



ANZCA
FPM

Bulletin

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

AUTUMN 2020

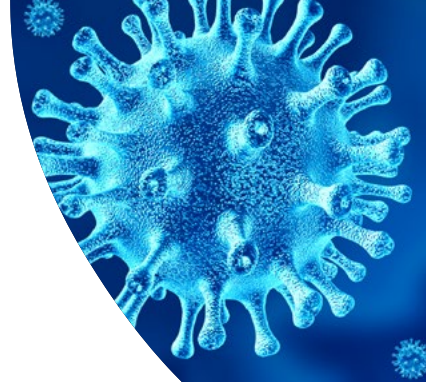
Anaesthesia on the frontline of COVID-19 response

Quarantine on
Christmas Island

A fellow's first person account of the
coronavirus evacuation from Wuhan

Beyond city limits

Taking the pulse of working
and living in regional
Western Australia



Coverage of the college's response to COVID-19 begins on page 12

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ANZCA Bulletin

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

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Trying time of crisis tests all of us

FIVE SHORT WEEKS ago I penned an article exploring the structure of the primary exam, in what will be my final *Bulletin* article as president.

I am clearly not an education expert, but as a clinician who has worked alongside many junior trainees, I have often enough pondered the sheer volume of knowledge required to be mastered in order to pass the first-part exam. Along with the significant personal toll seemingly inevitably extracted, I can't help but wonder if the heavily "academic" style assessment is inadvertently selecting against those otherwise very capable trainees who are struggling with circumstantial issues, such as raising children, illness, or socio-economic disadvantage.

Emma Giles, Chair of the Primary Exam Committee, has conveyed to me her hope that one day the format will be such that studying for the exam will be remembered as a fulfilling time of scientific exploration and discovery for junior trainees, and recalled as the time they gained an understanding of the science behind the art of their chosen profession.

However, as we confront the biggest acute public health crisis of our generation, five weeks seems a lifetime ago, and it seems more appropriate to save that lengthy discussion for another day.

During this tumultuous period we remain focused on providing excellence in patient care, which dovetails with our attention to supporting and protecting our workforce.

In the coming weeks and months, we need to prepare to meet potential challenges of an intensity unprecedented in the relatively short history of our profession. Through the course of my interactions with many of you, I am reminded that the world-class outcomes our college achieves represent nothing more than the collective efforts of so many highly talented and generous colleagues. We are indeed the sum of our parts.

“Whatever form the challenges ahead ultimately take, they couldn't be managed by a more capable group of professionals.”

Please see page 12 for our COVID-19 feature

Core college roles

I am particularly grateful to our COVID-19 Expert Advisory Group, comprising colleagues with recognised clinical expertise relating to the pandemic, and representing each of the jurisdictions and societies (the Australian Society of Anaesthetists and the New Zealand Society of Anaesthetists).

They are reviewing and collating the "infonami" which threatens to overwhelm us, and working with our library staff to present this information in the Library Guides (libguides.anzca.edu.au/covid-19/clinical) in a manner readily accessible to an audience of time-poor clinicians.

The indications for and availability of personal protective equipment (PPE) has become of utmost concern. We have developed a statement addressing the use of PPEs ([anzca.edu.au/documents/anzca-covid-ppe-statement-v24-09042020-\(1\).pdf](http://anzca.edu.au/documents/anzca-covid-ppe-statement-v24-09042020-(1).pdf)), which is intended to provide a single bi-national benchmark for best practice, recognising the unequivocal need to tailor the recommendations to regional requirements, based on advice (as available) from local infectious diseases and public health expertise.

Aside from the clinical issues confronting us at work, the college has had to make some important decisions in relation to our core roles of training and education.

One of the first of these decisions, following the increasing restrictions placed by governments on travel and gatherings, was to cancel the ANZCA Annual Scientific Meeting. This is the single biggest event on the college calendar, and the culmination of years of work by the Western Australian Regional Organising Committee in developing what promised to be a memorable event. This decision was soon followed by the cancellation of our other scientific meetings to the end of 2020.

These cancellations will, of course, have a major impact on continuing professional development (CPD) so it was pleasing to see the Medical Board of Australia and the Medical Council of New Zealand relax the mandatory CPD requirements of doctors in both countries.

In March we made the decision to postpone the May vivas for both the primary and final exams. At the time of writing, we are still planning to run both the primary and final viva examinations in October, but we are not yet in a position to make a firm decision regarding the date or format of either.

We are extremely conscious of our trainees' ability to adequately prepare for and attend exams, taking into account factors including redeployment within hospitals, effects on volume of practice and the cancellation of key courses.



The effect of the pandemic on the financial position of our college has been significant, primarily due to ramifications for our investment portfolio, and non-recoverable costs associated with the ASM. Our external financial advice has fortunately been sound, but nonetheless we are having to make carefully considered cuts to our expenditure.

I must also mention our tireless ANZCA staff who have been working from home since 17 March to keep our college functioning. I congratulate our chief executive officer Nigel Fidgeon and his team for barely missing a beat in these challenging times.

Some broader observations

Rural communities may well suffer disproportionately during the COVID-19 pandemic due to a lack of intensive care facilities, and retrieval services being unable to manage with the demand for their services.

Where there are only two or three anaesthetists in a rural hospital, to lose one member of staff can be crippling. Where no resident ID or public health expertise exists, obtaining specialist advice on local epidemiological factors can be impossible. I would encourage "whole of jurisdiction" workforce planning, rather than purely institutionally-based consideration.

We are also likely to be entering a period of time when demand will outstrip availability of resources. Clinical as well as ethical-moral decisions made during the stress and intensity of the looming crisis are likely to cause much individual angst and torment when we have emerged from the other side, and when we have time to reflect on the decisions we made.

As demand for our services outstrips capacity, we are likely to need to increasingly make judgements relating to futility of care. The elderly members of our

community will need reassurance that clinical decisions to withhold invasive treatment will be based, as they always are, on carefully considered clinical judgements around futility, and not on "how old you are".

Looking after ourselves

This emergency may last for a good number of months. We will need to be kind to ourselves, and each other, during this time. Please consider utilising the Doctor's Health and Wellbeing resources on the ANZCA website and in the ANZCA Library.

Last message

So, it has now been a week since I rewrote this *Bulletin* article, and with the editor asking for the final script by the end of the day, even a week seems a long time ago.

We are witnessing chaos in New York and the UK is still experiencing many hundreds of deaths each day, but here at home social distancing appears to be having its desired effect, and over the past week the curve is showing clear signs of flattening. For the first time I am hearing colleagues express a cautious glimmer of hope that we may be spared the mayhem experienced by our colleagues in Europe and the US.

I have learnt many things in my role over the past two years. The most lasting of those lessons is what good people anaesthetists are. Intelligent, humble, committed, hard-working, insightful, team players. Whatever form the challenges ahead ultimately take, they couldn't be managed by a more capable group of professionals.

Thank you.

Dr Rod Mitchell
ANZCA President

Challenging times for all in COVID-19 response



AS OUR AUTUMN edition of the *Bulletin* goes live the obvious immediate focus and priority for the college has been the evolving impacts associated with the worldwide effects of COVID-19. It goes without saying that our hospitals and health system are under enormous pressure in responding to this crisis, and critically the role of our fellows, trainees and specialist international medical graduates (SIMGs) along with colleagues across the health workforce is now more than ever critical in responding to this public health emergency.

The difficult, but what I believe to be the “right” decision, was made to physically close all ANZCA offices across Australia and New Zealand from 17 March. This decision was made to protect the health and wellbeing of our staff, recognise that at that point we had no contamination within any ANZCA facility or impacted staff and to ensure the essential work of the college could continue. Following announcements made on 23 March by the New Zealand government to implement level 4 restrictions across NZ on Wednesday 25 March, we have extended the remote working from home arrangement across the college until 1 May at this stage.

ANZCA is fortunate in that we have the capacity to have all our staff work remotely from their homes and securely access all IT systems and networks to allow them to continue in their roles. My sincere thanks and acknowledgment goes to our IT team who rapidly responded with the implementation of our new videoconferencing platform – Zoom. This had been scheduled for implementation in April however, the need became urgent to ensure the college, staff,

council and the faculty could remain in contact. This implementation has gone incredibly successfully and this platform is being utilised across Australia and New Zealand throughout the day. On a daily basis we have approximately 120 staff all connected simultaneously to our VPN network and it's all systems go!

In these uncharted times there has been a lot of work taking place across the college in managing the impacts, in particular to exams, education activities, events, continuing medical education and for our fellows, trainees and SIMGs that are dealing with these unprecedented times. The decision to cancel the May ANZCA Annual Scientific Meeting (ASM) in Perth was also another consequence of the world we are now in! I would like to personally acknowledge and thank the WA Regional Organising Committee (ROC) and the events team for their dedication, hard work and the subsequent realisation that we needed to cancel this event – an outcome never experienced in the college's history. It is some consolation to the ROC that we will hold the 2022 ASM in Perth.

This has been extremely challenging trying to “reimagine” how things can be managed moving forward, and as we continually see on a daily basis, it's a moving feast. The college will continue to communicate how we will manage in these unprecedented times.

I have been in contact with fellows and trainees, many who have been working unbelievable hours and days in hospitals on the frontline responding to this crisis.. The personal cost of this to individuals, families and loved ones is overwhelming. Please be reminded that our ANZCA Doctor's Support Program is available free for all fellows, trainees, SIMGs and immediate family members if you need support at this time – anzca.edu.au/resources/doctors-welfare.

There is a significant amount of work taking place from staff across Australia and New Zealand. The ANZCA Council and the FPM Board have established a number of executive governance teams to manage a range of issues for the college in the most agile and responsive way possible. These include the Clinical Expert Advisory Group, as well as groups advising on education, training, fellowship, finance and operations. These teams are meeting regularly to co-ordinate and make decisions for the college and how to support our members through this period.

Given the current information seems to be rapidly changing the college will continue to provide ongoing updates via our website anzca.edu.au.

Nigel Fidgeon
ANZCA Chief Executive Officer

Awards

Australia Day Honour

Retired ANZCA fellow **Dr Walter John Russell AM**, was recognised for significant service to medicine in the field of anaesthesia, and to medical health standards.

NZ New Year Honour

Retired ANZCA and CICM fellow **Dr Edward (Ted) Ward, CNZM**, was recognised for services to intensive care practice.

Letter to the editor



Diversity and selecting trainees

The “principles statement” published in the December 2019 edition of the *ANZCA Bulletin* states that the college opposes all forms of discrimination, but in his president's message in the same issue Dr Mitchell encourages those of us involved in the selection of new trainees to give preference to, for example, Muslim candidates, or those of Sub-Saharan origin.

It apparently needs stating that in preferring candidates of one religion one must discriminate against those not of that religion. The pointy end of this is to witness a candidate wearing a yarmulke, or no religious insignia, missing out on a place in the college training program to a less well-qualified candidate who wears a hijab to the interview.

ANZCA officeholders are at liberty as private citizens to promote their favoured political and social policies all the way to perdition but they should not co-opt the college membership in doing so and nor should they encourage discrimination by fellows on the basis of sex, race, ethnicity, religion or any other “identity”. It may be true that other colleges are already doing so, but it is nonetheless a great shame that our president sees fit to promote such discrimination.

Dr Toby Nichols, FANZCA
Perth, Western Australia

Response from Dr Rod Mitchell, ANZCA President:

The issue you raise is important. So it is important to be accurate about what I said.

I did not suggest that “a candidate wearing a yarmulke, or no religious insignia, (should miss) out on a place in the college training program to a less well-qualified candidate who wears a hijab to the interview”. Nor should my comment be paraphrased as such.

My message invited discussion on whether “merit” should carry a more rounded meaning, by recognising how cultural diversity enriches our workforce. A good doctor is more than just a bundle of qualifications. We need to look beyond the purely academic credentials of our trainee applicants, and consider what attributes the whole person will bring.

For example, someone who moves competently and confidently in two or more languages and cultures has acquired not just technical language skills, but an understanding of the nature of language, and the relationship between culture and world view. Applicants from some marginalised groups (minority/socio-economically disadvantaged/recent migrant) have often had to overcome significant obstacles and in doing so, their determination, resilience and maturity should be recognised and acknowledged. I believe these are just some of the reasons to recognise the importance of diversity within our workforce. It enlarges our capacity to understand, and to deliver the healthcare that our community wants and requires.

ANZCA and FPM in the news

Coronavirus, ANZCA research and opioids lead media coverage

PRINT, ONLINE AND BROADCAST

articles and segments focusing on COVID-19 and ANZCA research projects in Australia and New Zealand reached over three million people.

ANZCA President Dr Rod Mitchell was interviewed on Australian radio stations 3AW in Melbourne on the top rating Ross and John breakfast program, ABC Radio Melbourne and ABC News Radio segments nationally following our joint statement with other medical colleges expressing grave concerns about the Federal Government decision to extend non-urgent elective surgery in private hospitals. Dr Mitchell was also interviewed about ANZCA's concerns with personal protective equipment supply shortages.

In New Zealand, Radio NZ featured an interview with NZ fellow, Auckland anaesthetist and pain specialist Dr Leinani Aiono-le Tagaloa about how she was preparing for the pandemic.

ANZCA councillor Dr Sean McManus was interviewed for the ABC's national AM program about the impact of COVID-19 on regional Australian hospitals. Geelong fellow Dr Diarmuid McCoy featured in a *Herald Sun* article about plans for specialists, including anaesthetists and specialist pain medicine physicians, to be deployed to ICUs and other hospital departments during the coronavirus crisis.

Fellow Dr Warren Pavey, a Perth cardiac anaesthetist, featured in an exclusive 1200-word article "Medics beating

the odds" in *The West Australian* on 11 January. The article highlighted his research into heart transplants. Dr Pavey leads a research team that received an \$A82,000 ANZCA Research Foundation grant to study heart resuscitation methods. An ANZCA media release was also distributed to coincide with the article's publication.

Professor Philip Peyton's 2020 ANZCA Research Foundation grant for a study that aims to reduce knee and hip replacement waiting times was featured in a page 3 *Herald Sun* article on 27 December. The story, developed from an ANZCA media release, ran in print and online and was also covered in other online News Limited publications nationally.

In New Zealand, the *Listener*, a leading current affairs magazine, featured two ANZCA fellows and anaesthesia researchers, Dr Tim Short and Dr Doug Campbell, in its January 2020 edition in a piece titled "Different strokes". The article led with Dr Campbell's clinical trial, NeuroVISION, which is examining cognitive decline post-surgery in older patients. It also reported on the ANZCA Clinical Trials Network's extensive international Balanced Study's findings.

FPM Dean Dr Meredith Craigie was interviewed by SBS News for a news radio broadcast on 19 November about a new opioid patient guide released by Choosing Wisely Australia with the support of the faculty.

Dr Craigie and the faculty also featured in an article on crikey.com.au outlining concerns about a \$A20 million grant awarded to the Pharmacy Guild of Australia for the rollout of the Chronic Pain MedsCheck scheme.

Fellow Dr Barbara Robertson, head of anaesthesia at Albury Wodonga Health, was interviewed by *The Saturday Age* about emergency waiting times in regional Victoria on 28 December. The article also appeared as a page one story in *The Border Mail*.

FPM Vice-Dean Associate Professor Michael Vagg was interviewed by *The Age* and *Sydney Morning Herald* about the faculty's 2018 Choosing Wisely statement on spinal surgery. The article "Canberra backtracks on back operation ruling" appeared on 30 December in print and online. Associate Professor Vagg was also interviewed by *The Age* about Melbourne's first cannabis dispensary on 6 February.

Queensland Sunshine Coast University Hospital anaesthetist and director of trauma Dr Dan Holmes was featured in a 3 February article in the *Courier Mail* for leading the Christmas Island medical response for Australians repatriated from Wuhan, the epicentre of the coronavirus. Dr Holmes headed up the specialist Australian Medical Assistance Team (AUSMAT) on Christmas Island.

New Zealand fellow, Timaru anaesthetist Dr Peter Doran, was featured in a stuff.co.nz article on 12 February about his cycling fund raising campaign. Dr Doran is hoping to raise \$NZ5000 by cycling from Cape Reinga to Bluff to help fund a psychologist to help adolescents grappling with mental health issues.

Carolyn Jones
Media Manager, ANZCA

Since the December 2019 edition of the *ANZCA Bulletin*, ANZCA and FPM have featured in:

- 10 print reports.
- 35 online reports.
- 12 radio reports.

Since the December *Bulletin* the communications team has distributed six media releases which can be found at anzca.edu.au/communications/media/media-releases-2020.

ANZCA and government

National medical workforce planning

Australia

The emergence of and response to COVID-19 has disrupted many planned advocacy efforts in 2020.

Elections are scheduled to take place in the Northern Territory, the Australian Capital Territory and Queensland during 2020. College staff are continuing to monitor statements and initiatives of governments in Australia and engage with departments and agencies on workforce, safety and quality and standards of practice issues. Please visit the college website for the latest updates, information and clinical resources in relation to COVID-19.

National workforce planning

College staff and fellows have participated in consultations for the development of the National Medical Workforce Strategy around the country, including regional areas. The strategy, including a five-year implementation plan, is expected to be finalised by the end of this year.

Related to the development of the strategy, the Commonwealth Department of Health is seeking to obtain comprehensive data from specialist medical colleges in relation to vocational training, supervision and overseas trained specialists. This will contribute to the endeavours of more consistent and accurate data being shared between the Commonwealth, state and territories and specialist medical colleges.

In the first part of the year, college staff and fellows have continued to participate in a range of data workshops and consultations, with ANZCA among a small number of colleges consistently invited to present and discuss national workforce and training data and strategies.

The annual collection of training data will be used to create an aggregate picture of the training pipeline, for inclusion in the strategy and future medical workforce modelling of specialist workforces.

In February, the college hosted a forum for all specialist medical colleges and provided rooms for meetings between the department and individual colleges. The forum and meetings were designed to address concerns raised by colleges in December 2019 that the data request was very large, duplicated existing data collections and created difficulties in supplying requested data from college systems.

Specialist Training Program update

In February ANZCA lodged the Specialist Training Program (STP) performance report for 2019 with the Commonwealth Department of Health. The college was pleased to see continued improvement in the uptake of funded training posts and progress against key performance indicators. The college is confident of continuing this improvement in 2020 and beyond, and acknowledges the fantastic work of all fellows, trainees and training sites in making this important program a success.

ANZCA staff recently attended a STP intercollege meeting where colleges were informed of the department's policy approval for an extension of the current funding arrangements for the program for 2021. The Commonwealth has acknowledged that colleges were expecting a multi-year agreement to be offered, however, due to a need for alignment of STP with recommendations from the National Medical Workforce Strategy, the Commonwealth will be pursuing this extended option for the next funding cycle, from 2022.

ANZCA staff will continue to work with the Commonwealth to establish an additional STP expression of Interest round for new 2021 posts, and will notify sites of key dates when they are confirmed.

Pain management advocacy

The dean of the Faculty of Pain Medicine, Dr Meredith Craigie met with the Queensland Minister for Health, Steven Miles on 13 February to encourage his state's support for the National Strategic Action Plan for Pain Management. They also discussed service capacity for pain medicine in Queensland, particularly in regional areas; the need for more pain medicine training positions; and the pain medicine needs of Indigenous communities.

This follows meetings in 2019 between Dr Craigie and college president Dr Rod Mitchell, and jurisdictional ministers of health and their representatives in New South Wales, Victoria, South Australia, Tasmania and the Northern Territory.



STP staff from colleges and department of health staff at RANZCOG House during the meeting.



New Zealand

The COVID-19 pandemic has caused unprecedented disruption in New Zealand. A level 4 alert putting the entire country into lockdown came into effect at 11.59pm on 25 March. Parliament has been adjourned for an indefinite period, and the government's legislative program is on hold.

It is unclear what impact this will have on New Zealand's general election, scheduled for 19 September, although the prime minister has said there are no plans to postpone the election as yet.

At the election the public will also be asked to vote on two referendums; about whether recreational use of cannabis should be legalised; and about whether people with a terminal illness should be allowed to request medically-assisted dying.

ANZCA representatives had planned to meet with government officials to discuss these issues. A key message to officials was that if medically assisted dying is introduced in New Zealand, it must not become a substitute for good-quality palliative care. It is doubtful that planned meetings will be able to proceed, so other advocacy activities will be identified when appropriate.

In February, the prime minister announced an infrastructure package, which includes approximately \$300 million of spending for health. This includes \$96 million for three new mental health and addiction services across New Zealand; \$83 million for upgrading neonatal care and maternity facilities; and \$75 million for hospital infrastructure upgrades.

Since the COVID-19 crisis took over, the prime minister has also announced an extra \$500 million for the health system. This includes \$32 million to intensive care units, \$50 million to GPs and primary health; \$20 million to teleconferencing systems to improve remote access, and \$20 million to healthline.

Another issue to watch this year will be the outcome of the New Zealand Health and Disability System Review. Final recommendations of the review were due to government in March. These are likely to focus on a health system that better meets its obligations under the Treaty of Waitangi. This is consistent with the focus of other organisations in the health sector, such as the Medical Council of New Zealand, which released updated recertification standards late last year stating that cultural safety must be embedded in all CPD activities for doctors, as a minimum standard.

Clea Hincks

Executive Director, Policy and Communications

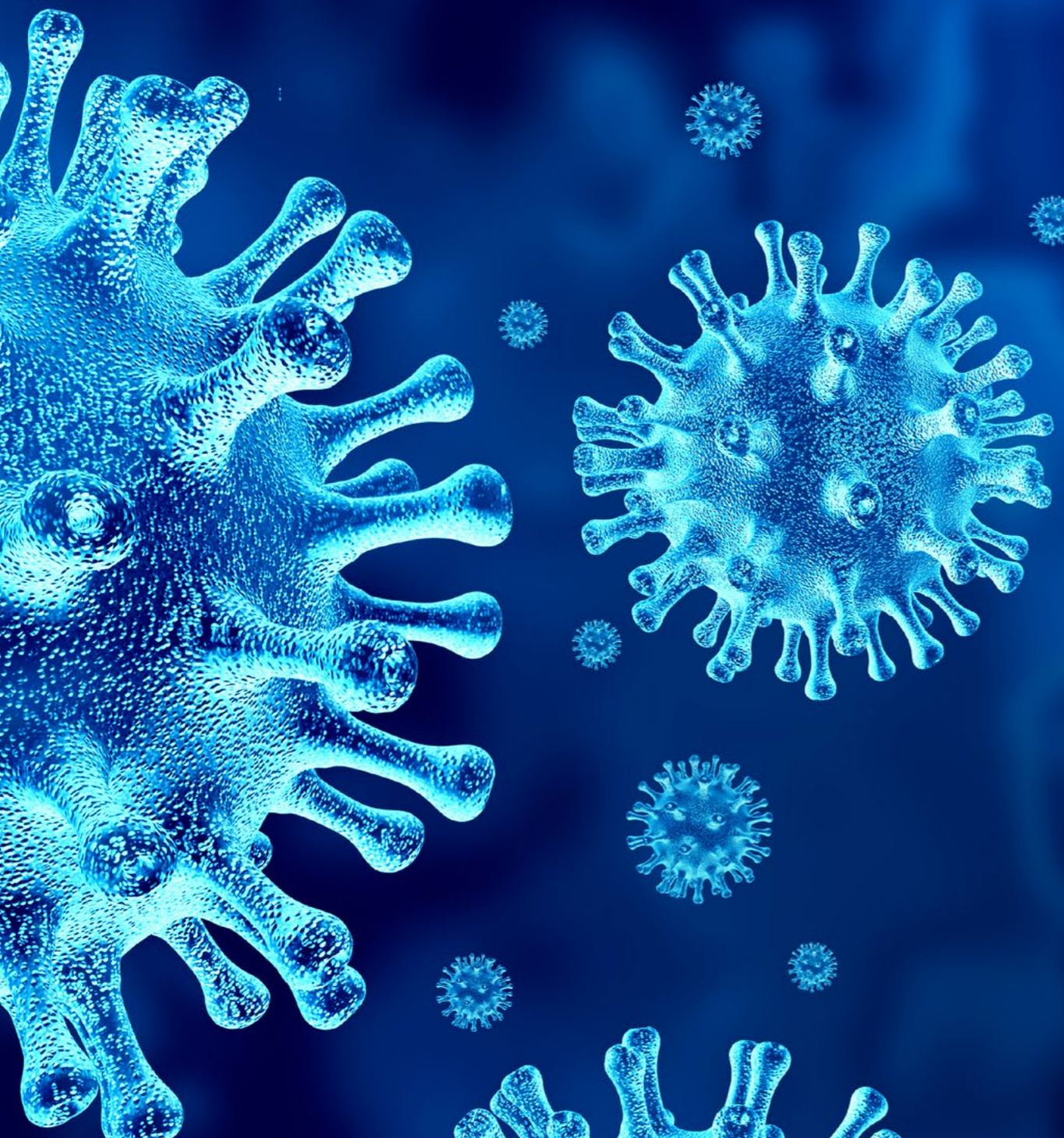
Submissions – Australia

- Medical Board of Australia: Draft revised Registration standard: Continuing professional development.

Submissions – New Zealand

- Medical Council of New Zealand: Publication of notices about orders or directions.
- Archives New Zealand: Proposed approach to disposal of health records.
- New Zealand Ministry of Health: Maternal Fetal Medicine Action Plan.
- Medsafe: Proposed changes to paracetamol warning and advisory statements.
- Medsafe's Medicines Classification Committee about reclassification of pholcodine to a restricted medicine.

COVID-19: Coping in a crisis



How ANZCA is managing COVID-19

The impact of the COVID-19 pandemic on ANZCA and FPM fellows, trainees, SIMGs and staff has been swift and brutal as Australia and New Zealand work to avoid the devastation caused by the virus in places like China, Italy, Spain, the UK and the US.

On Friday 13 March, with Australian and New Zealand governments placing restrictions on travel and large gatherings, the difficult decision was made to cancel the biggest event on the college calendar, the ANZCA Annual Scientific Meeting to have been held in Perth in May.

Face-to-face meetings were also halted, and the following week college offices around Australia and in New Zealand were closed and staff began working from home. Next came the decision to postpone primary and final exam vivas scheduled for May.

Since then other events have been postponed or cancelled and there have been numerous, long discussions by college leaders about the impact of the COVID-19 pandemic on core college activities – what does continuing professional development (CPD) look like now? How has training been impacted? Should exams go ahead and if so, how? Can hospital accreditation processes continue? How do we assess specialist international medical graduates (SIMGs)?

The college is very conscious of trainee ability to adequately prepare for and attend exams and of other impacts on training including redeployment within hospitals, effects on volume of practice and the cancellation of key courses. All are being taken into account as the college manages the training program.

ANZCA President Dr Rod Mitchell has been working closely with other college and society presidents as well as key government officials including Australian Deputy Chief Medical Officer Dr Nick Coatsworth, an infectious diseases physician.

An early action was to join other colleges in pushing for the cancellation of non-urgent elective surgery. The Australian government initially complied with the advice of ANZCA and other colleges to cancel this surgery but then extended the cancellation deadline by a week, leading the colleges to condemn the move in a public statement.

