesthetists, and perioperative care professionals can enhance patient outcomes and quality of care in the preoperative setting.

Sally Griffin, Senior Complex Obesity Dietitian
Logan Hospital, Queensland

References:

1. Griffin SB, Ross LJ, Burstow MJ *et al.* (2021) Efficacy of a dietitian-led very low calorie diet (VLCD) based model of care to facilitate weight loss for obese patients prior to elective, non-bariatric surgery. *Journal of Human Nutrition and Dietetics: the official journal of the British Dietetic Association* 34, 188-198.



Supportive approach gives training in Tasmania the edge

"It's that sense of home, that sense of belonging and being part of a community in a beautiful place that is so important."

Dr Bing Chang's introduction to Hobart was when she visited the city from Malaysia as a tourist with her family. With its crisp clean air, stunning scenery and bustling food scene the city made such an impression that she decided to return and enrol in medicine at the University of Tasmania.

The anaesthesia registrar at Royal Hobart Hospital plans to head to Launceston next year for her provisional fellowship through the Tasmanian Anaesthetic Training Program (TATP) once she passes the ANZCA final exam.

The program provides anaesthesia training at all three Tasmanian Health Service (NWRH) hospitals – Royal Hobart, Launceston General and the North West Regional Hospital in Burnie. It has 30-35 positions each year including up to seven provisional fellowship positions.

Dr Chang reflected on her anaesthesia training in Tasmania when the *ANZCA Bulletin* visited the state recently as part of its Beyond City Limits series. She is nearing the end of her training through the Integrated Rural Training Pipeline initiative (IRTP), an extension of the Commonwealth-funded Specialist Training Program (STP).

Consultants, heads of department, supervisors of training (SOTs) and trainees all highlight the collegial and supportive approach to training in the state through the TATP. The bonus of beaches, mountains, food, wine and culture is increasingly becoming a significant drawcard for trainees and consultants wanting to live and work in Tasmania.

Dr Chang thought the first year of her TATP training at the start of the 2020 hospital year would be straightforward and uneventful. As a first-year trainee she had been placed at the NWRH, a 160-bed regional hospital providing health care and specialist services to North West Tasmania and King Island. Within a few weeks of starting her training the COVID-19 pandemic was under way and she and her colleagues were forced to isolate for two weeks when the hospital was closed for a deep clean.

Once the hospital reopened Dr Chang was able to continue her introduction to anaesthesia training in Burnie, learning the basics of anaesthesia needed for general surgery through to ear, nose and throat surgery.

"Being able to progress through the three hospitals in Tasmania has meant I have been exposed to a variety of specialties – cardiac, neurosurgery, major trauma, obstetrics and paediatrics. The advantage is that you get to stay at the one hospital for either a year or two years depending on where you are in your training."

"Everyone at all three hospitals has been so supportive. Here in Hobart we are a relatively small department compared to other states but this means we all know each other well."

According to specialist anaesthetist Dr Lia Freestone, Chair of the TATP and an ANZCA Rotational Supervisor at Royal Hobart Hospital, the Tasmanian program is unique because all

trainees are included in and supported by the TATP and are assured of structured generalist training and dedicated exam support across the state's three hospital sites.

"We really are blessed in Tasmania. It's not only a beautiful place but the anaesthesia training in Tasmania is quite special. The Tasmanian Anaesthetic Program has been in place since 2009 and it is one of the few, arguably the only rotational training program that provides one program for the whole state, for all trainees and that is unique," she explains.

"Every trainee in the state and the three training sites are all looked after by the TATP and the program provides all their training requirements -- all their clinical time and all their volume of practice -- but it also provides other important needs such as support and collegiality. The level of consultant engagement also makes the training program stronger.

"It's these things – support, collegiality, wellbeing and our strengths as a small intimate program where we know you really well and you know us really well. This means we can customise the approach to training, including flexible training options as you need them so we can look after you as an individual, not just as an ANZCA trainee. That aspect of our program is very special."

Dr Freestone has lived in Tasmania for most of her life.

"The outdoors here are wonderful. We've now got this fantastic food and wine culture and boutique arts, music and theatre scene. I grew up here, it's home, it's a great place for my kids to go to school. I did a lot of my training interstate but we always knew we were coming home. It's that sense of home, that sense of belonging and being part of a community in a beautiful place that is so important."

Dr Freestone believes the anaesthesia trainee exam results speak for themselves with the TATP trainees often performing well above average compared with other states and territories. And she says the support from the state's hospitals' heads of department, SOTs and the Tasmanian consultant body has helped make the TATP such a success.

"We ensure that targeted exam support is provided to trainees and the consultants are heavily engaged in the process too. It means we can optimise and tailor support for all our trainees."

Dr Freestone says many trainees are Tasmanian born and bred and this can often be a factor in them deciding to stay on as consultants after they are admitted to fellowship.

In Burnie, at the North West Regional Hospital, SOT Dr Greg Bulman says trainees have direct access to consultants. Basic training is completed over two years in Burnie and Launceston and then advanced training is completed in Hobart.

"The program here provides trainees with the volume of practice they need and one of the big advantages of working here is that I know all our trainees very well. Our training empowers the registrars to take on responsibilities they might not get in other training programs.

"The other states and territories have independent trainees but here in Tasmania we work very hard as it is an integrated system. You are guaranteed to get your volume of practice through a complete training program.

"Being a generalist doesn't suit everyone but here in Burnie our trainees are given a broad range of exposure to anaesthesia that they would not get anywhere else."

Dr Bulman, from the UK, has lived in Burnie for the last five years with his partner, also an anaesthetist. After completing his anaesthesia training in Melbourne he first moved to Burnie as a locum anaesthetist for four weeks. He enjoyed the work and the location so much that he decided to stay on.

Activities such as bushwalking, hiking and water sports provide much needed relief away from the hospital. Dr Bulman lives 20 minutes from Burnie on a five-acre block and his daily coastal drive commute involves views of the ever-changing Bass Strait.

"While I loved my own training experience (three months in paediatrics and three months in obstetrics for example) I decided I didn't want to sub-specialise as I like doing different things. In a smaller hospital such as Burnie you get to know your bosses really well and it means you get access to a complete training program."

"We ensure that targeted exam support is provided to trainees and the consultants are heavily engaged in the process too. It means we can optimise and tailor support for all our trainees."

The head of the anaesthesia department at Royal Hobart Hospital, Dr Ruth Matters says it is hoped a recently ratified three-year enterprise bargaining agreement between salaried medical practitioners and the Tasmanian government will encourage more specialists to live and work in Tasmania. The new deal means pay rates in the public system in Tasmania are now competitive with Victoria.

"We expect the new award will make a difference to long term consultant interest in Tasmania," she explains. Previously we found that most people who work here longer term are either trained here, grew up here or their partners are from here. This does mean we work with staff we have trained with, but we look forward to more anaesthetists becoming interested in working with us.

"Irrespective of that, though our TATP has always had huge interest and is a great success."

Dr Matters, a paediatric anaesthetist who, like Dr Freestone grew up in Hobart, leads a department of 100 consultants, registrars, residents and acute pain nurses.

"The RHH is a great place to work for lots of reasons. Longer term it means that as a consultant member of staff you get a broad range of patients that you can care for every day – ranging from small babies to the 90-year-old very sick patient, and obstetrics to neurosurgery.

"It's not only great for our consultants but also good for our trainees who get an ongoing exposure to a very broad range of cases during their traineeship.

"We try and care for our staff as a high priority. Our department is so collegial and supportive so no one feels isolated. We really are like a big family.

"We place a significant emphasis on ensuring all our consultant staff have equal access to the clinical work they are interested in. This includes our new consultants who are allocated work they want to do, which keeps them happy in their employment. Everyone here is given a fair share of all the things they want to do and we try and avoid things they don't like doing. That's really a priority for us," she says.

"We very much value the work that people do in their clinical support time as this contributes to developing our department and the perioperative services in the hospital. We protect this time and it's rare that we would pull people off their clinical support time."

Launceston anaesthetist Dr Bruce Newman chairs ANZCA's Tasmanian Regional Committee and is one of Launceston General Hospital's SOTs. Dr Newman grew up in Tasmania and decided to start anaesthesia training after working as a paramedic in Hobart in the early 1990s. He believes the close-knit nature of anaesthesia training in the state benefits both trainees and consultants.

Speaking to the *Bulletin* in the anaesthesia department during a break from a urology list, Dr Newman says connections to the state are often significant considerations for trainees and consultants when making work and lifestyle decisions.

"Nothing is too far away and here in Launceston Cradle Mountain is less than two hours away and Cataract Gorge is a 10-minute drive from here. We get beautiful, clear crisp winter days here and the climate here during summer is never too hot.

"Most people who come here will have a connection or some sort of other link here. When they do move here they see the true benefits of working in a smaller hospital and community. You know everybody and those interactions can be very positive.

Image left: Tasmanian anaesthetic training program trainees, (from left) Dr Bing Chang, Dr Dr Sandeep Sidhu and Dr Ben Rose

Image above: Dr Bruce Newman and Dr Ben O'Sullivan at Launceston General Hospital

Image left: Launceston's Cataract Gorge is a popular scenic spot for locals and tourists.

Image below: Launceston anaesthetist Dr Joanne Samuel

"The clinical work is very broad. While we are a generalist hospital a lot of people do have a specialty interest which may range from regional anaesthesia to paediatrics or pain and there are opportunities to develop these as well.

"We have a smaller number of trainees and that allows us to know them really well. We have a positive record for trainees sitting their primary exam and supporting them through that. We are aware of the pressures on trainees and consultants and we have to keep an eye out for burnout and general wellbeing issues."

Fellow Dr Joanne Samuel is also an SOT at the hospital. As a first-year consultant she was appointed co-convenor of the 2019 ANZCA Annual Scientific Meeting in Kuala Lumpur.

After completing her medical degree in the UK, Dr Samuel visited Tasmania on holiday with her husband, an obstetrician, and applied for an anaesthesia training post.

"While we are a regional hospital we get exposure to all specialties apart from cardiac anaesthesia and neuro anaesthesia. There is a slight misconception that we are a small country town but we actually do quite a lot of major surgery including upper gastro-intestinal surgery. We have some subspecialties that keep the flavour of work very interesting on a daily basis.

"We have about 30 staff specialists and visiting specialists, everybody knows everyone. The teams in theatre are people that you work with day in and day out so you are familiar with everyone. This really comes together especially when we are in crisis situations where that team work really means a lot."

The easy lifestyle and short commuting times are important for Dr Samuel and her family. "I can be at work in 10 minutes after dropping my son off at school. Living here, your children get to enjoy their extracurricular activities and it's a great place to live if you are a foodie. Being from Malaysia that is a big plus for me and it is also a beautiful place with access to cycling and bushwalking. Everything is pretty much an hour's drive from where we live."

Dr Freestone echoes Dr Samuel's comments and highlights the success of the TATP.

"The TATP is a wonderful, inclusive, holistic training program that caters for the needs of all trainees in Tasmania, provides pre-vocational and vocational opportunities, transition to satisfying specialist work in all regions of the state and really punches above its weight for clinical experience, academic success, collegiality and wellbeing and importantly the lifestyle and work-life balance offered by our awesome state."

Carolyn Jones
Media Manager, ANZCA

The view from Tasmania

The Tasmanian Anaesthetic Training Program is Australia's only state-wide anaesthesia training program.

There are between 35-40 trainees from all training years, across three hospitals, who receive coordinated and integrated training.

Dr Ben O'Sullivan, provisional fellow Launceston

Dr O'Sullivan grew up in Victoria but moved to Tasmania with his wife, a Launceston GP. With their three-month-old baby they have settled in Launceston and Dr O'Sullivan hopes to stay on as a consultant.

"The benefits here are that you are working in a smaller community with a smaller department so you form relationships with colleagues and the department very quickly. I'm still getting the same breadth of practice when I was working in Melbourne but just not the quantity. You might see a one-year-old baby requiring plastic surgery and then a 96-year-old needing a hip replacement all in the same day."

Dr Sandeep Sidhu, advanced trainee (AT-1) Hobart, a member of ANZCA's Tasmania Trainee Committee

Dr Sidhu moved to Hobart this year from Launceston and is preparing for the final exam in March next year.

"The Tasmanian program focuses trainees on becoming a generalist. It teaches a really strong sense of adaptability and that goes a long way not only in work but also in life as it means you are better at adapting to different situations and having mental fortitude. The supervision by the bosses here is excellent and the department ensures each trainee gets the volume of practice they need."

Dr Nico Reeve, trainee, Royal Hobart Hospital

Dr Reeve grew up in Hobart.

"It's a good statewide teaching set-up for both the part 1 and part 2 exam because everyone has worked across all the hospitals in Tasmania. All the consultants who do the lectures know who you are and it's a good sized group for learning and interaction.

"The lifestyle is great here. You're still working in a tertiary centre but with access to the big four: beaches, mountains, good food and wine."

Associate Professor Deb Wilson, ANZCA councillor and Director of the Tasmanian Rural and Regional Postgraduate Training Hub.

Associate Professor Wilson moved to Burnie 25 years ago after meeting her Tasmanian-born husband while studying medicine in Western Australia. She completed a provisional fellowship year in Canada and is a former head of the department of anaesthesia at NWRH in Burnie.

"I first worked in Burnie when we had no statewide training program and each Tasmanian hospital would recruit their own registrars. Back then, we recruited some amazing registrars to Burnie but we were unable to offer them a pathway. It meant that many of those trainees ended up leaving the state. There was an increased turnover of trainees and it was more difficult to recruit consultants.

"The Tasmanian training program has made a big difference to the calibre of the registrars and it has also improved the registrars' experience because in a rural area you do a bit of everything. The program is committed to making sure the trainees can meet all the training requirements. They also know they will spend at least one year outside Hobart in either Burnie or Launceston.

"We established statewide teaching, especially for the primary exam, using a virtual format well before the pandemic. Because it is a co-ordinated program it allows us to think about what we are trying to achieve. The Tasmanian training program aims to build a workforce for Tasmania and has specific selection criteria to help achieve that aim.

"The other bonus for Burnie and Launceston is that the rotation ensures the registrars have rural experience so even if they don't end up working in a rural area and instead end up back in Hobart it gives them and others they work with a better understanding of the challenges of rural practice."

ANZCA grant success

A new grant provided under the Australian Specialist Training Program has enabled ANZCA to fund a part-time Tasmanian project officer for two years in Hobart.

Rebecca Harding has started her new role and is about to move into the college's new Hobart office in Elizabeth Street.

ANZCA has been successful in its application for the Tasmanian Anaesthetic Simulation, Education and Training Network (TASETN), which seeks to address maldistribution in training equipment and teaching capacity across the state.

The Flexible Approaches to Training in Expanded Settings (FATES) grant funds ANZCA to lead a new project in Tasmania that will benefit the local community. Through the Tasmanian Health Service, Royal Hobart Hospital, Launceston General Hospital, North West Regional Hospital and the University of Tasmania Rural Clinical School the project will extend and develop resources for the delivery of anaesthesia education and training with a focus on simulation-based learning.

