ANZCA
FPM

Bulletin

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

WINTER 2021

Exploring the virtual world of the 2021 ANZCA ASM

Substance abuse:
A personal account of one fellow's journey

Beyond city limits:
Working wild in the NZ West Coast

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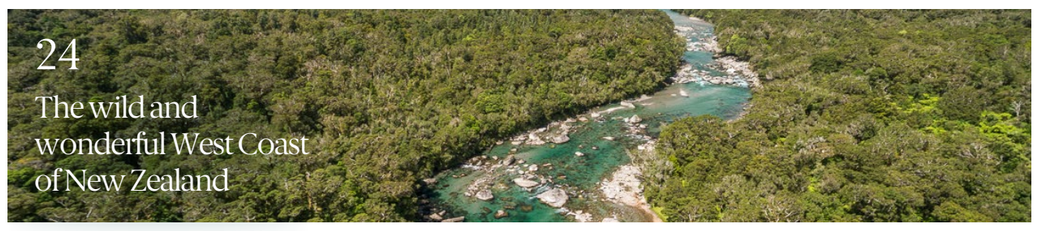

ANZCA Bulletin
The Australian and New Zealand College of Anaesthetists (ANZCA) is the professional medical body in Australia and New Zealand that conducts education, training and continuing professional development of anaesthetists and specialist pain medicine physicians. ANZCA comprises about 7500 fellows 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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Cover: Inside the engine room at the Melbourne Convention and Exhibition Centre which showcases the global virtual reach of the 2021 ANZCA ASM. Photo: Penny Stephens

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Pandemic reality a wake-up call for all

WHAT A DIFFERENCE A YEAR MAKES

This time last year, we had just started to understand that major restrictions on freedom would be with us for some time. Like all good anaesthetists, we wanted to know the rules, so that we could work with them, or around them, in an effort to re-establish life as we knew it.

Just as we thought we were over the worst, with the Trans-Tasman bubble opening, the vaccination program running (or plodding along), and days of no cases except in isolation or quarantine, more community outbreaks have struck in Victoria and now in Sydney. It could just have easily been Auckland or Adelaide. The coronavirus has again shown how nimbly it can slip through any gap in the fence. Normality is fragile, and will remain so until vaccination coverage is wide enough.

What is "wide enough" is no longer a domestic question. It is global. No one is safe until everyone is safe. That reality is confronting for societies where good healthcare has been primarily the preserve of the rich, who resist funding healthcare for the poor. In a pandemic, that ethos no longer works for anyone, anywhere in the world.

The life-or-death reality of COVID-19 has raised the importance of good public healthcare in people's values. Fortunately, this has flowed through to the collective consciousness of our politicians, and is reflected in governments' health strategies and spending priorities on both sides of the Tasman. Australians and New Zealanders have benefited from the willingness of our political leaders to take the best advice that science and medical practice has had to offer, and to apply it.

Alongside political leadership, the institutional memories of each country have played a significant part in responses to the pandemic. The relatively recent experiences of Ebola, SARS and MERS, and of measles in Sāmoa, have provided concrete reference points, and have thus become important motivators and unifiers of national responses.

MEANWHILE, BACK HOME...

Despite the disruptions, we have learnt to "pivot" and "regroup" (buzzwords of the day), and achieve what was planned, with COVID more of an inconvenience than a show-stopper. Triumphs include:

Exams

All 2020 and 2021.1 cohorts have completed them, thanks to a herculean effort from examiners, staff and candidates alike.

ASM

"Amazing" can sound like a clichéd, breathless, hyperbolic expression, but in case it aptly describes the achievement of putting together our first hybrid annual scientific meeting (ASM) (see page 50). The result was a meeting whose benefits will extend well into the future. Attendees could watch sessions "on demand". The hubs for the College Ceremony, and for some talks, were a great innovation, which allowed small groups to get together and celebrate some of the freedoms we used to take for granted. The ASM was the product of a phenomenal effort by ANZCA's Events team, with IT support that delivered all that was promised. Virtual meetings can be uninspiring, but not this time.

My thanks go to the chairs of the sessions, the presenters, the Events team, and the IT people for making it happen. Ninety-five hours of continuing professional development are available in your own time. To produce workshops of the highest calibre is nothing short of amazing. I make special mention to the airway can't intubate, can't oxygenate or CICO workshop leaders, who completely re-imagined how it could be presented virtually, and succeeded handsomely (see page 58).

ANZCA Council is looking forward to getting our other "big ticket" items under way again. These include the diploma of rural generalist anaesthesia, the clinical diploma of perioperative medicine, the combined College of Intensive Care Medicine and ANZCA program for dual fellowship, and all the things that have been paused, such as research.

Framework for international co-operation

The long-standing informal relationship between five international colleges of anaesthesiology now has a structure to support conjoint research and other projects. The Royal College of Anaesthetists (UK), the Royal College of Physicians and Surgeons of Canada, the College of Anaesthesiologists of Ireland, the Hong Kong College of Anaesthesiologists, and ANZCA have come together as the International Academy of Colleges of Anaesthesiologists – mercifully shortened to IACA.

IACA's first project was a virtual conference to consolidate and share the lessons learned from the COVID-19 pandemic, for the future of anaesthesia and critical care. It ran from 15-17 June UK time, and 16-18 June for Australia and New Zealand (see page 11). We were well represented on the conference scientific organising committee by Professor Dave Story and Dr Helen Lindsay. Presentations include a review of the papers that changed practice, ICU best practice, communication in a pandemic, SARS-CoV-2 sequencing to understand transmission, what we understand about long COVID, and the pandemic's aftermath.

Speakers included epidemiologist Professor Sir Michael Marmot, Executive Director of the WHO Health Emergencies Programme, microbiologist Associate Professor Siouxsie Wiles MNZM (New Zealander of the Year), Clinical Associate Professor Nick Coatsworth former Deputy Chief Medical Officer Australia, Professor Kristine Macartney, Director of the National Centre for Immunisation Research and Surveillance Australia and Professor Steve Shafer of Stanford University.