Dr Mitchell was interviewed on ABC radio and 3AW about the college's stance, citing unnecessary risks to healthcare workers and the consumption of valuable resources including personal protection equipment (PPE) likely to become in short supply.

The appropriate use and availability of PPE is one of the many challenges facing anaesthetists in this new world of COVID-19.

A COVID-19 Expert Advisory Group (CEAG) led by ANZCA Safety and Quality Committee chair, Dr Nigel Robertson, was formed with Professional Affairs Executive Committee Chair Associate Professor Leonie Watterson as his deputy.

CEAG led the development of a PPE statement intended to establish a standard based on the advice of Australian and New Zealand health authorities including infection control experts. The statement takes into account the varied character, magnitude and spread of COVID-19 and will change as more information becomes available.

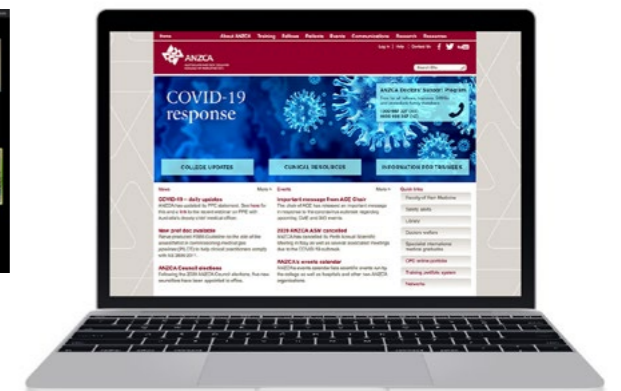
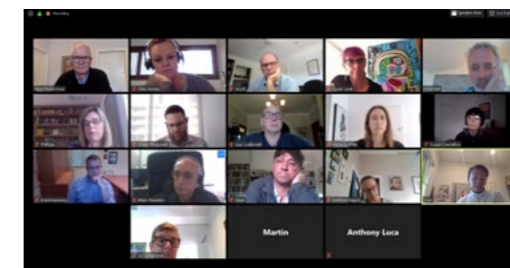
Curating the plethora of clinical resources and answering fellows' queries are two other roles of CEAG, which is made up of representatives from all Australian and New Zealand jurisdictions, special interest groups (airways, obstetrics and rural) and representatives from the Australian Society of Anaesthetists and the New Zealand Society of Anaesthetists.

There are many other groups affected by COVID-19 including rural anaesthetists with limited access to intensive care facilities, FPM fellows trying to treat patients under the restraints of social distancing (changes to telehealth Medicare regulations have helped here).

The pressures on our college community are significant at this difficult time. Please be aware of the college's free, confidential counselling services accessed via the college website as we work through these difficult months.

Clea Hincks
Executive Director,
Policy and Communications

The college has moved towards online meetings via Zoom. The Safety and Quality Committee met on April 3; All the latest college COVID-19 information is uploaded to the ANZCA and FPM websites.



VIEW FROM THE QUARANTINE FRONTLINE

Queensland FANZCA Dr Dan Holmes led the specialist Australian Medical Assistance Team (AUSMAT) COVID-19 medical evacuation response to Christmas Island when Australians were repatriated from Wuhan, China in early February. Just three months earlier he had led an AUSMAT team into Samoa, to assist with the Pacific Island nation's measles epidemic, which killed more than 80 people, mostly young children. Here, he describes the logistics of the COVID-19 quarantine mission.



“The evacuees were exhausted, they had been travelling for 36 hours or more. I think they were just relieved when they arrived. They were obviously scared as they didn't quite know what to expect.”



Left: Dr Dan Holmes (far right) with members of the Christmas Island evacuation leadership team.

Above from top: The Christmas Island crabs; A screening team performing their daily examination of evacuees.

All the background staff that you need for running a camp also had to be supported and given guidance on the best way to do things, given the risks and the fact that people were in quarantine. This included advice on how to reduce the risk of transmission and how to keep ADF staff and others safe.

We arrived on the Saturday afternoon and the first people arrived on the Monday night so we had less than 48 hours to get everything set up. We had to set up what it was we were going to do on a daily basis and how we were going to look after people.

We had no idea of the formations of the first group of 242 people until they arrived so we didn't know how many families there were. We had to have a plan for when they arrived so we could check them, give them medical screening, give them back their luggage and then allocate them accommodation depending on their needs. That all had to be done as smoothly and as quickly as possible.

Their arrival all happened in the middle of the night between 11pm and 6am. The camp is located in a remote area alongside an unsealed, potholed road covered in the famous Christmas Island crabs. It took about 45 minutes to get there from the airport and that had to be repeated four times because of the size of the group. The evacuees had to fly to the mainland from Wuhan first, and then board one of four charter flights which left at two hourly intervals.

The evacuees were exhausted, they had been travelling for 36 hours or more. I think they were just relieved when they arrived. They were obviously scared as they didn't quite know what to expect.

The straightforward things were to make sure the evacuees understood we were going to visit them every day to check their temperature and go through a screening questionnaire so we had teams of staff who would go into each accommodation block. It was always the same team who went to the same block every day. Each block contained up to 60 people. One team of three staff would go in every day for the screening process and ask about each person's health. The advantage of having the same staff was that it limited the number of staff exposed to each group.

They got to know them really well and ended up having a really good rapport.

“I GOT THE phone call on the Thursday night to ask if I could get to Brisbane airport and fly on Friday morning. I said a quick goodbye to the kids and left at 6am to get to the airport and then on to Darwin. I had to get my own brief and I then had to brief the team, because I was the mission team leader. I already knew some of the team, but a number were on their first AUSMAT mission. There's a lot of reassurance involved and I had to make sure everyone was ok.

We had 25 AUSMAT staff on Christmas Island, and some of them had gone to Wuhan on the Qantas plane to pick up the evacuees and travel with them to Christmas Island. I was working for nearly three weeks on the island. The first few days were spent getting an understanding of what the facility had, what was involved, and coming up with a plan as to how we were going to do this.

We didn't know how many people were coming at first. The media were reporting that up to 600 people had registered in Wuhan so that was the first challenge. The second challenge was that the Australian Border Force, who have the responsibility for running the facility, had to replace their usual private contractor with the Australian Defence Force (ADF), to make sure it was suitable and that everything there was working properly, such as waste disposal, food, and making sure the air conditioners and washing machines were working.





One of the children with a special "screening teddy".



Two of the younger Wuhan evacuees with drawings they've made for children at the local Christmas Island primary school.

“There’s always a bit of adjusting back to normal life after these deployments. You go from an environment where you’re dealing with everything really quickly and then back home where things are more bureaucratic and can take a lot longer.”

In addition to the AUSMAT team there were also six ADF medical staff including medics, a nurse and a radiologist. They also lived in on site and provided a much needed physical training session each morning at 6am for us. We all lived and worked as a single team and that was really important.

We had a few patients who needed testing for COVID-19 and all of those tests were sent to the mainland. We did have a testing machine that we could use about halfway through the deployment which was very useful, but we always double checked by sending samples back to Westmead Hospital in Sydney. That gave us confidence that the people who had been tested were negative. Some of the evacuees did arrive with a cold so that’s why the daily checks were important. The good news is we didn’t have any diseases that spread and no cases of COVID-19. Even those evacuees who arrived with a cold didn’t spread it to anyone else.

We were quite reassured that our quarantining was as good as it could have been. The ideal standard is to be quarantined in your own house but obviously that wasn’t the situation there. You couldn’t reasonably expect people to stay in their accommodation in their facility on Christmas Island for two weeks. The accommodation is not designed for living inside for all that time.

All you can do is mitigate the risk as much as possible. You try to spread accommodation out so one family is not right next door to another family and the evacuees were advised to always wash their hands regularly and to always wear a face mask when outside their accommodation. They were also told not to mix with other family groups but we had to accept that children will.

We weren’t there to force people into anything. All you can do is give people the best advice and make sure they understand that.

People were quite well screened before they were allowed on to the flights from Wuhan. Many of them had already been self isolating in their own home so as far as residents of Wuhan could have been, we knew they were probably low risk. We think though that some of them may have had the virus several weeks before and had completely recovered, but we can’t be sure.

Another group of 36 people came 48 hours after the first group via New Zealand so they had to be accommodated in a completely separate block.

The evacuees didn’t mix. All meals were delivered in individual boxes as there was no communal eating.

If you were interacting with the evacuees you were required to wear personal protective equipment. As I wasn’t doing clinical work I didn’t need to do that too often. Instead, a lot of my role as an AUSMAT mission leader involved working with multiple agencies and managing concerns of team members such as fatigue, anxiety and interactions.

Anaesthetists are often in a good position to do these roles because of their experience and skills in managing a theatre environment where there are occasional emergencies, conflicting priorities and managing different craft groups.

Anaesthesia is the only specialty that has been on every AUSMAT deployment that has gone out, in large part because of those other skills anaesthetists have.

Once everyone was settled into a routine, our focus quickly moved to making sure people were as comfortable as possible. One of the team members suggested putting on a concert so we organised a Chinese lantern festival concert for the evacuees and some of them played instruments and sang. We made sure everyone stayed far enough apart and we organised three of the concerts back to back so everyone could attend.

The facility had some instruments and some of the children had their own instruments. I played the piano and one of the ADF members played guitar.

We also got the local Christmas Island school children to write some letters to the kids at the facility and some of the evacuee kids wrote back to the children. When we knew it was someone’s birthday, the ADF baked a cake. All those things were important.

Below: One of the three evening concerts the Christmas Island team organised for the evacuees.

All photos courtesy of Dr Dan Holmes.



Dr Dan Holmes preparing for his AUSMAT deployment to Christmas Island.

Obviously it’s not just medical people who bring all this together. In my experience this was the best deployment in terms of everyone coming together and being on the same page. To quarantine people on Christmas Island and to have them feel positive about their two-week isolation was the work of not only the medical team but a lot of other people. There were lots of agencies that made that happen, and everyone in the team was delighted when many people said in the media that they’d have been happy to stay longer!

There’s always a bit of adjusting back to normal life after these deployments. You go from an environment where you’re dealing with everything really quickly and then back home where things are more bureaucratic and can take a lot longer.

I’d had a busy few months as I had been in Samoa, and then came home for Christmas and then went onto Christmas Island so it was good to see the family again. My oldest son who’s 15 said to me for the first time that he didn’t want me to go because of the fear around this virus so I just made sure I sat with him and his siblings to reassure them.”

*Dr Holmes is Acting Deputy Director Anaesthetics and Acting Director of Trauma at Sunshine Coast University Hospital. He spoke to ANZCA Media Manager Carolyn Jones about the Christmas Island mission on 13 March.

COVID-19 and CPD

Fellows in Australia and New Zealand will not be penalised for being unable to meet their continuing professional development (CPD) requirements in 2020 due to the COVID-19 pandemic.

THE MEDICAL BOARD of Australia issued a statement saying they will not take action if fellows “cannot meet the CPD registration standard when renewing their medical registrations” while the Medical Council of New Zealand has agreed to waive recertification requirements for the next 11 months.

Both organisations cited their recognition of the difficulties doctors are likely to have accessing the usual channels and methods to undertake learning and development to meet requirements.

The ANZCA and FPM CPD Committee is considering all communications from the regulatory authorities and how this will impact CPD participants annual and triennial requirements.

Fellows are encouraged to continue doing CPD relevant to their scope of practice where possible.

New COVID-19 emergency response

A new emergency response standard relating to airway management and essential use of personal protective equipment (PPE) has been developed in response to the COVID-19 pandemic.

This has been added to the CPD portfolio in April, and no recognition of suitability application process will be required.

Maintaining skills

The committee will continue to explore how the college can support fellows maintain their skills in this challenging time.

Options include a wealth of online education tools. For example, when a fellow logs in to ANZCA with their personal ID number and password and clicks on Networks they will then be able to access the emergency response module for Perioperative Anaphylaxis.

Cultural Competency is available as an online activity. Intercultural competency, and completion adds valuable practice evaluation credits to your CPD portfolio.

The ANZCA Library Guides are a remote learning support resource that offers excellent online education opportunities. Full credit to our talented library staff who actively source material to assist maintenance of currency in academia.

Once in the guides section click on the professional development hub to start online learning. It has links to educational material with simple advice on where to claim credits when entering the data into your personal portfolio.

There are a range of quizzes through third parties tailored to personal choice, for example, read an article you are interested in and then test your understanding of the material.

Registration for audio digest is available as a free service and podcasts are accessible for a diverse range of topics. The “Read by QxMD” app is a useful option to keep current.

Knowledge and skills

Remaining cognisant of timely education updates on COVID-19 is applicable for CPD under knowledge and skills. For example, learning the optimal personal protective equipment or best practice intubation technique for suspected COVID-19 patients.

Preparation with focused and continuing education is how we deliver health care at our best and illustrates why CPD remains relevant in the current climate.

Committee work continues

As the crisis unfolds the CPD committee will continue to meet via teleconference to assess how to manage the portfolio and requirements for 2020.

Daily college updates are provided on the ANZCA website, with a regular message from the president. That will include any key CPD information.

A new COVID-19 and CPD webpage has been created for updates, COVID-19 specific frequently asked questions (FAQs), and a list of key CPD activities resources – anzca.edu.au/fellows/continuing-professional-development.

Our best advice is to utilise the ANZCA website online education tools and communicate electronically with colleagues to share remote learning opportunities. More importantly we wish for all fellows’ healthy work and social behaviours such that all remain safe.

Dr Debra Devonshire, FANZCA
Chair, ANZCA and FPM CPD Committee

Building resources to support a pandemic

THE EVER-EVOLVING ANZCA Coronavirus/COVID-19 library guide was formed over several months.

Initially, it started as a news item on the library’s latest news page, first published in late January 2020 in response to the production of a growing list of freely available resources and open-access articles. The initial resources included Medline’s coronavirus search widget and a series of pre-populated PubMed searches. This news item continued to expand throughout February as other resources became available.

By early March – just as the college was moving to a working-from-home model – it quickly became apparent that a more robust resources guide was required for fellows, trainees and staff. On a very long Monday 16 March, a Coronavirus/COVID-19 library guide was created and released. This guide incorporated the resources from the existing news items plus initial contributions from a number of ANZCA fellows and staff, including a list of wellbeing resources collated by ANZCA Director of Professional Affairs, and Chair, Trainee Wellbeing Project Group, Dr Lindy Roberts AM.

Professional Affairs Executive Committee chair, Associate Professor Leonie Watterson provided critical support in compiling a list of key clinical resources and a new Clinical Resources tab was established. An exponential increase in the release of information resulted in the guide being updated numerous times daily.

On 25 March, the college convened a new Clinical Expert Advisory Group (CEAG) with Safety and Quality Committee Chair Dr Nigel Robertson as chair and Associate Professor Watterson as co-chair. Part of this group’s remit is identifying additional resources

for inclusion and vetting suggested content. Dr Greg Downey – chair of the Wellbeing Special Interest Group – and Mairead Jacques from ANZCA collated additional wellbeing resources for the guide. Similar contributions were also made by Dr Meredith Craigie and Juliette Whittington from FPM, the ANZCA’s Safety and Quality team and many others, with Associate Professor Watterson continuing to lead the assessment of new clinical resources.

On Friday 3 April, the ANZCA Library created a new Safety & Advocacy resources hub to help bring together resources related to safety, standards of practice, advocacy and Indigenous and global health, of which the Coronavirus/COVID-19 library guide is a crucial part. This follows similar resource hubs being created for training and examinations and professional development.

By 6 April, the Coronavirus/COVID-19 library guide has been accessed more than 13,000 times and continues to be updated almost daily.

- The Coronavirus/COVID-19 library guide can be located at: <https://libguides.anzca.edu.au/covid-19>
- The new Safety & Advocacy resources hub can be found at: <https://libguides.anzca.edu.au/safetyadv>

Something to add? Email the library (library@anzca.edu.au) with your suggestion.

ANZCA Library would like to thank the many other organisations, medical libraries and health support professionals who have worked tirelessly to not only support their clinicians but who have also taken the time to share their information with their colleagues.

NRFit update from New Zealand

Hospitals across Australia and New Zealand are gearing up for the changeover from Luer to NRFit connectors – but the Auckland District Health Board (ADHB) with FANZCA Matthew Drake at the helm is leading the pack. Here Dr Drake explains how the rollout is progressing and the lessons learnt from his recent visit to an Austrian hospital that has successfully completed the changeover.

The Luer connector enables virtually all medical devices to be interconnected. This is very convenient but has potential for harm, for example, the administration of enteral feed down an epidural catheter, or local anaesthetic for a wound catheter to be administered intravenously.

The current changes to the Luer standard were agreed internationally in 2016, with the intention of ensuring small bore medical device connectors could not be connected if they were intended for different routes of administration. There are six different connector types in the new small bore medical connector devices, shown in figure 1. Enteral feeding has now mostly transitioned to the new part 3 (ENFit) connector standard. Intravenous applications fall within part 7 of the new standard, which is exactly the same as the existing Luer connector standard.

NRFit is the pseudonym for part 6 of the 2016 International Organisation for Standardisation (ISO) standard 80369 for small bore connectors in medical devices. Devices that fall under the NRFit standard are listed in the panel on page 22 – broadly this affects equipment for spinals, epidurals and nerve blocks, as well as specialist neurosurgical equipment. Specifically excluded, however, is local anaesthetic infiltration to the skin using hypodermic needles.

“We were keen to adopt the new NRFit standard as soon as possible in Auckland, as it is a system-level way of reducing wrong route errors” explained Dr Drake, a specialist anaesthetist and Deputy Service Clinical Director, National Women’s Health.

“Little did I know that such a large number of items would be affected, nor how many spinal needles were used for non-neuraxial use in various parts of the hospital. Being one of the first hospitals in Australasia to make this transition has also added to the complexity of trying to source appropriate replacement items.”

The NRFit project began in earnest in the middle of 2019 with a series of workshops held with all the manufacturers of affected items and representatives of all affected clinical areas in the hospital. Because NRFit is a relatively new standard, not all manufacturers have all their current Luer products available in NRFit – some are being developed, while others will not be available in NRFit.

The clinical representatives throughout the hospital submitted lists of items they felt could be affected by NRFit, and the hospital’s inventory management also supplied a list of items they saw as potential NRFit products. These lists were compared and several additional items were identified that would not have been included if only one data source had been used.

“We had to get this list absolutely perfect,” Dr Drake explained.

“There are no NRFit-Luer adapters available, so every affected product has to be available on the changeover day with no stray Luer equipment still in clinical areas. Being a new standard we cannot just phone the hospital down the road to borrow NRFit items we have run out of or forgot to order, as they won’t have any to give us.”

Soon after the workshops it became clear that there were only two needle/syringe manufacturers with a large range of NRFit products available and able to supply in adequate volumes in New Zealand (Pajunk and B Braun), with smaller bespoke items available from Obex and Rocket Medical.

Contractual issues dictated that the incumbent should supply a like-for-like product in NRFit, and if one did not exist a similar item was identified. This process took a great deal of effort, negotiation, diplomacy and planning

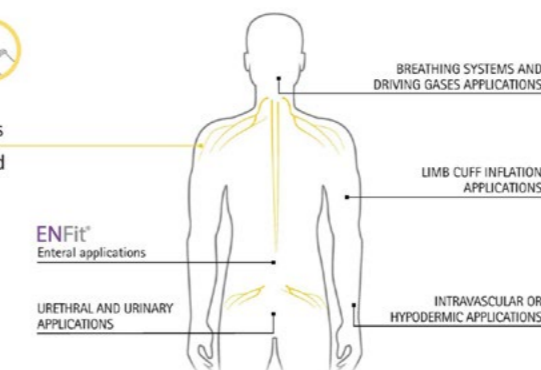


Figure 1. The six different applications of the ISO 2016:80369 standard for small bore connectors in medical devices.

FIELDS OF APPLICATION



Neuraxial & Regional Anesthesia applications
Connector design based on ISO 80369-6



Safety and quality

The NRFit block trolley, with a drawer of selected Luer items; The Austrian hospital which Dr Drake visited.



Situation awareness and anaesthesia crises

One of the recent recurrent phrases in the human factors and safety literature is “situation awareness”. There are many misconceptions about what situation awareness is. The term has morphed into “situational awareness” in the education literature but is essentially the same thing.

IMAGINE YOU ARE anaesthetising a young patient for a minor plastic surgery procedure. She has asthma but is otherwise healthy. Shortly after induction she develops high airway pressures, which you assume is associated with her asthma. Inhaled salbutamol, deepening the anaesthetic and a rapid check of the anaesthetic circuit do not resolve the issue.

The surgeon is keen to start and distracts you from noticing that blood pressure cuff is now cycling for the third time; the third time without producing a measurement.

An independent observer might easily identify the failure to measure a blood pressure as an indicator of a severe allergic reaction.

However, the anaesthetist involved may fail to notice the potential hypotension, missing a crucial sign of anaphylaxis, and adhere to their initial and incorrect diagnosis of acute severe asthma.

The scenario described here is commonplace and reflects something psychologists refer to as a “fixation error”. This is a situation where pieces of information that might conceivably be able to refute a diagnosis are not only not noticed but are even in some circumstances subconsciously

suppressed to prevent the change to an initial impression. A “fixation error” is exactly the same as a “loss of situation awareness” and can only be diagnosed with the benefit of hindsight, or by an outside observer.

So how can an anaesthetist guard against becoming fixated? Unfortunately, there are only two countermeasures; getting an external view of the situation and having a comprehensive method to evaluate whether anything has been missed.

An external view could mean routinely giving a registrar or an anaesthetic assistant permission to speak up if they observe anything unusual or that may have been missed. Summarising the situation and asking for the provision of any information that has not been mentioned, as well as for suggestions regarding ongoing management, is good leadership behaviour in any non-routine situation.

Another way to get an outsider’s view is to call for help; often a pair of fresh eyes can identify a solution or delineate the problem more accurately.

Finally, having a systematic approach to a problem can prevent us from overlooking items which in other circumstances might be completely obvious.

In this case, calling for help and using a cognitive aid such as a crisis manual booklet or the ANZCA/ANZAAG Perioperative Anaphylaxis cognitive aid differential diagnosis card could help identify the problem and point to further actions. Assigning another person with the sole task of reading the cognitive aid might also be helpful to offload some of the cognitive workload in a difficult situation.

Losing situation awareness is by definition something we can never fully appreciate in the moment. However, empowering others to consider alternatives and speak up and using checklists or algorithms can help recognise and mitigate serious mishaps.

Dr Stuart Marshall, FANZCA CJ CHCK
Research, Fellow, Monash University

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Products affected by NRFit implementation

List of products impacted by ISO 80369-6

Epidural/spinal applications

0.2 Micron disc filter
0.2 Micron needle filter
Adapter for epidural blood patch
Blood patch kit
Drawing up needle
Drawing up straws
Epidural administration sets
Epidural filter
Epidural needle
Epidural stopcocks
Filter needle
Individually packaged slip syringes
Infusion pump accessories
LOR syringes
Patient access catheter connector
Slip syringes
Spinal introducer
Spinal manometer
Spinal needle
Syringe to syringe transfer device
Three way tap
Major regional anaesthesia
Individually packaged draw up needles
Individually packaged lock syringes
Nerve block needles
Syringe caps

Continuous wound infusion

Catheter for wound infusion
Individually packaged draw up needles
Individually packaged lock syringes
Silastic LA infusion device

Equipment for specialist training

CSF pressure transducer sets
External ventricular accessories
External ventricular drains
Huber needles
Omnaya reservoir needles
RF accessories
RF needles
Spinal catheters

with clinicians who liked product X and didn’t want to swap to product Y, even if their dimensions were identical.

Dr Drake was fortunate to be able to arrange a visit to a hospital in Austria which was one of the early adopters of NRFit. They have successfully transitioned all the hospitals in the region almost exclusively to NRFit. Their process included a consolidation of existing equipment to reduce the numbers of affected products they would need to change, and even two years after the transition, new items that are NR-Fit affected have to be approved by the NRFit clinical lead. The hospital worked directly with both Pajunk and B Braun to identify, prioritise and develop the items they needed. Despite this collaboration, there remains a small number of NRFit items, principally within neurosurgery, that remain as Luer connectors, which the hospital aims to transition once they become available.

Because skin infiltration with local anaesthetic falls under the Luer standard, they have developed “block trolleys” with clearly identifiable Luer and NRFit items. The ISO standard does not prescribe the colour of equipment, but most NRFit items have been coloured yellow – their block trolleys contain one drawer of non-yellow Luer equipment for this purpose.

The Austrian experience is that, with good planning and execution of the swap-out of items together with education of staff involved, NRFit has been very successful in terms of acceptability and lack of adverse events related to misconnections.

Back in Auckland, it became clear that the backup of having a Luer-NRFit adapter would not be possible, and that

the transition from Luer would have to be over a very short period of time, by clinical regions of the hospital, to avoid incompatibility problems. Having finalised the “shopping list”, Auckland DHB are in the process of gaining the necessary financial approvals for old stock write-off and the increased cost of some NRFit items, and intend to roll out NRFit later this year.

Some areas which use NRFit-affected items for non-neuraxial use – principally radiology where spinal needles are used for all sorts of intervention – will have an “NRFit” trolley for interventional procedures involving NRFit applications, with the remainder of their inventory remaining as Luer. Workarounds have also had to be developed for prefilled chemotherapy syringes which will not be available until later in 2020. Neurosurgical equipment is also completely excluded from the NRFit implementation, as it is not available, though lumbar punctures on the neurosurgical wards will be performed with NRFit equipment. Epidural blood patches will be carried out with a specific set from Pajunk that contains a Luer male to NRFit female adapter to draw blood directly into an NRFit syringe.

Intensive planning for the NRFit changeover and an education/awareness campaign to most of the hospital’s clinical staff is now under way. Many other NZ hospitals are keenly awaiting ADHB’s NRFit transition program to conclude, so that learnings from this program and supplier inventory can be leveraged to facilitate their migration to NRFit.

Dr Matthew Drake, FANZCA
Specialist anaesthetist, Auckland District Health Board

WebAIRS: An uncommon cause for postoperative sore throat

Case report

A 26-year-old ASA-PS1 female underwent an elective left sided L4/5 microdiscectomy. At the time of surgery she was well, a non-smoker, not on any regular medications and weighed 82 kilograms (BMI of 28.4 kg/m²).

Her background was significant for previous morbid obesity for which she had a gastric band at 15 years of age and a Roux-en-y bypass at 17 years of age.

Anaesthesia was induced with fentanyl, propofol, and ketamine, and rocuronium was used for muscle relaxation. Intubation was performed by a senior registrar who found a grade 1 Cormack-Lehane view and placed an oral 7.5 reinforced endotracheal tube (ETT) on first attempt.

The patient was then rotated from the supine position to the prone position, with care given to axial stability and pressure sites. The operation time from induction to reversal of anaesthesia was one hour and 45 minutes.

The ETT was exchanged for a laryngeal mask airway (LMA) at the end of the case, prior to transferring the patient to the post-anaesthesia care unit (PACU).