ANZCA will work with the project partners to:

Purchase and install simulation equipment at the three consortium hospital member sites to support equitable access to training equipment.

- Develop simulation skills training for educators.
- Deliver simulation skills workshops to educators at the three consortium hospital member sites.
- Train simulation leads and new educators to deliver training on simulation equipment.
- Provide funding for protected clinical time and administration support.

This project will benefit not only ANZCA trainees and supervisors but also trainees in intensive care, emergency medicine, surgery, nurses, junior doctors, health support workers and medical students that rotate through our hospitals.

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College bursaries

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

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

Applications for 2024 will open in mid-November.

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

Applications close 26 January 2024.

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

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Steuart Henderson Award

Nominations are being received for the 2023 ANZCA Steuart Henderson Award: awarded to a fellow who has demonstrated excellence and provided outstanding contribution, scholarship and mentorship to medical education in the field of anaesthesia and/or pain medicine. All fellows of ANZCA and FPM are eligible for the award.

For nomination information including eligibility criteria visit the ANZCA website.

Nominations close
15 February 2024.

Anaesthetist takes centre stage for trauma care

Hobart anaesthetist Dr Adam Mahoney, Director of Trauma at the Royal Hobart Hospital, grew up in Perth before moving to NSW with his family for school. He moved to Tasmania in 2011 as an intern after his wife Brita, a GP, moved to the state to complete her medical degree. He started training in 2013 and spent two years in Burnie as part of his training. He says fellows can have a diverse anaesthesia practice in Tasmania including supporting global outreach programs and working with the Australian Antarctic Division.

Director of Trauma at the Royal Hobart Hospital, Dr Adam Mahoney.

Dr Adam Mahoney sometimes likens his role to that of an orchestra conductor.

The Director of Trauma at the Royal Hobart Hospital is driving a new model of care in Tasmania that aims to not only improve the patient journey but also recognises the importance of a multi-disciplinary approach to patient care.

His department is the first port of call for trauma cases at the hospital. The trauma team, most of whom are emergency physicians and nurses, admit patients and identify their injuries before directing them to a relevant sub-specialty such as neurosurgery, orthopaedics, geriatrics or rehabilitation medicine.

"Anaesthetists are natural co-ordinators so in some ways conducting the trauma orchestra really is similar to my role as an anaesthetist running the floor in theatre," he says.

Dr Mahoney has been in the role since 2019 and he splits his time as director of the specialist in-patient trauma unit with placement on the on-call roster of anaesthetists. He is also a full-time military medical specialist in the Australian Defence Force and says his experience and training as an anaesthetist and intensivist (he is completing a fellowship in intensive care medicine) is crucial for deployments.

For several months in late 2020 he was posted to Baghdad where he was embedded with a US military unit at an American hospital.

"My time in Iraq encouraged me to enhance my intensive care skills so I can practice outside of my main specialty if needed," he explains.

In addition to his clinical work Dr Mahoney is about to take on a new role as an ANZCA primary examiner. When the *Bulletin* caught up with him recently in Hobart he was about to take parental leave for the birth of his third child.

"Here in Hobart we see about 250-300 major trauma patients each year, mostly adults, but also some paediatric cases. Patients come from all over the state, they may come directly to the Royal as aeromedical retrieval cases from car, farming or hiking accidents or they have been transferred from North West Regional Hospital or Launceston General Hospital after receiving initial care at a regional trauma centre.

"Our patients may have multiple or complex injuries, or they may be older, frail patients who have fallen or been struck as a pedestrian."

"Anaesthetists are natural co-ordinators so in some ways conducting the trauma orchestra really is similar to my role as an anaesthetist running the floor in theatre."

Dr Mahoney, who is a member of the board of the Australian and New Zealand Trauma Society, says there is a strong history of anaesthetists working seamlessly in hospital trauma teams. Half the Hobart team are nurses including a nurse manager and a clinical nurse consultant.

"Doctors don't have all the answers so the contributions of other non-medical craft groups are very important," he says.

"Anaesthesia is closely aligned with trauma care. Anaesthetists tend to the similar needs of patients in the perioperative period as trauma specialists and they of course also work in theatre during surgery to optimise patients in their post-surgical recovery."

The busiest time for the trauma unit is during summer when there is an influx of tourist and adventure seekers who travel around the island for bushwalking, biking and driving (often on unfamiliar roads.)

After setting up the trauma unit with nurse Clare Collins (now trauma program manager) Dr Mahoney helped establish Tasmania's first trauma registry. A clinical data co-ordinator was employed to build a business case for service expansion and three trauma nurse managers were also brought in. The registry allows for benchmarking against hospitals in Australia and New Zealand.

"If you're injured, your journey through hospital can at times be chaotic and quite confronting. Victims of trauma very often need a lot of special care involving nurses and allied health staff. You might see 30 different faces in the space of a few days so it's important that you have a case manager who can follow you through. Having a dedicated trauma team looking after a trauma patient can make a huge difference to recovery," Dr Mahoney explains.

"Trauma is a team sport so if you're an anaesthetist your skills are recognised and you in turn benefit from the experience of others in the team. Being an anaesthetist gives you a lot of insight into how the different surgical teams work with each other.

"In trauma, you also get a real insight into the work of geriatricians and other physicians and this gives you scope to expand your collaboration with other specialties in the perioperative period too. It also leads to better integration with GPs post-discharge and this in turn affects the quality of life for the patient after they have left hospital."

Dr Mahoney says he has been encouraged by the positive feedback from patients and hospital administrators regarding the Hobart trauma model with its emphasis on patient-centred care.

"The trauma community in Australia and New Zealand is quite small, and we have been inspired by the work of other hospital trauma teams including those at the Gold Coast University Hospital and the Alfred Hospital in Melbourne.

"What we now want to do is examine the impact on patient length of stay and the rates of preventable adverse events as part of the Tasmanian trauma registry."

Dr Mahoney is working on a collaborative research project with the University of Tasmania to better understand patient recovery experiences, particularly the outcomes for older trauma patients who often have other complex chronic conditions.

"In Tasmania we can focus on research that answers questions relevant to our local community. We may not do large clinical trials because of the small population but we can gain a better understanding of the patient experience and then translate that to better clinical practice."

Dr Mahoney would like to expand the trauma registry model to Launceston and North West Regional Hospital, as he notes the number of hospitals with a dedicated trauma service is growing.

He says many developments in anaesthesia and trauma care over the last decade have been "game changers" for patients. These include regional anaesthesia and pain relief for people with chest fractures. Drugs that prevent blood clots and the use of blood products for haemostatic resuscitation have also provided significant benefits for patient recovery along with the development of interventional radiology and point-of-care ultrasound to detect significant organ injuries.

Dr Mahoney in his other role with the Australian Defence Force. Photo supplied.

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Call for abstracts

NOW OPEN

KEY DATES

Program available
Mid November 2023

ASM Registrations open
Late November 2023

Abstract submissions close
21 January 2024

Abstract notification to authors
Early March 2024

FPM Symposium
3 May 2024

ANZCA ASM
3 -7 May 2024

What's more rewarding than showcasing your research at Australasia's premier anaesthesia meeting? The 2024 ANZCA ASM will be attended by over 2000 delegates in the country's fastest growing capital, the 'summer always' Brisbane!

"I look forward to receiving submissions that signify the limitless potential of this field, in the operating room and beyond, as perioperative physicians, healthcare leaders, administrators, environmentalists, health informaticians, and health economists. I encourage submissions that have innovative and inspiring ideas, leading us into the future of anaesthesia."

Dr Usha Gurunathan,
Abstract and ePoster Convenor

LIMITLESS

ANZCA ASM 2024 3–7 May, Brisbane

Safety and quality

Neural connector changeover update

The International Standard *ISO 80369-6:2016 Small bore connectors for liquids and gases in healthcare applications – Part 6: Connectors for neuraxial applications* was introduced with the aim of reducing erroneous, harmful administration of fluids via intrathecal, epidural and other neural routes and reducing erroneous administration of substances intended for neural routes to other sites.

Back in 2017, ANZCA and the Australian Commission on Safety and Quality in Health Care published a joint statement recommending that medical devices incorporating small-bore connectors be adopted in Australia as part of this global initiative to improve patient safety.

Manufacturers are now producing devices with ISO 80369-6 compliant connectors for neural applications, and we have foreshadowed that production lines of devices not incorporating these connectors will be shut down, and thus Luer equipment will stop being supplied at some point.

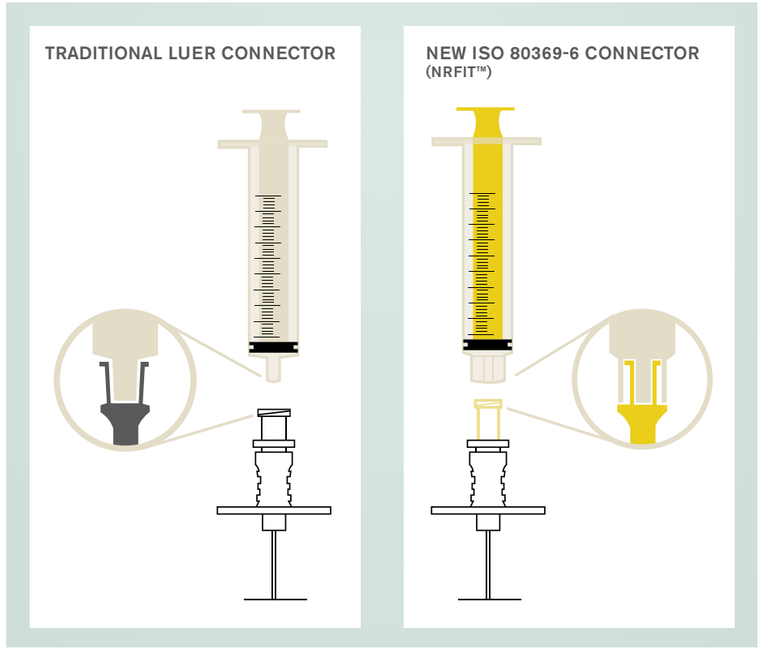
There is still some uncertainty about the certainty of global production and supply chains being able to supply to the Australian and New Zealand market, and this was likely exacerbated by a shift in focus to supply products required to respond to the COVID-19 pandemic.

The changeover to ISO 80369-6 compliant devices is obligatory although the timeframe is still undetermined. The current situation in Australia is that timelines will not be imposed on implementation and health services are being advised to implement according to local requirements.

Neural, including neuraxial, devices with connectors are required to be compliant with ISO 80369-6: 2016 and safe implementation must be carefully planned. The implementation of a changeover of neural connector devices requires both clinical and procurement involvement within health service organisations.

Resources

We have collated a comprehensive collection of ACSQHC advisories, articles, publications, and case studies relating to the changeover from Luer devices to ISO 80369-6 devices in our NRFit Changeover Library Guide, including a fact sheet for practitioners. Go to www.anzca.edu.au/safety-advocacy/standards-of-practice/neural-connector-changeover



How the connectors will change.

Procedural sedation for people with an intellectual disability

ANZCA's Safety and Quality Committee Chair Associate Professor Joanna Sutherland represented the college at a roundtable discussion on 25 July, chaired by the Australian Assistant Minister for Health and Aged Care, Ms Ged Kearney. Here, Associate Professor Sutherland explains how the roundtable explored better pathways to procedural sedation for people with intellectual disability.

BACKGROUND

The National Roadmap for Improving the Health of People with Intellectual Disability is overseen by the Roadmap Implementation Governance Group (RIGG). The RIGG has highlighted the need for better pathways to procedural sedation for people with intellectual disability so they can access the health care they need. Care which is currently being foregone for some vulnerable people (who may be unable to accept interventions without sedation) includes vaccination, blood tests and diagnostic procedures, as well as some aspects of self-care. The COVID-19 pandemic saw better access to procedural sedation in some states, including Victoria and NSW.

Current pathways to access procedural sedation are inconsistent and often only available at the discretion of individual health care providers. This issue is pervasive across all stages of life, with limited pathways in paediatric hospitals, and fewer services available for adults. The inability of patients to access the health care they need contributes to health care inequity in this population.

Some examples of best practice pathways to procedural sedation include:

- Westmead Hospital (NSW): Operates as a multi-disciplinary, coordinated day-admission service in the existing mainstream health care system for patients with complex disabilities. This clinic was featured earlier this year in 'Minding the gap' on the national ABC *7.30* program.
- Monash Health / Centre for Developmental Disability Health (CDDH) (Vic): an investigation under sedation model was piloted for patients with complex needs. This involved conducting blood tests, immunisations, imaging, and oral health reviews. During the COVID-19 pandemic, patients were assessed and an individualised care plan was developed to assist them to access health care. This helped decrease the use of pharmaceuticals.

Initiatives such as disability liaison officer (DLO) programs can help support people to access and navigate these pathways. These officers are mandated in NSW local health districts but may be required to cover large populations and distances, and in practice are not accessed by many primary care providers.

ROUNDTABLE PRESENTATIONS

The group heard from people with lived experience of the barriers to access for patient-centred care, including from Luke Nelson, policy officer, Inclusion Australia and Dariane McLean, senior policy officer, Inclusion Australia and mother of Hayden McLean. These experts highlighted:

- The importance of *reasonable adjustments* and supported decision making to improve access to health care, and
- How access to sedation enables people to access the health care they need.

The roundtable also heard from Chris Nelson, senior service manager, SA Intellectual Disability Health Service (SAIDHS) who gave a brief presentation on pathways to access sedation in primary care and hospital settings, and current challenges.

I then gave a brief overview of the ANZCA guidelines addressing procedural sedation *(PG09)* including outside hospital settings, describing the risk framework and safety considerations involved. We noted that sedation and anaesthesia form a continuum, and that risk increases with the depth of sedation, and also includes patient specific factors.

I also emphasised that the risk related to sedation was not necessarily related to the procedural risk, and that's how you can get to the situation where patients (especially children) are often required to travel considerable distances for relatively minor procedures, in order to access the skills and facilities they need.

DISCUSSION

1. Reasonable adjustments

There was much discussion about "reasonable adjustments" in the context of trying to avoid the need for sedation wherever possible.

The Australian Commission on Safety and Quality in Healthcare explanation for reasonable adjustments is here: https://www.safetyandquality.gov.au/our-work/intellectual-disability-and-inclusive-health-care/reasonable-adjustments

Reasonable adjustments can include allowing people to wait in a quiet space or providing information in plain English.

Suggestions for reasonable adjustments can come from the person with disability, a family member, a support worker or disability professionals, for example a behaviour support practitioner.

In practice, ANZCA incorporates concepts similar to "reasonable adjustments" in *PG09*. In particular, we acknowledge that children might become distressed by many staff, so it may be reasonable to keep staffing numbers to a minimum. We also note that provision of oxygen prior to sedation is ideal, but that it may not be achievable in people with an intellectual disability (due to patient distress).

2. Patient-centred care

There was discussion about people with intellectual disability being kept for "mandatory" recovery times in post-anaesthesia care units (PACUs) and the distress that this produces for patients/carers and staff. ANZCA *PS04* encompasses criteria-based discharge from PACUs, and the move from time-based to criteria-based discharge from PACUs may be an area which departments could consider reviewing and updating where appropriate.