Recordings of presentations can be found at www.rcoa.ac.uk. Those enrolled can watch the sessions on demand, at a time of their choice. Declaration of interest: I have succeeded Dr Brian Kinirons, President of the College of Anaesthesiologists of Ireland, as the chair of the academy.

AND FINALLY...

Being able to visit ANZCA's Melbourne base, and especially Ulimoroa, for the first time in 15 months has brought home to me how much I have missed the camaraderie and sense of purpose that lights everyone up. Enthusiasts get together in each other's company. I wish us all a speedy return to the sense of community and fellowship that being a FANZCA brings.

Dr Vanessa Beavis
ANZCA President

Queen's Birthday Honours

Congratulations to our fellows and and our long-serving community representative Helen Maxwell-Wright for being recognised in this year's Queen's Birthday Honours.

Member in the General Division (AM)

- **Professor Michael Heywood Bennett FANZCA** (NSW).
  For significant service to medical education, and to hyperbaric medicine.
- **Dr Nigel Ronald Jones FRACS, FFPMANZCA** (SA).
  For significant service to neurosurgical medicine, and to medical societies.
- **Ms Helen Maxwell-Wright** Community representative (Vic).
  For significant service to child welfare, to diabetes research, and to the community.

Medal in the General Division (OAM)

- **Dr Scott Comber Fortey FANZCA** (NSW).
  For service to medicine as an anaesthetist.
- **Dr John David Paull FANZCA** (Tas).
  For service to medicine, and to history.

Medal in the Military Division (OAM)

- **Colonel Susan Kaye Winter FANZCA CSC.**
  For meritorious service as a specialist anaesthetist and intensivist on multiple overseas deployments and specialist medical advisor to the 2nd General Health Battalion, 3rd Health Support Battalion and Army Health Services.

Challenges still ahead but small steps are positive

AS WE ENTER the middle of 2021 it's hard to see where the year has gone as we continue to emerge from the effects of COVID-19 that we experienced in 2020. The "new norm" remains a challenge and there is still a degree of uncertainty for the college and the community, especially in the context of what is happening globally and the devastating experiences of so many countries.

As a college we learnt a lot over the past 15 months and have incorporated much of this into our college activities. The recent ANZCA Annual Scientific Meeting was a first, a virtual event with nearly 2500 delegates from as far afield as Europe and North America watched 95+ hours of live and pre-recorded sessions run online over eight days. Almost all delegates participated in 75 online workshops, and 135 delegates registered for the fully virtual FPM Symposium. A further 350 registered for the joint special interest group meeting, both streamed from Melbourne as satellite events.

About 220 new ANZCA and FPM fellows presented in person or virtually for the College Ceremony staged simultaneously at nine hubs around Australia, Aotearoa New Zealand, and in Hong Kong. More than 1400 people watched the ceremony via our Facebook LIVE feed.

It goes without saying to our trainees, specialist international medical graduates and examiners that COVID-19 had a significant impact on the ability to conduct exams in the traditional format. The ability to respond by holding some online was also a first, and the many learnings from 2020 have carried over to 2021 where we have continued to refine and build on our experiences. This year we have had to revert to the online option for our Western Australian trainees as a result of local travel restrictions. The obvious impact on the training program has required changes to be adopted by the college, including changes to regulations.

The past year's experiences have amplified the pressure on many individuals, families, friends and workplaces which has impacted on relationship dynamics. In many ways this has been a strength, however unfortunately for some it has been a real challenge. For me it has highlighted the importance of teamwork and the terrific support and work that so many people undertake tirelessly, and often without recognition on a daily basis, and the personal cost that comes with this.

Some of the pressures of the past year have resulted in added stress levels in the workplace and on professional lives and relationships. The recent results for ANZCA in the Medical Board of Australia's medical training survey highlighted that of the 41 per cent of our trainees who responded to the survey, 22 per cent had experienced bullying, harassment or intimidation and 38 per cent had witnessed it.

This was also recognised in the ANZCA trainee survey (see page 77) conducted in the later part of 2020 which had a 42 per cent response rate. Our survey showed that 24 per cent of respondents had personally experienced bullying in the workplace with 40 per cent having witnessed it.

Pleasingly, our survey showed a downward trend in reports of these behaviours compared to 2016. However, it shows we have more work to do to address this issue.

The prevalence of workplace bullying and harassment is still a disturbing reality for many and as a college it is something we need to recognise and address with the aim of zero tolerance for this behaviour.

At present within the college there is a body of work being undertaken to consider what actions can be put in place to address these issues.

In late 2020, ANZCA updated its "Policy on bullying, discrimination and harassment for fellows, trainees and specialist international medical graduates acting on behalf of the college". The college considers bullying, discrimination and harassment to be unacceptable behaviours that will not be tolerated under any circumstances. It is acknowledged that some of these situations relate to the employee/employer relationship where ANZCA does not have any authority to take action, however there are ways the college can provide support and advice.

Complaints are managed in accordance with the college's "Notifications and management of complaints and concerns policy" (see the ANZCA website).

If you have experienced or have observed inappropriate behaviour by a college representative please bring it to our attention by completing our confidential online form which can be found at onlineapplications.anzca.edu.au/#/login. All notifications are treated as confidential unless we request your permission to the contrary. If you would like to discuss your concerns before submitting the notification form, please contact me via ceo@anzca.edu.au.

As a binational college the opening of the Trans-Tasman bubble has been a positive development, gradually allowing some travel for college activities across both sides of the Tasman.

Here's hoping we continue on the path out of the experiences of the past year and towards a more stable landscape.

Nigel Fidgeon
ANZCA Chief Executive Officer

Letter to the editor

VOLUNTARY ASSISTED DYING – TIME TO TAKE MORE INTEREST?

ANZCA fellows should be aware of several unfavourable provisions of the voluntary assisted dying acts of Victoria and Western Australia.

Both states have made self-administration the default option over practitioner administration. Yet there is no reason to give one mode of administration favoured status and to deny patient choice.

Intravenous self-administration is not excluded by either act. It finds favour because:

- The patient can be in complete control of timing.
- The practitioner is not called on to inject a lethal drug.
- It least disturbs conversation, atmosphere, and ambience.