The LMA was expelled by the patient after 20 minutes in PACU. The patient was reviewed by the neurosurgical team prior to discharge and was found to be well, in no pain, and eating and drinking.

Two days postoperatively, the patient's GP contacted the consultant anaesthetist requesting further advice on an abnormal looking uvula in the setting of a sore throat after anaesthesia. The patient was advised to present to the emergency department of the same hospital.

In the emergency department, she was found to have some throat irritation, tolerating oral intake with mild dysphagia, no change in her voice and no concerns for her airway or breathing. She was then reviewed by the ear, nose and throat team, who confirmed a necrotic uvula (see figure 1). She was discharged with simple analgesia and a limited script of oxycodone for break through pain and a five-day course of antibiotics. She had complete resolution of symptoms at day three post-anaesthesia.

Discussion

Uvular necrosis is a rare complication of oropharyngeal devices. It presents from one hour to two days postoperatively and typically resolves by two weeks.

Patients will have uvular ischaemia which can appear as a swollen, erythematous uvula with a necrotic or sloughy tip and they may describe symptoms of a sore throat or dysphagia. Ischaemia is thought to be a result of mechanical compression of blood supply of the uvula against the hard palate by an oropharyngeal device (that is, endotracheal tubes, laryngeal masks, upper gastrointestinal endoscopy, transoesophageal echocardiogram, aggressive oropharyngeal suction)¹.

Over the past 40 years, there have been 53 reported cases of uvular necrosis worldwide^{2,3}. Males represented three-quarters of all reported cases but there were no other associations with type or length of procedure, or the type or size of oropharyngeal airway³.

The largest study included 10 patients and reported an incidence of 0.034 per cent over four years at a single tertiary centre⁴.

Treatment of uvular necrosis has most commonly been observation and analgesia, while some cases have been treated with steroids to reduce airway swelling or antibiotics to prevent secondary infection⁵. Prevention of uvular necrosis may be reduced by placing any oropharyngeal devices away from the midline, avoid blind suctioning and lowering the power of suction devices⁵.

Web-based Anaesthesia Incident Reporting System (WebAIRS) is a de-identified anaesthesia incident reporting system available to all members from ANZCA, the Australian Society of Anaesthetists and the New Zealand Society of Anaesthetists. Reporting adverse events or near misses via WebAIRS also qualifies for CPD points.

This case was reported to the department's airway lead and entered into the WebAIRS database as an adverse event. Incident reporting is essential for rare adverse events to identify emerging risks to patient safety and identify preventable factors.

Dr Matthew Bright, Dr Sandra Concha Blamey, Dr Linda Beckmann and the ANZTADC Case Report Writing Group

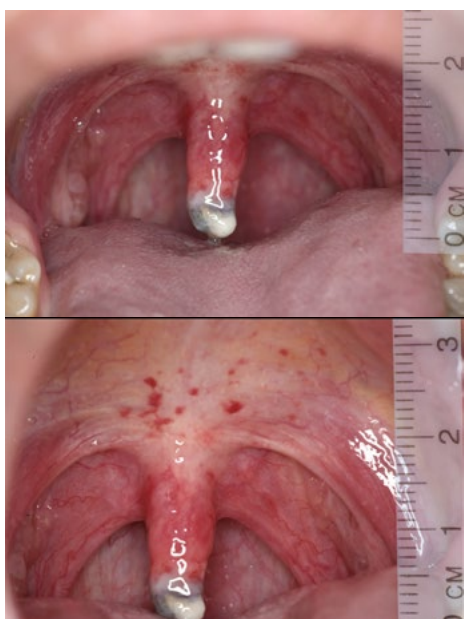
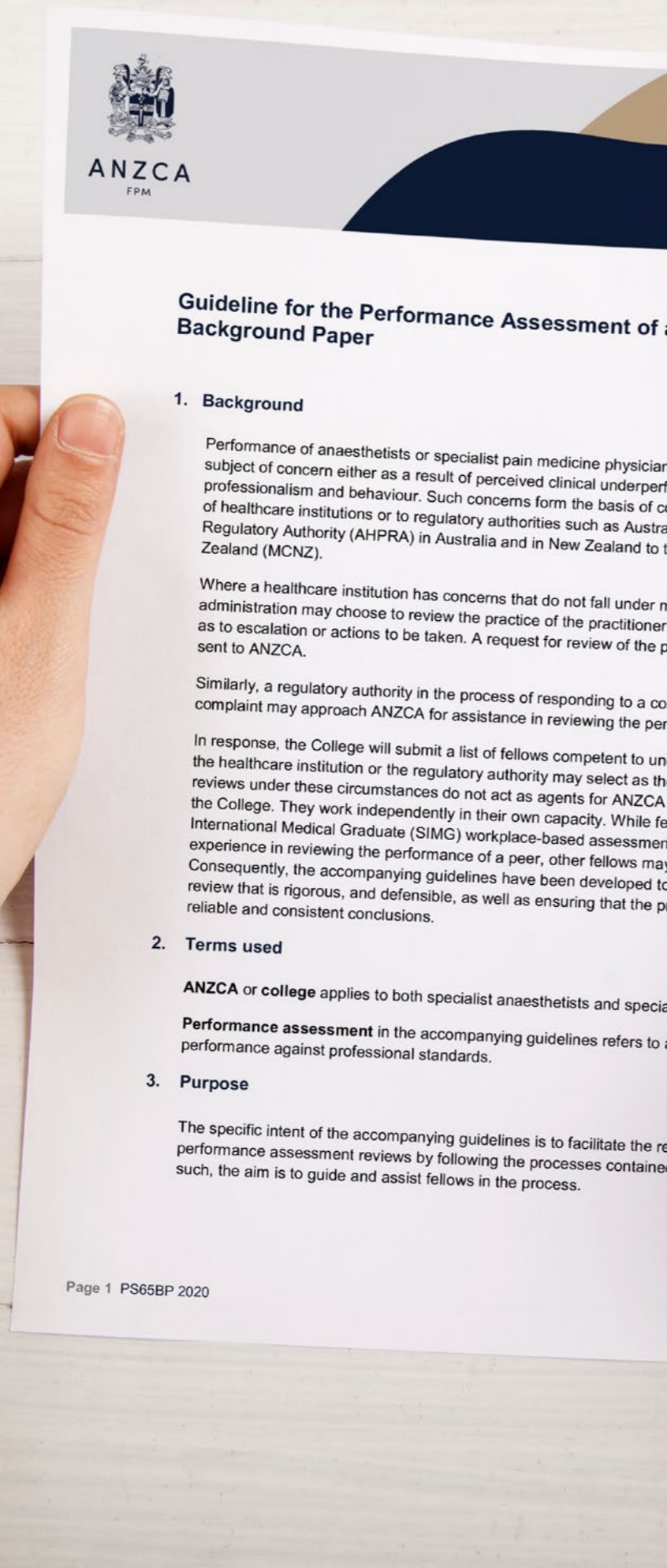


Figure 1: Necrotic uvula.

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ANZCA's prof docs



Page 1 PS65BP 2020

What would you do?

Dr Peter Roessler explains ANZCA's professional documents using practical examples.



WITH THE BEGINNING of this year heralding the start of a new decade it is opportune to reflect but also to look forward. Having a vision for ongoing improvement in patient care will be determined to some extent by reflection on past experiences, as well as conceiving of and exploring new ideas – “thinking outside the box”.

Naturally, any resulting ideas or innovations for clinical care need to be evaluated against standards of safety and quality. Where such innovations meet standards and enhance outcomes their uptake is aided through education and effective communication. ANZCA professional documents, whose development/review is governed by *A01 Policy for the Development and Review of Professional Documents* and *A01BP (ANZCA) and AP01 Policy for the development and review of professional documents - 2018 (FPM)*, set standards for anaesthesia, pain medicine, and perioperative medicine against which comparisons can be made.

Clinical anaesthesia, pain medicine, and perioperative medicine are not practised in isolation but instead involve multidisciplinary teams. In the operating room environment, it would be remiss to fail to recognise and acknowledge that patient care is a team effort involving our nursing colleagues, surgical colleagues, and theatre technicians.

Similarly, this can be witnessed in sporting events, such as the famous Lorne Pier to Pub swim in Victoria where medical practitioners from different specialties, nurses and ambulance paramedics come together to make up such teams.

Evidence suggests that team performance rather than individual performance has the greater impact on patient outcomes. Any siloing in such environments is counterproductive and consequently, an understanding and appreciation of team player roles and value is

essential. At the risk of sounding paternalistic it is worth recalling that effective communication between members is central to achieving such understanding, as is being respectful and receptive to team members' views.

Given that clinical environments in which we work involve teams whose members have varied training and backgrounds, each of whom brings their specialised skillsets, how are ANZCA professional documents and standards perceived by team members? Clearly each medical and nursing college has its own set of standards. However, ANZCA “prof docs” in issuing guidance regarding patient safety and outcomes, will impact on other team members, which raises the important issue of the role of collaboration with stakeholders to ensure a co-operative culture and a greater likelihood of achieving the shared common goal.

The following scenario is intended to emphasise the principle of collaboration and working towards all team players/members being part of a unified “us” as opposed to creating a polarised “us and them” situation.

The day-stay procedural hospital at which you are credentialled would like you to assist the administration in developing its discharge policy. They are happy for you to assemble a team to assist you with your task.

What would you do?

Who would be in your team and what issues would you consider important in selecting team members? How would you address any perceived limitations and mitigate unforeseen consequences, keeping in mind that the purpose is to develop an efficient and workable policy that enhances patient care?

Clearly, there needs to be an appreciation and understanding of the problem driving the demand for the policy as applicable to the institution seeking your advice. Proceduralists, anaesthetists/sedationists, and nurses, will all be involved in caring for patients at the facility.

A01 (ANZCA) and AP01 (FPM) outline the policy from which it is clear that for ANZCA/FPM professional documents stakeholders are to be involved in the development/review process. The stage at which this occurs may vary depending on circumstances, however, it is an integral part of the process.

The breadth of consultation is determined by relevance and on occasions includes regulatory authorities, indemnifiers, and community representatives. This is especially significant as ANZCA spans two separate countries with different laws and regulations.

On our website the following are co-badged with other colleges – *PS52 Guidelines for Transport of Critically Ill Patients* with the Australasian College for Emergency

Medicine (ACEM), the College of Intensive Care Medicine (CICM) and ANZCA, and *PS63 Guideline for Safe Care for Patients Sedated in Health Care Facilities for Acute Behavioural Disturbance* with ACEM, CICM, the Royal Australian and New Zealand College of Psychiatrists and ANZCA.

PS29 Guideline for the Provision of Anaesthesia Care to Children is being considered for co-badging with the Society for Paediatric Anaesthesia in New Zealand and Australia, and while *PS09 Guidelines on Sedation and/or Analgesia for Diagnostic and Interventional Medical, Dental or Surgical Procedures* is currently endorsed it will be co-badged with many of the colleges and stakeholders following its review this year. For co-badged documents major stakeholders contribute as document development group members, which fosters greater engagement and ownership.

Where ANZCA professional documents may exert influence over non-anaesthetists the relevant colleges are invited to provide feedback during the stakeholder consultation stage.

PS04 Statement on the Post-Anaesthesia Care Unit issues guidance on staffing levels and training of nurses, however, this is a matter for the nursing colleges. In

recognition of their invaluable input the document references the ACORN standards and ACPAN Statements and NZNO feedback.

When it comes to assistants to the anaesthetist *PS08 Statement on the Assistant for the Anaesthetist* received support through collaboration with nursing colleges and theatre technician societies.

With *PS26 Guidelines on Consent for Anaesthesia or Sedation*, feedback was received from numerous sources including the Health and Disability Commissioner – NZ.

Clearly, *PS28 Guidelines on Infection Control in Anaesthesia* involved input from infection control nurses as well as infectious diseases physicians. *PS53 on handover* is another example of non-anaesthetists who are impacted by an ANZCA prof doc and whose stakeholder input was invaluable.

So, when it comes to developing the policy for your hospital, appreciating the value and role of team members is critical. In order for any policy to be effective there is value in consulting and collaborating with all those that may be impacted by the policy. The incidence of unintended consequences, which can ultimately make a policy unworkable is likely to be significantly reduced by such actions.

Dr Peter Roessler
Director of Professional Affairs, Policy

Professional documents – update

The complete range of ANZCA professional documents is available via anzca.edu.au/resources/professional-documents and the FPM professional documents via fpm.anzca.edu.au/resources/professional-documents.

Recent updates

- Document development group membership has been established for the review of *PS09 Guideline on sedation and/or analgesia for diagnostic and interventional medical, dental or surgical procedures* and the review will commence shortly.
- Document development group membership is pending confirmation for the development of *PS67 Professional document on end-of-life care for patients scheduled for surgery*.

- Post-consultation review has been undertaken on new professional document *PS66 Guideline on the role of the anaesthetist in commissioning medical gas pipelines* with the draft document pending consideration for pilot phase.
- Work has commenced on the review of *PS55 Recommendations on minimum facilities for safe administration of anaesthesia in operating suites and other anaesthetising locations* with the draft document pending consideration for release to consultation with stakeholders.
- Work has progressed on the review of *PS56 Guideline on equipment to manage a difficult airway during anaesthesia* with the draft document pending consideration for release to consultation with stakeholders.
- Post-consultation review has been undertaken on *PS26 Guideline on consent for anaesthesia or sedation* with the draft document pending consideration for pilot phase.
- Post pilot review is being undertaken on *PS04 Statement on the post-anaesthesia care unit*.

In pilot

- PS06 Guideline on the anaesthesia record* (until August 2020).
- PS29 Guideline for the provision of anaesthesia care to children* (until August 2020).
- PS43 Guideline on fatigue risk management in anaesthesia practice* (until August 2020).

Recent release

- PS02 Statement on credentialling and defining the scope of clinical practice in anaesthesia*.
- PS65 Guideline for the performance assessment of a peer*.

Feedback is welcomed during the pilot phase for all professional documents. All comments and queries regarding professional documents can be sent to profdocs@anzca.edu.au.

Flinders' recycling initiative

We continue our series looking at how hospitals are trying to become more sustainable. ANZCA's Environmental Sustainability Working Group would like to hear what your hospital is doing in this space. Please email communications@anzca.edu.au.

AT FLINDERS MEDICAL CENTRE (FMC) in South Australia anaesthesia nurse Darren Bradbrook started a theatre recycling project in 2017 with the aim of looking at how best to manage the volume of waste and how it could be diverted from landfill to a recyclable product.

To address some of the perceived barriers to these changes issues such as staff engagement and education – especially when trainee turnover is high – and ease of carrying out the processes were identified and solutions sought. These included extensive face-to-face and continuing education of all perioperative staff with posters where the recycling bins were located; placing more receptacles for recyclable products near the generation of this waste to ensure that the sustainable choice is the path of least resistance; and discouraging production of landfill by ensuring these bins were smaller and co-located with sharps containers to better inform staff about what is waste versus what is recyclable.

In another initiative, a multi-disciplinary group of recycling champions was identified – a sub-group of people passionate about sustainability – which included not only anaesthetists, but perioperative nurses and surgeons. Changes included initiating PVC recycling of intravenous fluid bags, oxygen masks and tubing, which previously had been sent to landfill; separation of high- and low-grade plastic waste which can be fully diverted from landfill by recycling and reusing; and recycling aluminium inhalational anaesthetic canisters from landfill. These had previously been disposed of at a cost to us, so we have now made financial savings in addition to the environmental benefits.

Since the project's inception there has been a roll out to other departments with about 10 locations across our health network now involved in a network-wide recycling initiative. To date, this has diverted:

- More than 3.2 tonnes (3200 kilograms) of PVC from landfill, which has been recycled into 20 kilometres of garden hose and over 450 play mats for children.
- More than 1520 cubic metres of plastics – equivalent to 1.5 Olympic-sized swimming pools of compressed plastic – from landfill. The plastic has been used as Processed Engineered Fuel coal substitute.
- More than 2400 aluminium anaesthesia gas canisters, that have been made into children's bike frames.

One further initiative has seen a life-sized mosaic designed and created by anaesthesia nurse Maria Cmielewski, and contributed to by a group of anaesthesia nurses, with FMC Arts In Health, made entirely from discarded items that would have once ended up in landfill. It is aimed at showing ways in which we care for our patients and the broader community by adopting sustainable practice.

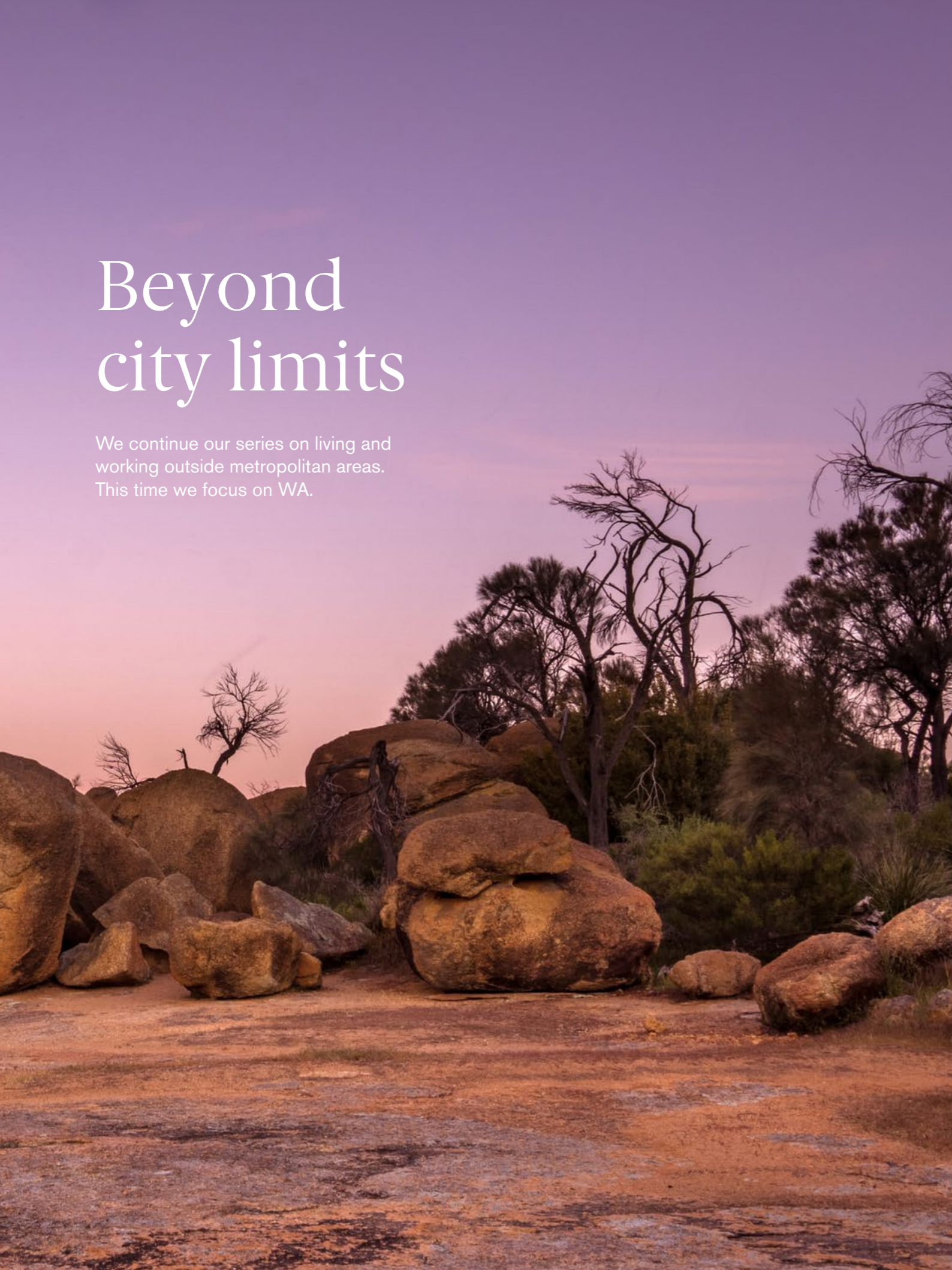
Dr Alexandra Zanker, BSc, BMBS, FANZCA
Senior Consultant Anaesthetist, Flinders Medical Centre

Life-sized mosaic designed and created by anaesthetic nurse Maria Cmielewski, with FMC Arts In Health, made entirely from discarded items which would have once ended up in landfill.



Beyond city limits

We continue our series on living and working outside metropolitan areas. This time we focus on WA.



Below: Late afternoon on Busselton beach, a popular spot in the heart of WA's south-west surfing mecca. Photo: Carolyn Jones.

Going west to get the best of both worlds

ANZCA fellows in Western Australia have a vast area in which to live and work. Here, we speak to some of them to get their thoughts on how they navigate life in regional areas.

DR EMILY FERGIE thought there was something familiar about her patient at the Albany Hospital so when she heard "I knew you as a toddler" she knew she had been right.

Having grown up in a farming community in Kendenup, a small town near Albany, 400 kilometres south-east of Perth, Dr Fergie realised that the patient was an old friend of her parents. She couldn't help but think that the chances of seeing a familiar face from her childhood would have been unlikely while she was completing her anaesthesia training in Perth.

Dr Fergie is one of several ANZCA fellows in WA who grew up in regional or remote areas of the state and who have either worked or returned to work as specialists in their home regions. A Perth-based consultant anaesthetist she now spends two days a week working in Albany at both a private hospital and Albany Hospital.

She and her family stick to a tight weekly schedule. Every Wednesday afternoon she and her 14-month-old son Raphael board a Rex Airlines flight from Perth for the 50-minute journey to Albany. Her husband, an engineer, flies in for the weekend and they spend time overseeing the building of their new home outside Albany before returning to Perth on Sunday night. She then works another day in Perth during the week.

Dr Fergie first trained as a GP anaesthetist, moving east to Wangaratta Base Hospital in Victoria in 2007-8. She gained her ANZCA fellowship in 2016. One of her two brothers, Alex, trained as an emergency doctor and he also works at Albany Hospital.

"Having a balance between work and other interests has always been important to me and I have always thought about the best way to set up a practice and have a family. A few things came into play in the last couple of years which has made it all possible," she told the *Bulletin*.

"Being able to return and work as an anaesthetist in the community where I grew up is not only very rewarding but I'm also working with a group of talented specialists in the area including rural surgeon Mr Tom Bowles and palliative care physician Dr Kirsten Auret. The quality of healthcare in Albany is excellent and the GPs and GP anaesthetists here are extremely dedicated and committed to the community. There's also a strong culture of fostering excellence in clinical leadership and surgical and specialist training too."

Medical and hospital services in WA's Great Southern region have expanded in recent years to cater for the burgeoning population of retirees and downsizers, many of whom have relocated from Perth. Many procedures and operations can now be performed in Albany in either the public or private system. Until a few years ago patients and their families would have had to travel to Perth for consultations with some specialists and now this is becoming more of a rarity rather than the norm.

Dr Fergie studied medicine at the University of Western Australia after receiving a RAMUS (Rural Australia Medical Undergraduate Scholarship): "At the time I wasn't on a bonded scholarship so there was no onus on me to return to a rural or regional area after I had completed my medical degree but I soon realised that the pull of family, community and life-long friends were important to me.

"When you're working in a smaller community you form long-term relationships with both patients and the other staff you work with. I feel very honoured to work with some inspiring, dedicated and very talented people. I really do feel blessed to be able to come back and work in the area that supported me when I was growing up."





“I really do feel blessed to be able to come back and work in the area that supported me when I was growing up.”

Anaesthetist Dr Emily Fergie with her son Raphael divides her time between Perth and Albany in WA's south-east. Photo: Carolyn Jones.

Dr Fergie also takes on locum work when possible. Earlier this year she spent time in the Pilbara and in Kununurra in the state's far north-west and likes to work in other rural areas where possible.

Like Dr Fergie, Perth obstetric anaesthetist Dr Graeme Johnson also grew up in regional WA. A member of ANZCA's WA Regional Committee, Dr Johnson spent his early childhood in Esperance and York, the oldest inland town in WA, 97 kilometres east of Perth. He first trained as a GP anaesthetist in 2006 and spent three and a half years in Kununurra at a 32-bed hospital before gaining ANZCA fellowship in 2016.

He has also worked in Derby and Kalgoorlie and has extensive experience working with local Aboriginal communities in the Kimberley region of Western Australia.

“If you've grown up in a small town it's far less foreign to venture and work in small towns. For me it was far less daunting as I think I had an understanding of the dynamics of living and working in a small community, more than if I had only been raised in the city,” Dr Johnson explained.

“There's definitely a comfort factor as it means you have an idea on how to integrate more easily into a small community. With a family you can understand the appeal of smaller communities in many ways. My motivation for when I was living in the remote north of the state concerned equity of health access and service to the community. I do think the remote, rural medical practice experience helped to make me a better doctor. I have learned not to worry so much about the small stuff.”

Two hundred kilometres south of Perth anaesthetist Dr Sean Oberholzer works as a consultant in Busselton and Bunbury in both the public and private sector. A former South African body boarding champion, Dr Oberholzer migrated to Perth from Cape Town five years ago. He spent his first year in Australia working at Fiona Stanley Hospital and then settled in Yallingup in the heart of WA's south-west surf mecca. Yallingup is a 25-minute drive from Busselton and a one-hour drive from Bunbury.

Dr Oberholzer splits his working week as a visiting medical officer (VMO) between Busselton Hospital and Bunbury Hospital and enjoys his work life balance. He and his wife Angela, a yoga teacher, live on a one hectare property with a veggie patch. The beach is a 10-minute walk away.

“When I first arrived here in Busselton and Bunbury the region was short of anaesthetists. Now the situation has improved and I'm working hard trying to build up my own practice and doing relief work when I can.”

Though he doesn't get to body board as much as he would like Dr Oberholzer says there are many advantages to living and working in a regional area.

“There's virtually no traffic – just four traffic lights when I drive to Bunbury – and we're surrounded by great food and good wineries. We have some of the most beautiful beaches in Australia here and last year Yallingup was crowned as Australia's Best Town (by *Australian Traveller* magazine).”



“When I first arrived here in Busselton and Bunbury the region was short of anaesthetists. Now the situation has improved and I’m working hard trying to build up my own practice and doing relief work when I can.”

Busselton has three operating theatres and carries out elective eye surgeries, joint replacements and gynaecological, urological and general surgeries. Back in South Africa, much of Dr Oberholzer’s work was dominated by trauma cases – mainly stabbings and gunshot wounds. In Busselton and Bunbury Dr Oberholzer works closely with the hospitals’ GP anaesthetists and says there is far more support for consultant anaesthetists in Australia than in South Africa.

Bunbury Hospital, where 8000 theatre cases are carried out each year, is the only rural training site for anaesthetists in WA. The hospital has two Specialist Training Program (STP) anaesthesia trainees each year – and has also assisted the College of Intensive Care Medicine with STP anaesthesia rotations in the past.