Other issues discussed were the importance of supported (rather than "shared") decision making, with the preference for patients/carers having input into the level of sedation offered (and including patient-centred reasonable adjustments so wherever possible, sedation can be avoided). That lead to some interesting discussion about risks, and in particular risk tolerance and the need to avoid assumptions (from both patients and providers).

3. Local pathway development

Much of the group discussion covered the need to develop local sedation pathways, based on the tiers of support outlined below, and the desirability to avoid hospitalisation wherever possible. Health Pathways was nominated as the ideal local process which brings together primary and acute care, both as a means of developing local relationships and pathways, and a platform to share information. Some anaesthetists in Australia and New Zealand have already been involved in this kind of pathway development work (mostly unrelated to sedation), and sedation pathway development for communities is clearly much needed.

Tier 1 – Minimal support (non-pharmacological/reasonable adjustments)

Patients who need some support to access health care without pharmacological support. Patients may be supported by a low sensory environment or with other reasonable adjustments. This could include a support plan with individualised strategies.

Tier 2 – Minimal support (pharmacological)

Patients who require oral sedation/anxiolytic (medication to reduce anxiety) in combination with other non-pharmacological strategies. This could be administered by a GP in a primary care setting, clinical staff in a hospital setting, a dentist, or a support person.

Tier 3 – Moderate support

Patients who require increased sedation but are not admitted to hospital. Though examples of services providing this level of care are limited, moderate support sedation may occur in purpose designed community clinics or hospital outpatient clinics with relevant protocols and oversight, in combination with other non-pharmacological strategies

RIGG Working Group members with experience in this space have advised that conscious sedation can be administered through various routes. This level of sedation must be administered in a setting where clinical monitoring is available and there is the ability to provide resuscitation if required.

Tier 4 – High support

Patients who require a high level of support including deep sedation or general anaesthesia in combination with other non-pharmacological strategies. This level of sedation requires patients to be admitted to hospital and is dependent on theatre time being available.

Associate Professor Joanna Sutherland, FANZCA
Chair, ANZCA Safety and Quality Committee

Inadvertent spinal administration of tranexamic acid

The use of tranexamic acid has increased globally to reduce the incidence of deaths related to post-partum haemorrhage[1]. The implementation of this World Health Organization recommendation has exposed an unanticipated risk associated with the increased use of tranexamic acid[2].

Tranexamic acid is a potent neurotoxin. Inadvertent intrathecal administration results in refractory seizures, in association with massive sympathetic stimulation, with a mortality rate of 50%[3]. Between 1960 and 2018, 21 cases of inadvertent intrathecal injection of tranexamic acid were reported, sixteen of these occurring after 2008[4]. Twenty of the cases had life-threatening complications and 10 were fatal[4]. In all 20 cases, ampoule error was responsible[4].

Following these reports, drug safety alerts were issued by the US Food and Drug Administration and the World Health Organization. In February 2023, ANZCA also issued a safety alert[5]. Early cerebrospinal fluid lavage has been described as successful in some cases; however, management of intrathecal administration of tranexamic acid remains largely supportive, requiring ventilation and control of seizures, hypertension and arrhythmias[3].

In anticipation of its use at caesarean delivery, tranexamic acid ampoules are now frequently stored in the anaesthetic drug trolley in the operating room. The risk is that tranexamic acid may be mistaken for a spinal anaesthetic drug and injected intrathecally before caesarean delivery. This drug error risk is heightened by the similarity in shape and size of the ampoules containing tranexamic acid and those containing drugs used for spinal anaesthesia (for example, hyperbaric bupivacaine) [figure 1].

Commonly used, 0.5% hyperbaric bupivacaine is currently available in 4mL vials in sterile packaging, which may limit substitution errors. Tranexamic acid is available in 5mL and 10 mL ampoules, with the 5mL ampoule similar in shape to the 4mL preparations of hyperbaric bupivacaine. In a climate of frequent supply-chain disruption, clinicians must be aware of the potential for this catastrophic medication error. The risk also exists in other surgical settings such as arthroplasty, where spinal anaesthesia and tranexamic acid are both commonly administered.

A recent analysis of caesarean delivery incidents entered into WebAIRS revealed no cases of intrathecal administration of tranexamic acid during the years 2009–2022[6]. A substitution error that involved tranexamic acid was reported, however. We recommend anaesthetists and anaesthetic assistants are made aware of the risk of inadvertent intrathecal administration of tranexamic acid. Hospitals and health networks should have policies facilitating the separate storage of tranexamic acid and medications intended for intrathecal use. Anaesthetists should check medications with another clinician when preparing medications for intrathecal administration and follow local guidelines regarding user-applied labelling of medications[7].

Dr Nicole Sheridan, Professor Victoria Eley
Obstetric Anaesthesia Special Interest Group

Ampoules that look similar risk serious drug errors

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Anaesthesia-related deaths

Death following colonoscopy

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

CASE 3: GENERAL SURGERY

An 81-year-old male admitted for colonoscopy investigating PR bleeding.

Background history

Ischemic Heart Disease. Interstitial lung disease, moderate pulmonary hypertension, Type 2 diabetes mellitus.

Anaesthetic details

The patient was given Propofol TCI (target-controlled infusion) for the procedure - 2-3 µg/ml. During the procedure the patient started to desaturate, and bile-stained secretions were noted in his mouth. He then proceeded to cough vigorously. Saturations dropped to 80%.

The procedure was terminated and the anaesthetic ceased.

In recovery a chest X-ray revealed left lower lobe opacity and the patient was showing signs of labored breathing.

A trial of non-invasive ventilation failed to improve oxygenation, so he was intubated.

In intensive care ARDS was noted.

He failed extubation a few days later and was reintubated, but despite maximal support and prone ventilation, he died 10 days after his procedure.

Learning points

- Aspiration is a risk with procedural sedation.
- Aspiration can occur in fasted patients and patients need to be assessed based on their individual risk.
- Being aware that this can occur during the procedure and having a plan to manage it when it does happen is important.
- Waking the patient up or intubating them at the time of the event are both suitable options depending on the degree of suspected aspiration and patient condition at the time.
- When using TCI, the actual dosage given to achieve plasma and then maintain effect site concentrations, can accumulate to be quite large over time. It is important to be aware of this.

Source:

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

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

Never, rarely, sometimes, always... glycine and the anaesthetist

Although many anaesthetists may not have encountered glycine irrigation fluid in clinical practice for some years, we have been reminded by recent reports of adverse events that "it's still out there".

Glycine has been used for irrigation for trans-urethral prostate surgery since 1948. For many years it was considered the ideal irrigating fluid, as it was cheap to produce, with good optical properties and poor conductivity (important when combined with monopolar diathermy). As an endogenous amino acid, it was regarded as innocuous in the early years of its use.

However, glycine, as those of us "of a certain age" will recall (after being well-drilled for various ANZCA examinations) has its own problems – both direct glycine toxicity when absorbed in large volume, and the risk also of exacerbating dilutional hyponatremia (thought to be due to direct stimulation of vasopressin/ADH by glycine).

Symptoms of direct glycine toxicity can include confusion and visual disturbance. Transurethral resection of the prostate (TURP) syndrome (attributed to direct absorption of large volumes of hypo-osmolar fluid) results in acute hypervolemia and (typically) hyponatraemia, presenting with ECG changes, nausea and vomiting, confusion, convulsions, coma and cardiovascular collapse.

Both glycine toxicity and TURP syndrome are more common where surgical time is greater than one hour, where a large volume of irrigating fluid is administered, and where bladder perforation has occurred - often these risks occur in the presence of a large gland requiring significant surgical resection. Spinal anaesthesia has been recommended where the risk of these syndromes is significant, to enable early detection and treatment.

In recent years most transurethral prostate surgery has tended to be performed via laser resection, or with the use of bipolar diathermy, neither of which requires the use of glycine.

In many hospitals, glycine has completely vanished from the shelves, having been replaced by isotonic electrolyte-containing solutions, for which outcome most anaesthetists will give a rousing cheer. We were surprised, therefore, to receive reports from anaesthetists who have observed cases of apparent glycine toxicity (and who themselves have been surprised to discover that glycine is in continued use, for at least *some* cases in some institutions).

We made inquiries of the Urological Society of Australia and New Zealand (USANZ) as to the prevalence of glycine use. We received the following advice: *"…..bipolar TURP or laser TURP which utilises saline can negate the risk of TURP syndrome. However, not all hospitals have access to these technologies due to cost and expertise…. Monopolar TURP remains the most common benign prostatic enlargement (BPE) surgery performed in Australia and in many regional hospitals, monopolar TURP remains the only BPE surgical technology…."*

Consequently, we advise anaesthetists to check with their urological colleagues as to the type of irrigation fluid being used at their institutions, and to be aware that even if glycine is not routinely employed, they may find it reserved for the occasional challenging case (for example, large volume prostate or anticipated lengthy surgery). In fact, precisely the sort of case which historically our well-prepared exam answer would be: poses a significant risk for glycine toxicity, or hyponatraemia/TURP syndrome.

Associate Professor Joanna Sutherland
Chair, ANZCA Safety and Quality Committee

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WebAIRS:
Wrong blood in the tube

This incident was discussed at an Australian Society of Anaesthetists (ASA) Mortality and Morbidity meeting, analysed by the authors, and published in the July edition of the ASA *Australian Anaesthetist* magazine.

CASE REPORTED TO WEBAIRS

Blood was taken from a patient for a routine group and hold. The tube was hand labelled, and the pathology request form filled out and witnessed. In the blood bank, the blood was tested and found to be different to the blood group previously recorded for a patient with the same three independent identifiers of name, date of birth and hospital record number.

On further investigation, it was found that after drawing the blood the vial was left in the patient's room. The blood tube was labelled and witnessed outside of the room, rather than at the time and site of collection. This resulted in the tube being labelled with another patient's details.

DEFINITION

Wrong blood in tube (WBIT) events have typically been described in relation to blood transfusion with validated definitions developed by the International Haemovigilance Network in 2012[1]. WBIT occurs when:

- Blood is taken from the wrong patient labelled with the intended patient's details ("miscollected") or
- Blood is taken from the intended patient but labelled with another patient's details ("mislabelled").

These WBIT errors may cause catastrophic outcomes regardless of the blood test but particularly when they result in an incompatible blood transfusion.

ESTIMATED FREQUENCY

The webAIRS database of over 10,000 incident reports was interrogated and there were four cases of suspected WBIT.

The incidence of WBIT has been studied using different methods and consistently found to be between 1 in 1500 to 1 in 3000 samples[2]. WBIT in emergency departments has been found to occur 1.7 times higher than inpatient wards and 5.1 times higher than outpatient clinics[5]. Quantifying the incidence of WBIT arising from operating theatres has been difficult. One study found an incidence of WBIT of 1 in 2283 samples, with none of the samples collected in the operating theatre[4].

The incidence of WBIT sampling errors arising from theatres may be low due to the model of care of one patient at a time and the infrequent occurrence of collecting blood samples.

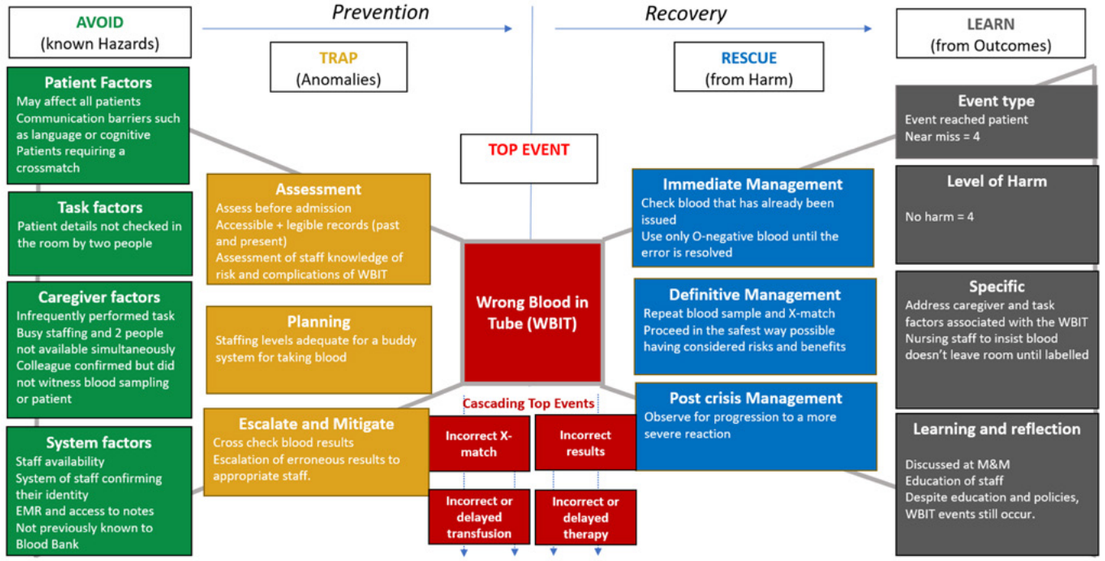
However, the consequences of incompatible blood transfusion may be more severe due to delayed reporting of symptoms or recognition of signs when patients are under sedation or general anaesthesia.

Errors occurring in blood sample collection such as wrong tube type, insufficient sample quantity or quality are estimated at 1 in 2000 samples. Mislabelling of tubes occurs more frequently with an estimated incidence of 1 in 40 samples[5–7] and may include missing or incorrect patient identifiers, without WBIT[6–8].

BOWTIE DIAGRAM

The bowtie diagram method to analyse incidents in anaesthesia was first described in 2016[9]. It represents a fusion of a fault tree and an event tree, connected by the top event in the middle, thereby creating its distinctive shape.

Figure 1: A bowtie diagram summarising the analysis of WBIT.



HAZARDS

Hazards or risk factors are divided into patient, task, caregiver, and system factors. A WBIT event may affect any patient. No single intervention has been found to reduce the incidence of WBIT to zero or produce a lasting effect on reducing WBIT[2].

Positive patient identification is integral to many aspects of patient safety as well as minimising WBIT. This requires a wristband and where possible verbal confirmation of the patient's identity and ensuring patient samples are correctly labelled at the bedside[2]. Communication barriers due to cognitive deficits, reduced conscious state and language differences may impair a patient's ability to accurately confirm their identity at the time blood is taken. Patient wristbands that are damaged, changed or removed are a risk factor for WBIT[10] and other events.

Task factors are often presented as hospital protocols, such as having two staff members witnessing patient identification and labelling the samples at the point of sampling. The introduction of handwritten request forms and not permitting the use of addressograph labels is thought to encourage caregivers to focus on positive patient identification[2] however for anaesthetists caring for patients undergoing anaesthesia, this may result in task distraction and other adverse consequences.