But this mode is not supported by statewide pharmacies.

Separate authorisations for self- versus practitioner-administration mean that once self-administration is started, the practitioner cannot intervene. If the procedure fails, the person must be allowed to awaken. However uncommon, this would be a cruel outcome.

Voluntary assisted dying is a significant medical procedure. Yet, it can be conducted without medical supervision. No facility may be available to manage airway obstruction that is a complication of unconsciousness.

Practitioners require experience, training, and intrusive vetting (WA), yet are given health department directives with respect to drug use, rather than autonomy within college guidelines. This may affect recruitment.

Pentobarbitone is widely accepted for both oral and intravenous administration and works without a muscle relaxant. Yet, for reasons unstated, its intravenous use is restricted in favour of a combination of propofol and rocuronium in questionable dosage.

A patient cannot simply choose practitioner administration. It is the co-ordinating practitioner who must tell the patient that they are not suitable for self-administration. In a catch-22, the co-ordinating practitioner bases that decision on information provided by the patient.

Midazolam can be used for co-induction with propofol, yet fentanyl, with equally useful actions, cannot be used.

Failure to recommend an intravenous indwelling cannula for all cases, and a giving set for intravenous administration would not reach the expectations of an average anaesthetist.

These are just a sample of adverse provisions as they apply currently. They do not address the narrowly defined criteria that, for example, do not include patients with Alzheimer's disease, those aged less than 18 years and facing a fatal illness, or very elderly, well patients who feel they have completed their lives.

Anaesthetists are well positioned to make a significant contribution to voluntary assisted dying yet have had next to no influence on its legislation or implementation. It is hoped this letter will encourage more interest.

Dr Peter G Beahan, FANZCA
(retired anaesthetist from WA)

ANZCA Staff Recognition Awards

College staff have been recognised for achievements in 2020 in the annual staff awards presented by CEO Nigel Fidgeon at ANZCA House in April.

The aim of the Staff Recognition Awards program is to recognise excellence in service delivery and to acknowledge those who have achieved outstanding results that have contributed to ANZCA's priorities and objectives and/or had a significant impact on work colleagues and others in the college community.

- The joint winners of the Staff Excellence Award for Customer Service were Policy Officer Kate Davis and Membership Services Officer Gabby White.
- The winner of the Staff Excellence Award for Innovation or Process Improvement was Moira Besterwitch, Co-ordinator, Primary & DHM Exams.
- The winner of the Team Award was IT Operations – ZOOM and COVID. Team members were Alvin Choong, Kathryn Cooper, Anthony Lam, Christopher Reay and Rima Wassef.

The judges also awarded highly commended certificates to Alicia Hamilton – Innovation and Process Improvement and the Website Project Management Team – Alan Dicks, Eric Kuang and Rima Wassef.

Cannabis leads media coverage

MEDICINAL CANNABIS, COVID-19 and the ANZCA Annual Scientific Meeting and FPM Symposium featured in recent media requests for expert comment from ANZCA, anaesthetists and specialist pain medicine physicians.

FPM Dean Associate Professor Mick Vagg was interviewed for an exclusive news article on 23 March by the *Sydney Morning Herald* about the faculty's joint Choosing Wisely recommendation for medical practitioners not to prescribe medicinal cannabis to patients for chronic non-cancer pain unless the patient is enrolled in a registered clinical trial. The article was syndicated to *The Age, the Brisbane Times* and *WA Today* reaching more than 700,000 readers. The dean authored an article for *The Conversation* "Medicinal cannabis to manage chronic pain? We don't have evidence it works" which reached an audience of more than 850,000 people and was syndicated to the *New Daily*. He was also interviewed on the ABC Radio Sydney breakfast program reaching 90,000 listeners.

The dean was interviewed by the ABC's *World Today* program and *MJA Insight* about cannabidiol for acute low back pain on 19 April. A study published in the *Medical Journal of Australia* found the product was no more effective than a placebo for people dealing with acute lower back pain.

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

Queensland FANZCA Dr Paul Scott was interviewed for a Ten News Brisbane segment on 7 May about his safety shield invention for ventilating patients with beards and retired Melbourne anaesthetist Dr Bob Smith and FANZCA Dr Nicole Sheridan were interviewed for a Nine News Melbourne segment on 21 March about Dr Smith bringing new life into the operating theatre through his art.

ANZCA 2021 ASM and FPM Symposium presentations also featured in the media. Read more on page 55.

Carolyn Jones
Media Manager, ANZCA

Online activities grow

Environmental sustainability in hospitals is a hot topic. Our feature on The Alfred ditching desflurane was met with a flurry of shares, likes and positive comments on Twitter, Facebook, Instagram and LinkedIn. And the Operation Clean Up story with Dr Kerstin Wyssusek showing us how she found alternatives for blueys to help reduce waste in her hospital was a hit on Instagram.

Inclusion and diversity is another important issue to many of you. For International Women's Day we asked you to post your questions on things like unconscious bias and gender balance to our Instagram page for our Gender Equity Subcommittee. These videos can be found in our #IWD story highlight on our Instagram.

Unsurprisingly, doctors' health and wellbeing continues to create conversation and cause change. It was inspiring to see how many of you took part in the "Crazy socks for docs day" to help raise awareness about mental health in the medical profession.

We've grown our online engagement activities considerably over the past 12 months. ANZCA now has well-established and active profiles on all the key social media platforms; meaning we're connecting and communicating with more members and promoting the college and our achievements more widely than ever.

Twitter continues to be our most active platform, with nearly 10,000 people following our @ANZCA and @ANZCA_FPM accounts. It's a really easy way for us to send out instant updates about things like exams and events, especially with all the disruptions we're experiencing at the moment. In the last three months we received 658.1k tweet impressions and posted 294 tweets from both the ANZCA and FPM accounts. Our efforts are supported by the ever-growing number of ANZCA councillors and FPM board members with active accounts.