Dr Miles Earl, Busselton hospital’s clinical lead, anaesthesia, moved his young family to Margaret River from Perth in 2015. After acting in the clinical lead role he formally took on the position two years ago.

Born in Perth he completed his medical degree in Queensland and did anaesthesia fellowships in paediatrics and trauma in Adelaide and London before returning to Perth. The Margaret River holiday home he and his wife owned eventually became their primary residence when he started taking consultant positions in Bunbury and Busselton.

Dr Earl said the time he had spent away on fellowships made it that little bit harder to secure salaried roles in Perth so he and his wife decided to move down south. At first he was driving between Margaret River, Bunbury Hospital and Busselton Hospital, notching up 40,000 kilometres a year. But the opportunity to take on a salaried position at Busselton meant he could spend less time on the road and more time with the family.

“It was a big decision to make after I received a phone call offering me a position in Bunbury but we were familiar with the area and it was a significant role. I’m lucky now in that I only have a 30-minute drive to work so I do have a better work/life balance.”

Since taking on the permanent leadership role in Busselton Dr Earl has established an acute pain service at the hospital and plays a key role in managing the crucial ongoing relationship between specialist anaesthetists and GP anaesthetists at the hospital.



Above: WA anaesthetist Dr Sean Oberholzer. Photo: Carolyn Jones.

“My goal is to maintain a robust and safe clinical service and ideally work towards having an anaesthesia trainee, possibly on a regional fellowship arrangement,” he explained.

Busselton hospital is the regional WA leader in eye surgeries and aims to perform 300 joint replacements this year. In addition to gynaecological, dental and general surgeries it has a 24 hour, seven days a week epidural service.

Dr Earl admits that some of the challenges of daily life such as car breakdowns can be just that little harder to fix when you’re living in a regional area.

“Trying to organise car hire or a lift from a surgeon to get from home to the hospital after your car engine blows up can be a bit trying but you end up doing what you can and it all works out in the end.”

Carolyn Jones
Media Manager, ANZCA

Vital role for simulation education in WA regions

Over the past 10 years Dr Claire McTernan has grown quite attached to 3G SIM man, a well-travelled high fidelity mannequin that she and several other anaesthetists and anaesthetic technicians in Western Australia use for simulation education in emergency airway skills management (EAM).

SIM man is key to the lectures and workshops that Dr McTernan, a consultant anaesthetist at Fiona Stanley Hospital in Perth helps roll out to remote and rural hospitals in WA as part of a team that is funded by the Federal Department of Health.

As one of the clinical leads for the Medical Specialists Outreach Assistance Programme (MSOAP), Dr McTernan works closely with the co-ordinator, anaesthetist Dr Christine Grobler from Royal Perth Hospital and lead anaesthesia technicians Janice Haydon and Selvan Govindhan-Vairavan to ensure that hospitals in regional and remote areas such as Kununurra near the Northern Territory border, Albany to the south, Merredin to the east and Geraldton to the north, have access to the team’s simulation and clinical expertise.

Dr McTernan explained the logistics of each visit: “The team either flies or drives depending on the distance from Perth. Once the team arrives, it’s straight to the hospital. We first meet with the nurse manager to choose the areas we can setup for our lectures and workshops. We also go through their difficult airway trolley, their crisis trolley with anaphylaxis and their malignant hypothermia (MH) and local anaesthetic systemic toxicity (LAST) boxes and make sure they are standardised.

“We look at local protocol for calling for help and how to get blood etcetera. We also find out about any big code blues (such as trauma, airway bleeding,



anaphylaxis, obstetrics) that may have happened in the hospital of late. We often recreate these scenarios so further learning can occur and also to test drive any new polices and protocols such as local massive transfusion that may have changed as a result of the experience.

“We then get down to reassembling SIM man and hope that he has survived the journey as we send him and other equipment in 15 silver boxes by road train two weeks ahead of our arrival. The hospital nurse manager then takes delivery and puts him in storage until we arrive.”

The SIM man they use is quite versatile and high fidelity, being able to recreate cardiac arrhythmias, airway disasters, burns and trauma. He can even be transformed into a pregnant woman for obstetric scenarios.

“The program started about 15 years ago with the aim of providing airway crisis management education for both adult and paediatrics,” Dr McTernan said.

“Learning is facilitated through lectures, workshops and simulated scenarios for up to 20 people (usually emergency department GPs, GP anaesthetists, theatre and emergency nurses and the odd medical student thrown in!).”

The team is planning three visits this year (half the number of annual funded visits from when the program started as an initiative with the WA Centre for Remote and Rural Medicine and Dr Leigh Coombs, the then head of anaesthesia at Royal Perth Hospital). It runs as a joint program between Fiona Stanley Hospital, Royal Perth Hospital and Perth Children’s Hospital.

Dr McTernan said the feedback from participants was extremely positive as the sessions were not only informative and realistic but also gave the participants a chance to debrief difficult cases.

All the clinical leads involved in the program hold a fellowship in simulated medicine and are experienced in adult debriefing.

*The EAM team would like to acknowledge and thank lead anaesthetic technician Janice Haydon for all her hard work with the program over the past 15 years. They’re looking forward to working with her successor Selvan Govindhan-Vairavan.

Carolyn Jones
Media Manager, ANZCA

Top right: Dr Claire McTernan, consultant anaesthetist at Perth’s

Fiona Stanley Hospital. Below: Dr McTernan (left) with colleagues from the EAM program.



WA rural anaesthesia voice says regional focus is important

Dr Pat Coleman, a strong advocate for rural anaesthesia, at home with his boys Fergus and Ned.



PERTH ANAESTHETIST AND

specialist pain medicine physician Dr Pat Coleman isn't fazed when he rings a fellow or a GP anaesthetist, only to be greeted with "Oh, hello Lord Vader."

As clinical lead (anaesthesia) for the WA Country Health Service (WACHS), the largest country health service in Australia covering 2.5 million square kilometres, Dr Coleman has spent the past 10 years in a key role that involves supervising all 20 hospitals with operating theatres in WACHS outside Perth.

His position not only involves purchasing equipment and drugs (to keep rural hospitals up to date with their metro-based counterparts), training, upskilling and credentialing of GP anaesthetists, trainee registrars and WA rural generalists but also investigating and advising fellows on adverse outcomes. In addition the role involves selection and support to rural based or visiting FANZCAs of which there are about 15-25 living in the state's rural areas.

His previous role was as head of anaesthesia at Bunbury Hospital, the largest hospital in WACHS.

"In some ways Lord Vader is an apt description of the work I do. My role is mainly supportive and directive as it defines anaesthetic clinical privileges for non-specialist anaesthetists but it can also be educational and directive as I have to make sure anaesthetists and GP

anaesthetists learn from adverse events and are taking on appropriate cases," Dr Coleman explained.

Adverse outcomes are also de-identified and presented at three monthly morbidity and mortality teleconferences involving WA regional hospital representatives.

A member of the Rural Special Interest Group (SIG) Dr Coleman is an important voice for rural anaesthesia, not only in WA but in the other states and territories too. While he continues to practice privately, his non-clinical WACHS role gives him some serious clout in the specialty in rural WA.

When he first took on the role after his return from Bunbury he asked for, and got from the WA Health Department, an ultrasound machine at a cost of \$A40,000 each for all 20 rural and regional WA hospital operating theatres.

"My role is to look after rural credentialing, teaching, adverse outcomes and policy for all of the 20 theatres located outside Perth so being able to achieve something such as the ultrasound purchase (and training on how to use them) can make a big difference to patient safety and quality throughout the state," he said.

His role also includes purchasing suitable anaesthetic machines and providing standardised intubation trolleys and video laryngoscopes

and sugammadex in all theatres. He has also provided and guided the use of fibrinogen concentrate for obstetric haemorrhage in all WA regional maternity sites with Dr Roger Browning, an anaesthetist from Perth's King Edward Memorial Hospital.

WACHS covers hospitals across seven administrative regions supported by the central office in Perth where Dr Coleman is based – the Kimberley, Pilbara, Midwest, the Wheatbelt, the Goldfields, the South West and the Great Southern region.

Dr Coleman often travels to regional WA towns such as Derby, Collie, Carnarvon and Geraldton for teaching and support of non-specialist and specialist anaesthetists.

He says compared to other states, WA's health system is a national leader in the collection of data on hospital cases and adverse events and credentialing. (One of Dr Coleman's Rural SIG data presentations is available at: <http://airr.anzca.edu.au/anzcajspui/bitstream/11055/17/1/Concurrent-session-45-1545-Pat-Coleman.pdf>).

"Data collection can be problematic in other states where they have multiple health services and no overarching supervisory lead," he told the *Bulletin*.

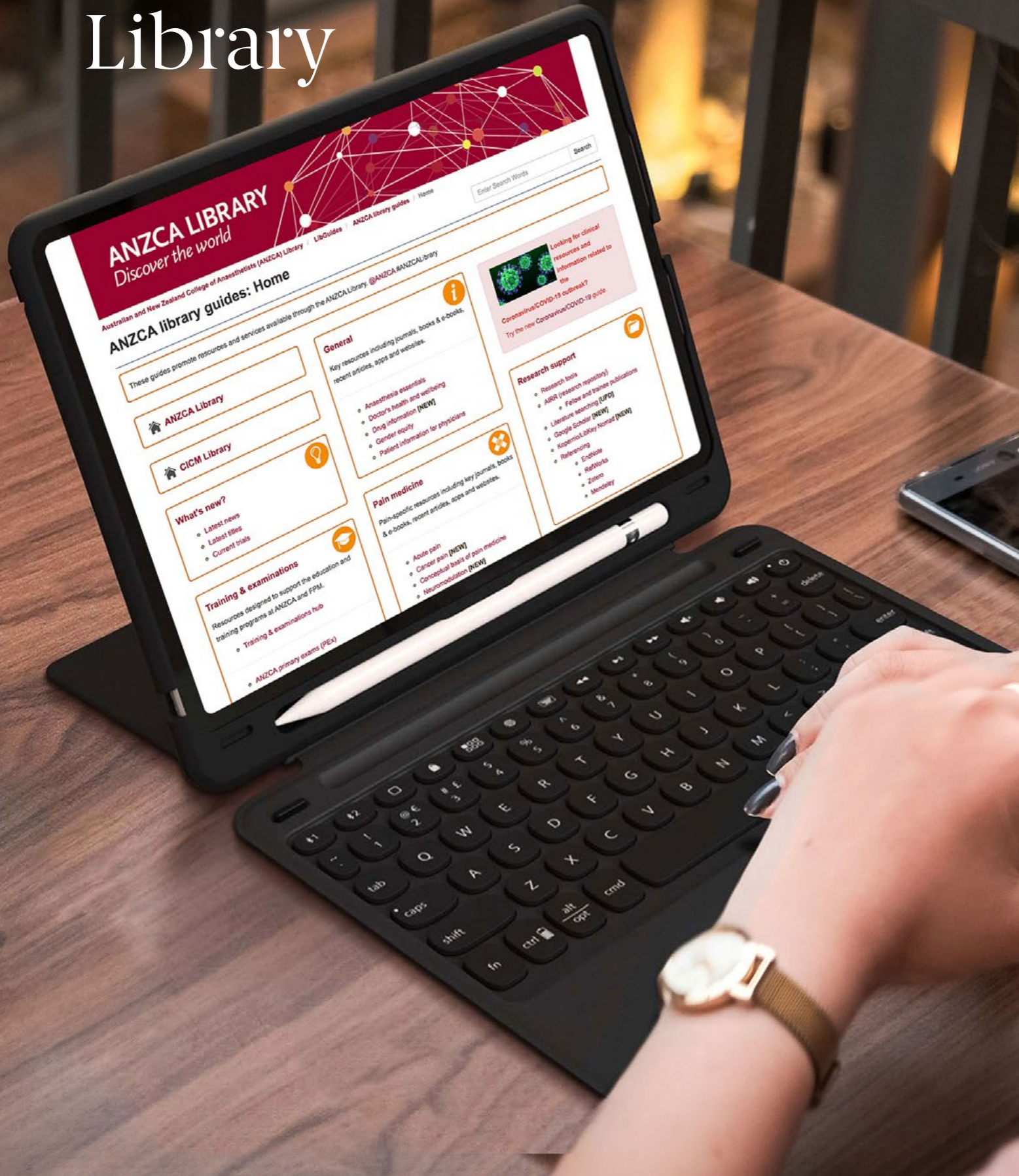
"This can manifest in such things as different types of video scopes or anaesthetic machines at different hospitals unlike in WA where equipment is standardised. Adverse outcomes at different WACHS sites are regularly analysed and changes made across all sites to prevent a re-occurrence."

Dr Coleman says the "tyranny of distance" has made it harder to attract specialists "out west" for temporary or permanent work and to entice them out of WA metro areas.

In his role on the Rural SIG Dr Coleman is hoping to raise the profile of rural anaesthesia among college fellows and trainees. Fellows who are interested in finding out more can contact Dr Coleman at Patrick.Coleman@health.wa.gov.au.

Carolyn Jones
Media Manager, ANZCA

The ANZCA Library



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For more information, see our dedicated Kopernio/ LibKey Nomad library guide: <https://libguides.anzca.edu.au/browserext>

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Once selected, the user will be taken to the ANZCA Library Search Articles service:

- If available full-text: select View Full Text link.
- If not available full-text: select Request article via Library link*, enter your personal details and click the Submit button.

*Automatically populates request form with article details. Articles are usually supplied within 2-3 working days.

For more information, see our dedicated PubMed library guide: libguides.anzca.edu.au/pmed.

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- Full-text access via Google Scholar: libguides.anzca.edu.au/google
- Full-text access via Read by QxMD: libguides.anzca.edu.au/apps/read
- Full-text access using BrowZine: libguides.anzca.edu.au/apps/browzine
- Full-text access via Ovid Medline: libguides.anzca.edu.au/medline

Better searching for anaesthesia- and pain-related articles

Every year the National Library of Medicine (NLM) update the Medical Subject Headings (MeSH) to include new topics that can be searched in the Medline/ PubMed database.

In 2020, a number of new terms have been added that are relevant to anaesthesia and pain medicine, including the following:

Enhanced Recovery After Surgery

A protocol of components related to pre-admission, preoperative, intraoperative, and postoperative care. The protocol is implemented with the goal of improving patient recovery, facilitating earlier discharge from the hospital, and potentially reducing health care costs without increasing complications or hospital readmissions. The protocol components may contribute to minimizing, and/or improving the response to, physiological stress associated with surgery.

Opioid Epidemic

Widespread use of OPIOIDS by disproportionately large numbers of individuals within a population, community, or region occurring within a relatively narrow window of time.

Perfusion Index

The ratio of arterial blood flow (PULSATILE FLOW) to venous, capillary, and tissue blood flow (non-pulsatile blood flow) – as measured regionally or peripherally.

Perioperative Medicine

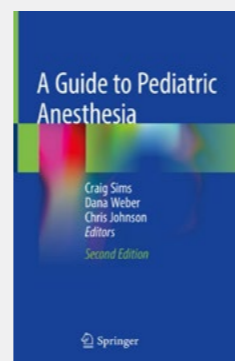
A medical specialty concerned with the patient before and after surgical procedures.

Postoperative Cognitive Complications

COGNITIVE IMPAIRMENT or functional decline after a surgical procedure.

A guide to Pediatric Anesthesia (NEW Edition)

The second edition of *A Guide to Pediatric Anesthesia* offers a practical, working knowledge base for paediatric anaesthesia. Almost completely rewritten with more illustrations and tables, the new edition includes two new chapters. "Crises and other scenarios in clinical practice" focuses on common, urgent situations during anaesthesia and includes clinical and non-technical skills important for successful management. The second new chapter, "A selection of clinical scenarios" has a series of scenarios and discussion written in a short answer question format.



Key features:

- Readable, consistent writing style presenting a practical approach to the care of children.
- Focuses on differences between paediatric and adult anaesthesia, assuming prior knowledge about the condition in adults to save reader's time and highlight what is different about children.
- Focuses on Australasian and UK techniques relevant for the exams and anaesthesia practice by following the exam curriculum.

Written in an exam-focused, non-academic writing style, chapters provide a clear explanation of each topic with a review of management options and clinical tips. The advantages and disadvantages of options are discussed, and a practical approach suggested. Many of the clinical tips are deceptively simple, derived from a practical approach to problems. Examples include bending the tip of a RAE endotracheal tube to facilitate intubation, or actively considering and excluding the four conditions other than sepsis that can cause catastrophic, rapid collapse in an infant.

The book contains the syllabus for the College exams, but is also full of practical techniques and discussion for trainees during their paediatric rotation. It is relevant and useful for anaesthetists who have completed their exams and are now caring for children in their practice. The book also has an accompanying blog: [Facebook.com/paediatricanaesthesia](https://facebook.com/paediatricanaesthesia).

Dr Craig Sims and Dr Dana Weber are paediatric anaesthetists with the Department of Anaesthesia and Pain Management at Perth Children's Hospital. Dr Chris Johnson is a paediatric anaesthetist in private practice in Perth. All are ANZCA fellows, and Dr Weber is a Fellow of the Faculty of Pain Management. Dr Sims and Dr Johnson have completed their 12-year tenures as final examiners with ANZCA.

The new edition can be found online on the Paediatric Anaesthesia library guide: libguides.anzca.edu.au/paediatric/, as well via the library discovery service: anzca.on.worldcat.org/discovery.

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Add your publications to ANZCA's new institutional repository (AIRR), and it will also be discoverable on both Google and Trove.

airr.anzca.edu.au

Recent contributions to AIRR:

- Weller JM, Naik VN, San Diego RJ. Systematic review and narrative synthesis of competency-based medical education in anaesthesia. *Br J Anaesth*. 30 Jan 2020. [published ahead of print] doi:10.1016/j.bja.2019.10.025.
- Speldewinde GC. Successful thermal neurotomy of the painful sacroiliac ligament/joint complex: a comparison of two techniques. *Pain Med*. 20 Nov 2019. [published ahead of print] doi:10.1093/pm/pnz282.
- Shakespeare TJ. *The inhibition of leukaemia inhibitory factor enhanced nerve regeneration by the action of the specific Nitric Oxide Synthase II inhibitor Aminoethylisothiourea*. 1999. [Thesis]

To learn more about the ANZCA and FPM institutional repository and how you can contribute, check out the dedicated AIRR Library guide: libguides.anzca.edu.au/research/airr.

Contact the library: +61 3 9093 4967 library@anzca.edu.au anzca.edu.au/resources/library

New titles in the library

New books for loan

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



Against all odds : the inside account of the Thai cave rescue, and the courageous Australians at the heart of it.

Challen C, Harris R. Australia: Viking, 2019.



Fentanyl, inc. : how rogue chemists are creating the deadliest wave of the opioid epidemic

Westhoff B. New York: Atlantic Monthly Press, 2019.

New eBooks

Anesthesiology applied exam board review

Gupta R, Tran MCJ. Oxford: Oxford University Press, 2018.

Anesthesiology critical care board review

Williams GW, Grewal NK, Popovich MJ [eds]. Oxford: Oxford University Press, 2019.

Comprehensive atlas of ultrasound-guided pain management injection techniques

Waldman, SD [ed]. Philadelphia: Wolters Kluwer, [2020].

Critical care examination and board review

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The other side of catastrophe

After a serious cycling accident in 2018 that required months of rehabilitation WA anaesthetist Dr Bruce Powell was forced to reassess his professional identity. Here is his story.

ON 16 SEPTEMBER 2018 my medical career ended.

It wasn't that I made a terrible mistake with a patient's care or falsified my tax return. I hadn't suffered an epiphany of self-doubt in the face of the tragedy and sadness that so often colours our lives as doctors.

I wouldn't even say that I had found the working pressures and expectations too onerous to bear any more, growing accustomed as we all must, to a professional life of clinical crises and administrative torment. In fact, I'd probably come to take my charmed life in Western Australia for granted having largely figured out how the patients, the people and the politics stuff really worked.

I think that I felt that I was at the peak of my powers, widely qualified across medicine, critical care and anaesthesia, working both publicly and privately. As the state's leader of DonateLife, donor numbers had almost tripled in six years and no one was more surprised than me that I was the longest-ever serving medical director.

Unfortunately it turns out that pride really does come before a fall. To be precise, on a damp chilly morning, descending the steep and slippery road into the Victorian coastal town of Apollo Bay, I cycled head-on into a street sign at 65 kmh.

I don't remember any of the bad stuff, the broken neck and shattered jaw, the partial scalping and the torn off ear, the crushed chest and multiple lumbar fractures. I missed the worst of the anxiety and pain, ventilated and restrained for a week while my family held a vigil at my bedside. I also missed the fear and the distress, the sleepless nights and the over-the-phone consents for stabilising trauma surgery that I inflicted upon them. Once I finally awoke in the intensive care unit many days later, my wonderfully gentle wife Anita repeatedly had to explain to me that I was a patient and not the on-call consultant.

Even after I had escaped the critical care and trauma wards, my befuddled brain still defaulted to familiar behaviours, wandering around the rehab hospital TV room in my pyjamas, examining other's wounds and drip sites on my daily "ward round". Afterwards, mentally exhausted, I would then fall asleep watching another Netflix series that I wouldn't remember.

In time honoured medical tradition, I even tried to cheat on my cognitive assessments by plotting with my dear brain-tumor roommate to memorise the questions that he was asked. Sadly I couldn't remember any of his prepared answers and failed miserably. It's a long journey back to medical expertise when you can only recite two of a list of 15 words that you're meant to remember.

Having returned from Melbourne six weeks after the crash, rehabilitation at Fiona Stanley Hospital in Perth was confronting and upsetting. The fight to recover drove a bewildering mix of emotions.



Below: Cycling on the Great Ocean Road the day before the crash.

Right: Dr Powell today in his Perth home. Photo: Stefan Gosatti.



“I don't remember any of the bad stuff, the broken neck and shattered jaw, the partial scalping and the torn off ear, the crushed chest and multiple lumbar fractures.”



Dr Powell in the Royal Melbourne Hospital's intensive care unit four days after the crash.



Dr Powell and his wife Anita, still smiling, in the garden of their Perth home. Photo: Stefan Gosatti.

“I won't ever anaesthetise again and that is hard to accept.”

I seemed to be the only one in clinic not in a wheelchair and for that I felt terrible guilt and perverse regret. I was ashamed because I even had to make up stories for each of my amazing carers, just to allow me to recall their names. Michelle (“two-little-legs-runner”) the occupational therapist cared for me with such patience and kindness. (“Whiffy”) Miffy at the state head injury unit was all optimism and empathy in the face of my stream of tangential consciousness and bitter rage.

Times had now changed. I was suddenly afraid of uncertainty, wary of my explosive, irrational anger and reckless nature. The diffuse axonal injuries had left my personality peppered with multiple micro-haemorrhagic holes and through them the irrationality could uncontrollably flow out. I would cry repeatedly during our hours together and each would sit quietly and wait for the emotional squalls to pass. In between showers of tears I would rage and laugh, wandering without embarrassment or insight across a whole range of unrelated personal topics.

My rehab consultant told me bluntly, when we first met unscheduled in a corridor, that she didn't know if I would ever work again. I was so angry and upset, having fought irrationally hard with only that single outcome in mind, that it wasn't until the rush hour train journey home that I calmed down enough to blub embarrassingly once more.

How could any of the rehab team know whether I was fit to practice? Who even knew what us gassers did?

“Exhaustive knowledge of human physiology?”

“Precise dosing of dangerous and complicated drugs?”

“Hours of intense concentration?”

All that sounded very challenging but nothing like what I did as a senior clinician.

It was only as the time came closer to reboot my expertly crafted 80s operating theatre playlists that the reality began to dawn. Physically, my “Jeff Bridges” beard now hid the metalwork in my chin and only the subtle neck and hand scars betrayed the plates and screws holding my head and hands on.

I looked pretty normal, long hair and all. As D-day of my return to work approached, through repeated sleepless nights, I was forced to admit to myself that I was afraid of the huge responsibility that us anaesthetists bear and realised how often I would have to hide my own anxieties to facilitate others doing their jobs. An anaesthetist's lot is not to take centre stage but to quietly keep everything in order.

Early on in our relationship, I tried to tell my brilliant private surgical partner of my concerns for a particular patient. “Sorry Bruce” he interrupted “I don't want you

to take this the wrong way but I'm not really interested. You know what you're doing. I'll just wait until you're ready.”

His dismissal of my concerns had me livid for a moment and then just as quickly very flattered and emboldened by his trust in me. We were a great team for that very reason, that and a shared love of beer and oysters.

Naturally it can be daunting to be a leader and us anaesthetists often have to step up. We are relied upon, trusted with command of the ship when the storm breaks, deliberately calm and precise. For all the time that I had fought to return to work, I had subconsciously belittled my role. I had focused upon the ease that 25 years of experience and hard graft had afforded me.

“I'm only an anaesthetist” I used to dismissively say.

On reflection that was true, in the same way that DonateLife's extraordinary donor co-ordinators are “only” administrators, mere facilitators. Of course the reality is that both groups are only noticed when things go wrong, when fault needs to be attributed. That is when we have to stand up and lead. Otherwise we just sit quietly, “drinking coffee”, “playing sudoku”, crediting others with the successes and the lives saved.

“The greatest ally of the physician is time” my first medical consultant used to recite before each ward round. I remind myself of that incantation when the black dog tries to interrupt my morning ocean swim. I won't ever anaesthetise again and that is hard to accept. I am acutely conscious that I am much luckier than other trauma victims and for that I quietly rejoice.

I think that I'm finally done trying to remember what happened yesterday.

I'm certain that today and tomorrow are much more important.

Dr Bruce Powell, FANZCA
Former Medical Director, DonateLife

Research



New ANZCA research grants deferred for 2021

In the interests of reducing the workload on anaesthetists and pain medicine physicians during the COVID-19 crisis, and ensuring fairness of opportunity, the college and the research committee have decided to suspend the current 2020-2021 ANZCA research grant round and resume funding new grants in the 2021-2022 grant round.

THE DECISION AFFECTS the 2021 the Lennard Travers Professorship, Academic Enhancement Grant, Simulation/Education Grant, Project Grants and Novice Grants.

The college will of course continue to support all grants currently in progress, including honouring existing second-year commitments for approved multi-year grants, pending fulfilment of the usual requirements.

The 2020 joint British Journal of Anaesthesia (BJA), Royal College of Anaesthetists (RCoA), and ANZCA Collaborative Research Grant has also been deferred for similar reasons, by the UK National Institute of Academic Anaesthesia (NIAA), until further notice. This three-year grant for a project between collaborating researchers in the UK and Australia/New Zealand, will be available when the NIAA resumes grant funding.

Help ANZCA research grants survive COVID-19

COVID-19 is having myriad adverse impacts on the college's near-future capacity to support grants for vital research led by anaesthetists and pain medicine physicians.

Your donations can help protect the future of this important research program from the full impact of this unprecedented crisis. Research, central to the quality of critical care being delivered by anaesthetists in this crisis right now, will also play a key role in specialists' preparations for coping effectively with future crises.

Donations to help protect the research grants program can be made via the foundation pages on the ANZCA website, with subscription payments, or by directly contacting the foundation.