In terms of care-giver factors, having a multitude of staff undertaking the sampling of blood across a health facility increases the risk of WBIT, as opposed to a limited number of staff who have undertaken specific education and competency training. A UK audit found that doctors were the cohort most likely to make errors and phlebotomists the least likely[11]. This may be due to system factors, such as being more likely to perform blood sampling after hours, or not having bedside access to clinical computer systems. Medical staff may not have been taught the importance of positive patient identification. Reductions in the incidence of WBIT have been reported following education interventions and by utilising specifically trained phlebotomists[2,12]

Breaches to hospital protocols on positive patient identification and labelling samples before leaving the patient are more likely to occur in areas with rapid patient turnover, busy workloads or inadequate staffing[10].

In terms of system factors, standardised processes of unique positive patient identification reduce the incidence of WBIT. Lack of access to the charts and notes in the patient's room or having an electronic medical record (EMR) open on another patient also pose a risk. Barcode technology is an evolving technology[2], however this too may result in workarounds and human error contributing to WBIT. Conducting continual audit and providing regular feedback has been shown to reduce the incidence of WBIT. This is seen as critical for engaging with clinical teams to support changes in practice[2].

TRAP

The second column in the bowtie diagram depicts examples of processes which might 'trap' the progression of hazards to prevent them from progressing to the 'top event'. Traps to prevent incidents might be further broken into the categories of assessment, planning and escalation and mitigation.

The WBIT in this case was detected due to the patient's blood type having been previously assessed prior to the admission. Pretransfusion sampling, prior to patient admission, and bedside confirmation of blood group reduces the incidence of WBIT and incompatible blood transfusion. This needs to be accompanied with accessible and legible records. The sharing of historical controls between institutions or having a centralised transfusion service database may further trap WBIT errors[2,10].

Staffing levels and staff training and competency should be regularly assessed to ensure that two staff members are available to witness blood being taken. Alternatively, having a limited number of trained and competent staff to take blood samples has been shown to reduce WBIT incidents.

In terms of mitigation, in this case the blood bank was able to cross check this sample with previous samples and notify the delivery suite. End-to-end electronic blood transfusion management systems have been shown to have a significant impact on patient safety. These systems not only address WBIT errors but other aspects of the transfusion process[2,13]. However, they cannot eliminate human error and need to be simple to use to reduce the risk of error.

In terms of escalation, in this case the blood bank was able to notify the delivery suite, so that a repeat sample could be taken from the correct patient. Having a system of identifying outlier, or aberrant results, and contacting a nurse or doctor who can investigate further has been recommended in other settings and would be beneficial in mitigating a WBIT incident. Identifying the patient from whom the blood has been mislabelled remains a challenge and is of concern particularly if the blood test showed a significantly aberrant result and the patient may have been discharged home, for example from the emergency department.

TOP EVENT

WBIT is the top event. The purpose for which the blood was drawn would impact the cascading top events. In this case, the blood was taken for cross match. Had the WBIT incident not been detected, this could have ultimately resulted in an ABO incompatible blood transfusion and an acute haemolytic transfusion reaction to the patient who had their label incorrectly placed on the blood tube. The patient from which the blood was taken, or "miscollected" would also not have a current group and hold which may result in delayed blood transfusion. Likewise, if the blood was taken for other investigations, then this could contribute to misdiagnosis and incorrect or delayed treatment.

RESCUE

The third column of the bowtie diagram addresses immediate, definitive, and post-crisis management. The immediate management of a WBIT event that could result in an incompatible blood transfusion would include checking for any blood that has already been issued and only use O-negative blood until the error has been resolved. Definitive management would be to re-sample the patient with positive patient identification and a two-person buddy system and repeat the cross match. The post-event management would be to address the latent factors listed in the first 'avoid hazards' column.

LEARN

In the final column, 'learn from outcomes', the analysis of the first 8000 reports revealed three other cases of WBIT making four in total. None of the cases resulted in harm and were classified as near miss WBIT events by the reporter as the error was detected before the blood was cross-matched. However, for the WBIT event, they could be viewed as Incidents with 'no harm' rather than 'near misses'. As shown in the diagram, WBIT could then lead to several cascading top events including an 'incorrect cross match' if not detected and therefore these cascading potential events were all near misses.

WBIT incidents keep occurring and although ABO incompatible blood transfusions are rare, with about 20 people dying yearly in the US[14], the most common cause of ABO incompatibility is administrative error. Sampling and mislabelling of blood resulting in WBIT is one of the procedural steps that contribute to this potentially fatal event.

Transfusion is a multistep, multidisciplinary process, and the literature indicates that the human error rate has remained unchanged despite educational and other interventions. Strategies to reduce WBIT need to address multiple hazards and traps and be sustained if the incidence is to remain low.

Dr Suzi Nou
FANZCA and the ANZTADC Case Report Writing Group

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Training and education

College seeks primary examiners

Primary Exam Court of Examiners

Become a primary examiner

For more information on becoming a primary examiner go to www.anzca.edu.au/become-a-primary-examiner

Being an ANZCA examiner is an extremely rewarding way for fellows to make a substantial contribution to their profession, their college and to maintaining the high standards that make anaesthesia so safe in Australia and New Zealand.

We are looking for consultants who are interested in becoming primary examiners, so we talked to Dr David Fahey, Chair of the Primary Examination Sub-committee, about what it takes and how to get involved.

"Other than being a FANZCA for at least three years, the main criteria is to be passionate about the applied sciences which underpin the art of anaesthesia. You don't need to be an expert on the whole syllabus, but familiarity with the major areas by way of regular teaching, is a good starting point. Ideally, you'll also have been involved with helping prepare registrars for the primary exam, through giving tutorials, teaching on exam prep courses, or giving practice vivas.

"You also need to be an excellent communicator. As we know from our own time as a trainee, all candidates are nervous to some extent during a viva. A good examiner is someone who can create an environment in which candidates can demonstrate their knowledge. Maintaining the fairness and integrity of the exam, and managing their own potential conflicts of interest, are also essential requirements for examiners.

"Understandably, there are some time commitments and travel requirements. However, these are planned well in advance and all costs are covered by the college. Camaraderie among the examiner group is strong, and it really is one of the most rewarding ways to get involved with the work of the college."

THE PROCESS

The first step in applying involves requesting an application pack from primaryexam@anzca.edu.au. There is an application form to complete, along with the supply of three referees, who are contacted separately. We require one reference from your head of department (or a senior colleague if you are only in private practice) in support of your application given that there is a time commitment involved. One referee should be a primary or final examiner, although if you don't know an examiner, you can discuss an alternative with the primary exam team.

If your application is suitable, you are invited to attend as an observer at one day of a viva exam, where you can see the exam in progress, and meet the chair to discuss your application. (Even if you are not applying to become an examiner, consultants involved in primary teaching can apply to observe for a day at the vivas.)

Successful applicants then need to attend a two-day (weekend) workshop, before being mentored as a probationary examiner at a viva exam.

The expected ongoing time commitment is to attend one viva exam per year (this requires four days of attendance), and be available to mark one short answer question (SAQ) a year. Some examiners choose to attend both viva exams. Examiners also contribute to writing and reviewing new questions during the year. There are opportunities to become more involved with question development with further seniority.

Dr David Fahey AM FANZCA MHPEd
Chair, Primary Examination Sub-committee

Meet a primary examiner

ANZCA is seeking consultants who are interested in becoming primary examiners.
Here, four FANZCAs who are primary examiners reveal what motivated them to take on the role.

DR LACHLAN RATHIE

Senior staff anaesthetist Toowoomba Hospital, Queensland.

'I do all the usual stuff in a busy regional centre – orthopaedics, general, ear, nose and throat, obstetrics, massively obese patients with multiple co-morbidities. We have an enormous catchment area that covers all of south-west Queensland. Some of our patients live 1000 km from the hospital.

I've been involved with primary exam teaching since I was a registrar and have organised teaching schedules for registrars at Toowoomba for as long as I can remember – about twenty years' worth.

I enjoy helping people pass the exam and have done so since I was a trainee. I am one of the few people who did the primary before starting training!

I find the academic challenge and mechanics of the exam process fascinating. I enjoy examining, especially face-to-face vivas, and I enjoy the privilege of celebrating with successful candidates and commiserating with those who are unsuccessful.

I find the opportunity to teach by assessment valuable and my personal knowledge of the core knowledge of our practice is much better than when I was a trainee. Most trainees sitting the exam have bought my exam book and that is very gratifying. The feedback has been very heartening.

My wife is a GP and my children are all studying (or intend to) medicine. My interests include birdkeeping, expanding my watch and giraffe collections, and writing books inspired by my adventures at work. My current project is called *The Anaesthetic Picture Book*. I think people will like it.

DR NIC RANDALL

Anaesthetist and intensive care specialist Middlemore Hospital, South Auckland.

"The work at Middlemore is very diverse. The hospital services an area of Auckland that has many social challenges, and much of the caseload is acute presentations.

I enjoy paediatric and general cases and I'm fortunate that I get an opportunity to work in these areas as the translational skills from anaesthesia to intensive care are extremely helpful and make an enormous difference when on call for the intensive care unit.

I'm involved in the regional teaching program in Auckland – and enjoy teaching on the local and national Part I courses.

The areas in which I find I am increasingly useful (and interested) is helping trainees understand the exam from a structural perspective and demystifying the process.

I always had the intention of becoming an examiner – the initial drivers were around a wish to be part of the education and assessment side of the exam. As I have become more senior I have discovered areas in the primary exam that are fascinating from an organisational and delivery perspective. This was particularly highlighted in the COVID dark ages – the ability of the trainees and examiners to come together and provide the exam in such exceptional circumstances was a remarkable demonstration of a resilience and commitment rarely seen and was humbling to be involved in.

My fellow examiners are a diverse and eclectic group of individuals who are so generous with their time, knowledge and friendship.

Life is stressful at times and we all need to wind down occasionally. I have a delightful and very patient wife, Kim, who has been supportive of the journey medicine has taken us. She fronts the band we are in (I play guitar) and this is an integral part of our life.

DR BARBARA RODRIGUEZ

Staff anaesthetist Monash Health, Melbourne.

"I work across three campuses – Clayton, the Victorian Heart Hospital and Moorabbin. My clinical work includes cardiac anaesthesia but working at Monash Health means that my practice is actually quite varied, including thoracics, neurosurgery, ear, nose and throat, vascular surgery, obstetrics, general surgery and the obligatory session in endoscopy. I'm also involved with the anaesthetic allergy testing for our service.

This is my sixth year as a primary examiner (the time goes more quickly than you realise), and I was involved with primary exam teaching for four to five years before that. As a junior consultant I was initially co-opted to teaching and then coordinating the second part teaching program.

I hadn't really thought about the primary exam until I was asked to contribute to some of the tutorials for the primary teaching program by Dr Noel Roberts, who was coordinating primary teaching for our network at the time. I found that I really enjoyed revisiting the basic sciences and thinking about how that foundational knowledge informs our practice.

From there, I became involved in the Monash Primary Revision Course, (also run by Noel) which gave me the opportunity to develop a number of vivas across a reasonably wide variety of topics (we all have our favourites) and gain more familiarity with the curriculum.

I thought being an examiner would be interesting, challenging, character building even, but most of all it has been far more personally rewarding than I had anticipated.

There is a lot of work involved with the exam, and the preparation leading up to it. At the end of the week though, reflecting on the enormity of the work behind the scenes that has gone into putting on the exam, the candidates' preparation, and the successful outcomes which are great for those individuals who achieve that milestone, and for the profession, it really does feel like an extraordinary privilege to be part of it."

DR JESSIE LY

Anaesthetist, Westmead public and private hospitals, Sydney.

"I work with incredible anaesthetic, surgical and nursing colleagues. My practice involves a range of specialties from neuroanaesthesia and vascular to upper gastrointestinal and gynaecology.

My provisional fellowship project was the development of a primary teaching long course for local trainees and I've been involved in primary-related and educational activities ever since. Becoming a primary examiner seemed to be a logical next step so I applied. It's been a thoroughly enjoyable experience thus far and I'm extremely glad I did it. I feel that it's helped make me a better anaesthetist and able to guide trainees through the exam more effectively.

I had initial reservations about fitting in with what I had presumed to be a very intellectual crowd but everyone I've met in this process has been really humble, generous, and friendly.

The primary examiners, as a group, are inquisitive, thoughtful, and occasionally a little bit eccentric (but aren't we all?!) They have eclectic interests and it's been fantastic learning from people from all around Australia and New Zealand about different challenges and clinical practices. It's a very warm and welcoming group.

I enjoy escape rooms, badminton, and chocolate in any form. I have more fountain pens than I'll ever use. My Maltese Yorkie Chewie rules my household and my lovely husband patiently tolerates my obsession with jigsaw puzzles."

If you are interested in becoming a primary examiner, you can find more information at www.anzca.edu.au/become-a-primary-examiner or contact us at primaryexam@anzca.edu.au

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

THEN APPLY NOW FOR THE 2024 ELC!
Please submit your application form (available on the 2024 ELC webpage), accompanied by your curriculum vitae, to Majella Coco at events@anzca.edu.au by **Friday 20 October 2023.** Successful applicants will be notified in early December.

THINKING OF APPLYING FOR THE 2024 EMERGING LEADERS CONFERENCE?

Check out what a few of our 2023 delegates had to say about their experience.

It's difficult to articulate how the emerging leaders conference can be so beneficial for the mind, body, and soul. I started day one with heavy doses of self-doubt and finished day three recognising the strength in my own vulnerability. A wide range of emotions occurred between those days due to the breadth and quality of the talks.

The immersive nature of the program allowed for self and team reflection, and I found this to be invaluable. The ELC has been the most relevant and impactful conference – both personally and professionally – I've had the privilege of attending.

I'm deeply grateful for the support of both the NZNC and ANZCA for this opportunity and I strongly encourage anyone eligible to apply.

Dr Priya Shanmuganathan FANZCA

The 2023 Emerging Leaders Conference was a truly rewarding and engaging meeting. An indelible experience at an important time in my nascent career, and we barely discussed any clinical anaesthesia! Leadership through shared experience was the theme, and our impressive group of speakers and mentors delivered authentic accounts of life through leadership. We were encouraged to embrace and share our own vulnerability and failures on the journey to successful leadership.

I'm grateful to my fellow delegates, our mentors, and speakers who set the tone of the meeting and generously shared their own experiences. Special appreciation is due for ANZCA who supported the event, council leaders who gave their time and inspiration, Majella Coco with a superlative effort to corral a group of busy specialists, and Jessica Lim and Chris Yong who co-convened the meeting.

Dr Andrew Wilson FANZCA

I had a highly positive experience attending the 2023 Emerging Leaders Conference. My key takeaway lessons included:

- New perspectives on leadership.
- Useful communication skills.
- The importance of vulnerability.
- Improved understanding of cultural safety and inclusivity.
- A better understanding of corporate structures and how to make change within hospital systems.
- New reflections on my personal goals and ways to ensure my own wellbeing.
- Our approach to patient care and comfort in sitting with grief and vulnerability.

The opportunities for networking and relationship building with colleagues and key members of the college and council was a highlight.