Our Facebook account has almost 6500 followers, and is one of the best ways to keep in the loop about upcoming events and courses. If you're looking to connect with the college community professionally, join the increasing number of fellows, trainees, and specialist international medical graduates associating themselves with ANZCA on LinkedIn.

For a uniquely intimate insight on college life, follow us on Instagram. It's proving to be a popular platform for us. Since we launched our account last October 2020, we've accumulated almost 1000 followers.

Our social media channels were an important way for us to communicate during the ANZCA annual scientific meeting. To see all the social media highlights, check out page 55.

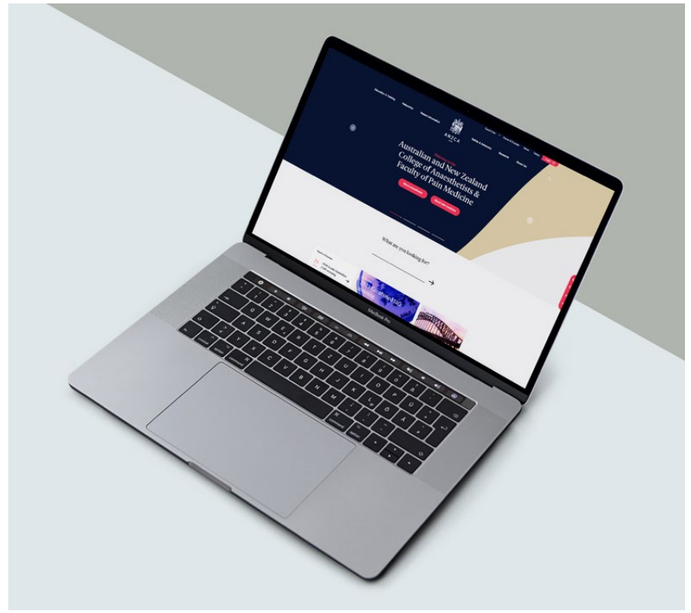
Who to follow on Twitter

If you're new to Twitter and don't know who to follow, some of our college leaders accounts are a good place to start:

Dr Vanessa Beavis (@VBeavis); Associate Professor Michael Vagg (@mickvagg); Mr Nigel Fidgeon @NFidgeon; Dr Debra Devonshire (@debjdevonshire); Dr Michael Jones (@Michael27044912); Dr Scott Ma (@scruff888); Dr Stu Marshall (@hypoxicchicken); Dr Tanya Selak (@GongGasGirl); Dr Maryann Turner (@MaryannCTurner); and Associate Professor Leonie Watterson (@LeonieWatterson).

Website update

Our new combined college website turns one this month. Digital Communications Manager Al Dicks discusses what we've been working on since go-live and what's to come in the year ahead.



BEDDING DOWN a brand-new website in the middle of a global pandemic was never going to be easy; especially when your core users are frontline healthcare workers; your entire project team is in lockdown; and your developers are 10,000 kilometres away!

Transitioning to new technologies can be a taxing experience, even in the easiest of circumstances. So firstly, thank you all for your patience; your feedback; and for finding the time to familiarise yourselves with yet another "new normal".

WHAT WE'VE DONE SINCE GO-LIVE

After fixing a few inevitable glitches, our first priority was to follow up on the frustrations some of you were finding with the new user experience (UX) or user interface (UI). Although the new site received an overwhelmingly positive response from our members, in the eight-week formal feedback period about 80 people identified issues. Most were around navigation and not being able to find content. We made a number of notable changes to the navigation and other front-end functionality, including: Fewer moving components; less sensitive mega menus; and more prominent promotion of popular content such as prof docs and past exam reports.

But the vast bulk of our UX and UI enhancement work has been to the back end. In fact, since July 2020 we've identified and implemented more than 140 technical improvements ranging from refined search algorithms and accessibility compliance to content filtering functionality and social media sharing. Most were minor tweaks that won't have made much difference to your day-to-day experience, but definitely put us in a better position to progress to the second stage of development.

WHAT'S TO COME

Phase two focuses on delivering a range of exciting new functions and features for fellows, trainees, specialist international medical graduates, and other authenticated users (that is, anyone with a college ID, such as continuing professional development (CPD) program participants and staff), designed to save you time and make sure you don't miss out on the information and opportunities that matter most to you.

By the end of phase two, every logged-in user will be taken directly to a personalised dashboard not dissimilar to ones we're familiar with from online banking and retail sites like Amazon and eBay (albeit on a much smaller scale). Your MyANZCA dashboard will display a selection of specially curated content and notifications such as safety alerts; news; events and courses; job vacancies; and leadership opportunities based on your location; training stage or specialist status; special interest group and committee memberships; and supervisory roles.

As an authenticated user, you'll be able to bookmark content from across the site that you can then access and manage at the click of a button through your dashboard. This will also be where you access other online services such as Networks, your CPD portfolio, the training portfolio system, and updating your details.

Other new features you can look forward to in the year ahead include an interactive, easily searchable map and accompanying database of accredited training sites; enhanced search and filtering functionality; and a more consistent approach to downloading documents.

Work is already well under way on this exciting new evolution in our online services. But we still have a long way to go, and progress has been slower than anticipated due to the ongoing impacts of India's COVID-19 crisis on our offshore development team. So please bear with us a little longer.

Australian and New Zealand budgets delivered

AUSTRALIA

Aged care reforms and mental health initiatives capture new health spending in 2021-22 budget

Treasurer Josh Frydenberg delivered the 2021-22 federal budget on 11 May. This follows only six months after the last federal budget which was deferred due to COVID-19. The big health ticket items announced in the budget centre on aged care ($17.7 billion to address recommendation from the Royal Commission into Aged Care Quality and Safety), mental health ($2.3 billion) and the COVID-19 vaccination rollout. Some relevant highlights include:

COVID-19 response

- New measures to enable more GPs and community pharmacies to administer vaccines including a specific, temporary COVID-19 vaccination MBS item and Practice Incentive Program payment to support vaccination through GPs and a temporary community pharmacy program to leverage community pharmacies to administer both vaccine doses to patients throughout Phase 2 and Phase 3 of the rollout.