Dr Phillip Peyton.

CSL Behring ANZCA Research Award for 2020

A funding grant of \$A80,000 has now been received from Gold Leadership Circle supporter, CSL Behring, for its second biannual award for ANZCA researcher-led studies in coagulation, gastric, orthopaedic, transplantation or other areas of surgical interest, for "A prospective randomised controlled pilot trial of preoperative microvascular protection in patients undergoing major abdominal surgery" led by Associate Professor Laurence Weinberg from the Austin Hospital. The foundation sincerely thanks CSL Behring for its ongoing support.

Medibank Better Health Foundation grant support

In December and January, the ANZCA Research Foundation also received combined funding of about \$A100,000 as part of its collaboration with the Medibank Better Health Foundation, for two new collaborative targeted grants for ANZCA investigator-led research: "Developing a predictive risk model of unplanned critical care utilisation following elective hip and Knee Arthroplasty", led by Professor Philip Peyton of the Austin Hospital, and "Exploring patient outcomes with private health insurer data and informatics", led by Professor David Story, Foundation Chair of Anaesthesia at the Melbourne Medical School.

The foundation is involved in further discussions with Medibank Better Health Foundation around the progress of these studies, and further potential collaboration in research supporting excellence in clinical practice.



Dr Lachlan Miles.



Dr Patrick Tan.

ANZCA, the Research Foundation Committee, and the foundation team sincerely thank all donors for their vision and generous support in saving and improving lives.

ANZCA Melbourne Emerging Researcher Scholarship and Award

The foundation is delighted to announce the recipients of the 2020 ANZCA Melbourne Emerging Researcher Scholarship (\$A20,000) and the ANZCA Melbourne Emerging Anaesthesia Researcher Award (\$A10,000), thanks to the committed patronage of Dr Peter Lowe.

The scholarship has been awarded to Dr Lachlan Miles of the Austin Hospital for the project "IDOCS – Influence of iron deficiency on outcome after cardiac surgery", related to his PhD studies at the University of Melbourne. The award has been conferred on Dr Patrick Tan of The Alfred hospital for his project "High flow humidified nasal oxygen for prevention of hypoxaemia associated with remifentanyl patient controlled analgesia (PCA) in labouring women – a safety and feasibility study".

The foundation congratulates Dr Miles and Dr Tan and thanks Dr Lowe for once again providing these grants for the vital purpose of supporting the development of emerging researchers.

Events

The ANZCA CTN and ANZCA Research Foundation dinner at the Royal Perth Yacht Club planned for 1 May 2020, with keynote speaker Dr Craig Challen, co-Australian of the Year 2019 with Dr Richard Harris for the Thai cave rescue, has been cancelled due to COVID-19 virus concerns. The event was intended to celebrate the CTN's history, increase awareness of ANZCA research, and attract new support.

The foundation will investigate holding a similar dinner event in the future, and would like to thank all those who very generously supported the event plans especially all those who agreed to sponsor tables at the event.

ANZCA Named Research Awards

As these awards were scheduled for the annual Foundation Reception at the now-cancelled Annual Scientific Meeting from 1-5 May at the Perth Convention Centre, the foundation will seek an appropriate alternative date to formally confer these prestigious awards upon their deserving 2020 recipients.

Subscriptions appeal update

Foundation donors have again generously supported the work we support, by adding donations to their annual subscriptions payments, resulting in \$A47,000 donated to date.

Most gifts have been general support for foundation programs. Most of the designated gifts were in support of the annual research grants program, with some donations designated for the ANZCA overseas aid and Indigenous health support programs.

Patrons

Many of our highly-valued patrons have also made their annual committed gifts during the subscriptions period. We particularly recognise the ongoing commitments made by all foundation patrons, at the associate patron, patron, president's patron, life patron and governor levels.

The ongoing support commitments made by our patrons constitute one of the few regular and sustainable streams of gift income we have available, upon which we can rely as we plan our research grant funding commitments each year. If you are a Patron, please accept our sincere, special thanks, on behalf of every fellow and trainee and patient who has benefited directly or indirectly from your support of the foundation and ANZCA grants programs.

Gifts in perpetuity

For those interested in supporting excellence in anaesthesia and pain medicine across future generations through a Will, the foundation is always available to talk through your objectives, options, and how we can help.

Supporting advancement through the foundation

Donations can be made to the foundation to help seed-fund vital research studies, or to support ANZCA overseas aid or Indigenous health programs.

Donations can be made via the foundation pages on the ANZCA website, with subscription payments, or by directly contacting the foundation.

ANZCA, the Research Foundation Committee, and the foundation team sincerely thanks all of our patrons and other donors who have already donated through their subscriptions, especially during this difficult time.

Research co-ordinators are vital to the sustainability of research departments

The ANZCA Clinical Trial Network (CTN) is supported by a large and dedicated network of more than 160 research coordinators facilitating anaesthesia research in Australia and New Zealand, collectively known as the Anaesthesia Research Co-ordinator Network (ARCN).

Research co-ordinators' dedication, hard work, attention to detail and expertise is the foundation of the success and productivity of the network to deliver high-quality large multicentre clinical trials to improve patient outcomes. The research co-ordinator role is diverse with many competing priorities. Within their role of facilitating research, a co-ordinator could, on any given day, find themselves consenting patients to clinical trials, collecting data, completing education with other departments and hospital wards, engaging with supporting departments such as surgery or pharmacy, completing ethics and governance applications, writing publications, protocols and standard operating procedures and contributing towards grant

applications, all while working within the bounds of strict clinical guidelines to ensure the best standard of patient care and safety. Research co-ordinators are the backbone of research departments. They are highly skilled and trained, often with a master's degree, and are an invaluable resource to any research department that complements and supports the work of our ANZCA fellows and trainees.

Led by Ms Allison Kearney, the ARCN Sub-Committee which is a formal ANZCA committee reporting into the CTN Executive, provides leadership and oversees the activities of the ARCN. The Sub-Committee ensures that research co-ordinators are supported in their role, linked with peers and the resources of the network, and provides regional representation of each state and territory in Australia, and the North and South Islands in New Zealand.

Together with the CTN office and the CTN Executive, we have supported departments to build a case to employ a research co-ordinator and have increased the workforce in our network. Convened by Ms Gillian Ormond and based at the CTN office, we run monthly inservice sessions on research topics to increase knowledge and encourage discussion and sharing of ideas, experiences and tools; an almanac to share information on their diverse backgrounds, primarily in nursing, allied health and science; and to promote their skills and interests. The annual ANZCA CTN Strategic Research Workshop enhances networking opportunities and strengthens relationships among research co-ordinators, who often work in isolation. A mentoring scheme is also available for new co-ordinators to be mentored by a more experienced co-ordinator through the CTN office.

Contact the CTN office – ctn@anzca.edu.au or +61 3 9903 0942 – to join the mailing list and learn about the business case we developed to support the employment of a co-ordinator. We have a number of resources and support available to research co-ordinators, fellows and trainees who want to build a sustainable research department.

Ms Gillian Ormond
Anaesthesia Research Co-ordinators Network Sub-Committee Member

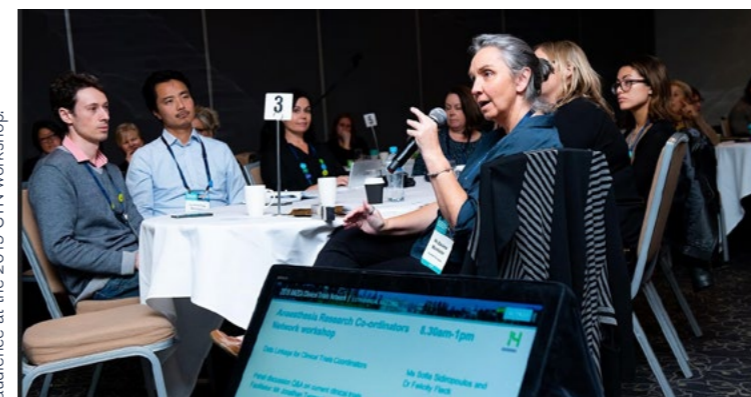
Ms Allison Kearney
Anaesthesia Research Co-ordinators Network Chair

Ms Karen Goulding
CTN Manager

Ms Dhiraj Bhatia Dwivedi and Dr Violet Mukaro at the 2019 CTN workshop.



Ms Davina McAllister addressing the audience at the 2019 CTN workshop.



The ABC of reducing postoperative infections

An Auckland study, *Anaesthetists Be Cleaner, (ABC)* funded by the ANZCA Research Foundation (through the Harry Daly Research Award in 2017) is investigating whether a bundle of practical clinical interventions to improve key aseptic practices by anaesthetists can reduce postoperative infection and its associated human and financial costs.

PROFESSOR ALAN MERRY has been working alongside Professor Simon Mitchell, Dr Derryn Gargiulo and others, to lead the development of the infection prevention bundle. This is a co-design process working closely with many clinical colleagues.

Professor Merry says anaesthetists rightly pride themselves on being leaders in patient safety. “They’ll be keen to help find solutions in response to recent research in both New Zealand and the US that has revealed that anaesthetists have a direct impact on bacterial transmission and hence infection rates in surgical patients.”

“We all know how demanding our specialty can be. We have to inject a high number of intravenous medications (on average 10 injections per patient, and sometimes many more) often under considerable time pressure. At the same time we have to look after the patient’s airway, and somehow keep them in a safe haemodynamic state. It is not difficult to accidentally contaminate our work environment and even the medications we are injecting,” says Professor Merry.

Most of the elements of the bundle are already specified in ANZCA guidelines. Professor Merry says one reason why they may not always be perfectly followed might be the fact that infections that follow failures in aseptic practice manifest long after anaesthesia has finished.

“Postoperative infection is very rarely tracked back to its source, so there is no feedback to the anaesthetists about the consequences of any failures in their technique.”

He says in practice, it is quite difficult to achieve perfect aseptic practice during the dynamic and complex conduct of anaesthesia, and there are often more immediate threats to the patient.

“Part of the issue is motivation to maintain asepsis, but part of it is making it easy to do this – and we have really tried to keep the bundle as simple as possible.”

The story behind sepsis

Postoperative infections in New Zealand alone costs in excess of \$NZ136 million a year. Surgical site infection occurs in up to 5 per cent of “clean” operations. Disturbingly, postoperative sepsis has increased in New Zealand from seven per 1000 at-risk admissions between 2005 and 2009, to 11 per 1000 in 2013. In 2016-2017, 28 per cent of the Accident Compensation Corporation costs (\$NZ15 million out of \$NZ55 million) attributed to personal injury suffered during medical treatment were directed towards infections following surgery.

This is also a health equity issue. Health outcomes are, in general, worse in Māori and Pacific peoples than their non-Māori/non-Pacific counterparts. Factors that contribute to infection after surgery include comorbidities such as obesity, diabetes and skin infections that are more prevalent in Māori and Pacific populations.

The study

The study into the effectiveness of the bundle is being rolled out in five departments in four large metropolitan hospitals in Auckland: Auckland City Hospital, Starship Children’s Hospital, Middlemore Hospital and North Shore Hospital. Clinical teams providing anaesthesia, perfusion and immediate postoperative care in the recovery unit for patients undergoing hip or knee arthroplasty or cardiac surgery are participating.

The researchers will compare outcomes between approximately 5000 cases before and 5000 cases after implementation of the bundle. Outcome data will be collected from existing national and hospital databases. The primary outcome will be days alive and out of hospital to 90 days, which is expected to reflect all serious postoperative infections. The secondary outcome will be the rate of surgical site infection. Aseptic practice will be observed in sampled cases in each cluster before and after implementation of the bundle. The bundle is summarised in figure 1.

Buy in

Professor Merry, Professor Mitchell and the whole ABC team are really grateful for the support and participant buy-in for this study. Champions have been appointed in each participating department. These champions are taking part in and supporting all presentations and communications about the study.



Outcomes

The success of the use of the bundle of aseptic practices will be measured by the increase in the days alive and out of hospital to 90 days (DAOH90). The results will add to existing evidence on whether or not that the practices of anaesthesia providers are a factor in the genesis of postoperative infections. If they are it will be quite easy to roll out this bundle nationally.

“Our bundle was designed to be simple and practicable. Yet the potential benefits in relation to reducing patient harm and the costs associated with this are substantial, and the implications for Māori and Pacific patients may be particularly important.”

Interestingly an equivalent study is currently under way in North America, led by Dr Randy Loftus whose research has shown very similar results to that of the New Zealand group.

Adele Broadbent

Communications Manager NZ, ANZCA

Figure 1

The bundle consists of the following steps:

- Wipe skin with alcohol (with or without chlorhexidine) and allow to dry before inserting any IV line.
- Inject all IV bolus medications except propofol through a 0.2-µm filter incorporated into each patient’s IV line.
- Use a meticulous aseptic technique when drawing up or injecting propofol, and discard syringes, needles or the medication in the event of any suspected contamination.
- Perform hand hygiene: Before and after interacting with each new patient. Before and after any procedure creating risk of infection. After blood and body fluid exposure.
- Maintain clean working surfaces.

See the *Anaesthetists Be Cleaner (ABC)* study website (<http://abc.auckland.ac.nz/>) for further resources.

COVID-19 and the ABC Study

Like many other projects, the ABC Study has been put on hold during the Level-4 lockdown in New Zealand. This is because elective surgery has stopped, it is not appropriate for our research staff to be going into the operating rooms, and managing patients during this pandemic leaves little cognitive reserve for complying with research projects.

Our objective has been to improve aseptic techniques in anaesthesia with the aim of safeguarding our patients. The importance of some of the elements of our bundle has been reinforced by the COVID-19 pandemic – but now the emphasis is on safeguarding both patients and ourselves.

Of course, doing this in the face of a highly infective coronavirus goes well beyond the ABC bundle. When we are able to resume the ABC study we will need to reflect on the implications of the pandemic for the study. The standard aseptic practices of anaesthesia team members will presumably have changed substantially and permanently (at least in regard to hand hygiene). We will be exceptionally well placed to measure the impact of improved aseptic anaesthetic practices in general on postoperative infection, although we may not be able to attribute any such changes to our bundle in particular.

We have applied for a time extension and plan to resume the ABC Study as soon as reasonably possible. In the meantime, our focus, like that of everyone else, is to get through this pandemic as safely and effectively as possible.

Once again, we thank all our participating anaesthetists and anaesthetic technicians for their amazing support of our research into improving the safety of anaesthesia.

Professor Alan Merry, Dr Derryn Gargiulo and Professor Simon Mitchell

Continuing professional development



2017-2019 end of triennium update

Our congratulations to more than 3000 continuing professional development (CPD) participants who have completed their 2017-2019 triennium.

This is the largest cohort the ANZCA and FPM CPD Program has experienced, and is more than 99 per cent complete. The CPD committee are attempting to contact the outstanding CPD participants to support them in meeting their remaining CPD requirements.

We remind you that compliance with the ANZCA CPD standard is mandated by the Medical Board of Australia (MBA) and Medical Council of New Zealand (MCNZ); and by ANZCA.

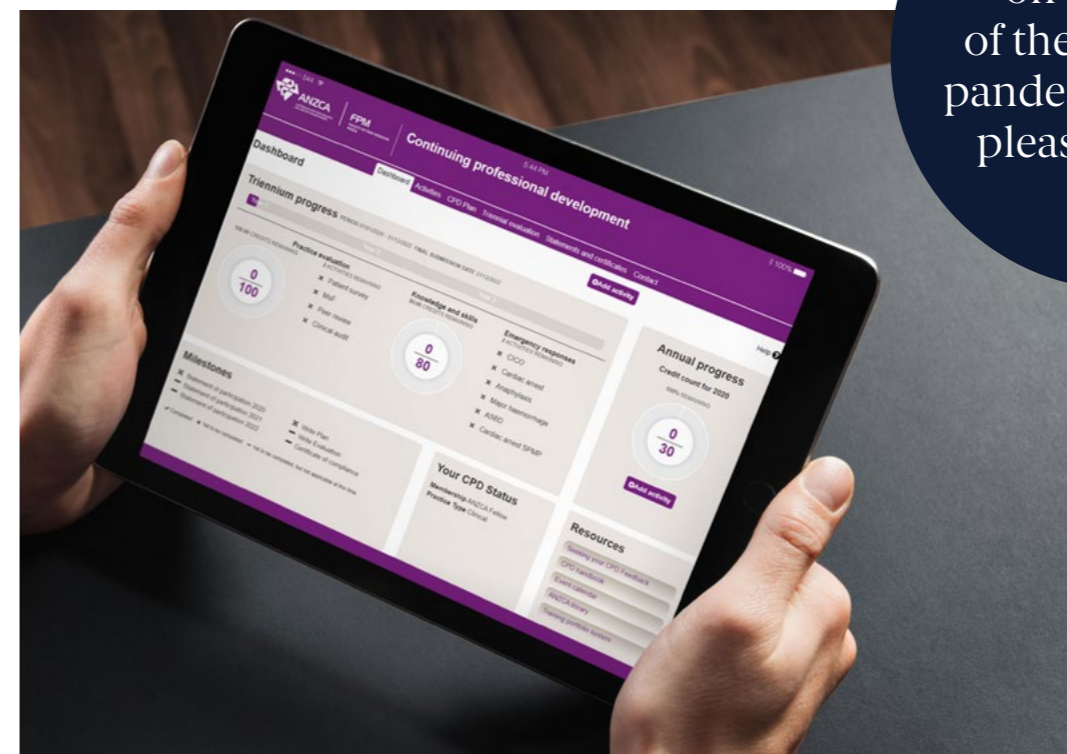
Participants who do not meet their CPD requirements will be recorded as non-compliant for the triennium and will consequently be automatically selected as part of the annual verification of CPD activities. If you have any questions or concerns about your CPD requirements, or feel you have not yet met this CPD triennium, please contact the CPD team at cpd@anzca.edu.au.

Have you been selected for the 2019 verification of CPD activities?

The CPD team worked through the verification checks between January and March. Confirmation of selected participant's compliance status will be sent once all checks have been completed. Our thanks to those selected for your patience, we appreciate the time taken in preparing your CPD portfolio. It is a requirement for the college to verify a percentage of CPD participants each year. The CPD team will be in contact if those selected require further evidence.



For information on the effect of the COVID-19 pandemic on CPD, please see page 18.



Starting a new CPD triennium?

We have more than 3000 CPD participants starting their new 2020-2022 triennium. Taking a moment to plan your CPD for the next three years will assist in assuring that activities undertaken are meaningful and relevant to your needs. Your CPD plan, within the CPD portfolio, has been designed to support this consideration with helpful prompts and questions.

To complete your CPD plan, log into your CPD portfolio and click the tab “CPD Plan”. Once in your CPD plan click the purple button “edit” and respond to the seven listed boxes (across five steps) and “save” your responses.

Step 1: Practice evaluation category

This provides an area for you to consider what activities in this category you will or would like to be involved in and when they might be completed. It may be helpful to consider completing at least one of the mandatory activities at the start of your triennium. The patient experience survey, multi-source feedback and peer review of practice are examples of activities that may highlight possible focus areas for CPD and help you identify learning needs in step 2.

Step 2: Knowledge and skills you wish to learn or develop

This step is broken into three sections to support your self-evaluation in identifying knowledge and skills that you wish to learn or develop. Questions that may prompt consideration of the CPD activities most beneficial to you include:

Step 2.1

- What are my roles and responsibilities of practice?
- Will my role or responsibilities change in the coming one to three years and, if so, how?
- Are there any particular topic areas in which I need to update my knowledge?

Step 2.2

- Are there any skills I only use from time to time, or in an emergency, that I need to practise so I can respond appropriately when needed?
- What professional areas could I learn more about or improve on, such as, communication, teamwork, management and leadership, or research?
- Have practice evaluation activities, including feedback from colleagues and co-workers, identified any needs?

Step 2.3

- What knowledge and skills would I like to further develop over the next few years?

Step 3: Knowledge and skills category

This follows on from step 2, where you have identified what you intend to learn more about or further develop, consider learning activities that:

1. Are most appropriate for your learning style (that is, do you prefer to learn on your own or in a group)?
2. Suit the subject matter (that is, a hands-on workshop is more appropriate than a lecture-style presentation to learn a new procedural skill).
3. You are likely to complete (that is, plan to attend a conference every other year, if it is unlikely you will have the time to attend a conference annually. Make the most of workshops for emergency responses that are conducted in conjunction with a meeting you are already attending. If organised activities are problematic, consider updating knowledge via journal reading or completing online learning).

Step 4: Emergency responses category

Be mindful that to complete ANZCA and FPM CPD Program requirements a minimum of two activities relating to the management of emergency responses must be undertaken in each triennium. Please note all activities can be completed via an education session, workshops or course, which includes the opportunity to practice related skills. Anaphylaxis and management of major haemorrhage can be completed via online learning modules.

Step 5: Health and wellbeing

A new question from 2020, on activities supporting your own health and wellbeing.

- What activities will I undertake to develop a greater understanding of my own health and wellbeing over the next three years?

The inclusion of this question specifically highlights the importance of Doctor’s Wellbeing as part of a participant’s professional development.

While the main driver for completion of your CPD plan is to support your preparation of your professional development; the CPD plan must be completed to receive annual statements of participation and a triennial certificate of compliance. For more information please refer to the CPD Handbook, appendix 17.

CPD program review update

The ANZCA and FPM CPD Committee and CPD team have continued discussions on the impending formal process to review the CPD program and ANZCA CPD standard. Highlighted in previous *Bulletin* articles, the review’s timelines and scope are largely governed by the Medical Board of Australia’s (MBA) proposed professional performance framework and the Medical Council of New Zealand’s (MCNZ) Strengthened recertification requirements.

MBA’s proposed professional performance framework

Whilst ministerial approval for the MBA proposed framework is anticipated later this year, ANZCA has provided a robust response to the interlinked public consultation for the MBA’s draft revised registration standard: Continuing professional development.

A key focus of the submission was to allow our program to continue with weighted credits as opposed to purely time based credits. This considered response to the MBA was made in every effort to uphold our innovative and pioneering CPD program. A final version and implementation date is expected following ministerial approval of the MBA’s proposed framework and revised standard.

For more information, please consult:

- MBA proposed professional performance framework www.medicalboard.gov.au/Registration/Professional-Performance-Framework.aspx
- Public consultation: Draft revised Registration standard: Continuing professional development www.medicalboard.gov.au/News/Current-Consultations.aspx

MCNZ strengthened recertification requirements

MCNZ have officially released their strengthened recertification requirements for vocationally registered doctors in New Zealand. These requirements build off existing systems and emphasise recertification activities that relate to the actual work doctors do and those that are most likely to improve practice. ANZCA, and other accredited recertification program providers, are expected to work towards these new requirements with implementation by 1 July 2022.

Elements of particular interest include embedding cultural safety/health equity across all CPD activities, guidance and structure for annual conversations and reporting non-compliance to MCNZ. ANZCA and the CPD committee will continue consultations with MCNZ with efforts to work towards these requirements and the set implementation date.

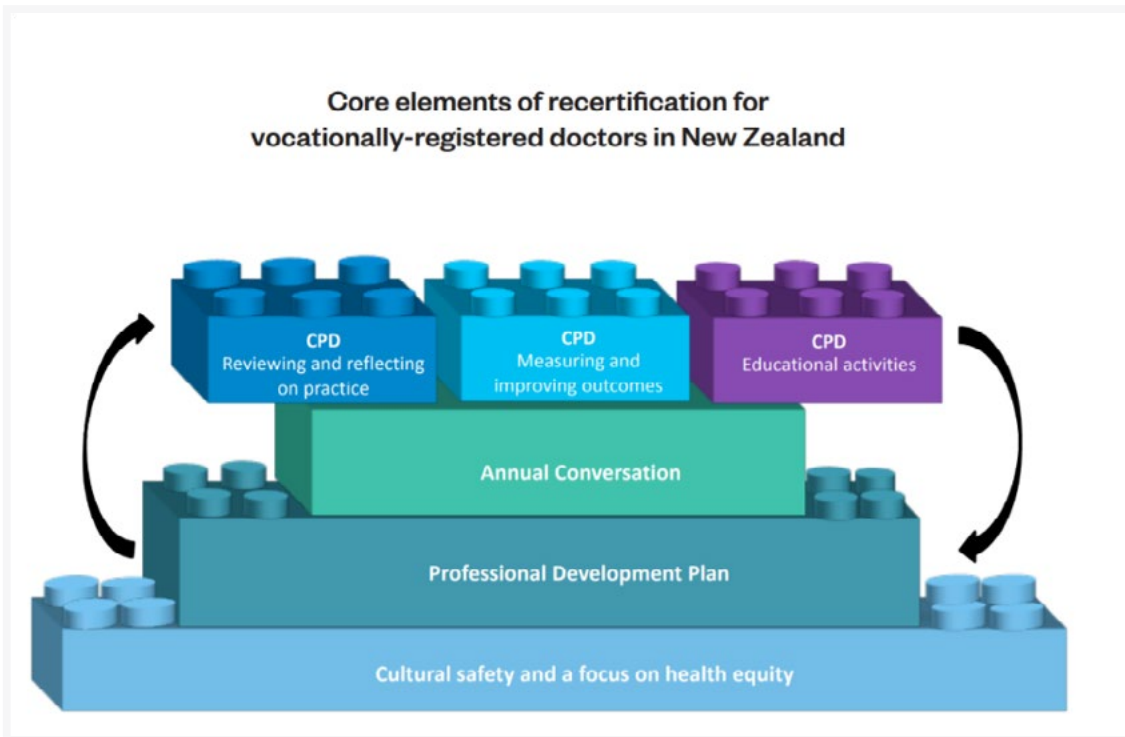
For more information, please consult:

- MCNZ recertification and professional development <https://www.mcnz.org.nz/registration/maintain-or-renew-registration/recertification-and-professional-development/recertification-requirements/recertification-for-doctors-on-a-vocational-scope-of-practice/>

The CPD committee and team are actively engaging with both regulators, and we ask that all participants continue to update their CPD portfolio and regularly review college communications. If changes are required ANZCA will communicate this in a timely manner to all CPD participants.



Core elements of recertification for vocationally-registered doctors in New Zealand



Did you hear – 2020 changes to the CPD program?

The below changes to the ANZCA CPD standard have been approved, and implemented into the CPD program from 1 January 2020.

- Cultural competency may be claimed under the practice evaluation category at two credits per hour, credit cap of 10 credits annually.
- Examiner for the final exams of the ANZCA Training Program will be able to claim group viva discussion and examiner assessor activities under the Practice evaluation category at two credits per hour, credit cap of 10 credits annually.
- New emergency response activity, a new standard for Cardiac arrest – Specialist Pain Medicine Physicians (SPMP) requiring Advanced Life Support (ALS) training will be introduced specially for faculty fellows.
- New CPD Plan question – participants starting their triennium from 2020 will complete a specific question on activities supporting their own health and wellbeing.

Please note, the triennial and annual CPD requirements remain the same for all practice types. These changes are new offerings or amendments to current elements/activity. For more information please review our article in December's ANZCA *Bulletin*, pages 48-49.