Dr Hannah Bennett FFPMANZCA

Harnessing the power of ChatGPT:

Opportunities and challenges for anaesthesia practice

Healthcare stands on the cusp of an AI revolution. Here, Dr Angus Low, a resident medical officer with an interest in anaesthesia, explores its clinical applications, limitations and potential risks for anaesthetic practice.

Since its introduction in 2018, OpenAI's Generative Pretrained Transformer (GPT) has marked a significant advancement in the field of artificial intelligence (AI). The 2022 launch of ChatGPT, a chatbot application by OpenAI, offered the public a firsthand experience with this cutting-edge AI technology leading to its rapid adoption and making it the fastest-growing consumer application in internet history[1,2]. This meteoric rise spurred competition and ignited debates about its societal implications, prompting calls for developmental restraint[2].

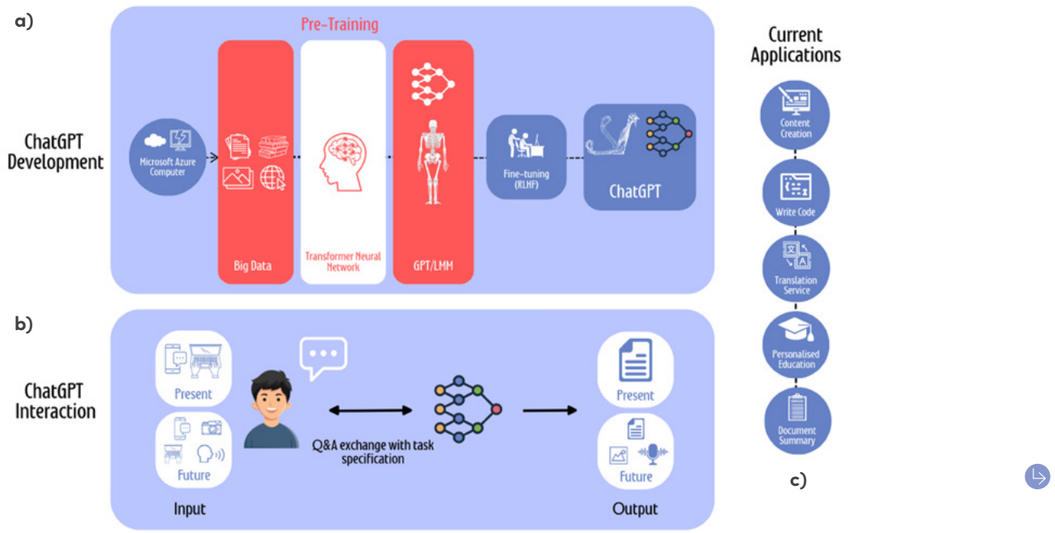
Healthcare stands on the cusp of an artificial intelligence revolution. Predictive analytics, speech and natural language processing, and automated image interpretation are just a few areas where AI is making significant inroads[3]. Even specialities that traditionally rely on hands-on expertise, such as anaesthesia, aren't immune, with predictive analytics already being implemented in various capacities[4]. As AI finds its place in anaesthetic practice, ChatGPT emerges as a pioneering technology, uniquely offering users direct interaction. This article will focus on its text based clinical applications, limitations, and risks specific to its integration into anaesthesia practice.

GPT AND CHATGPT: HOW DOES IT WORK AND WHAT'S THE DIFFERENCE?

GPT is an AI computer program trained to understand and generate language. It acts as a foundational model, which can then be further refined for specific tasks or applications[5]. GPT is built on an intricate AI mechanism known as transformer neural networks. During the training, this network is exposed to vast amounts of internet data and learns how to predict the next word in a sentence. At this stage in development it can be considered "GPT" a type of large language model (LLM). However, it's not particularly easy to interact with. In fact, a prompt will result in a wide array of responses not necessarily in line with the user's intent. The newest version, GPT-4, can be considered a large multi-modal model (LMM), based on its ability to process images and text[5].

On the other hand, ChatGPT is an example of a generative AI application- a foundation model that has been fine-tuned for a specific task, which is to generate human-like text based on the input it receives. For the original ChatGPT, the LLM GPT 3.5 served as the foundation model which will shortly be replaced by GPT-4. OpenAI achieves the fine-tuning through a process called reinforcement learning with human feedback (RLHF) and helps GPT refine its responses, ensuring they align more closely with human values and objectives[5].

Figure 1. a) Simplified visual representation of the ChatGPT development process. The skeleton represents GPT, the foundational framework for understanding language. ChatGPT is represented by muscle, uses the foundation but adds functionality. b) Demonstrates basic user interaction with present/future sensory capabilities. c) Highlights a few general applications



ChatGPT's multifaceted uses range from assisting the visually impaired via "Be My Eyes" to supporting Iceland in safeguarding its linguistic legacy[5].

To summarise, while GPT provides the foundational capabilities, specific generative AI applications, such as chatGPT, determine how those capabilities are harnessed and expressed. Current versions only allow for text input/outputs, however, future versions of ChatGPT will enhance its sensory capabilities, integrating voice and image processing with text[5].

CLINICAL APPLICATIONS AND PATIENT CARE

ChatGPT could be a game-changer, especially in pre-operative assessment and in developing strategies for anaesthesia delivery.

For instance, ChatGPT has the potential of scanning a patient's chart and generating a concise summary of the medical history, detailing previous anaesthesia, and flagging complications and potential anaesthetic risks. Moreover, by providing ChatGPT with patient records, intended surgery and current physiological monitoring, it could generate a variety of anaesthetic strategies with anaesthetic "recipes"[6].

Another potential use is to improve intra and post-operative monitoring. As well as assembling input from various monitoring devices, ChatGPT could assist in recording spoken events including procedures and drug administrations. Information could then be analysed and attending medical staff alerted to abnormalities and potential complications[7].

Finally, ChatGPT could facilitate patient communication by serving as an interactive tool (pre and post-operatively), answering frequently asked questions about anaesthetics and generating personalised educational content[6,8,9].

EDUCATIONAL POTENTIAL

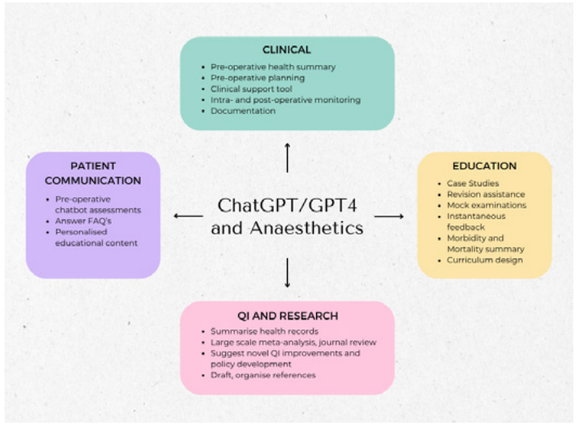
The educational prospects of ChatGPT in anaesthesia are numerous. It can act as a personalised online tutor, adapting its responses to cater to individual user needs[1].

For instance, trainees or consultants could present their clinical decisions to ChatGPT and receive feedback on their rationale, helping them understand best practices and areas of improvement. Similarly, ChatGPT could simulate patient scenarios, allowing trainees to virtually manage a patient's anaesthesia care from pre-operative assessment to post-operative recovery.

For revision purposes, it could be possible to query ChatGPT with specific topics or questions, receiving concise explanations to aid their understanding. Furthermore, the platform's capability to generate mock exams based on the ANZCA curriculum offers the opportunity to test the user's knowledge and receive immediate feedback on their performance, ensuring continuous self-assessment.

Finally, it could be utilised to customise training by analysing past experiences, reactions, and results. This helps pinpoint the strengths and weaknesses of each clinician, suggesting specific content for review and further examination. From generating concise summaries to crafting detailed study plans and offering innovative learning methodologies, ChatGPT promises to be an invaluable tool[1,6,10].

Figure 2: Potential applications of ChatGPT in anaesthetics. Template sourced from CANVA



QUALITY IMPROVEMENT AND RESEARCH

In terms of quality improvement (QI) and auditing, ChatGPT can be transformative. It has the potential to pull, summarise, and compare patient data with gold-standard benchmarks in real time[10,11].

This immediate data comparison could highlight discrepancies and areas that need attention. For research, ChatGPT can currently assist in the early stages, summarising articles, organising references, and facilitating background research[12]. New functions on ChatGPT integrate add-ons like 'Scholar AI' and 'Link Reader'. These enable the user to bring journals and information, not currently included in its training data, to further enhance its utility. As ChatGPT gains access to more extensive journal databases, it could perform large-scale meta-analyses, from which it could suggest novel research questions and aid in study design[3,12].

LIMITATIONS AND CHALLENGES

Like any technology, ChatGPT has its limitations. Its current training data only extends up to 2021, limiting its ability to give up to date clinical advice[5].

Offsetting this GPT4 has recently been incorporated into the web browser Bing (although with limited functions). Also, being a text-based system, ChatGPT may miss nuances present in other communication forms, reflecting a lack of practical medical expertise[10]. Similarly, it won't be able to go and listen to patients' heart and lungs (yet). In terms of its knowledge base, ChatGPT has shown that it can pass numerous standardised examinations including an approximate pass mark for the Royal College of Anaesthetists primary exam[13,14]. However, there are inconsistencies in its applied knowledge, leading to potential errors in specific scenarios. For instance, while it can accurately describe medical concepts (dead space, Mapleson system), ChatGPT has been observed making clinical errors, such as recommending rapid sequence induction without neuromuscular blockade, and attempting to increase the concentration of isoflurane by turning the vaporiser down[14].

RISKS

The potential risks and uncertainties associated with the integration of ChatGPT and other LMMs into anaesthesia practice are vast and beyond the scope of this article to adequately assess. However, I will touch on a few.

Firstly, patient safety. There's a worry that the usual caution for new technologies is not applied to LMMs consistently; they may lack adherence to values like transparency, inclusion, and rigorous evaluation[15,16]. This relative lack of regulation opens the door for developers to rush products and overlook key safety features.

Such premature implementation of untested systems might result in healthcare errors, harm patients, diminished trust in AI, thus hindering the long-term global benefits of these technologies[10]. Furthermore, comprehending the reasoning will likely hinder our ability to judge the reliability of the recommendations. This phenomenon is commonly known as the 'black box effect', whereby the explanations for its results and conclusions remain hidden within the neural network that it was trained on[10].

Another, more insidious, risk is the phenomenon of "digital hallucinations", where ChatGPT generates seemingly credible but incorrect information[5]. There are many examples where ChatGPT has created non-existent journal articles by using real authors and journals while merging information from multiple sources[17]. This has a number of potentially damaging consequences including misinformation in journals, fabrication of research, and plagiarism, ultimately leading to the spread of false healthcare information.

Of significant concern also are the inherent biases in AI tools like ChatGPT. Neural networks require vast amounts of accurate data for training. Biases can manifest depending on the objectives set for the AI, the quality of its training, and the magnitude and representativeness of its data[5,6,11]. For instance, AI trained using data primarily from middle-aged male patients will likely provide skewed recommendations for young female patients, simply because the latter weren't adequately represented in the training data.

Issues of data privacy and ownership are also at the forefront. The current landscape lacks clarity on data ownership, its processing, access rights, and the ethics of its use in training future GPT models[5]. Coupled with the emerging capability of AI to de-anonymise data, there's a potential threat to patient confidentiality, especially if chatGPT is not integrated securely within health systems[18].

Lastly, who is to be held accountable in scenarios where harm ensues from either adhering to or ignoring GPT's advice? Developers of AI are beginning to frame the technology as a clinical tool, perhaps implying that accountability remains solely with the clinician.[10] These risks underscore the imperative for caution, transparency, and rigorous oversight when deploying LMMs like ChatGPT, ensuring alignment with professional standards and societal values.

CONCLUSION

While ChatGPT and similar models offer immense potential for anaesthesia, their safe and effective clinical implementation requires significantly more work. Their current strengths lie in drafting, idea generation, data summarisation, and research assistance. However, this is a rapidly moving field and collaboration across individual, departmental, and organisational levels is crucial for their responsible exploration and use.

Dr Angus Low, RMO
Queensland Health

Acknowledgements

ChatGPT was used for the initial drafting and to suggest ideas for content. Editing was completed by the author.

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Why equity, diversity and inclusion are important

A letter to the editor in the Winter 2023 *ANZCA Bulletin* titled "Pride march not part of college's mission or vision" has started a conversation about the college's activities in equity, diversity and inclusion.

As chair of the ANZCA Gender Equity Sub-committee I am supporting my colleague Dr Sophie Unell in outlining the reasons and evidence base for the promotion of diversity and inclusion by our college.

ANZCA's mission is "to serve our communities by leading high quality care in anaesthesia, perioperative and pain medicine, optimising health and reducing the burden of pain". The college vision is "to be a recognised world leader in training, education, research and in setting standards for anaesthesia and pain medicine". Two populations benefit from ANZCA's equity work: the patients we care for and the colleagues we work with.

The promotion of equity, diversity and inclusion in medicine has been shown to improve patient health outcomes. Gomez & Burnett (2019) conducted a meta-analysis of 16 reviews and found that healthcare quality and financial performance were positively associated with team diversity. In particular, innovation, team communication and risk assessments were seen to be stronger within more diverse healthcare cultures.

A 2021 quality improvement project outlined in the *New England Journal of Medicine* highlights the value of workforce diversity as part of an overall aim to improve equity in healthcare. As clinicians we are responsible for ensuring consistency in our quality of care regardless of patient background. Our patients represent diversity of gender, race, ethnicities, cultures, religions, ages, abilities and socioeconomic backgrounds. We therefore urge all FANZCAs to assess whether they bring unconscious bias to their practice through our newly developed Unconscious Bias toolkit www.anzca.edu.au/Anzca/media/Anzca/ANZCA_GE-unconscious-bias_toolkit-2023.pdf, with thanks to Dr Adele MacMillan and Dr Louise Lowes).

In addition to promoting positive patient outcomes, an associated benefit of diversity and inclusion policy is a happier and healthier workforce. Our colleagues in Australia and New Zealand come from countries all over the world with different religious beliefs, racial backgrounds, sexuality and genders. *The Diversity Bonus* by Scott E. Page outlines the strong evidence that diversity in teams leads to organisational benefits including improved problem solving and increased innovation.

While this evidence supports the workforce argument for diversity and inclusion, much work remains to be done to improve the workplace for minority group colleagues. For example, Holmberg, Martin & Lunn (2020) outlined that healthcare workers who identify as sexual and/or gender minority experience more discrimination in the workplace. Many withhold personal information in the workplace for fear of job loss or discrimination (despite this being illegal in all jurisdictions in Australia).

Intersectionality recognises that being a member of multiple minority groups leads to compounded marginalisation while allyship encourages those from the more strongly represented and leadership groups to actively educate their members about the issues facing minorities. Strong workplace culture helps to prevent burnout and aid staff retention despite the hugely challenging workplace that healthcare can be.

By recognising these issues, supporting our colleagues through strong allyship, and promoting diverse and healthy workplaces, we can create a workplace environment which allows our colleagues to thrive and provide the highest quality care to our patients.