Medicare and telehealth

- $711.7 million in new and amended items on the MBS (around 50 per cent of this for mental health services and treatments).
- $204.6 million to extend telehealth services for a further six months (until 31 December) while the long-term design is developed in conjunction with medical groups and the community.

Medicines and medical devices (Pharmaceutical Benefits Scheme – PBS)

- An additional $878.7 million in new and amended PBS listings.
- From May 2021, Epidyolex (cannabidiol) has been included on the PBS for use in the treatment of Dravet syndrome.

Digital health

- $301.8 million for continued investments in My Health Record and $87.5 million for the Australian Digital Health Agency.
- $36 million for streamlining reimbursement approvals for health products through the Health Products Portal to allow the sector to digitally manage applications to the Pharmaceutical Benefits Advisory Committee, Medical Services Advisory Committee and the Prostheses List.

Research

- $6 million over four years to continue the Encouraging More Clinical Trials in Australia program which supports collaboration with jurisdictions to grow the number of clinical trials run in Australia.

Aboriginal and Torres Strait Islander Health

- $781 million in new spending across the forward estimates to improve Aboriginal and Torres Strait Islander health outcomes, the vast bulk of this in aged care services ($630 million) and mental health ($79 million).

Hospitals and private health insurance

- No major announcements, with some additional funding for hospitals to ensure capacity through COVID-19.

Rural health

- An additional $65 million for GPs working in rural Australia through an increase in the Rural Bulk Billing Incentive payment from the current $9.80 per consultation to $10.40 for consultations in medium-sized rural towns to $12.35 for those in very remote communities. While the initiative has been labelled a "game-changer" by the Rural Doctors' Association of Australia, there has been some criticism from remote GPs that the move is a "drop in the ocean" and unlikely to have a significant impact.
- $29.5 million for a funding pool for non-GP medical specialist training from 1 January 2022. This will fund activities such as trials of networked training models, supervision models, and transition of junior specialists to practice in rural settings, and continued professional development for rural medical specialists.

NEW ZEALAND

New Zealand Budget 2021: Vote Health a winner on the day

At a glance:

- $200 million over four years for Pharmac, to help 370,000 patients a year.
- $46.7 million more for primary healthcare, such as GPs.
- Almost $500 million for the first stage of the government health reforms.

The health budget sees the first tranche of funding for the health reforms Health Minister Andrew Little is implementing: Allocation of $486 million to move from the district health boards (DHBs) model to a central Health NZ agency. The budget also establishes the Māori Health Authority, which will be set up out of a $243 million allocation for Māori health.

- $2.7 billion over four years for DHBs, $675m more a year.
- $700 million for capital projects, such as hospital buildings.
- $516 million to boost the health infrastructure system, such as the patient records system.
- $400 million to support those with long-term impairments.

District health boards to be abolished

New Zealand medical colleges have welcomed the wide-ranging health system reforms announced by the Minister of Health, Hon Andrew Little on 21 April 2021. In a media release, Dr John Bonning, Chair of the Council of Medical Colleges (CMC), said "...we commend the government for establishing a Māori Health Authority (MHA) with commissioning powers and a leadership role in developing strategy and policy for the whole sector. This is a necessary step to support equitable health outcomes for Māori and meet obligations under Te Tiriti o Waitangi."

The reforms include replacing the 20 District Health Boards (DHBs) with a new crown entity, Health New Zealand (HNZ), that will be responsible for the day-to-day running of the health system. The MHA will also have commissioning powers and the authority to work alongside the Ministry of Health on strategy and policy. Also a new public health agency will be established within the Ministry of Health.

Dr Bonning echoed the reaction around the country that the reforms are major. "There's a lot of work ahead of the sector. We know one of the first pieces of work will be designing a New Zealand health charter to set the culture for the new system. Te Tiriti o Waitangi and cultural safety will need to be at the heart of the charter, and CMC is looking forward to working closely with government on this."

Commentators from either end of the spectrum have scrambled to analyse the sweeping changes that went further than the recommendations of the Health and Disability Systems Review. The review had suggested just cutting the number of DHBs not disbanding the system. It had also not given the recommended MHA any commissioning responsibilities. Māori health advocate Lance Norman said the budget [for the MHA] now needs to be $5 billion – a quarter of the total health spend – because Māori make up 25 per cent of the those using the health system, despite only making up 16 per cent of the population.

ANZCA New Zealand Executive Director, Kiri Rikihana and Senior Policy Advisor, Renaldo Christians attended a meeting with the Minister of Health as well as senior officials from the Transition Unit, the group responsible for implementing the recommended changes. The minister was asked specifically to comment on improving equity as well as DHB funding in relation to current budget deficits. The Transition Unit will meet with ANZCA to further discuss our views on promoting equity in the system.

Submissions

The college prepares submissions and makes representations to government and other stakeholders on a range of policy initiatives and inquiries, many of these in response to requests for college feedback and input. Our submissions to public inquiries are available on the college website following the inquiry closing date. Note that some inquiries and requests for college input are confidential.

AUSTRALIA

- Australian Commission on Safety and Quality in Health Care: Draft credentialing and defining scop of clinical practice: A guide for managers and clinicians.
- Australian Commission on Safety and Quality in Health Care: Draft low back pain clinical care standard.
- Australian Commission on Safety and Quality in Health Care: National opioid analgesic stewardship program.
- Australian Commission on Safety and Quality in Health Care: Peripheral intravenous catheter clinical care standard.
- Australian Government Senate Standing Committee on Community Affairs: Inquiry into the administration of registration and notifications by the Australian Health Practitioner Regulation Agency and related entities under the Health Practitioner Regulation National Law.
- Australian Health Practitioner Regulation Agency: Public consultation on revised regulatory principles for the National Scheme.
- Australian Medical Council: National framework for prevocational medical training.
- Australian Resuscitation Council: ANZCOR paediatric final draft guidelines.
- Department of Health: District of workforce shortage system for specialists.
- Department of Health: Draft National Aboriginal and Torres Strait Islander health plan 2021-2031.
- Department of Health: How accreditation practices impact building a non-GP rural specialist medical workforce.
- Health Chief Executives Forum: Health Practitioner Regulation National Law Amendment Bill 2021.
- Medical Board of Australia: Review of the English language skills registration standards.
- New South Wales Ministry of Health: Amendments to the Private Health Facilities Act 2007 - information sharing for reportable incidents.
- Royal Australian and New Zealand College of Radiologists: Standards of practice for interventional radiology.
- Skills IQ: Consultation on draft diploma of anaesthetic technology and practice qualification.
- Therapeutic Goods Administration: Repurposing of prescription medicines.