Cultural competency

As mentioned above, Cultural competency has relocated to the CPD program's practice evaluation category. As over half of our CPD participants start their new 2020-2022 triennium, this may be the opportune time to consider undertaking or plan for cultural competency training with an Indigenous organisation local to your health service. Even if you have previously completed similar training, make cultural competency training a regular part of your CPD plan each triennium.

Examples of cultural competency resources are available in the CPD handbook's appendix 20, and are intended as a guide to learning opportunities that are available to participants to accrue credits toward the CPD Program. It is not a comprehensive list and CPD participants with enquiries may contact the CPD team at cpd@anzca.edu.au for advice.

Nadja Kaye
CPD Co-ordinator

Training and education



Evolving a competency-based training in ANZCA

THE CURRENT ANZCA Training Program was instituted in 2013 and the college's education committees are working towards revisions and improvements. This is to ensure alignment with best practice and advances in post-graduate medical education, in the same way that other Australasian and international colleges regularly review and update their training programs. Importantly, these changes will be required over time by the Australian Medical Council – the body that undertakes accreditation for binational colleges like ANZCA.

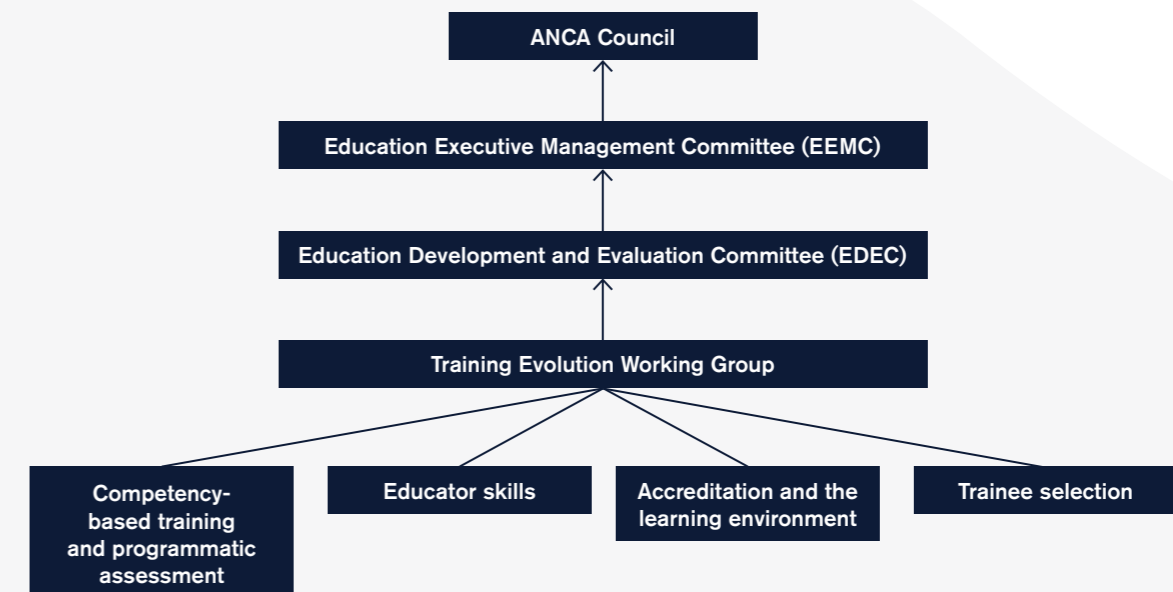
The Training Program Evolution Exploration Group identified four areas of the training program to explore: (See figure 1. Committee structure).

- Competency-based training and programmatic assessment.
- Educator skills.
- Accreditation and the clinical learning environment.
- Trainee selection.

This article will focus on the first of these: competency-based training and programmatic assessment. Note the dual purpose of programmatic assessment, where “routine information about the learner’s competence and progress is continually collected, analysed ... with the intent to both maximally inform the learner and their mentor and allow for high-stakes decisions at the end of a training phase¹.” For ANZCA trainees this means supporting trainees to learn through constructive and regular feedback, and to ensure trainees are competent to do the work required of them at each level of training from introductory training (IT) through to fellowship.



Figure 1: Committee structure



The Training Program Evolution Exploration Group of the Education Development and Evaluation Committee (EDEC) is responsible for producing well researched recommendations to ANZCA Council for these developments in our training program.

is to put forward sound recommendations to ANZCA Council for revisions in our 2013 system of assessments to keep abreast of best practice in medical education and changing societal demands for competent practitioners.

Table 1. Group membership

Competency-Based Training and Programmatic Assessment Project Group		
Professor Jennifer Weller, Fellow	EDEC member, Chair	Auckland
Dr Lindy Roberts, Fellow	EDEC member, DPA	Perth
Dr Kate Hames, Fellow	EDEC member	Brisbane
Dr Emma Giles, Fellow	PESC representative	Perth
Dr Fiona Johnson, Fellow	FESC representative	Melbourne
Dr Sarah Turner	Trainee representative, EDEC member	NSW
Dr Neroli Chadderton, Fellow	EDEC member	Wellington
Dr Hugh Harricks, Fellow	ITC representative	Sydney
Dr Andrew Huang, Fellow	FPM representative	Melbourne
Dr Chris Wilde, Fellow	Invitee	Hobart
Dr Sancha Robinson, Fellow	Invitee	NSW
Dr Sharon Tivey, Fellow	Invitee	NSW
Dr Graham Roper, Fellow	Invitee	Christchurch
Ms Phoebe Navin, Administrative support	Strategic Education Projects Lead	Melbourne

ANZCA, relative to many other colleges, is well placed to embrace competency-based medical education (CBME): our existing curriculum is written in terms of training outcomes; we have already embedded the workplace-based assessments (WBA) necessary to operationalise any CBME curriculum; WBAs are submitted online to a central database – the Trainee Portfolio System (TPS); and, through many years of evaluation and research, we have a large amount of information about how our workplace assessment are actually functioning across the training sites.

The ANZCA curriculum is far from “broken” but neither is it perfect for today’s environment. This is hardly surprising given the current curriculum was introduced seven years ago and the work done to develop it began over a decade ago. The work of the competency-based training and programmatic assessment project group

Best practice in specialist medical education

The principles and aspirations of CBME are established as the current standard for medical curricula². Who could argue against ensuring graduates are competent to do the work they are expected to do?

Best practice on high stakes assessments (that is, important assessments that trainees need to pass) is by group-decision making, where these decisions are made by a group rather than resting with one individual, for example, the supervisor of training (SOT)³. Assessment decisions by a single assessor are prone to inaccuracy and bias, such as an individual supervisor’s relationship with the trainee, their preferences in clinical practice, the supervisor’s skills in assessment, their general tendency to be harsh or lenient, or lack of support to make a decision that adversely affects a trainee.

Assessment of performance in the workplace is the mainstay of CBME. Supervisors assess trainee performances in the clinical environment on a regular basis to provide constructive feedback for learning. These assessments in the workplace then contribute to a portfolio of evidence to provide information to those tasked with making high stakes decisions on the trainee’s ability to progress to the next training level.

How is the ANZCA Training Program working in practice?

Based on analysis of 10s of thousands of WBAs in the ANZCA training portfolio system, we’ve demonstrated that with sufficient numbers, a portfolio of WBAs can be reliable (that is, the score is a reliable measure of the trainee’s ability and gathering more assessments won’t change the score for that trainee). Reliability is further enhanced by using the entrustment scale we use in ANZCA, where supervisors use their routine clinical judgement to score the trainee on the extent to which they could be trusted to manage that case, or similar cases (I needed to be in theatre; I needed to be in the hospital; I could have been at home)^{4,5}.

- The different WBAs have different levels of reliability: MSF>CbD>Mini-EX>DOPS.
- A portfolio of 15-20 WBAs of different types can produce an overall score for a trainee’s workplace ability that is as reliable as their score for the Final Exam⁵.

However, despite this evidence derived from large numbers of assessments in the TPS, we know that, for a variety of reasons, the WBAs are not being used consistently by SOTs to inform decisions on trainee progression⁶. These include inadequate numbers assessments, and lack of trust in the scores given (limited supervisor assessment skills, trainee gaming in choice of case and assessor, tick box exercise). It appears SOTs are seeking different or additional information on trainees, to make their decisions⁷.

- Local approaches to gathering information on trainee workplace performance have emerged in addition to the formal WBAs. These local practices vary widely.
- There is wide variability in how decisions are made on trainee progression at Core Unit reviews between different training sites, particularly in Introductory Training.

Stakeholder feedback also suggests there is room for improvement.

- Trainees have expressed dissatisfaction with the variable requirements between training sites, particularly with the Initial Assessment of Anaesthetic Competence (IAAC) during IT, and see this as unfair.
- SOTs have expressed dissatisfaction with the conflicting pressures of their role, in particular when the decision to hold a trainee back rests only with them.

Working principles of the competency-based training project group

The working principles of this group are best practice, consultation and co-design.

Best Practice

The CBME project group is reviewing world literature on CBME in Anaesthesia, different approaches to gathering information on workplace performance, and best practice in group decision making. To date, we have a systematic review of CBME in anaesthesia training⁸ and a new systematic review is under way on new approaches to workplace assessments.

Consultation

We are in the process of consultation with Australasian colleges and international colleges of anaesthesia. The purpose is to find out what’s happening outside of ANZCA, what’s working and what’s not.

We are also talking to clinical supervisors, SOTs and trainees to find out what’s happening within the college – the training program as enacted as opposed to the training program as imagined or written down in our training handbook. To date we have talked to a number of SOTs from every training region to establish the range of approaches currently undertaken for the IAAC. We are holding focus groups at regional SOT meetings to explore local practices in group decision making. This year we will begin interviews with individual supervisors and SOTs to explore how information is collected about trainees, and what information SOTs really need to feel confident to decide a trainee is ready to progress to the next level.

Co-design

Change imposed from above is less likely to be adopted than change which has been co-designed by those who are implementing it. Building on the knowledge and understanding of best practices, experiences in other training programmes, and what’s actually happening in ANZCA, we aim to work with groups of SOTs to co-design a system of workplace assessment and decision making that fits the needs of those undertaking it. Trainee input into the process will also help to ensure that it is consistent, fair and robust and through improved feedback and clear expectations for performance it is anticipated this will bring an improved experience for both supervisors and trainees.



Glossary of terms and acronyms	
CBME Competency based medical education	CBME can be characterised as having two distinct features: a focus on specific domains of competence, and a relative independence of time in training, making it an individualized approach that is particularly applicable in workplace training. It is not the length of training that determines a person’s readiness for unsupervised practice, but the attained competence or competencies.
WBA Workplace-based assessment	WBA refers to a battery of assessment instruments that assesses the actual practice of a trainee in the workplace. The current interest in WBA is mainly due to the inability of traditional assessment methods to assess the actual practice of a doctor.
Programmatic assessment	In programmatic assessment, routine information about the trainee’s competence and progress is continually collected and analysed. Where the information is ambiguous or conflicting, it can be complemented with purposively collected additional assessment information. The intent is to both maximally provide constructive feedback to the trainee and allow for high-stakes decisions at the end of a training phase.
EPA Entrustable Professional Activity	An EPA is a key task or domain of practice of a discipline that an individual can be trusted to perform, in a given health care context, once sufficient competence has been demonstrated.
IAAC Initial Assessment of Anaesthetic Competence	The IAAC is a requirement for Introductory Training (IT) in ANZCA. The IAAC consists of a number of WBAs and competency questions mapped to the curriculum learning outcomes for IT. The scope is quite broad and has a clinical focus, primarily assessing the new trainee’s ability to safely perform core clinical duties without direct supervision. Formats vary between training departments, from a relaxed 20-minute discussion of key topics to extensive interrogations lasting over an hour.

Project outcomes and timeline

The project group will report on their recommendations in November 2020, with a view to subsequently starting out with a pilot in Introductory Training.

The program of work for 2020 includes the following:

- Group decision making: developing recommendations on a feasible, cost-effective and robust approach to group decision making at Core Unit Reviews.
- Trainee assessment portfolio: developing recommendations on a portfolio of workplace assessments relevant to each training level (IT to PF) that inform the decision on trainee progression at Core Unit Review.
- IT pilot: develop recommendations to pilot the revised workplace assessment portfolio, the Initial Assessment of Anaesthesia Competence (IAAC) and group decision-making process at the Introductory Training Core Unit Review.

Professor Jennifer Weller
Chair, Education Development and Evaluation Committee

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FLITE: Breaking down education in the OT

THE FLITE EDUCATION tool was created after attending the ANZCA Educators Program (AEP) and realising that many of the principles are easily applied with a little guidance.

The FLITE lanyard card (and poster) was designed to help trainees identify and guide their own learning in theatre by creating a structured way to discuss learning goals with their supervising consultant, while also creating the opportunity for feedback and completion of workplace-based assessments.

The card has easy steps to follow for the trainee on one side and further information or examples on the back (see images). With ethics approval from St Vincent's Hospital (Melbourne) to trial the tool, trainees were selected to voluntarily participate during a "normal" four-week roster cycle between October 2019 and January 2020.

The trainees were approached prior to commencing week three of the cycle and asked to take a short survey about their learning experiences in theatre for the two weeks prior (as to not bias their usual practice). The same survey

was conducted at the end of week four after using the tool for two weeks to see if there was any difference. Although 12 trainees initially met the eligibility criteria to participate, due to unforeseen leave and roster changes the number of trainees that completed the four-week trial was small, seven trainees in total (three basic trainees, one advanced trainee and three provisional fellows). Although this tool was created mostly for more junior trainees, almost half of the trainees were provisional fellows.

General feedback was that the tool was better suited to more junior trainees, but there was still an overall positive trend seen at all trainee levels.

Interestingly, despite discussing level of supervision more than twice as often than usual practice, level of supervision remained the same in both groups. Learning goals were also established more than twice as often.

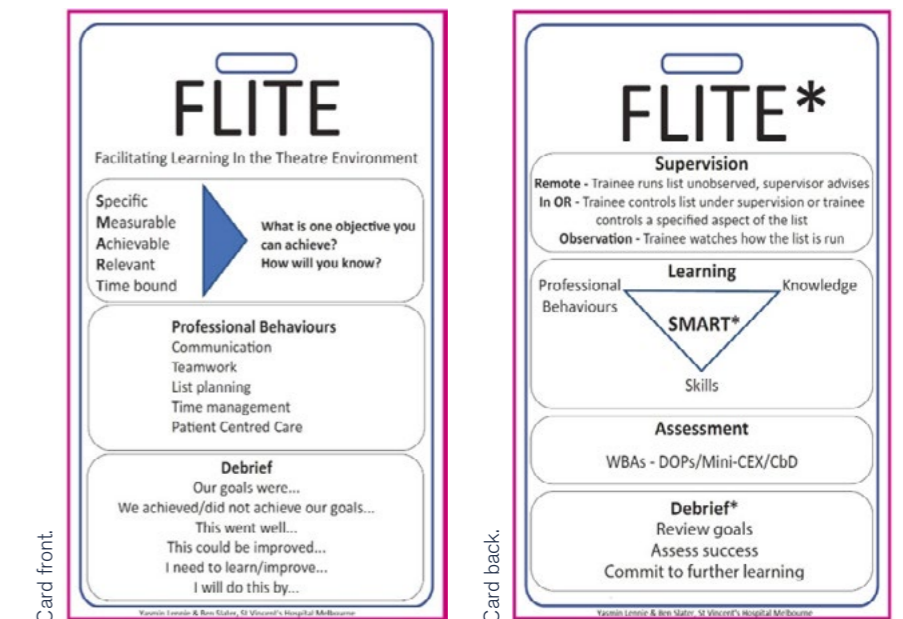
Despite the group being made up of almost half provisional fellows, WBA rates also increased with nine WBAs completed in the group compared to five WBAs completed in the fortnight without using the tool. Feedback was also provided at least twice as often.

Despite the obvious limitations in this small pilot project, it did show an overall positive trend that has created further dialogue about how to move forward. The ideal scenario is that this discussion becomes usual practice, and certainly there will be those who already encourage this routinely.

The next step is to create a "consultant" card for those supervising trainees with a similar layout but with additional information on providing feedback. Eventually, perhaps an app-based platform will make this more readily available. Anyone wishing to try out this tool should contact Dr Yasmin Lennie via dryasminlennie@gmail.com.

A special thanks to Ben Slater for helping in the creation and design of this tool, the Department of Anaesthesia at St Vincent's Melbourne for supporting this project, and to Maurice Hennessy from ANZCA for providing valuable feedback.

Dr Yasmin Lennie
Trainee, St Vincent's Hospital, Melbourne



Trainee-led research network shows strong results

TRAINEE-LED RESEARCH networks (TRNs) are an established collaborative research model which improve research engagement and participation among trainees and facilitate the delivery of high-quality multicentre studies^{1,2}.

The Queensland Anaesthetic Registrars' Research Collaborative (QARRC) is Australia's first anaesthesia TRN. Recognising the need to empower trainees to access quality research opportunities, QARRC was established by two provisional fellows in 2018.

QARRC meets approximately four times per year, with options available for physical or virtual attendance at meetings to optimise participation. There is a well-established social media network between trainees, comprising a WhatsApp group to facilitate discussion, trouble-shooting and information-sharing, a website (qarrc.org) and a Twitter account (@qarrc1). Professor André van Zundert is the patron of QARRC and his support of trainee-led research is appreciated.

QARRC's first project was designed to assess the level of trainee involvement in research in Queensland at the time of introduction of the TRN. Registrars were surveyed and it was found that there was a desire among the majority of respondents to be more actively engaged in research¹. The survey highlighted frequently encountered barriers to trainee engagement in research:

- Limited time to participate.
- Rotational training schemes disrupting research opportunities.
- That research was deemed too difficult, or trainees didn't know how to start a research project.

These results were presented as an e-poster at the 2019 ANZCA Annual Scientific Meeting in Kuala Lumpur.

QARRC members are now running the intraoperative Hypotension in Elderly Patients¹ study (iHYPE-QLD), first presented at the 2018 ANZCA Clinical Trials Network conference in Coogee. A multi-site ethics application has reduced the amount of time individual trainees had to spend on ethics and governance. The collaborative model, which is utilising social media and email communication, allows site leads to handover

outstanding tasks to counterparts who are rotating to their hospital, overcoming the barrier of rotational change. Support from experienced researchers who form the senior membership of the collaborative allows trainees to lead the research process. Sixty-three per cent (12/19) of training hospitals in Queensland have a self-nominated site-lead (see table 1). Data collection has largely been completed, with analysis, write up and submission for publication estimated for mid-year. Site leads will be listed as collaborators on the study.

In June 2019, QARRC held a project ideas night to enable trainees to present TRN project ideas for the collaborative to run in 2020. Of the six projects presented (see table 2), to this point two have had multi-site ethics applications submitted. One project will look at the perioperative management of SGLT's inhibitors, and the other will audit volatile anaesthetic agent usage across Queensland. These will be conducted via the QARRC network in a similar manner to 2019's iHYPE-QLD.

The QARRC Executive has encouraged the other presenters to submit ethics applications at a local level, and are keen to work with trainees to help transform their ideas into research projects.

We have been impressed by the level of enthusiasm for trainee-led research as well as the leadership and collaboration exhibited by registrars representing the various sites. We look forward to further state-wide projects and plan to engage with TRNs in other regions as their local networks evolve. Please contact us at info@qarrc.org if you would like further information or you would like to get involved!

Scott Popham FANZCA,
Gold Coast University Hospital

Maryann Turner FANZCA,
Great Ormond Street Hospital, UK

Co-Chairs, QARRC

References:

1. www.qarrc.org/survey1/
2. www.qarrc.org/ihype-qld/

Table 1

QUEENSLAND HOSPITAL	SITE LEAD FOR IHYPE
Princess Alexandra Hospital	Stefan Saric
Royal Brisbane and Womens' Hospital	Rom Ranasinghe/Matthew Black
Gold Coast University Hospital	Ben Cahill/Harry Burnett
Sunshine Coast University Hospital	Anna Pietsch/Cecelia Xu
Townsville Hospital	Nicole Galletly
Redlands Hospital	Hamish Raniga
Queen Elizabeth II Hospital	Esmond Hii/Matthew Greber
Redcliffe Hospital	Leonie Roberts
Mater Hospital Brisbane	Konica Chatterjee
Cairns Base Hospital	Tessa Finney-Brown
Mackay Base Hospital	Casey Steele
Rockhampton Hospital	Siobhan Lane

Table 2

PROJECT PRESENTER	HOSPITAL	PROJECT THEME
Ben Cahill	Gold Coast University Hospital	Anaphylaxis
Harry Burnett	Gold Coast University Hospital	BIS usage
William Curtis	Sunshine Coast University Hospital	Electronic Health Record Implementation
Casey Steele	Mackay Base Hospital	LMA usage in the obese
Jimin Kang	Princess Alexandra Hospital	SGLT2-inhibitor use
Thar Lwin	Princess Alexandra Hospital	Volatile anaesthetic use in Queensland

Evolving ANZCA hospital accreditation

Anyone who is or was a trainee understands how every hospital has its own “feel” or culture. In educational terms, this is the **clinical learning environment (CLE)**^{1,2}.

It's how trainees experience the ANZCA curriculum in their workplaces – largely unique to each training department. The CLE is a social system, so relationships between trainees and other staff play a huge part. Social atmosphere, social support, formal and informal learning opportunities, and quality of supervision and feedback are also crucial.

Hospital accreditation ensures that departments are suitable for training. The training evolution project is an opportunity to review college accreditation practices, to retain those that are working well and to strengthen those that need it.

The Accreditation and Learning Environment Group (ALEPG), aims to:

1. Benchmark ANZCA against best practice in accreditation.
2. Improve how ANZCA accreditation evaluates the clinical learning environment.

This aligns with the college's vision of educational excellence. ALEPG members (box 1) include a trainee and fellows with diverse expertise and perspectives in accreditation, education, simulation, research, training and leadership. We're supported by staff in the ANZCA Education unit. As the group responsible for ANZCA accreditation, the Training Accreditation Committee (TAC) has a central role in this project. The FPM Training Unit Accreditation Committee is also represented.

Our initial steps have been:

1. Review of existing ANZCA accreditation practices.
2. An ANZCA accreditation visitor survey about what works well and ideas for improvement.
3. Literature review of accreditation practice and research.
4. Interviews with anaesthetists and staff in colleges and other accrediting bodies in Australia, New Zealand, USA, Canada, United Kingdom and Ireland about their accreditation approaches.

The college recognises that many players have an interest in accreditation of anaesthesia departments – not least trainees, supervisors, heads of department, health services, jurisdictions and other colleges. We will consult on our draft recommendations with these groups. Watch out for future updates.

Your feedback and ideas about accreditation are welcome to tac@anzca.edu.au.

Dr Lindy Roberts AM
Director of Professional Affairs

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2. Sidhu NS, Clissold E. Developing and validating a tool for measuring the educational environment in clinical anaesthesia. *Can J Anaesth* 2018;65:1228-39.

MBA survey provides trainee snapshot

“There are opportunities to improve trainee access to health and well-being support programs.”

THE FINDINGS OF the Medical Board of Australia's first national medical trainee survey captured the responses of nearly 10,000 doctors in training in all states and territories including 280 anaesthesia trainees.

With a response rate of 26.8 per cent it provided a single, national snapshot of the state of medical training in Australia. About 18 per cent of ANZCA's 1590 anaesthesia trainees responded to the survey, 45 per cent of whom were female and 52 per cent male.

ANZCA regularly conducts its own detailed surveys of anaesthesia trainees to gain valuable insights into their experiences. The last ANZCA trainee survey in 2018 received 740 responses, 49 per cent of all trainees.

In her foreword to the report, Medical Board Chair Dr Anne Tonkin said “trainees have sent a loud message about bullying and harassment and it is incumbent on all of us to heed it.”

“We must all redouble our efforts to strengthen professional behaviour and deal effectively with unacceptable behaviour to... improve the culture of medicine,” she wrote.

“There are opportunities to improve trainee access to health and well-being support programs.”

The results found that:

- 54 per cent of ANZCA trainees agreed that they had a good work balance compared to 59 per cent of the total cohort.
- 70 per cent of ANZCA trainees agreed that bullying, harassment and discrimination is not tolerated at their workplace, compared to the national response of 75 per cent.
- 42 per cent of ANZCA trainees said they had witnessed bullying, harassment and discrimination compared to 27 per cent of the total. (ANZCA's own trainee survey in 2018 found that 45 per cent said they had witnessed workplace bullying).
- 24 per cent of ANZCA trainees said they had experienced bullying, harassment and discrimination compared to 22 per cent of the total. (ANZCA's own trainee survey in 2018 found that 28 per cent said they had experienced workplace bullying).
- 67 per cent of ANZCA trainees said these reports had been followed up compared to 52 per cent of the total.

ANZCA's 2018 trainee survey

- In 2018, ANZCA trainees were surveyed on Bullying, Discrimination and Sexual Harassment (BDSH). A total of 740 trainees completed the ANZCA Trainee Committee survey of 1501 trainees invited. Of these, 690 chose to complete the BDSH section of the survey.
- The ANZCA trainee survey found that 28 per cent had personally experienced workplace bullying (down from 30 per cent in 2016) and 45 per cent (down from 54 per cent in 2016) had personally witnessed it. Trainees were more likely to witness bullying of registrar anaesthetists and surgeons by consultant anaesthetists and surgeons. A total of 63 per cent felt adequately prepared and supported to deal with bullying and 30 per cent had received formal education and training in identifying, managing or preventing bullying. In relation to knowing how to report or seek help regarding bullying, 87 per cent know how to through their hospital department, 64 per cent through their hospital, 50 per cent through the college and 31 per cent through outside bodies.

For more information about the survey go to www.medicaltrainingsurvey.gov.au/

Carolyn Jones
Media Manager, ANZCA

Dr Lindy Roberts, fellow and DPA (WA) (chair)
Dr Kieren Davis, FPM fellow and Board member (NZ)
Dr Jeff Kim, ANZCA fellow (NSW)
Dr Vaughan Launson, DPA assessor (NZ)
Dr Cate McIntosh, fellow and EMAC subcommittee chair (NSW)
Dr Craig Noonan, fellow and TAC member (VIC)
Dr Bronwyn Posselt, trainee committee (Tas)
Dr Natalie Smith, fellow and educational expert (NSW)
Professor Michael Veltman, FPM fellow and TUAC chair (WA)
Associate Professor Deb Wilson, ANZCA fellow and councillor (Tas)
Dr Mark Young, fellow and TAC member (Qld)

Never too old at 90

In November 2019, Dr Ron Trubuhovich ONZM (BDS, MB, ChB, BMedSc [all UNZ]; MSc [Oxon]; MD [UoA]; FRCA, FANZCA, FCICM) graduated with a doctorate in medicine at the University of Auckland aged 90. As Adele Broadbent discovered, he says there's more to do and more to write.

FOR MUCH OF his life since he retired, Dr Trubuhovich has been researching and documenting the work of medical practitioners who pioneered intensive care medicine. In the beginning, these practitioners were anaesthetists.