We hope this summary has provided an evidence base for ongoing college representation in equity, diversity and work.

Dr Claire Stewart, FANZCA
Dr Sophie Unell, FANZCA
Westmead Hospital, NSW

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GENDER EQUITY ACTION PLAN 2023-25

Key areas of focus in the 2023-25 Gender Equity Action Plan include workplace inequity, boosting gender equity within target stakeholder groups, and expanding the diversity and inclusion footprint of the college. To learn more, see the plan here:

Faculty of

Pain Medicine

Faculty direct entry program on hold for now

DIRECT ENTRY PROGRAM FOR PAIN MEDICINE

Over the past year we have been looking at the concept of creating a direct entry program (DEP) for pain medicine with the broad idea of a five-year training program without the need for a primary specialist degree. This program would run alongside our current program and the end qualification would be the same.

The first step was to commission an external group to do a feasibility study and after going out to tender the Curio group took up the challenge. The key outcomes we were looking for were *Desirability, Viability, Feasibility* and their approach had five key elements: a survey of current fellows and trainees, workshops with current fellows and trainees, interviews with training site directors and supervisors of training (SOTs), interviews and desktop research into other specialty colleges and workshops with undergraduate students and early post graduate doctors.

The key outcome was that a direct entry program is currently not feasible, not viable and not desirable, but there are steps that the faculty can take to bring about the conditions for future success.

Image left: Dr Raj Menon (left) and Dr Roger Goucke at the opening of the Dr Roger Goucke Pain Management Centre.

DESIRABILITY

The result showed that 50 per cent of fellows believed we should not proceed at this time with a DEP while fewer than 25 per cent believed we should. Of fellows and trainees, more than 60 per cent said they would not have found a DEP attractive were it available while less than 15 per cent said they would. The reasons for this varied from the desirability of having a "fallback" second specialty to the lack of a clear plan on how a DEP would work.

This is a very clear message from our fellows and trainees that now is not the right time to proceed. If we are to proceed we must have buy-in and support of our fellows. There were also concerns that pain medicine is not a specialty that medical students and junior doctors are drawn to and we need to raise the profile of the specialty by making it a core part of medical school education and having medical students in pain clinics.

VIABILITY/FEASIBILITY

It is also the view of unit directors and SOTs that it would not be feasible to proceed with the DEP. The issues they raised were that the variability in supervision, assessment and training is too great. This is an issue that we are aware of and we are now going through a review of assessments. We also have a plan to review and support our SOTs to try and ensure that they are all trained and supported in their roles.

There were also concerns that there is no funding for these potential positions and a five-year training program would divert funding from our current trainees.

The FPM Board has decided not to progress with the DEP project. What we will do is create a clear plan on what needs to be done over the next few years to position us so that we can consider this project again in the future.

PERIOPERATIVE MEDICINE

Following concerns raised that the recognition pathway for the college's Diploma of Perioperative Medicine did not properly recognise our pain medicine fellowship, the process has been adjusted so that points can be allocated as part of the process.

Fellows who have not met the points requirement in applications already submitted are being contacted by college staff to adjust their application, while those who have not applied should contact the college if they believe these extra points will help push them over the line.

Dr Kieran Davis
FPM Dean

Faculty celebrates key milestone

DR ROGER GOUCKE PAIN CLINIC OPENS

A new pain clinic in Perth has been named after a former FPM Dean Dr Roger Goucke.

The WA Minister for Health, Ms Amber-Jade Sanderson, opened the Dr Roger Goucke Pain Management Centre at Osborne Park Hospital on 25 July (above).

Dr Goucke was faculty dean from 2006-2008 and served as head of the department of pain management at Sir Charles Gairdner Hospital for 24 years before his retirement.

The clinic uses a multidisciplinary approach to the treatment of persistent or chronic pain and is expected to provide services to about 5000 patients each year.

Ms Sanderson said the new clinic honours Dr Goucke's many years of dedication to the countless number of patients and clinicians that he has helped.

One of Dr Goucke's significant achievements has been the development and implementation of the Essential Pain Management program, alongside Dr Wayne Morriss and with support from ANZCA and FPM.

PROCEDURES ENDORSEMENT PROGRAM – CALL FOR SUPERVISORS

Are you an FPM fellow experienced in pain medicine procedures, looking to play a key role in training the next generation of procedurally-capable specialist pain medicine physicians?

If so, we encourage you to apply to become an accredited supervisor in the Procedures Endorsement Program to hone your skills as a mentor and educator and set and uphold standards for procedures.

The supervisor application process includes endorsement in pain medicine procedures through the practice assessment pathway to ensure your practice complies with *PS11 Procedures in Pain Medicine Clinical Care Standard (CCS)*. Endorsement in procedures will become the gold standard for quality in this area.

As a supervisor engaged in the program, your valuable feedback and evaluation will be sought at supervisor workshops to continue to enhance and grow the program. Supervisors who undertake work-place based assessments for endorsees will automatically have these activities added to their continuing professional development (CPD) portfolio if they are participating in the ANZCA and FPM CPD program.

To learn more about the role of a supervisor in the Procedures Endorsement Program and how to apply, please contact fpm@anzca.edu.au or visit anzca.edu.au.

NEW FELLOWS

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

Dr Erica Remedios, FANZCA, FFPMANZCA (WA)

Dr Emily Rickman, FRACGP, FFPMANZCA (VIC)

Dr Nicole Vogts, FANZCA, FFPMANZCA (NZ)

We congratulate the following doctor on admission to FPM fellowship through completion of the Specialist International Medical Graduate (SIMG) pathway:

Dr Robert Wright, The American Board of Anesthesiology, FFPMANZCA (VIC)

CELEBRATING 25 YEARS OF FPM

Raise a glass and honour the remarkable achievements of FPM as we toast our 25-year anniversary. We are delighted to introduce our collection of commemorative glassware, designed exclusively for the faculty by Mon Verre to celebrate this milestone. You can choose from a selection of wine, martini, and champagne glasses and a whiskey tumbler to suit any taste.

They are offered as a time-limited, direct from supplier purchase with a special discount for our fellowship. The faculty will not receive any proceeds from glassware sales and will not have supplies for purchase. We encourage you to buy while they are available and embrace the opportunity to own a piece of history.

For those of you who who attended the 2023 specially-themed FPM Spring Meeting– *'Let's celebrate! From silver lining to silver anniversary'* in Adelaide we hope you enjoyed catching up.

For further information, visit www.anzca.edu.au/news/fpm-news/the-faculty-turns-25

Best practice in opioid rotation

A recent case from a state coroner has highlighted some of the potential risks in the management of complex opioid regimens, especially during periods of transition from one type of treatment to another, and when clinical handover is required between specialists and GPs.

CASE SCENARIO

A 33-year-old woman was admitted for an inpatient ketamine-assisted opioid rotation from oxycodone to methadone. She had been taking 140mg per day of oxycodone in divided doses and formulations as part of the management of her chronic lumbar pain that she had developed 10 years earlier. She was also taking 225mg pregabalin twice daily and up to 15mg per day of diazepam.

She was found deceased from what was determined to be hypoxic encephalopathy in the setting of prescription drug toxicity a week after discharge from the ketamine infusion. She had been commenced as planned on methadone at a dose of 5mg twice daily, plus up to three further doses of 5mg per day if required for breakthrough pain. Handover to her GP had been done by a combination of discharge letter and text message.

Lessons to be drawn from the case

The coronial findings drew attention to the following lessons that FPM fellows should take from this case.

1. High-dose buprenorphine has a substantially better safety profile for high-dose opioid rotation, especially in the setting of other sedating drugs being prescribed, compared to methadone. It should therefore be considered as the first choice for this purpose.
2. Face-to-face reviews rather than telehealth should be routine and should be frequent during the period of potentially unstable plasma levels.
3. Use of ketamine infusions as facilitation for opioid manipulation should include planning for post-discharge handover to the treating GP and very clear, timely documentation regarding the expectations for ongoing prescribing and dose changes. In this case, the coroner drew particular attention to the importance of communication between the discharging specialist pain medicine physician (SPMP) and the reviewing GP regarding dose changes.
4. The prescription of take-home naloxone for high-dose opioid patients should be routine as it may mitigate the harm from overdoses, whether deliberate or unintentional.

The ability to manage risk in this setting while maintaining patient functional outcomes is a fundamental skill expected from SPMPs (Curriculum learning outcomes 2.1.23, 2.1.36) and care is needed to balance ethical responsibilities towards the patient, their family and support network, their GP and other health care providers with regulatory obligations and professional standards of acceptable practice. Pragmatism must frequently be balanced against the platonic ideals of safe prescribing.

Negotiating these competing demands requires clear goal-setting and documentation of agreed priorities and actions. A typical example would be the paradigm of patient-led deprescribing whereby prescriber and patient collaborate to agree on the rate of dose reduction and the expected final dose, and these agreed parameters are documented in the patient's record.

In the case of discharge from an inpatient stay, the communication from SPMP in the form of the discharge summary should be accurate and timely and contain information about the discharge medication regimen and responsibilities of the discharging specialist and GP. Verbal communication prior to discharge may be prudent in the case of high-risk patients.

With the recent changes to the Australian pharmaceutical benefits scheme which are aimed at providing better access to buprenorphine high-dose formulations, it is timely for SPMPs to consider their practice and ensure that opioid rotations are conducted safely in the light of this case.

Associate Professor Michael Vagg
Director of Professional Affairs, FPM

Call for a rethink of the specialty

Emery Brown thinks it's time we started rethinking anaesthesia.

And he should know.

Professor Brown has a unique skillset – he's a neuroscientist, a statistician, and an anaesthesiologist – even he admits, "we're not a dime a dozen".

He's also one of the international invited speakers at the Aotearoa NZ Anaesthesia Annual Scientific Meeting (ASM) 2023, being held in Dunedin from 9-11 November.

Professor Brown's trip down under from his Boston home will mark his first visit to New Zealand in almost 20 years, and a break from his work as the Warren M. Zapol Professor of Anaesthesia at Harvard Medical School, and a practising anaesthesiologist at Massachusetts General Hospital.

He is also the Edward Hood Taplin Professor of Medical Engineering and Computational Neuroscience at the Massachusetts Institute of Technology.

Rethinking anaesthesia will be the theme of his ASM address.

"I think we know enough about how the current drugs work to start planning new strategies on how we should use them, and I think we should put more emphasis on coming up with better ways to do anaesthesia," Professor Brown says.

While he doesn't yet know what that might look like, Professor Brown draws comparisons with recent targeted immunotherapies in oncology that have developed through a deeper understanding of cancer biology.

"The analogy is if we have a much deeper understanding of the brain, we should be able to devise much more precise techniques for anaesthesia. What they'll look like will depend on what that deeper understanding looks like, but we haven't done that yet."

Professor Brown is an advocate for the electroencephalogram (EEG) to be used more by anaesthetists to track patient brain states under anaesthesia.

"If you look at the use of EEG signals, the one that has the highest signal-to-noise ratio is anaesthesia. Because as soon as the drugs take effect all the movement artifact goes away, and what you're seeing is a very pure signal. If we can't use the EEG, then really nobody else can because we have the cleanest signal. So, we should be at the vanguard of its use.

"Anaesthesiologists are some of the best respiratory and cardiovascular physiologists. And there's no reason why we can't be some of the best neurophysiologists. Nobody affects the brain more dramatically than we do on a day-to-day basis. The EEG gives us an important window into the magnitude and the consequences of that effect."

Artificial intelligence is already changing many professions, and Professor Brown says anaesthesiology will not be immune to its impact.

"We know enough about how the current drugs work to start planning new strategies on how we should use them."

"I think it may help us keep track of information better, it may help us carry out some diagnostic procedures better, it may help us remember things on the spur of the moment that we may not remember otherwise – seeing a constellation of symptoms and saying there's an imminent possibility of respiratory failure.

"It all depends on how the AI entity is attached to the patient and can collect and feed back information to the anaesthesiologist. I see those sorts of assistants as being very likely in the future."

But while artificial intelligence is likely to change the face of anaesthesia, in the meantime, the human element remains vital.

Professor Brown says it is important to think about the language anaesthetists use with patients, in particular references to patients going to "sleep".

"We often say sleep, which is a bad habit. It's a bad metaphor to use because patients are definitely not asleep – if they were, we'd wait till they fell asleep then rush them down to the operating theatre and operate on them. And you can imagine how far that would get."

He says patients perhaps don't fully appreciate the impact of anaesthesia – but it's not their fault.

"We've done ourselves a disservice because for many years we'd say we didn't know how it worked. On one end that makes it appear magical, you have to be part of the club to know how to do it. But if you don't know how it works you can't explain to patients and you can't really legitimately assuage any of their concerns."

Professor Brown is looking forward to his return to New Zealand, his first trip back since attending a statistics conference in 2005. November's ASM will mark his first visit to Dunedin, and the opportunity to speak at conferences and learn from fellow medical professionals is one he enjoys.

"I think it's important to share what we're learning and to really have a sense of where the field is and understand how research is progressing and how clinical practice has progressed."

Last year, Professor Brown was awarded the Gruber Neuroscience Prize, the latest in a long list of awards that has also seen him admitted as a member of all three branches of the United States' prestigious National Academies – the National Academy of Medicine, National Academy of Sciences and National Academy of Engineering. He is the first African American and the first anaesthesiologist to be elected to all three branches.

Professor Emery Brown (above) will speak on 'rethinking anaesthesia' at the Aotearoa NZ Anaesthesia ASM 2023. Photo: Len Rubenstein.

While thrilled at the recognition, Professor Brown's focus remains firmly on outcomes not for himself, but for those under the care of anaesthetists.

"It's a tremendous honour to get into one national academy in the states, and to get into all three of them, it means somebody thinks I'm having some impact.

"I hope not only that people are paying attention, but I hope we're able to make things better for patients, that's what would excite me even more."

Reon Suddaby
Senior Communications Advisor
New Zealand, ANZCA

Ultrasound-guided regional anaesthesia in PNG

Adelaide FANZCA Dr Gilberto Arenas recently spent a week in Port Moresby teaching ultrasound-guided regional anaesthesia in Papua New Guinea.

With support from the medical equipment company Sonosite, Dr Arenas's trip gave local anaesthetists an opportunity to enhance their ultrasound skills through a series of simulation sessions. The company supplied two Edge II ultrasound machines, each with three probes, to facilitate Dr Arenas's teaching. These models are already familiar to anaesthetists working at Port Moresby Hospital where they have been used for several months.

Sonosite also donated one L25 Linear Array Probe transducer for intravenous and arterial line procedures for use during the teaching sessions.

Dr Arenas spent three days teaching consultants, anaesthesia intensive care and emergency registrars, and medical students. Several teaching stations were set up for the sessions with medical students volunteering as scanning "patients" for the sessions.

Dr Arenas said the sessions were popular with both students and consultants.

"They are all hard workers and quick learners. It was very fulfilling to see the spark in their eyes when they could visualise what they were doing 'blindly' before," he said.