NEW ZEALAND

- Medical Council of New Zealand/Te Kaunihera Rata o Aotearoa: Proposed Council fees and disciplinary levy.
- Medical Council of New Zealand/ Te Kaunihera Rata o Aotearoa: Conducting medical assessments for third parties.
- Ministry of Health/Manatū Hauora: Smokefree Aotearoa 2025 action plan.
- Allen and Clarke: Guidelines for consultation with obstetric and related medical services survey.
- Pharmac/Te Pātaka Whaioranga: Support for reclassification of hyalase as a prescription medicine.

ANZCA
FPM

Dr Ray Hader Award for Pastoral Care

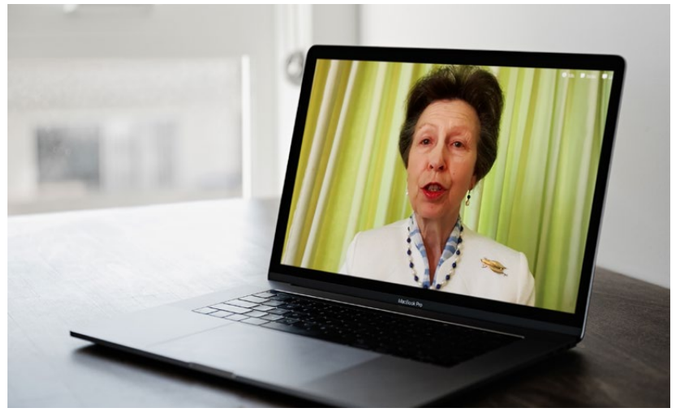
Applications are now open for the Dr Ray Hader Award for Pastoral Care. This award acknowledges the significant contribution by an ANZCA fellow or trainee to the welfare of one or more ANZCA trainees. The nature of such a contribution may be direct, in the form of support and encouragement, or indirect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

Application forms can be found on our website and must be emailed to training@anzca.edu.au by Friday 24 September 2021.

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

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

International academy examines lessons from COVID-19



"...the anaesthetic community has found new ways to meet the demand for care, making vital contributions towards keeping the world safe and for that, I give heartfelt thanks."

HRH THE PRINCESS ROYAL

Patron of the Royal College of Anaesthetists (UK), HRH The Princess Royal giving her opening conference message.

ANZCA PRESIDENT Dr Vanessa Beavis and college fellows were key participants in a global virtual COVID-19 conference organised by the International Academy of Colleges of Anaesthesiologists (IACA).

Dr Beavis succeeded Dr Brian Kinirons, President of the College of Anaesthesiologists of Ireland, as the chair of the academy in May this year and was one of several Australian and New Zealand speakers at the "COVID-19: Lessons for the future of anaesthesia and critical care" conference from 15-17 June.

More than 1000 delegates registered for the conference which examined lessons learned from the COVID-19 pandemic and how these could enhance anaesthesia and critical care practice. Speakers included representatives from the World Health Organization, microbiologist Associate Professor Siouxsie Wiles MNZM (New Zealander of the Year), Clinical Associate Professor Nick Coatsworth (former Deputy Chief Medical Officer Australia) and Professor Kristine Macartney, Director of the National Centre for Immunisation Research and Surveillance Australia.

ANZCA councillor and Safety and Quality Committee Chair Professor David Story and Auckland fellow Dr Helen Lindsay were members of the conference scientific organising committee.

The conference was the first global event by the academy which supports joint research and projects by five international colleges of anaesthesiology including ANZCA – the Royal College of Anaesthetists (UK), the Royal College of Physicians and Surgeons of Canada, the College of Anaesthesiologists of Ireland and the Hong Kong College of Anaesthesiologists.

In her opening conference message, the patron of the Royal College of Anaesthetists (UK), HRH The Princess Royal, said the "anaesthetic community has found new ways to meet the demand for care, making vital contributions towards keeping the world safe and for that, I give heartfelt thanks."

In recognition of the formal grouping of the colleges as an academy ANZCA designer Frances Rowsell created a logo for the academy to use as part of its suite of digital resources which will also include a new page link on the ANZCA website.

For further information visit www.anzca.edu.au/news/fellowship-news/2021-iaca-conference.

IACA INTERNATIONAL ACADEMY OF COLLEGES OF ANAESTHESIOLOGISTS

Work towards perioperative diploma continues

RECOGNITION OF PRIOR learning (RPL) in perioperative medicine – either through other recognised qualifications or significant experience – will be an important undertaking in the ongoing development of a diploma in perioperative medicine.

There was significant discussion relating to RPL at the June meeting of the Perioperative Steering Committee and the chair of the Perioperative Medicine Education Working Group Dr Joel Symons will lead the development of a document addressing RPL and grandparenting. The initial draft of this document will be presented to the steering committee later this year.

The education working group has been meeting to develop the curriculum and assessment of the six core modules of the Diploma of Perioperative Medicine:

- Perioperative impact of major disease.
- Planning for appropriate care.
- Optimisation.
- Intraoperative impacts on patient outcomes.
- Safe recovery in hospital.
- Discharge planning and rehabilitation.

This working group includes representation from anaesthesia, pain medicine, general practice, physicians (including rehabilitation and geriatrics), intensive care, surgery and rural and remote medicine. To date, members have approved the structure of the modules and are providing feedback on the content of modules 1, 2 and 4 and developing the curriculum and assessment for modules 3, 5 and 6.

The Perioperative Medicine Care Working Group continues to refine the perioperative care framework, which maps the patient journey from the time surgery is contemplated through to recovery.