He is a New Zealander who began his medical career specialising in anaesthesia. He worked as an anaesthesia registrar at Dunedin Hospital and in 1965 he was awarded a Nuffield Dominion Scholarship to the Nuffield Department of Anaesthetics at Oxford, at the Radcliffe Infirmary. In 1966 he obtained the English fellowship in anaesthesia. FFARCS (Eng), and, in 1968, he completed a research MSc (Oxon). He returned from Britain to an Auckland Hospital appointment at Dr Matthew Spence's Acute Respiratory Unit (later renamed the Department of Critical Care Medicine) as its deputy medical officer-in-charge. He worked there for 30 years and in the last four years of that stint, he worked as a departmental locum.

The next decade was spent overseeing repatriation of sick New Zealanders from all over the globe, while also writing papers in medical history.

Dr Trubuhovich was a representative for intensive care medicine at the New Zealand Regional Committee of the Faculty of Anaesthesia (FoA)/ANZCA for some years; one-time chairman of the FoA's Section of Intensive Care; then, 1993-96, inaugural Vice-Dean of ANZCA's Faculty of Intensive Care. He was a faculty/college examiner in intensive care for a decade around the turn of the century. He was awarded the College of Intensive Care Medicine's Medal in 2008.

After years of petitioning he obtained Medical Council of New Zealand recognition of intensive care as a separate specialty in NZ, in 1999 by Order-in-Council (before comparable recognition later in Australia).

Dr Trubuhovich's doctoral thesis *Resuscitation and the Origins of Intensive Care/Critical Care Medicine* was supervised, "to my great fortune", he says, by Professor Alan Merry at Auckland University's Department of Anaesthesiology.

"The thesis with the aid of accounts from principal participants, is a retelling of the story from Denmark, especially for 27 August 1952, which day in this context can be described as a landmark. It was the start of a new line of treatment for ventilatory failure in poliomyelitis,

which had its origin in the anaesthetic world and in anaesthetists who, principally, were the first practitioners of ICM/CCM. The prime mover was Dr Bjørn Ibsen." [An extract from Dr Trubuhovich's thesis]

Dr Trubuhovich is no stranger to research or writing having been the lead author (with Dr James Judson) of a 2001 history of intensive care in New Zealand, as part of their department's 40th anniversary. At his most prolific, he was publishing up to two papers a year including one on Alexander the Great's famed early "tracheotomy", debunking lore that the conqueror used the tip of his sword to pierce the throat of a soldier who was choking. He also wrote a paper on the Indigenous-North American origin, and the later 18th century Europe-wide practice, of attempted resuscitation by rectal fumigation with tobacco smoke.

Of his thesis, he admits "it has had a good reception in Europe from some appropriate medical people (in Denmark, Sweden, Norway, France, Poland) and England, Scotland, the US, Australia and New Zealand ... among those I have sent it to."

In the abstract to his thesis he explains his motivation to keep on writing:

"We now stand on the shoulders of our pioneers and value and honour the contributions they made in having treatments started with results unknown or unproven. The work of self-sacrificing pioneers such as Bjørn Ibsen, J O'Dwyer, G Fell, among many, warrants being held in the highest esteem. However, the development of this specialty is far from over. Even today, there are many areas where patients still die through lack of knowledge, effective treatments and appropriate technology. By examining the past, this thesis aims to emphasise such a viewpoint."

But there are now those who stand on the shoulders of this prestigious fellow. And a few who stand beside including Professor Barry Baker who said:

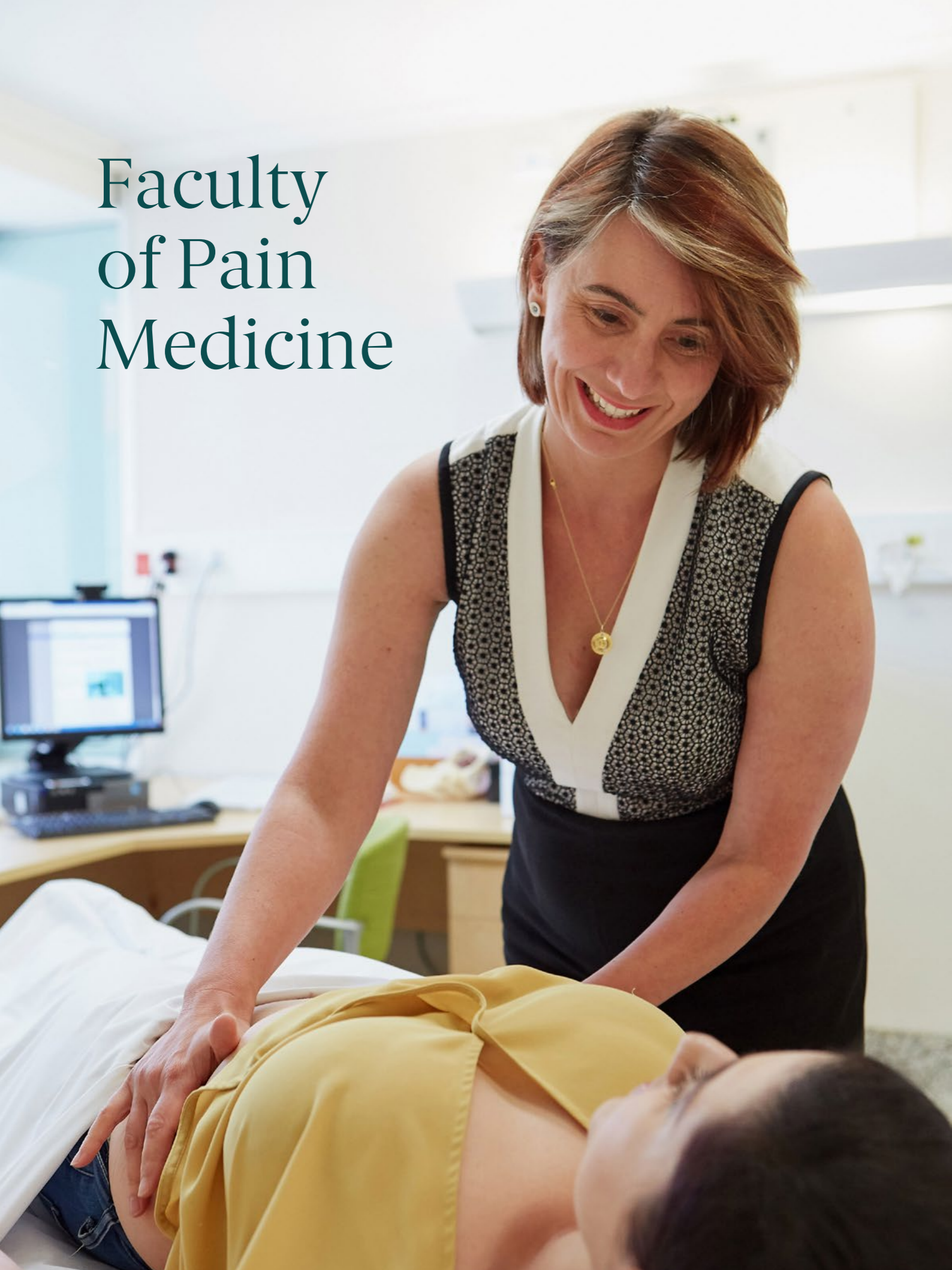
"The College of Intensive Care Medicine salutes Dr Ron Trubuhovich for his achievement at the age of 90 years, and for his dedication to the research required to set down the development and early days of our specialty, to say nothing of his own dedication as a practitioner for over 50 years to fostering the specialty and thus the care of the many patients who have benefitted from his clinical care."



Ron Trubuhovich.

"The development of this specialty is far from over. Even today, there are many areas where patients still die through lack of knowledge, effective treatments and appropriate technology."

Faculty of Pain Medicine



DEAN'S MESSAGE

Difficult times draw communities together



patient ambassador Mr Howard Clark who shared his lived experience of pain expertly guided by the inimitable Dr Diarmuid McCoy.

My thanks also to FPM fellows Associate Professor Mick Vagg and Dr Melissa Viney, stalwarts of the course and Dr Charlotte Johnstone who flew in from Sydney for the day, Dr Robert O'Brien, Executive Director, Education and Research, Mr John Prentice, head of ANZCA library services, and faculty staff, Ms Juliette Whittington and Ms Caroline Beaney, who made the weekend work seamlessly.

There were many compliments from the trainees about the warm welcome they received and the generosity of faculty fellows and staff throughout the weekend not to mention the amazing catering.

I was particularly struck by the diversity of our new trainees this year. They come from overseas as well as Australia and New Zealand. They are rehabilitation medicine physicians, general practitioners, anaesthetists, paediatricians including a paediatric palliative medicine physician, psychiatrists, general physicians, obstetrician/gynaecologists, rural and remote medicine physicians and a neurosurgeon.

The range of personal and clinical skills they bring into pain medicine augurs well for the future our foundation fellows envisioned when they established the faculty as a multidisciplinary medical academy. We can be proud of the faculty's continuing leadership with the recent publication of the *PM11: Procedures in Pain Medicine Clinical Care Standard* (fpm.anzca.edu.au/resources/professional-documents).

Over the past two years, organisational diversity has been a focus within ANZCA/FPM for council, board and all higher-level committees. The board has delegations from ANZCA Council (regulation 40) to enable it to conduct faculty business.

It is very important therefore that the decision-makers around the board table provide a broad range of perspectives, reflecting the diversity that exists within our fellowship and the communities we serve, so that

the best possible outcomes can be achieved. Desirable board member characteristics start with considering that the faculty first and foremost is bi-national and multidisciplinary. Considerations of gender and cultural diversity, being in public or private practice; metropolitan, regional or rural practice; and having specialist knowledge and skills follow. The board has therefore revised by-law 1 to reflect the evolution of the faculty over its first two decades and looking to having the right skill mix to address the future.

Board members are elected to progress the faculty's business and not represent the interests of any particular group. They are expected to have a good understanding of faculty structures and processes and to participate actively in faculty affairs such as chairing a committee or being a committee member, being an annual scientific meeting/event organiser or a representative on an ANZCA committee or external organisation besides being ex officio on their local regional committee.

I am very grateful to the current board members who give their time and expertise on a pro-bono basis and work very hard across a range of faculty affairs.

As this is my last dean's message, I would like to acknowledge the incredible support and leadership from ANZCA President Dr Rod Mitchell and CEO Mr Nigel Fidgeon and the faculty's hardworking and dedicated staff, particularly general manager, Ms Helen Morris, who left the faculty at the end of 2019. We thank her very much for her many years of devotion and untiring efforts to support and promote the faculty. We wish her well for the future. Finally, my heart-felt thanks go to acting general manager Ms Juliette Whittington for her unfailing support especially throughout the last year.

I leave the faculty with strong leadership as Associate Professor Michael Vagg takes over as dean, and Dr Kieran Davis as vice-dean. I wish the faculty a very bright future and hope all fellows and trainees keep safe and well during this challenging time.

Dr Meredith Craigie
Dean, Faculty of Pain Medicine

AS WE ALL grapple with the fall-out of the COVID-19 pandemic and worry about the longer-term implications for our patients, our colleagues, our communities and ourselves, I have been reflecting on many conversations from the past few weeks.

Patients have been incredibly understanding as my pain unit has moved to telephone consulting and cancelled all procedures except the most urgent. Colleagues tell of innovative ways of consulting while others are struggling.

Others reflected on past difficult times drawing communities together. This has happened within the faculty and wider ANZCA community now. The staff quietly moved out of ANZCA House in mid-March to work from home.

Besides continuing regular business, the staff and many fellows have taken on additional workload with many extra emergency meetings on a wide range of issues including implications for training and examinations, clinical practice and continuing professional development, financial concerns, cancellation of all conferences in 2020 and answering the extra queries from anxious trainees and fellows, especially our anaesthesia colleagues who are on the front line and very concerned about their personal safety. Thank you all for your commitment to the faculty and our pain medicine community.

The exciting start to this year seems a distant memory. Once again the faculty hosted the Basic Clinical Skills Course at ANZCA House in early February to welcome its latest cohort of trainees. It was a fun, jam-packed weekend. I would particularly like to thank our

New emergency response standard: Cardiac arrest for specialist pain medicine physicians



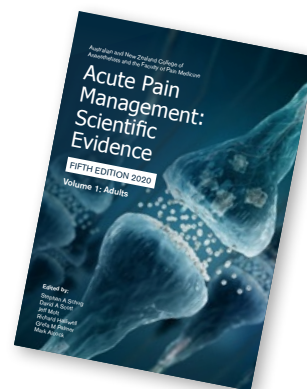
Dr Mark Alcock.

ANZCA AND FPM continuing professional development (CPD) program participants with the clinical practice type are required to complete two emergency response activities per triennium. Course providers who want to deliver emergency response activities for ANZCA and FPM CPD participants can apply for recognition of suitability in accordance with our established standards.

Over the past two years, FPM fellows have taken the lead to create emergency response standards specifically relevant to pain medicine. The second pain medicine emergency response standard *Cardiac arrest for specialist pain medicine physicians* was approved for implementation in the ANZCA and FPM CPD program from 1 January 2020. It was developed by Dr Mark Alcock (FANZCA, FFPMANZCA, pictured), in liaison with the ANZCA and FPM CPD Committee and the FPM Professional Standards Committee.

Acute Pain Management: Scientific Evidence

Virtual launch of the fifth edition coming soon in 2020.



New fellows

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

- Dr Eric Cheok, FAFRM(RACP), FFPMANZCA (NSW).
- Dr Gretel Davidson, FANZCA, FFPMANZCA (NSW).
- Dr Kate Drummond, FANZCA, FFPMANZCA (NSW).
- Dr Daniel Ellyard, FANZCA, FFPMANZCA (WA).
- Dr Jennifer Hudson, FANZCA, FFPMANZCA (NZ).
- Dr Brian Lee, FANZCA, FFPMANZCA (WA).
- Dr Yi-Ching Lee, FCICM, FFPMANZCA (NSW).
- Dr Konara Samarakoon, FANZCA, FFPMANZCA (Qld).
- Dr Vidya Shirumalla, FCICM, FFPMANZCA (Qld).
- Dr Bethany White, FANZCA, FFPMANZCA (Vic).

We would also like to congratulate **Dr Saad Anis**, FANZCA, FFPMANZCA (New Zealand) for his admission to FPM fellowship through the specialist international medical graduate pathway.

Training unit accreditation

The following units have been accredited for pain medicine training:

- Austin Health, Victoria.
- Burwood Hospital, New Zealand.
- St Vincent's Hospital Melbourne, Victoria.
- St Vincent's Hospital Sydney, NSW.
- Sydney Pain Management Centre, NSW.

Meeting with the Queensland Minister for Health

FPM DEAN Dr Meredith Craigie and ANZCA Executive Director, Policy and Communications Ms Clea Hincks met with Minister for Health in Queensland Dr Steven Miles on 13 February following the request we sent after the launch of the National Strategic Action Plan for Pain Management.



Queensland Minister for Health Dr Steven Miles and FPM Dean Dr Meredith Craigie.

Delivering the National Strategic Action Plan workshop

ON MONDAY 24 FEBRUARY, the faculty joined with PainAustralia to host a workshop on how the National Strategic Action Plan for Pain Management could be delivered. Key pain medicine organisations from around Australia, the Therapeutic Goods Administration and Department of Health attended to consider this question and specifically identify groups who have the expertise and capacity to deliver the different goals identified in the plan.

Professor Paul Kelly, Deputy Chief Medical Officer in Australia presented “The State of Pain in Australia”, covering the burden of pain in Australia, recent government funding in the area including grant opportunities that have been offered as a result of the National Strategic Action Plan for Pain Management, and the anticipated future priorities for the government. Participants worked in groups to consider what existing resources and initiatives were being delivered by different organisations that aligned to the eight goals articulated in the National Strategic Action Plan for Pain Management and the resource gaps for each goal. It was felt that a nationally co-ordinated multi-organisational approach was needed to deliver the National Strategic Action Plan. A report from the workshop is being prepared and will be circulated to participating organisations and the health minister in due course.



Below from left: NSAP workshop; FPM Dean Dr Meredith Craigie, CEO of PainAustralia Carol Bennett, FPM Vice-Dean Associate Professor Mick Vagg and ANZCA CEO Mr Nigel Fidgeon.



New Zealand



COVID-19 – How New Zealand’s response unfolded

The New Zealand government chose to “go hard and go early” with the announcement of a Level 2 alert for the COVID-19 response on 21 March, while preparing the country with an outline of what Level 4 would look like.

Just two days later, on 23 March, the first cases of community spread were confirmed. The Prime Minister Jacinda Ardern immediately announced New Zealand would move to Level 3, and progress to Level 4 in 48 hours, giving some time to ensure essential services were in place.

The Level 4 lockdown placed severe restrictions on the community, with only supermarkets, pharmacies, service stations and health providers allowed to operate. People were told only to interact with members of their household – referred to as their “bubble”. New Zealand’s borders closed, and New Zealanders returning home were told to self-isolate for 14 days.

Level 4 involved major reprioritisation of health services, including deferring elective surgery and other procedures. The health system worked rapidly in New

Zealand to assess ventilator and ICU-bed capacity across District Health Boards in preparation for a potential wave of COVID-19 patients. Personal Protective Equipment (PPE) was a big issue, with assurances from the Ministry of Health that New Zealand had plenty of PPE, through to media stories and reports of frontline health practitioners struggling to access the PPE needed. The Director General of Health made it clear that New Zealand’s goal for COVID-19 had to be eradication, as the health sector would struggle to cope with the alternative scenario of failed eradication.

In general, the public have supported the government’s approach. Ms Arden has been praised for her clear communication and empathetic approach. When announcing the Level 4 lockdown, she stated “I do not underestimate what I am asking New Zealanders to do. It’s huge. And I know it will feel daunting.”

The economic consequences as a result of COVID-19 are unprecedented. Treasury has forecast unemployment figures ranging from 13-25 per cent by the end of the year, depending on the length

of lockdown and size of government stimulus. The minister of finance has announced more than \$20 billion worth of government stimulus packages so far, including wage subsidy schemes to keep people employed, and the promise of spending on “shovel-ready” infrastructure projects once lockdown is eased.

Hard hit sectors in New Zealand include hospitality, tourism and media, with job losses and staff asked to take pay cuts. In a move of solidarity Ms Arden announced on 15 April that she would take a pay cut of 20 per cent, along with other government ministers and public sector CEOs. She was clear that this is an issue of leadership – rather than having any significant impact on the government’s books.

At the time of writing, focus has shifted to nailing down the detail of how the government will exit the Level 4 lockdown. Cabinet will decide its next steps on 20 April, based on the information it has to hand. The finance minister has indicated a shift down to Level 3 would focus on allowing “safe” economic activity, as well as the current “essential” economic activity.

One year on

It is a year on from the 15 March mosque attacks in Christchurch and the ramifications are still being felt by victims and health workers.



- 51 people killed, 48 victims admitted to Christchurch Hospital on 15 March.
- 94 surgical operations over 182 hours carried out on victims in Christchurch Hospital between March and August.
- 81 further people presented later with anxiety, chest pain and other health-related issues.
- More than 1856 treat-ments being provided to 121 people as at mid-October.
- \$5.6 million estimated impact on Canterbury District Health Board (DHB) secondary services in 2018-9.
- 1390 free general practice consultations funded by the DHB, as at 31 October, for people affected by the mosque attacks.
- \$4.328 million additional funding through to June 2020 provided by the Ministry of Health towards the DHB’s wellbeing and recovery plan to address the ongoing impact.

Victoria



Final full-time course

Held in the ANZCA House Auditorium from Monday 10 to Friday 14 February this pre-fellowship course covers 22 topics and continues to be well attended with 68 trainees attending this sitting. As in the past it was encouraging to have among our attendees trainees from New Zealand and interstate. To the convenor, Dr Glenn Downey and all of the valued presenters of the course, we would like to offer our sincere thanks for their time and commitment to our academic activities.

Final anatomy course

Following on from the final full-time course, the anatomy course was also held at the college the following Monday 17 February. There were four anatomy-based lectures in lower and upper limb; anatomy of the spine and its attachment; head and neck; and anatomy of the heart and lungs.

Our many thanks to each of the presenters for their time, commitment and the valuable experience they bring to each of the attending trainees within this course.

Final medical refresher course

Originally this course runs over four Saturday morning sessions but, with large numbers of 41 trainees to accommodate, we had 18 hospital sessions organised overall on various days/nights at The Alfred, Austin, Box Hill, Monash, Royal Melbourne and St Vincent hospitals for this sitting. Many thanks to all those involved in the hospitals to bring this together, and the registrars for running extra sessions to accommodate the number of trainees. Their support and dedication is so appreciated – thank you!

Part Zero Course

The Victorian Part Zero Course was held at ANZCA House on Friday 28 February. The full day course was attended by a healthy balance of new Victorian introductory trainees and resident medical officers aspiring to be trainees and anaesthetists.

The trainees were welcomed by the convenor, Dr Lucky De Silva, along with co-convenors and trainees Dr Andrew Goldberg and Dr Aaron Paul. The presentations covered welfare of anaesthetists, introduction of TPS/WBAs, curriculum, updates on college resources, Victorian Trainee Committee, ASA, and survival guides – hearing stories from other trainees.

A significant part of the course was run by trainees for trainees. There was also an interactive question and answer sessions with supervisors of training and the day finished with group airway sessions aimed at teamwork and team learning. The highlight for the day is the opportunity for trainees to network and forge friendships. Many thanks to our valued presenters, SOTs and workshop facilitators for their contributions, and also thank you for the support of the convenor, Dr Lucky De Silva, and co-convenors Dr Andrew Goldberg and Dr Aaron Paul for their help to bring this meeting together.

FPM March evening meeting

Hosted by Dr Clayton Thomas, the FPM VRC education officer, this evening lecture was held at the college on Wednesday 4 March. The topic of the lecture “Is pain simply a symptom of post-traumatic stress disorder (PTSD)?” was presented by Dr Maryam E Dar, MD MPsych FRANZCP Adv Cert CL Psych. It was a very well received meeting with 34 registered and delegates that were not able to attend in person requesting slides and recordings of the talk. Our warm thanks go to Dr Thomas, Dr Dar, our sponsor Seqirus, and all participants.



From right: Part Zero Course 2020 – Lucky De Silva (convenor) & Aaron Paul and Andrew Goldberg (co-convenors); Part Zero Course 2020 – airways workshop.



New South Wales



ACE Regional meeting

The annual NSW ACE Spring Meeting “Anaesthesia 2020: Same same but different...” was held from 16-17 November at the Gibraltar Hotel, Bowral. The meeting attracted more than 100 delegates with 21 speakers and workshop facilitators across the weekend.

The two-day meeting was a huge success both scientifically and socially generating extremely positive feedback.

Thank you to all the speakers and especially the convenors Dr David Elliott and Dr Iain Stewart who dedicated their valuable time to make it a success.

NSW Part II Refresher Course

The NSW Regional Committee conducted a very successful Part II Refresher Course in anaesthesia at Vibe hotel, North Sydney from December 9-13.

The exam-focused course included presentations and discussions on core topics, as well as preparation for the different components of the final examination. Speakers included many current and past examiners, as well as trainees who provided advice and spoke of their recent examination experience.

A highlight of the course was the anatomical workshop held at the Department of Anatomy and Histology, University of Sydney, conducted by seven lecturers in a hands-on workshop.

A special thanks to all the speakers who devoted a huge amount of time and effort in assisting the candidates to prepare for their final examination, and especially to Dr Sally Wharton.



Dr Sean Duncan, Dr Jamie Calder, Dr Felicity Bennett, Dr Roma Steele, Dr Mariko Hylands and Dr Luke Bromilow.

Part Zero Course

The Part Zero Course for new trainees was held at the Crows Nest Centre, at Crows Nest on Saturday 9 November. There were 65 new trainees who attended the day program which included sessions on training, navigating TPS, examination preparation, career options, welfare and mentorship.

Many thanks to those trainees, consultants and non-anaesthetists who volunteered their time to take part. Thanks to the NSW Trainee Committee for organising a great day, which provided an opportunity for new trainees to meet and mingle with other trainees and consultants, and a special thank you to the convenors, Dr Katherine Gough and Dr Rebecca Lewis.

NSW Primary Refresher Course

The NSW Regional Committee conducted a very successful NSW Primary Refresher course at the Kolling Building, Royal North Shore Hospital from December 2-6. There were 46 participants on the course, with 68 per cent from NSW.

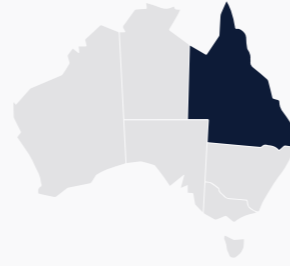
The course was designed to help prepare candidates sitting the primary exam in March. It included some didactic teaching sessions, which focused on areas which candidates commonly find difficult. Most of the course was taught in an interactive style, including the use of many practice SAQs. Friday was entirely viva-focused using small groups of six.

There were 12 tutors from seven hospitals teaching on the course. A special thanks goes to all the tutors who devoted a huge amount of time and effort in assisting the candidates to prepare for their primary examinations, and especially to the course director, Dr David Fahey.



Dr Luke Bromilow with Part II Refresher course participants.

Queensland



Annual ACE meeting

Unfortunately, we have made the difficult decision to postpone the 2020 Queensland ACE meeting “To infinity and beyond: Hot topics for the 2020s”. The event will now be held on Saturday 24 July 2021 at the Brisbane Convention and Exhibition Centre.

CME evenings

At the first FPM evening meeting of the year held on 24 February, we were delighted to be joined by Dr Tasha Stanton, Associate Professor of Clinical Pain Neuroscience from the University of South Australia. Dr Stanton presented “New insights from pain neuroscience to guide our assessment and treatment of people with chronic pain”. The ACE March evening was held on 10 March, and we were fortunate to be joined by bariatric surgeon Dr Anthony Cheng, and local anaesthetists Dr Sarah Bowman, Dr Noam Winter, and Dr Alexander Kelly for an evening exploring “Future directions in bariatric surgery”. Both evenings received positive feedback, and were very well attended both in person and remotely. Thank you to all the speakers who dedicated their valuable time to make these evening meetings a success.



Courses

The Part Zero Course for introductory and basic trainees was held on 15 February, followed by the Final Exam Prep Course from 17-21 February. Both courses were well received. We would like to offer our sincere thanks to all the convenors and presenters for their time and commitment to these courses.

Queensland Trainee Committee

We welcome the trainee committee members for 2020: Dr Joseph Bauer, Dr Hannah Bellwood, Dr Larissa Cowley, Dr Siobhan Lane, Dr Joyce Leung, Dr Alyce McKenzie, Dr Louven Menzies, Dr Sofia Padhy, Dr Romitha Ranasinghe, Dr Anna Shirley, and Dr Joel Thomas. We look forward to working with the committee during 2020.

Above: 2020 Queensland Trainee Committee Co-chairs Dr Hannah Bellwood and Dr Larissa Cowley.