The sessions included time spent in the Port Moresby Hospital operating rooms so the participants could apply their skills. Dr Arenas supervised ultrasound-guided regional anaesthesia techniques including: interscalene brachial plexus block, supraclavicular brachial plexus block, erector spinae plane block, femoral nerve block and popliteal sciatic block.

During his visit Dr Arenas also presented a session on his implementation of the erector spinae plane block at the Royal Adelaide Hospital.

Dr Arenas said the anaesthetists at Port Moresby Hospital were confident performing the blocks since the hospital bought two Edge II Machines with three probes each a few months ago.

"Our colleagues in PNG have noted that patients are using less opioids and are getting very good analgesia / anaesthesia.

"It is a great start for ultrasound-guided regional anaesthesia in PNG and we are hoping this will be the first of an annual teaching visit."

Dr Gilberto Arenas FANZCA
Senior Consultant Anaesthetist
Royal Adelaide Hospital
Director STACE Anaesthetists SA

**Dr Arenas's trip to Port Moresby was sponsored by ANZCA's Global Development Committee with equipment provided by Sonosite. Visit the global health pages of the ANZCA website for more information about our work to support education, training and the development of safety and quality in anaesthesia and pain medicine in the Asia Pacific region.*

Dr Gilberto Arenas (centre) with simulation session participants in Port Moresby.

Foundation update

Professor Victoria Brazil and PPRN Executive Chair Professor Kirsty Forrest.

PROFESSIONAL PRACTICE RESEARCH NETWORK WEBINAR

More than 70 delegates registered for the successful foundation and Professional Practice Research Network (PPRN) special webinar on "Leadership and High-Performance Teams" on 20 September.

PPRN Executive Chair Professor Kirsty Forrest delivered an overview of the PPRN, and the importance of professional practice and simulation research, as a resource for healthcare teams working together to deliver excellent clinical and patient outcomes.

Director of Simulation at Gold Coast's Bond University, medical educator Professor Victoria Brazil, presented insights from three of her research studies in education and simulation which included supervisor and trainee relationships. Answers were provided to a range of questions from attendees.

Professor Brazil was recently honoured with the 'Ray Page Award' from the peak body Simulation Australia Limited for outstanding contributions to simulation, translation, leadership, and communications.

RESEARCH COMMITTEE DECIDES 2024 GRANTS

The Research Committee met on 8 September to assess 43 research grant applications for funding in 2024.

The process was again highly competitive with many high-quality applications received. The annual grant success rate is usually between 40 and 50 per cent, however, for 2024, it was just over 50 per cent.

Although many applications are unsuccessful each year, often by a small margin, the committee always encourages applicants who have not yet been successful to continue to apply, utilising previous reviewer feedback when preparing new applications.

The foundation and the Research Committee are again very grateful for the significant efforts of all our expert voluntary reviewers, who contribute hundreds of hours to our robust and impartial peer-reviews, and make the high standards of ANZCA Foundation supported research possible.

And we are similarly grateful to all our committed regular donors, without whom we could not maintain our current level of funding for high-quality globally influential research.

This commitment to supporting quality contributes to the international standing of the college as a leader in medical research in anaesthesia, pain medicine, and importantly, in perioperative medicine. It also assures foundation donors of the quality, importance, and potential impact of the work and people they are supporting.

INAUGURAL ANZCA INNOVATION AND TECHNOLOGY RESEARCH AWARD

The Research Committee has awarded the ANZCA Foundation's first 'Innovation and Technology ANZCA Research Award', made possible by the generosity of new Governor Patron Dr Stan Tay, to Dr Rachel Bourke from Gold Coast Hospital for her study "Machine Learning to Predict Postoperative Hypotension in a Tertiary Australian Hospital".

The foundation established the award in recognition of Dr Tay's outstanding contribution as the first actively practising fellow to achieve Governor Patron status. Dr Tay's intention is to recognise outstanding research proposals in which the innovative use of technology intersects with the advancement of scientific knowledge for clinical practice in the specialties, but also to particularly encourage and support women as clinician investigators.

More information on all new ANZCA Foundation-funded studies, and their principal investigators and teams, as well as other recipients of our named awards for 2024, will be presented in the summer issue of the *ANZCA Bulletin*.

Dr Genevieve Goulding, past ANZCA President, speaks at the 2023 Anaesthesia Continuing Education (ACE) meeting in Cairns.

GLOBAL HEALTH CHALLENGES

At the recent 2023 Anaesthesia Continuing Education (ACE) meeting in Cairns, past ANZCA president Dr Genevieve Goulding delivered a powerful presentation on the need to improve perioperative services in the developing world, and ANZCA and the foundation's contributions through global development project funding.

One of the compelling statistics was the comparison of the average maternal death rate in the European Union of eight maternal deaths per 100,000 live births, and the estimated 1120 deaths per 100,000 live births in Sierra Leone – where a woman is 300 to 400 times more likely to die with each pregnancy, and around 1-in-80 pregnancies ends in the death of the mother.

The Lancet Commission on Global Surgery 2015 found five billion people globally lacked access to safe surgical care, and 2.2 million more anaesthetists, obstetricians and surgeons were needed.

These large numbers are strong reasons for doing more to reduce the gap. Important contributions are being made through ANZCA, the foundation and our donors. Dr Goulding pointed to recent examples including the "VAST" program (Vital Anaesthesia Simulation Training program) led by Dr Adam Mossenson, which uses low-cost simulation to improve training in developing countries, and the Essential Pain Management (EPM) train-the-trainer program now rolled out in over 60 countries.

The foundation donor-supported Global Safer Surgery and Global Health Equity programs provide annual grants for research, scholarships and professional development for anaesthetists, pain medicine physicians and trainees working in resource-limited contexts in Papua New Guinea, the Pacific, and beyond. The Global Development and Indigenous Health committees continue to offer other training and education opportunities for specialists and trainees.

THANKS TO OUR PRESIDENT'S PATRONS AND DONORS

The foundation warmly thanks our generous donors and patrons for their ongoing generous support. Your long-term vision and regular support assist the wonderful work and voluntary efforts of our fellows in research, global development, and Indigenous health.

If you are not a patron, please consider joining this program of inspiring philanthropists who regularly support excellence in research and education in the specialties.

CONTACT & SUPPORT

Supporting this work through the foundation is easy with our 'QR" code – just scan to donate direct from your phone or device.

Or just search "Gift Options – ANZCA" in your browser.

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ANZCA Clinical Trials Network news

The 2023 ANZCA Clinical Trials Network (CTN) Strategic Research workshop was an overwhelming success. It was the largest in-person workshop since 2009 when the first workshop was held at ANZCA House.

The workshop, in Coogee Beach from 3-6 August, brought together 77 research coordinators, 82 fellows and keynote speakers Professor Steve Webb, chair of the Australian Clinical Trials Alliance (ACTA) and Dr Julie Marsh, biostatistical lead at Adaptive Health Intelligence. Guests included Dr Masha Somi, Chief Executive Officer, Health and Medical Research Office, Ms Anne O'Neill, Acting Executive Director, NSW Office for Health and Medical Research and Ms Claire Wakefield from the Minderoo Foundation. Sponsors MDA National and Avant were thanked for their generous support.

Convenor Professor Tomás Corcoran opened the meeting with an impressive overview of achievements of our world leading network - nearly $A70 million awarded by CTN investigators in competitive grant funding, 55,000 patients recruited to our trials over the past 25 years resulting in an outstanding publication record and improved outcomes for patients. The first two days started with Professor Webb and Dr Marsh delivering thought provoking presentations on the benefits and the mechanics of setting up adaptive platform trials which require careful statistical planning.

The keynote presentations were followed by a session workshopping new research proposals by emerging and leading trialists, kicking off with the DECIDE trial led by Professor Rob Sanders, which is the latest success story of the CTN, securing $A4.1 million from the National Health and Medical Research Council. The trials and tribulations session first featured current CTN trials and set out to discuss strategies of running trials in overseas sites to improve generalisability of trial results and increase recruitment rates. This requires planning around international sponsors, collaborators, data protection and privacy, funding and insurance.

Part two featured strategies employed by trial teams to deal with setbacks experienced during the pandemic with Dr Somi providing an update on the Medical Research Future Fund initiative and contributing to the panel discussion on the challenges experienced by trial teams to meet recruitment milestones and budgets.

Day one concluded with funding and collaboration opportunities and a light-hearted and highly interactive session on real life research scenarios. These featured four role plays tackling the intricacies of what is informed consent and considerations for recruiting remote patients to trials. The feedback from delegates was harnessed through live polls, word clouds and in-room discussions through the integration of the event app, a key strategy to increase accessibility to research coordinators and contribution to discussions.

The Anaesthesia Research Coordinators Network (ARCN) and CTN business meeting highlighted that the CTN is on the road to recovery after the pandemic with feedback from fellows and research coordinators on ways to improve recruitment and build capacity at our network of sites. Dr Suresh Singaravelu showcased the outstanding contribution of our regional sites to CTN trials and the benefits of making trials accessible to rural and regional patients.

Professor David Story delivered the ANZCA research vision, where he encouraged researchers to undertake a PhD if wishing to pursue an academic research career. Professor Webb provided an update on several initiatives led by ACTA to support CTN and the need for the health sector to invest in research and development. This was followed by an interactive panel discussion with Ms O'Neill, who discussed some of the NSW Office of Health and Medical Research initiatives and resources available to increase the medical workforce capability in NSW.

Professor Trisha Peel, Professor Kate Leslie, Dr Masha Somi, Professor Paul Myles, Professor Philip Peyton, Professor Tomás Corcoran, Professor Andrew Davidson, Ms Karen Goulding, Ms Paige Druce and Ms Gill Ormond

The session on recipes for success to build research departments featured an impressive showcase of research departments and innovation by research teams to build a sustainable research workforce through funding permanent research coordinator positions and embedding a culture of research, which often involves contribution from trainees, junior doctors and resident medical officers in trial activities.

This session was complemented by a vivid poster display by research teams on strategies to improve efficiencies in trial delivery and research team models. Day two concluded with a packed audience of enthusiastic sites participating in the Sugammadex, Neostigmine and Postoperative Pulmonary Complication (SNaPP) start-up meeting, the latest CTN trial to get underway. The third and final day of the workshop featured an engaging session on the future of perioperative medicine delivered by our next generation trialists.

Based on previous feedback, the format of the workshop was revised to enhance the in-person delegate experience and networking opportunities. ARCN members met with their peers and regional mentors at their annual networking dinner reception before the workshop. Morning coffee and networking time was scheduled ahead of the program on each day. On the last night, delegates enjoyed a delicious dinner at Coogee Surf Life Saving Club with stunning night views of Coogee Beach. The emerging investigators breakfast kicked off day three. Delegates left excited and enthused with new and renewed friendships and collaborations.

ANZCA's audio visual partner Wallfly ensured the seamless delivery of the workshop and helped presenters with onsite state of the art technology. The delegate app allowed chairs to consolidate delegate feedback and questions.

We thank all delegates, chairs, speakers, sponsors, convenors, Professor Andrew Davidson and Professor Tomás Corcoran, CTN Executive, ARCN Sub-committee, ANZCA Events team, ANZCA Communications team, CTN office teams and Wallfly for delivering what has been touted the best CTN workshop to date. Stay tuned for information regarding the 2024 workshop.

From top:

Professor David Story, Dr Suresh Singaravelu, Professor Steve Webb, Ms Anne O'Neill, Professor Andrew Davidson and Ms Alli Kearney

Dr Julia Dubowitz and Professor Tomás Corcoran

Professor Andrew Davidson

Photographer: Peter Harrigan

Library news

NEW AND UPDATED TRAINING AND SUPPORT GUIDES

Several new library guides have recently been launched to support key college educational programs.

Anaesthesia training resources guide

The library has worked with the ANZCA Trainee Committee to develop a dedicated resources guide for the anaesthesia training program. The guide provides comprehensive resource support for all parts of the program and curriculum, including an extensive list of primary and final assessment and exam resources. Access the guide via the training & exams hub, Learn@ANZCA and the training program website.

Specialist International Medical Graduate (SIMG) resources guide

The library has collaborated with the SIMG Committee to develop a dedicated resources guide for the ANZCA SIMG program. The guide provides comprehensive resource support for all parts of the program and curriculum, including resources for those just starting out, communication & support, as well as assessment-related resources. Access the guide via the training & exams hub and the SIMG program website.

Perioperative medicine training guide

The library and the Perioperative Medicine (POM) Working Group – have just launched a Perioperative Medicine Training library guide to support the new POM course. The guide provides support resources for the POM framework, roles in practice, units of study readings (Unit 1 now available), and the numerous resources POM trainees may find useful. Watch this space as the guide grows in 2024 with the launch of the full POM course. Access the guide via the training & exams hub.

Rural Generalist Anaesthesia (RGA) training

A new RGA training resources guide was also launched earlier this year. The guide provides support resources covering roles in practice, clinical fundamentals, the specialist study units, assessment/exams, rural and remote practice, as well as the numerous apps, websites and resources RGA trainees may find useful. Access the guide via the training & exams hub and the DRGA program website.

RECENTLY UPDATED LIBRARY GUIDES

Pain medicine training guide

The library and the Faculty of Pain Medicine – have just finished redeveloping the Pain medicine training guide, including a complete update of all the essential topic area (ETA) readings. All readings can now be accessed "as live" via library subscribed content or via the Learn@ANZCA portal.

ANZCA Educators Program (AEP) guide

The library and the ANZCA Educators Sub-committee overhauled the AEP guide, including a complete revamp of all module-related resources. Access the guide via the training & exams hub and the AEP webpage.

Cardiac thoracic vascular and perfusion (CTVP) guide

The library has recently updated the CTVP guide, including an extensive resources update. This includes several new CVTP-related articles and podcasts, as well as newly added textbooks. Access the guide via the library guides home page.

NEW MCGRAW HILL ACCESS APP

It is now possible to access content from the *AccessAnesthesiology* and *AccessMedicine* collections using the newly launched **Access - by McGraw Hill** app. Think *Goodman & Gilman's* and *Harrison's* at your fingertips.

The new Access app is a personalised interactive learning solution that makes studying easier and more efficient. Learners can search vetted and trusted medical content across a variety of mediums that best fit their learning needs, including: books and chapters (including several exam-related texts), videos, podcasts, infographics, images, tables, and figures.

See our dedicated Access - by McGraw Hill guide for more information including full registration and access details.

LATEST AUDIODIGEST PODCASTS

Need a way to keep up-to-date on the run? AudioDigest provides instant online and mobile access to 260+ accredited anaesthesiology, pain medicine and critical care audio lectures presented by experts from leading institutions, bringing clinicians a convenient continuing medical education (CME/CE) experience. Each lecture includes: objectives, pre-test Q&A, summary & readings, post-test Q&A, evaluation.
Free registration required.

The latest lectures include:

- Short-Acting Spinal Anesthetics: Updates and Considerations for Ambulatory Anesthesia
- New Drugs in Pediatric Anesthesia for 2023
- Malpractice, Lawsuits, and Survival
- Diversity and Inclusion in Medical Research: Impact on Women's Heart Health
- Truncal Nerve Blocks

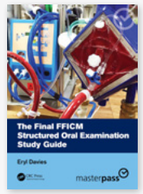
Latest books

Access the complete list of newly added titles on our website: https://libguides.anzca.edu.au/latest.