The framework document has been circulated for feedback from the:

- Safety and Quality Committee, ANZCA.
- Perioperative Medicine Special Interest Group executive.
- FPM Professional Standards Committee.
- College of Intensive Care Medicine.
- Royal Australasian College of Physicians' Policy and Advocacy Council.
- Australian and New Zealand Society for Geriatric Medicine.
- Rehabilitation Medicine Society of Australia and New Zealand.
- Royal Australasian College of Surgeons' Professional Standards and Advocacy Committee.
- Australian College of Rural and Remote Medicine.
- Royal Australian College of General Practitioners and the Royal New Zealand College of General Practitioners.

The framework was also sent to the Indigenous Health Committee to explore aspects such as cultural safety.

Another core task of the project is to establish the economic benefits of perioperative medicine through the engagement of a health economist later this year and using evidence from the literature review undertaken on behalf of the college prior to the COVID-19 pandemic.

A vacancy also exists for a representative from the Australian College of Rural and Remote Medicine, following the decision of Dr Eugene Wong who has stepped down from the committee.

Dr Sean McManus
Chair, Perioperative Medicine Steering Committee

What would you do?

Dr Peter Roessler explains ANZCA's professional documents using practical examples. In this edition he addresses after-hours rostering.

IT HAS BEEN said that growing old is unavoidable but growing up is optional. I have yet to exercise that option! Bearing that in mind I have on occasions asked myself "When is one too old to perform a task, or more importantly, a task at a given level?"

Benchmarks of performance can be considered in terms of physical or mental activities.

Insights into observed alterations in performance over time are the realm of physiology of ageing, with which I am most familiar, having lectured on this topic in the ANZCA Part 1 physiology course for over a decade . . . and now having experienced it firsthand.

Progressive loss of tissue and diminishing ability for gene replication leads to reduced organ function affecting every system in the body. The physical changes tend to be obvious – the mental or cognitive abilities less so.

Much work has been done on elucidating the decline of cognitive function associated with ageing in which there appear to be "swings and roundabouts". Accompanying deteriorating cognitive function is a diminished ability to rapidly process new challenges and develop new skills. However, there is also the wealth of experience and retention of long-term memory that facilitates maintenance of existing skills. This may explain, in part, the observed narrowing of scope of practice over time.

The following scenario is presented in this context.

You are sitting in the tea room when you overhear a discussion between the head of department and welfare advocate concerning after-hours (AH) rostering and whether senior anaesthetists should continue to be required to provide AH services.

The welfare advocate is concerned about increased susceptibility to fatigue with ageing and the consequent impact on patient care. The head of department is concerned about adequacy of workforce to cover AH as well as the potential for departmental conflict.

The welfare advocate notices you and calls you over to canvass your opinion. How would you respond?

WHAT WOULD YOU DO?

Wherever there appears to be competing needs there is the potential for conflict. Conflict resolution 101 (my version) dictates that redirecting perceptions of competition (us and them) towards perceptions of unity (we) refocuses attention to finding a common goal. Easier said than done!

In this scenario, one apparent need relates to senior anaesthetists while the perceived opposing need is that of younger colleagues. The common ground, however, is patient care.

Prof docs to the rescue! *PS43 Guideline on fatigue risk management in anaesthesia practice* recognises and identifies the risks of fatigue. It is a recognised concern for all anaesthetists irrespective of age and *PS43* highlights the responsibilities at the individual level as well as the departmental and organisational level in mitigating those risks. The accompanying background paper includes a toolkit of resources.

Of note in the background paper under item 3.3 Fatigue, is the statement that ageing is associated with reduced sleep efficiency as well as the capacity to recover from fatigue. These are supported by articles in the *British Medical Journal* in 2018 and *Sleep* in 2003.

In the context of the common goal of patient care is it reasonable to take that into consideration when rostering AH?

Of course, there is the other matter of wellbeing, which is again, applicable to anaesthetists irrespective of age or stage of career. *PS49 Guideline on the health of specialists, specialist international medical graduates, and trainees* is under review. The value of retaining experienced senior colleagues is underscored by inclusion within the professional section of several strategies aimed at promoting wellbeing. For example, recommendations for establishing mentor or buddy systems, and instituting the role of welfare advocate, both of which may be well served by senior colleagues.

Rostering is always a challenge given the limitations on resources in relation to the demand for services. Each location has its specific and local community needs. Rostering in a major quaternary centre accredited for training and staffed by both full-time and visiting staff will be quite different from a remote regional hospital staffed by visiting medical officers and locums, let alone covering AH in private practice.

What would be the impact in a regional centre where services are provided by a small number of FANZCAs (either visiting or locum), specialist international medical graduates (SIMGs), and GP anaesthetists (GPAs) if just one anaesthetist decided to retire due to being forced to provide AH services?

Clearly, there are many considerations. Several options exist including but not limited to:

- All anaesthetists be required to contribute (equally) to AH in order to retain their appointment.
- Set an age at which anaesthetists are excluded from AH services. What age? 55? 60? 65?
- Set an age at which anaesthetists can opt in.
- Set a base age after which anaesthetists can opt out.

Which, if any, of these would you favour?

Dr Peter Roessler
Director of Professional Affairs, Policy

SIMG champion: Dr Michael Steyn retires

MANY READERS WILL know of Michael through his roles on the Specialist International Medical Graduates (SIMG) Committee, the Overseas Trained Anaesthetists Network (OTSAN), and past director of anaesthesia at the Royal Brisbane and Women's Hospital. However, few will be aware of the enormous contribution to the college, the community, and SIMGs that Michael has made as chair of the SIMG Committee.

Michael is regarded by the SIMG team as the "ghostbuster" for SIMGs. Whenever there was a question, especially a curly one, "who you gonna call?" would ring out, followed by a resounding "Michael".

Michael started out in general practice in Scotland before "seeing the light" and embarking on his anaesthesia career. Having married Jacqui, an Australian-born nurse, Michael made the difficult decision, as do many SIMGs, to uproot himself and his family to emigrate to a new country.