Left, from top: Presenters Dr Anthony Cheng, Dr Sarah Bowman, Dr Alexander Kelly, Dr Noam Winter, and Queensland ACE CME Committee Chair Dr Edward Pilling; Final exam prep course series 1, 2020: Dr Joanne Rotherham is presenting her talk on Acute and Persistent Pain.



AUSTRALIAN REGIONS

South Australia and Northern Territory



Thai cave rescue – Against all odds

Several South Australian fellows and staff were fortunate to be able to attend The Bob Hawke Prime Ministerial Centre VIP Reception following the launch of Dr Richard “Harry” Harris and Dr Craig Challen’s book “Against all odds” in Adelaide in November.

Part Zero Course

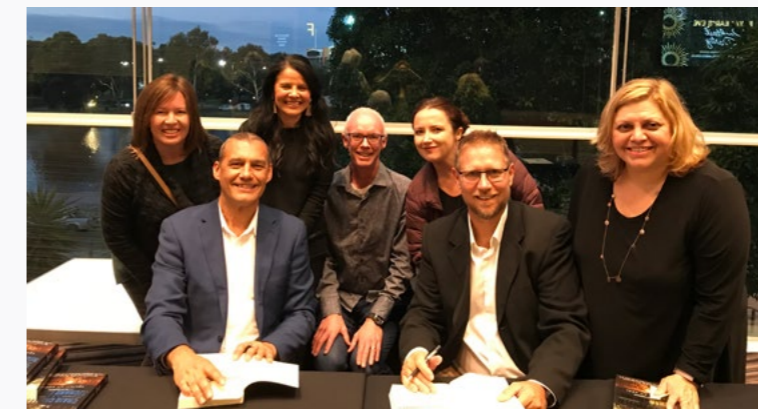
The SA/NT regional office held the Part Zero Course for introductory trainees commencing the training program on Saturday 18 January. The orientation course is designed to introduce new registrars to the ANZCA training program and includes information about the training portfolio system, workplace based assessments, exams, mentorship and work/life balance.

SA/NT Annual Trainee Dinner

Trainees enjoyed the evening at Orso restaurant on 2 November with guest speaker ANZCA President Dr Rod Mitchell. It was an informal evening where Dr Mitchell spoke about equity of access to healthcare, his personal insight into the benefit of working in rural Australia, and work-life balance. Trainees scrubbed up well, away from their scrubs, in a fun, relaxed and social get-together.

From top right: Part Zero Course attendees Hayley Adams, Alex Fawcett, Tim Wonders, Liana Van De Veerdonk, Mila Sterbova, Damien Johnson, Jolene Ralph, James Turnbull, Courtney Lloyd, Sam Willis, Ken Chin and Christine Hildyard; SANT Trainee Dinner attendees Nik Fraser, Ben McDonald, Mary-Claire Simmonds, Craig Morrison and Charlotte Taylor; ANZCA President Rod Mitchell and Charlotte Taylor.

Below: Adelaide-based fellows and staff who attended the book launch – Alison Cook, Dr Craig Challen, Michelle Gully, Dr Richard Walsh, Dr Agnieszka Szremska, Dr Richard Harris, and Teresa Camerelli.



Australian Capital Territory



2020 Scan and Ski Workshop Postponed

Unfortunately, we have made the difficult decision to postpone the Scan and Ski workshop in Thredbo from 6-8 August 2020. In good news though, we have been in touch with the workshop venue and we have secured a new date for the workshop. The event will now run from Thursday 22 July to Saturday 24 July, 2021. Further details, including a link to registration, will be circulated towards the end of the year.



ACT Trainee Committee

In 2020 we welcome a new trainee committee and look forward to getting to know them over the next year. The committee members are: Dr Daniel Foong, Dr Anneliese Kerr, Dr Cameron Maxwell (Deputy Chair), Dr Nicole Somi (Chair), Dr Kurt Zapasnik, Dr Aaron Pym (co-opted), Dr Claire Connelly (co-opted), Dr Liam Gleeson (co-opted), Dr Dharan Sukumar (co-opted) and Dr Fabio Longordo (co-opted).

We look forward to working closely with the Trainee Committee during 2020.



Western Australia

Part Zero Course

The Part Zero Course is run yearly in all regions and New Zealand to welcome new trainees into the ANZCA training program. The course is a face-to-face, full day event aimed at providing introductory trainees with information that is relevant to them and their training. It is also a fantastic opportunity to meet other trainees in the training program and build friendships and connections.

This year WA invited 16 new trainees to the Part Zero course and we once again welcomed guest speakers including trainees, supervisors of training, consultants and executive officers to discuss professionalism and performance, ANZCA resources, the Training Portfolio System, welfare, mentoring and training. ANZCA WA

would like to thank the fellows and trainees who provided support and expertise during the course. We would also like to offer our sincerest thanks to Dr Jay Bruce and Dr Kevin Hartley for their time and efforts in facilitating the Part Zero course, the extensive mix of experience she provided, has given the trainees with a greater understanding of role expectations and what the trainee positions will involve.

The EO/SOT Committee held their annual dinner meeting Wednesday 5 February at Tsunami in Mosman Park. The Regional Committee met on 18 February and the Trainee Committee had their first meeting of the year on 25 February.



Right: The Part Zero group.



Tasmania



A busy start to the year

Tasmania had three events in February aimed at different audiences with varying focuses. A large number of people have been involved in planning, preparing and presenting at these events. This clearly demonstrates the commitment and solidarity of those volunteering their time and expertise and sometimes sharing their personal journeys to help teach and encourage others.

Part Zero Course

Eleven participants attended the annual Part Zero Course on Saturday 15 February at the Mantra Charles Hotel in Launceston. Convened by Dr Joanne Samuel and Dr Rowena Lawson with presenters and delegates attending from all three regions of the state. Judging by both the verbal and written feedback, the day was a clear success. Positive comments were received with attendees enjoying the day and finding the tips for training and studying for exams particularly helpful.



Trainee Day

Registrars from all over Tasmania and even a few from interstate attended the annual Tasmanian Trainee Day on Friday 28 February at Hadley's Orient Hotel, Hobart. Altogether 27 attended the day, which has become a tradition in Tasmania. The international and interstate speakers attending for the Tasmanian ASM, and the ANZCA and ASA presidents and FPM Dean joined with local speakers to provide the delegates with a variety of interesting and sometimes challenging and insightful presentations.

The attendees greatly appreciated the opportunity to hear Professor Meg Rosenblatt from Mount Sinai in New York share her knowledge and expertise on local anaesthetic systemic toxicity, with presentations from interstate invited speakers Dr Jennifer Stevens and Professor Kirsty Forrest also valued.

Participants had the opportunity to hear about a variety of career opportunities in pain medicine, diving and hyperbaric medicine and global health.

The highlight from the day was an interactive panel discussion on maintaining wellbeing throughout your career. Joining the international and interstate speakers on the panel were the presidents of ANZCA and ASA, dean of the Faculty of Pain Medicine, and local northern wellbeing lead Dr Gregg Best. The delegates enjoyed hearing personal stories and shared experiences of the members of the panel and valued the insights it gave them to help care for themselves, as well as for each other, throughout their careers.

Co-Convenor and MC on the day, Dr James Correy thought the day went particularly well and saw the day as an opportunity for trainees to socialise and learn, not just with each other but with a variety of interesting speakers, who are leaders in their fields. The Tasmanian Regional Committee congratulates Co-Convenors Dr Bronwyn Posselt and Dr James Correy on an interesting, enjoyable day.



Left from top: The Part Zero Course provided opportunities for learning; Professor Kirsty Forrest presenting at the Tasmanian Trainee day.



Updates in PoM – 360 degrees

Thank you to all the delegates, our international speakers Professor Moonesinghe, Professor Ko, Dr Carlisle and Professor Levett, and our local speakers who joined us for the 8th Australian and New Zealand Symposium of Perioperative Medicine, “Updates in PoM – 360 degrees”, from 7-9 November 2019, at the Sofitel in Brisbane. In true tradition, it was yet again a fun, collaborative and educational meeting.

The quality of talks consistently exceeded expectations. Fittingly, the meeting kicked off with a session on “quality”, from quality of available evidence through to quality of care, which set the bar high for the remainder of the meeting.

Different craft groups’ perspectives on current and future perioperative pathways showcased that there is more than one way to achieve the same goal of exceptional patient-centred perioperative care. The common feature being the patient at the centre of the pathway, the patient is in the driver seat. We were also reminded to always remain cognisant of our personal agenda that we bring into the conversation with our patients and their family.

Some of us chose to start off Friday with yoga on the terrace overlooking the city. What better way to clear the mind and prepare the body for another day of knowledge acquisition and networking? Some of the braver souls tried their hand at Bujinkan Budo Taijitsu, led by our multi-talented former chair, Dr Dick Ongley. Delegates could pick from an array of great breakout sessions to attend in the morning while the afternoon was filled with a potpourri of PoM from perioperative

management of sleep disorders to the METs study, InS:PIRE and beyond, the opioid crisis and the ongoing process of aligning perioperative knowledge acquisition across the globe.

The final day highlighted the importance of teamwork. A special mention goes to Ianthe Boden and Thuy Buy, our allied health speakers, both progressive experts in their respective fields, who were exceptional. The importance of their input to the “functioning” of the team and the outcomes of our patients is undeniable and many of us were left wishing we could clone them to join our perioperative team.

My final meeting as a convener, I hand over to Dr Nicola Broadbent.

Dr Jill Van Acker
Convener

Associate Professor Ross Kerridge at GoMA.



Below from left: Invited international speaker Professor Ramani Moonesinghe; Yoga class for the delegates on the terrace.



Tasmanian ASM

The “LEAP” theme of “Learning and Excellence in Anaesthesia and Pain” seemed very appropriate for a Scientific meeting held on Saturday 29 February, followed by a half-day of workshops on Sunday 1 March.

About 120 delegates from all over Australia, and some from New Zealand, attended the meeting. They enjoyed the opportunity to hear from fascinating speakers covering a wide variety of topics. The meeting was privileged to have Professor Meg Rosenblatt from Mount Sinai in New York as our international guest, sharing her knowledge and expertise on ambulatory total joint replacements and regional anaesthesia in non-orthopaedic surgery.

Invited speaker Professor Kirsty Forrest spoke on “Communicating from behind the mask” as well as leading a “Feedback as a dialogue workshop” on the Sunday.

FPM Dean Dr Meredith Craigie chaired a pain session with Sydney’s Dr Jennifer Stevens speaking on preoperative opioid weaning, and locals Dr Chris Orlikowski and Dr Adrian Reynolds also shared their knowledge and experience.

Dr Dick Ongley, from Christchurch, New Zealand shared his knowledge on the developing specialty of perioperative medicine, with local speakers Dr Andrew Ottaway, Dr David Cooper and Dr Adam Mahoney also adding to the array of interesting presentations on the day.

Delegates enjoyed the opportunity to relax after a busy day on the Hobart waterfront enjoying locally-produced drinks and delicious canapes while watching the sunset over the Derwent River.

Sunday provided great hands-on workshop opportunities for delegates to practice regional anaesthesia nerve block techniques and ALS emergency response. Delegates also enjoyed learning the art of feedback as a dialogue, and major haemorrhage emergency response workshops. There was also the opportunity to enjoy a medical history walking tour of Hobart. The organising committee appreciate the time and effort of all our workshop facilitators.

Convener of the meeting, Dr Christopher Wilde was pleased with how the meeting went and was grateful for the contribution by the presenters towards the success of the meeting, as well as by the support of the trade who attended. He was also particularly impressed by the co-ordinated efforts of the organising committee. He explained that this meeting was the first time the organisers had formally targeted reducing the meeting’s environmental impact, and inclusion and diversity as overarching goals. The committee was pleased to have the program and abstract booklet online, reducing the use of plastics and single-use items, including reusing meeting lanyards. These measures will help reduce the environmental footprint of the meeting and these measures will continue into future meetings.



Dr Meredith Craigie chairing the pain session at the Tasmanian ASM.



Professor Meg Rosenblatt led small hands-on groups for a regional anaesthesia limb block workshop.



Delegates enjoying local drinks and canapes overlooking the Hobart waterfront.

Shared Decision Making (SDM) Workshop

The Shared Decision Making (SDM) Workshop for the Perioperative Clinician was held in Brisbane last November, immediately preceding the ANZCA Perioperative Medicine Special Interest Group Meeting.

The day began with an overview of SDM in the perioperative setting with a discussion around the unique challenges that face clinicians working with patients contemplating high-risk surgery. Professor Peter Martin, director of the Centre for Organisational Change in Person-Centred Healthcare (OCPH) based at Deakin University, presented on the importance of robust healthcare communication skills in effectively delivering SDM conversations. This prompted much discussion about the degree of variability in the quality of communication that patients receive during their healthcare encounters and how this may impact on their decision making around surgery.

The remainder of the day was dedicated to immersive experiential work. A record 24 participants attending were divided into three groups facilitated by Dr Debra Leung (Peter MacCallum Cancer Centre) alongside Professor Peter Martin and Ms Meg Chiswell from the OCPH. Each small group worked with a professional simulated patient on a high-fidelity perioperative SDM scenario. Specific learning objectives were identified to build on the skills that participants already possessed. Each participant then worked one-on-one in the scenario with a facilitator to give them a new set of skills that could be shaped to fit each individual communication style. Teaching about the evidence base behind all the communication skills was also interspersed throughout the experiential sessions. At the end of the workshop, each participant came away with an individualised take-home skill that they committed to implementing into their clinical practice, whether that be a specific communication technique to help aid those difficult conversations or a way to teach trainees.

Overall, a thought-provoking and challenging day was had by facilitators and participants alike. Many participants specifically made comment about how at the start of the day they were dreading role-plays. However, by the end of the day they were able to see a definable improvement in their communication skills which could act as a launching pad for them to continue exploring and developing their own communication style.

Dr Debra Leung
Convenor



Professor Peter Martin.

Symposium on Cardiopulmonary Exercise Testing (CPET) and Prehabilitation

The international multicentre METS study reported limited use of cardiopulmonary exercise testing (CPET) as a risk predictor for cardiac complications after surgery. Importantly, however, it highlighted the clinical utility of CPET as the only objective measure of functional capacity to predict the risk of non-cardiac complications after major surgery. This underpins the importance of identifying impaired functional capacity (and other modifiable risk) which can be mitigated through prehabilitation. This was reflected in the attendance by more than 100 clinicians at the two day Symposium on Cardiopulmonary Exercise Testing (CPET) and Prehabilitation that was held in conjunction with the annual Perioperative SIG meeting in Brisbane (November 2019). This symposium served as a primer for those attending a more formal course leading to accreditation in CPET by the Perioperative Exercise Testing and Training Society (POETTS) that is held annually in Melbourne and in the UK.

Symposium faculty consisted of international and national leaders with clinical and research interests in risk stratification and risk reduction in patients presenting for major surgery. Dr John Carlisle (UK) presented on the utility of incorporating CPET derived metrics into a risk calculator for prognosticating survival. This information is invaluable to patients

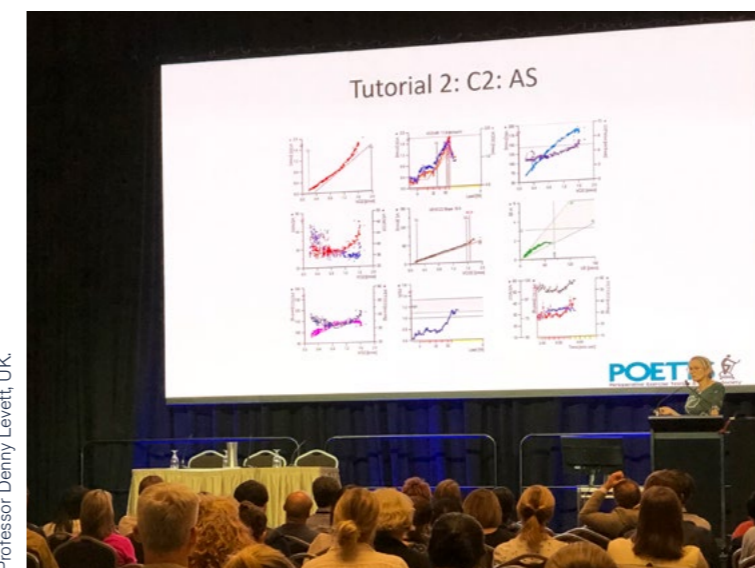
and clinicians when making decisions to embark on high-risk surgery and is invaluable to guiding prehabilitation or in very high risk patients to guiding the Shared Decision Making (SDM) process. Professor Denny Levett (UK) delivered a series of lectures and tutorials, which gave participants an excellent insight into the basic understanding of the physiological basis for CPET and exercise training. There were also a series of video tutorials with explanations of the indications, contraindications, and tips on determining the anaerobic threshold and peak VO₂ measurements.

While the symposium introduced attendees to CPET it also helped clarify its relevance to the emerging field of perioperative medicine and the importance of prehabilitation in addressing modifiable risk. As such, during the second day of the symposium attendees had the opportunity to learn from the experience of a number of clinicians with expertise in prehabilitation. Dr Hilmy Ismail and Professor Bernhard Riedel from the Peter MacCallum Cancer Centre were joined by Drs. Emma Strut, Camille Short, Lachlan Miles and Professor Denny Levett who shared their expertise on delivering the various components of prehabilitation (e.g. exercise, nutritional, haematinic and psychological interventions) within a comprehensive preoperative clinical service. Delegates were also introduced to how patient education could be incorporated into the clinical pathways in the form of a Surgery School, with emphasis on the important role of the patient and their relatives in preparing for the surgical journey through processes such as prehabilitation and ERAS.

The feedback from the group was one of positive appreciation to the faculty and the ANZCA organisers of the symposium and anticipation of future workshops to facilitate certification in CPET.

A CPET course for POETTS accreditation was to be held in Melbourne in March 2020 but given the COVID-19 pandemic all CPET-prehabilitation courses for 2020 have been cancelled and we hope to reconvene with the 4th World Prehabilitation Conference.

Professor Bernhard Riedel
Dr Hilmy Ismail
Co-Convenors



Professor Denny Levett, UK.

Professor Sir Malcolm Keith Sykes

MA (Cantab), MB BChir (Cantab), MA (Oxon),
FRCA, Hon FANZCA, Hon FCA(SA)

1925-2019



Professor Sir Malcolm Keith Sykes.

ONE OF THE doyens of world anaesthesia has died.

Professor Sir Keith Sykes, formerly Nuffield Professor of Anaesthetics at Oxford University and an honorary FANZCA (FFARACS 1979) died on 17 November 2019.

Keith Sykes was born on September 13, 1925 in Clevedon, Somerset, England. Following a peripatetic schooling, partly due to World War II, he graduated in 1949 from Cambridge University (Magdalene College) and University College Hospital (UCH) Medical School. After six months as a house physician at UCH and six as house surgeon at Norfolk and Norwich Hospital he did his national service in the Royal Army Medical Corps in Germany where in his first year, alongside his GP duties, he was medical officer to the hunt and a competitor and MO to the sailing club where he won medals¹. In his second year he worked as an anaesthetist in the British Military Hospital in Hamburg where one of his patients was a Major General who had a fractured odontoid peg following a fall from a horse. The surgeon had only one year's experience and his anaesthetist (Sykes) had

about six months' experience. The naso-tracheal tube was removed, before awakening, at the completion of the head and neck plaster only to find that the airway was completely obstructed, and he "was unable to relieve the obstruction by pushing the chin forward because it was all encased in plaster"¹. Fortunately the naso-tracheal tube was able to be reinserted blindly and events were successfully managed. Thus his interest was raised in anaesthesia.

On demobilisation he obtained an anaesthetic training position back at UCH. Towards the end of this time he obtained a scholarship that enabled him to spend a year at the Massachusetts General Hospital under Professor Henry Beecher. "The year in Boston proved most rewarding partly because it must be said that he (Beecher) was a most infuriating but stimulating person to be with"¹, and Sykes learnt research techniques which confirmed his wish to pursue an academic and research professional life in anaesthesia. At UCH he was soon appointed to a lectureship at the Postgraduate Medical School (PGMS) at Hammersmith Hospital. Just after this appointment Sykes was invited to Durban for six months to help establish and research the treatment of neonatal tetanus using paralysis. Although not the first to establish this technique (they were beaten by weeks by a team from Cape Town) the work there led to many publications which helped establish his name. Sykes said the only reason he had been given permission for this leave so soon after his appointment at PGMS was that, when he asked for permission, the dean seeing "that we both were wearing Magdalene College (Cambridge) ties, offered me six months leave of absence with pay"¹!

On return to PGMS he established research into lung physiology which became his lifetime research interest, and rapidly rose through the academic ranks to Professor of Clinical Anaesthesia – a term he chose as he considered himself "still to be essentially a clinical anaesthetist"¹. It was during this period (1969) that I first met Keith as I went to discuss with him my Oxford research. I had learnt that he was supervising Tony Adams on a similar research project. There were no research conflicts, and my next meeting with him was as my examiner two years later when submitting for my DPhil. I was his first postgraduate academic examinee. We kept in touch from then on, and I had a sabbatical leave with him in 1982.

The PGMS years were very productive in research and during this time he also published two books^{2,3} one of which, *Principles of Measurement for Anaesthetists*, became a classic examination study book for trainee anaesthetists worldwide. In 1979 he was invited as the faculty's International Visitor and Ellis Gillespie Lecturer to the RACS/Faculty GSM in Surfers Paradise, and was elected as an Honorary FFARACS.

When the second Nuffield Professor of Anaesthetics at Oxford University (Alex Crampton Smith) retired, Sykes was the official university assessor for the Nuffield Chair. There were 20 applicants for the position, none whom were considered suitable. The university asked him why he had not applied and he replied that he "had applied for the chair when Macintosh (the first Nuffield Professor) had retired and had not even received an acknowledgement from the University"¹. He was persuaded to resign from the appointment committee, and then later appointed to the chair in the Nuffield Department of Anaesthetics (NDA).

His early days in Oxford were fraught with administrative problems because of the relocation of the NDA from the Radcliffe Infirmary to the John Radcliffe Hospital and the fact that the NDA was spread across five locations around the city. There were also some tensions within both the academic and the clinical sections as evidenced early when, departing after the dinner welcoming him to Oxford, he was handed a phone requesting his attendance as consultant to anaesthetise a patient to drain a septic knee. "At first I thought this was a joke but the owner of the phone explained that whereas the junior staff coped with emergencies in the Radcliffe, John Radcliffe and Churchill hospitals, the Orthopaedic Hospital was covered by a consultant rota. No one had told me about this arrangement and none of the consultants present would answer the call"¹!

In Oxford Sykes continued his research activities building up research in the NDA from three teams to seven including a joint project with industry, which after a number of years and just as clinical trials were about to begin was scuttled by a commercial takeover and cancellation of the project.

"...we all owe a great debt of gratitude to him for his research and dedication which brought that about."

During his professional life many awards and distinctions were bestowed – Clover Medal, Dudley Buxton Prize & Gold Medal all from the RCoA; Snow Medal (AAGBI); Hickman Medal (RSM); and many honorary memberships of organisations. He was a board member of the Faculty of Anaesthetists RCS and Vice-President of AAGBI, President Section of Anaesthetics (RSM), and importantly Consultant Advisor in Anaesthetics to the Chief Medical Officer, UK Department of Health 1986-92. In 1991 he was appointed a Knight Bachelor – a rare honour for an anaesthetist. Sir Keith Sykes retired from the Nuffield Chair in 1991 which allowed for an expansion of his interest in medical, particularly anaesthetic, history.

In 1956 Keith married a UCH nurse Michelle (née Ratcliffe), who later became an art educator and Clore Education Officer at the Ashmolean Museum in Oxford. They had four children. Sadly Michelle and their son Jon both died from mesothelioma, one daughter (Karen) also predeceased him, and he is survived by Virginia and Susan. Keith remained alert and engaged until his last few days.

Towards the end of an interview he gave in 1997 Keith said that "in my time the thing that matters to me is that science has come into anaesthesia"⁴. He was one of the few people who made that happen, and we all owe a great debt of gratitude to him for his research and dedication which brought that about.

AB Baker
Emeritus Professor
University of Sydney

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With grateful acknowledgement to Susan (Susie) Sykes for assistance with many details.

Dr Lawrence Marikawa Sogoromo

1964-2020

IT WAS WITH great sadness that Australian and New Zealand anaesthetists who have had a long involvement in Papua New Guinea learnt of the recent passing of Dr Lawrence Sogoromo.

Lawrence was known to many who had worked on various visits to Port Moresby General Hospital in PNG, as a senior anaesthetist and the Director of Anaesthetic Services at Port Moresby General Hospital.

Lawrence was born in Maprik District in East Sepik Province. He went to Brandi High School in Wewak and then Aiyura National High School in the Eastern Highlands. He studied medicine at the School of Medicine and Health Sciences at the University of Papua New Guinea (UPNG), interrupting his training to return home and care for his ill father.

He graduated MB BS at the end of 1991 then completed his residency at ANGAU Memorial Hospital in Lae in 1992-3.

Lawrence returned to Port Moresby and went on to do the Diploma of Anaesthesia in 1996 and then spent a year at Townsville General Hospital in 1998. He undertook his Masters of Medicine in Anaesthesiology at UPNG from 1999-2003.

In 2004-5 he worked as a consultant anaesthetist in Pohnpei, Micronesia and was supported by the Australian Society of Anaesthetists to attend the Micronesia Anaesthesia Refresher Course and the inauguration of the Micronesia Society of Anaesthetists.

On returning to Port Moresby General Hospital, he was appointed as theatre coordinator and a senior medical officer in 2006. He had been awarded the ANZCA International Scholarship for promising young anaesthesia consultants in the Pacific in 2009 but was unfortunately unable to accept it. He had attended the combined ASA/New Zealand Society of Anaesthetists' meeting in Darwin in 2015 as an invited speaker.

Lawrence, as one of the most experienced anaesthetists in PNG, would regularly take on the very difficult cases – of which there was no shortage. His easy going and congenial manner made sure that the theatres ran smoothly and he was highly regarded for his judgement, statesmanship and advice. He was politically astute, currently being the treasurer of the PNG National Doctors Association. He mentored and encouraged the young trainees who came under his influence, helping to establish the younger cadre of enthusiastic anaesthetists now emerging in PNG.



Dr Lawrence Marikawa Sogoromo.

Anaesthesia and critical care are slowly and definitely improving in PNG and the anaesthetists are the new leaders in the care of the critically ill in the hospital system.

Lawrence was one of the key people in the development of this and his untimely death has left a large gap not only in PNG but in the greater Pacific. His passing has been a major blow to the anaesthesia community of PNG where there are only 25 consultants for a population of eight million people.

Lawrence died suddenly from asthma while away on leave in his home town of Wewak.

We extend our condolences to his wife Damaris, his children and extended family, and the entire anaesthesia community in Papua New Guinea.

Dr Arvin Karu

Dr Michael Cooper, FANZCA
Chair, ANZCA Overseas Aid Committee