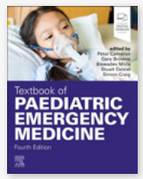
NEW TRAINING BOOKS

A number of new training-related titles are now available online: **https://libguides.anzca.edu.au/training-hub**

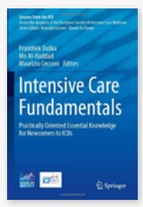
Rang and Dale's pharmacology, 10e
Ritter J, Flower RJ, Henderson G, et al. London: Elsevier, 2024.



The final FFICM structured oral examination study guide
Davies EA. Boca Raton, FL: CRC Press, Taylor & Francis Group, 2023.



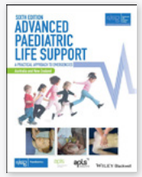
Textbook of paediatric emergency medicine, 4e
Cameron P, Browne GJ, Mitra B, Dalziel SR, Craig S [eds]. Philadelphia: Elsevier, 2024.



Intensive care fundamentals: practically oriented essential knowledge for newcomers to ICUs
Duška František, Al-Haddad M, Cecconi M [eds]. Cham: Springer, 2023.

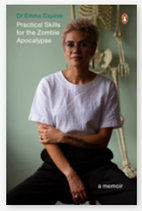
NEW BOOKS FOR LOAN

Books can be requested via the *ANZCA Library discovery service:* **https://libguides.anzca.edu.au/borrowing**

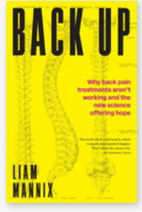


Advanced Paediatric Life Support: A Practical Approach to Emergencies, Australia and New Zealand, 6e
Samuels M, Wieteska S [eds]. Chichester, West Sussex, UK: John Wiley & Sons, 2017.

Every doctor : healthier doctors = healthier patients, 2e
Rowe L, Kidd MR, Abeygunawardana V. Boca Raton: CRC Press, 2023.

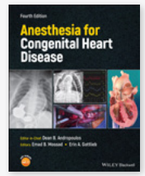


There's a cure for this: a memoir
Espiner E. Auckland, New Zealand: Penguin Random House New Zealand, 2023.

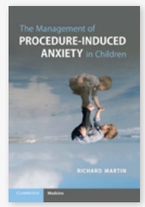


Back up: why back pain treatments aren't working and the new science offering hope
Mannix L. Sydney, NSW: NewSouth, 2023.

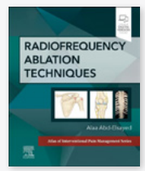
NEW EBOOKS



Anesthesia for congenital heart disease, 4e
Andropoulos DB, Mossad EB, Gottlieb EA, [eds]. Hoboken, NJ: John Wiley & Sons, 2023.



The management of procedure-induced anxiety in children
Martin R. Cambridge, United Kingdom: Cambridge University Press, 2021.



Radiofrequency ablation techniques: Atlas of Interventional Pain Management Series
Abd-Elsayed A. Philadelphia, PA: Elsevier, 2024.

Current therapy of trauma and surgical critical care, 3e
Asensio JA, Meredith JW. Philadelphia, PA: Elsevier, 2024.

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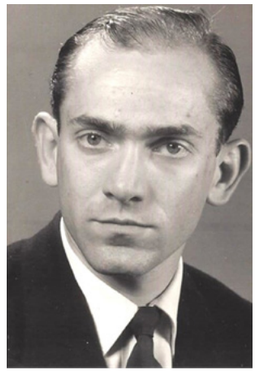

Thomas Andrew Gabriel Torda OAM

1934 – 2023

Tom was born in Budapest on 9 November 1932, the son of a faciomaxillary surgeon. At nine years of age, he and his family were forced into a concentration camp in Germany. They were not executed as they were regarded as a high value asset that could be "traded" to Switzerland.

In Switzerland, his father soon became the refugee camp doctor, causing the family to be relocated frequently. Tom lived in four different countries over a period of three years and became multilingual.

In 1948 the family emigrated to Australia and finally settled in Sydney. Tom attended Sydney Grammar School and obtained a Commonwealth Scholarship which allowed him to attend Sydney University to study medicine. While still a medical student he joined the Citizens Air Force, progressed to the rank of flight lieutenant, and learnt to fly. He graduated in 1958 and spent his internship at Sydney Hospital and then accepted an anaesthesia training position at Royal Perth Hospital.

In 1960 Tom decided to undertake further studies at St George's Hospital in London. He obtained a Diploma in Anaesthetics in 1961 and a fellowship of anaesthetics in 1962. During his time there he met and married Phyllis Howard, an operating theatre nurse and had their first child, Andrew. The family then moved to New York where he undertook a fellowship in anaesthesiology at the Montefiori Hospital in 1963. He then took up a position at the Albert Einstein College of Medicine in 1964 where their second child, Adrienne, was born.

The family returned to Australia in 1966 and Tom was appointed as a staff specialist in anaesthesia and intensive Care at Prince Henry Hospital. He developed one of the first intensive care units in Australia treating patients with respiratory failure due to poliomyelitis. Over the years these patients would return for ongoing medical care and there was always a bed available for them. He knew them all and they became part of his extended family.

Tom was also a physical fitness fanatic, and he was into running and scuba diving. When computers appeared he became a computer fanatic learning all the various programming languages that were being developed.

In 1979 he became academic head and chairman of the Department of Anaesthesia and Intensive Care at Prince Henry, Prince of Wales, and the Sydney Children's Hospital. He was a member of the NSW Regional Committee of the Faculty of Anaesthetics, Royal Australasian College of Surgeons. As a member of the Anaesthesia Continuing Education Committee he was the organiser and convenor of the first anaesthetic continuing medical education meeting in Australia. He was involved with the NSW Department of Health developing the occupational health and safety guideline for acceptable levels of anaesthetic gas pollution in operating theatres. This earned him many visiting professorships in Europe, the US, the Middle East, Southeast Asia and Australia.

Tom strove for excellence in everything he was involved with. He was passionate about his research, publishing almost 100 scientific papers and writing more than 13 book chapters. He was always willing to share his wisdom with those who sought his guidance. As such he was a great leader being very loyal and supportive. Through all of this he was able to give time to his family, patients, colleagues, and trainees.

In 2000 Tom was awarded the Medal of the Order of Australia (OAM) for his influence on the advancement of Australasian anaesthesia. Even after he stopped clinical work he continued teaching and his research at the university for many years.

On retirement he and Phyllis undertook many trips overseas where he pursued his love of photography. He was a doting grandfather and he and Phyllis moved house to be closer to their family. They regularly undertook child minding duties and attended soccer games and athletics carnivals. There was absolutely nothing the two wouldn't do for their grandchildren.

In 2016 Tom had a major stroke and was left with severe dysphasia and dyspraxia which made it necessary for him to move to a nursing home. The staff absolutely loved him there. He was very content and stable there until just a few weeks prior to his death. He decided it was his time to go and he passed away quickly and peacefully.

Tom taught us more than anaesthesia and critical care. He taught us how to manage patients and families under severe distress, with calmness and dignity. He taught us humility, compassion, and respect. We will be forever grateful for the time he gave us.

Dr Matthew Crawford AM, FANZCA, FFPMANZCA

Neville Opie AM

1946 – 2023

In retrospect, the choice to drive a beat-up old Volkswagen Kombi through the gates of Buckingham Palace may not have been Neville Opie's greatest decision. However common sense prevailed amongst the security guards, and he was duly admitted to be invested by Queen Elizabeth II of his honour of Membership of the Order of Australia, announced in the inaugural Australian Honours List in June 1975.

Prior to his training in anaesthesia, Neville had served in the Australian Army, and was Regimental Medical Officer of the 1 Pacific Island Regiment stationed in Papua New Guinea, when the Royal Australian Air Force's worst peacetime crash occurred killing 25 Australians and Papua New Guineans in August 1972.

Neville was part of the rescue team, and was winched down over 60 metres from a helicopter to the rescue site. His honour citation notes that he worked tirelessly for long hours under arduous and extremely oppressive conditions to extricate the bodies that had lain in the wreckage for some days. The aircraft was in a precarious position, being suspended by trees above a deep ravine. Later, he worked tirelessly to identify the remains of the deceased. The citation concludes that Neville worked without thought for his own wellbeing and safety.

Neville was not one to brag about this honour, with its extreme bravery and associated selflessness. For humility was one of Neville's characteristics – as befits one of nature's true gentlemen. It may seem extremely odd to describe Neville in this way, but the Oxford English Dictionary definition of a gentleman as a man of good, courteous and honourable conduct appears a most fitting description, characteristics which he demonstrated even in times of extreme professional and personal stress.

For over 30 years Neville was a consultant anaesthetist (and initially also an intensivist) at Sir Charles Gairdner Hospital in Perth, where his influence was in many areas. In the days of a single medical school in Western Australia, many medical students' first experience of anaesthesia was with Neville, and I, along with many others, will remember the extreme courtesy with which our examination in anaesthesia (for many our first clinical viva examination) was conducted. Many would have been drawn to anaesthesia as a career by Neville's teaching and conduct. He was a contributor to the first edition of Oh's *Intensive Care Manual*, and was amongst the early leaders in developing services and standards for anaesthesia in outside areas as it evolved within tertiary teaching hospitals.

As a clinician Neville excelled, being recognised by his colleagues as an extremely sound and reliable anaesthetist. In the words of one of his anaesthesia colleagues, he was the colleague that every clinician would like to have, and of another, he was trustworthy, his opinion was worth seeking, and any task asked of him diligently completed. He was caring to patients and all staff alike, and when required, fearless in the face of surgeons. A legendary interaction with a senior surgeon one Christmas Day has deservedly become part of his hospital's folklore.

Neville excelled outside the workplace as a sportsman, was a skilled tennis and squash player, and also in his time a basketballer. The initial part of Neville's retirement was in good health. However it must have been distressing to him that because of severe illness, including redo open heart surgery for valvular disease, he had to curtail his sporting activities and interests. Neville was not one to complain, taking his illnesses in his stride.

Born in Gawler South Australia, Neville John Opie won a scholarship to the then Adelaide Boys High School, and graduated with a Bachelor of Medicine and Bachelor of Surgery (MBBS) from the University of Adelaide in 1970. After his internship, he was appointed to regular army service for the period that he would have been engaged in the Australian Army to complete his remaining national service. With his army service terminated in Perth, he worked at the then Princess Margaret Hospital for Children and the King Edward Memorial Hospital for Women before undertaking anaesthesia training in Western Australia and in the UK.

In his final incapacitating illness, Neville was cared for at home by his wife Roshi, who was until recently a consultant surgeon at Sir Charles Gairdner Hospital, and their son Darius, who survive him along with his children Michael, Ben and Jennifer from a previous marriage and their families.

This obituary started with an account of Neville's entry to Buckingham Palace, to which we return. At the time of his award Neville was working in Wales, and originally thought that the envelope addressed to him at his hospital with Buckingham Palace as the sender was a prank from his colleagues. Eventually persuaded to open it, he found the invitation to the investiture.

Neville had been invited to meet the Queen in 1974 in Australia, and was invited to the inaugural Order of Australia investitures to be held in Canberra. On both occasions he was in Wales. His investiture therefore occurred in London, being preceded by the obligatory trip to Moss Bros to hire a morning suit. On being presented to the Queen, Neville lapsed in protocol, and immediately opened the conversation with the Queen with the phrase "Sorry I missed you in Canberra" – we shall never know whether or not the Queen was amused! Neville was sorry to have missed the Queen in Canberra, and we too will be sorry to be missing Neville.

Dr Andrew Gardner FANZCA

Daryl Salmon

1936 – 2023

Daryl Salmon died on 4 September and his funeral service was on 12 September. We talk about celebrating a man's life on such occasions and this was a genuine celebration. There was an atmosphere of respect for this unique man; not so much sombre respect, but a feeling that we were all fortunate to have shared Daryl's life in one way or another.

His life was full of many twists and turns. Two years after his residency in Melbourne, he joined the Australian Army and became a colonel, serving in Borneo and Vietnam. His experience was shared in one of surgery's most famous textbooks, *Hamilton Bailey's Emergency Surgery*, as well as giving lectures and advising government and professional bodies on mass casualties.

As an anaesthetist he was appointed Director of Anaesthetics and Intensive Care at Liverpool Hospital at a time when it was expanding to become one of the largest hospitals in Australia. Daryl's opinions and the respect that he was held in led him to become elected to the Australian Society of Anaesthetists (ASA) and to play a major role in the development of day only surgery. He never aspired to professional offices as an end. He was actively sought after for these positions.

His professional life then changed as he moved away from anaesthesia and managerial positions to pain medicine. During the early days of pain medicine, Daryl visited many well-known international pain centres, observing techniques from many experts as well as learning how pain centres operated. He was awarded a foundation fellowship of the Faculty of Pain Medicine in 1999. As with other ventures in his life, he not only became a pain specialist, but he established a department of pain medicine at Liverpool Hospital with a multidisciplinary staff of 13 people by 2013.

Daryl Salmon was a tall, very well built man, well over six feet on the old scale. And yet, he delivered anaesthesia in the most delicate and elegant way. Similarly with pain procedures. After he had mastered many of the complex procedures to manage people's pain, he embraced the concept of pain medicine to include other experts, such as psychologists. And just when you think you have the measure of the man and his abilities, he explores the role of cannabis for pain relief, delivering a lecture on *Cannabis: From Pagan to Patch*. He lived the mantra of treating the patient as the owner of pain, not the pain itself.

There are many other highlights in Daryl's professional life but he also played a role in advising and working with many people as they achieved their own goals. After nearly eight years working in Europe, I returned to Perth. For many reasons I wanted to return to Sydney, where my family were. Daryl must have found out about my plans and came to an intensive care conference in Perth and convinced me to come to Liverpool.

Daryl and I worked closely together as Liverpool grew into a large teaching hospital. He steered me through this period as we developed an integrated group of clinicians, all dedicated to deliver a high level of patient care. Daryl's respect among people at all levels in health care made it possible for us to develop a separate division of critical care (anaesthetics, intensive care, emergency medicine and pain medicine). Daryl convinced people that critical care comprised one third of the hospital's budget and staff numbers and, as such, we were no longer to be divided up under the conventional divisions of medicine and surgery.

Daryl was always there for me as he was for many others. He had an awe about him, especially in difficult situations. He would go silent, cough gently twice, expand his torso to its full height while sitting, stare at his victim, followed by a hint of a smile and deliver the most logical reasons why his argument would win the day. Interestingly, it wasn't his size that won the day, it was his reputation for fairness and good decision making. It is not common for men to share personal feelings but Daryl was also there for me when things were not going so well in my life.

Daryl delivered the same loyalty and generosity to his children, grandchildren and his wife, Glenda. This was abundantly clear at the funeral service. A unique man, a truly great man, who will be remembered and missed by many of us.

Professor Ken Hillman AO, FANZCA