Michael was interviewed after arriving in Australia and has been heard on occasions jokingly stating that he was interviewed by two of the authors of this article while the third was one of his examiners for the ANZCA exam. Our response has always been that it was the "best mistake we ever made!"At the time of his application to become recognised as a specialist in Australia and New Zealand, all SIMGs had to sit the full final examination, which he cleared on his first attempt.

A number of key players were responsible for the establishment of OTSAN. This was an important resource for SIMGs that was run by fellows alongside the college SIMG team with the aim of providing both personal support and practical guidance in preparing for the final examinations. Michael recognised the value of OTSAN and became actively involved at the outset and was one of its drivers.

The decision to settle in Queensland led to a position at the Royal Brisbane and Women's Hospital and later to appointment as director of the anaesthesia department to which suitable SIMGs were subsequently appointed. He also championed specific positions for SIMGs in Queensland to help upskill them for practice in Australia.

In his role at the college with the SIMG team, Michael served as an interviewer on the SIMG Interview Panel, as a workplace-based assessment assessor, as a member of the SIMG Committee, and finally as the longest serving chair of the committee.

As a result of his wide and varied experience with the Australian health system and appreciation of the value of SIMGs, including their contribution to regional and remote services, Michael was well positioned to champion SIMGs. This was always tempered by the college's responsibility as the agent for the Medical Board of Australia and Medical Council of New Zealand. Within this context a fine balance was struck between the prime consideration of community safety and fairness in the SIMG process.

As chair of the SIMG Committee, Michael was instrumental and heavily committed to the ongoing evolution of the SIMG process, which has seen significant improvements but also a strategy and plan in place to further this goal.

On behalf of the SIMG team and the college we would like to express our sincerest thanks to Michael and wish him and his family the very best for the future.

Dr Peter Roessler FANZCA
Ms Helen Maxwell-Wright FAICD
Dr Leona Wilson FANZCA

Substance abuse: A personal story of recovery and rehabilitation

DR COLIN BAIRD
AUCKLAND CITY HOSPITAL

MY NAME IS Colin and I'm an addict. As I write, I haven't used in four years and three months. I consider myself incredibly fortunate to have been given the support and opportunity to turn my life around and return to clinical anaesthesia.

I've decided to tell my story in order to try and give something back. By doing so, I hope to educate our community about the problem of addiction in anaesthetists, and also to help those among us who may find themselves in a similar situation to mine.

There is a long history of substance use disorder (SUD) in the medical profession, with alcohol the most widely abused substance. Anaesthetists though are more likely to abuse anaesthetic agents – most commonly quick acting lipid soluble opioids such as fentanyl.

We are in a unique position among healthcare providers in that we prepare and administer opioids and other drugs of abuse with very little oversight, and there are many opportunities for diversion within this process. The incidence of SUD in anaesthetists is around one to two per 1000 each year and many anaesthesia departments will have experienced SUD within their ranks.

The mortality among anaesthetists with addiction is high, and the death of a colleague has devastating repercussions for all affected, with some wondering whether they could have intervened sooner. SUD can also result in sub-optimal patient care and even direct patient harm in some cases.

> "I knew I had a serious problem but feared losing everything were I to admit this and ask for help."

I became addicted to fentanyl during a difficult and stressful time in my life, when I was susceptible to temptation and risk-taking behaviour.

What began as experimentation in pursuit of comfort, rapidly escalated into an addictive behaviour which dominated every facet of my life.

My entire professional identity was subsumed by the overarching need to maintain and conceal the addiction. It became a continuous cycle of anxiety, anticipation, consumption and remorse, and I could see no way out of the hole I found myself in. I knew I had a serious problem but feared losing everything were I to admit this and ask for help. I tried repeatedly to stop, but whenever the opportunity arose to divert and use, all my willpower melted away and I was back on the addiction merry-go-round.

It took an intervention to break the cycle. My increasingly erratic behaviour aroused the suspicion of colleagues who reported their concerns to the clinical director. I am forever indebted to them for doing this as a tragic outcome may otherwise have ensued. I was presented with the evidence and in that moment felt an overwhelming sense of relief.

Life couldn't continue in this way, I needed help and was ready to accept whatever had to happen. I was also given hope. A route back to medicine would be possible and this kernel of optimism provided an emerging sense of purpose as I left the intervention and began my rehabilitation process.

Could I return to clinical anaesthesia? I was fortunate to have the support to consider this option and decided to attempt a return. I knew it was a risk however, with as many as 10 per cent of anaesthetists who return to theatre suffering a fatal relapse. Willpower had failed me in the past, but things had changed. It was no longer a secret, I could talk openly about how I was feeling, there would be a support structure around me, and I would be subjected to regular and random toxicology screening.

This latter measure would be key for me, in providing a psychological safety net. A phased return was implemented, and a strategy enacted to ensure key individuals in the department were aware and available.

My colleagues were immensely respectful and supportive which helped to allay my anxieties as I had feared the opposite reception. As the days turned to weeks and months, I consolidated normal practice and left each day feeling satisfied and content rather than anxious and remorseful.

Journaling was an important aspect of my recovery and formed the basis of the article published in *Anaesthesia and Intensive Care* (DOI: 10.1177/0310057X20969704). Writing the article was an incredibly therapeutic and satisfying undertaking, which has helped my recovery immeasurably.

Since its publication, I have received correspondence from around the world thanking me for publicising this issue and helping to initiate important conversations around wellbeing and support. I hope that by telling my story, others in similar situations will see that there is a way through.

Help is available – ask for it.

Free ANZCA Doctors' Support Program

How to make an appointment:

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

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

Converge international

HELP IS ALSO AVAILABLE VIA THE

Doctors' Health Advisory Service:

NSW and ACT	02 9437 6552
NT and SA	08 8366 0250
Queensland	07 3833 4352
Tasmania and Victoria	03 9495 6011
WA	08 9321 3098
New Zealand	0800 471 2654
Lifeline	13 11 14
beyondblue	1300 224 636

Safety and Quality

Opioid regulatory changes in Australia and their impact on fellows and patients

OPIOID REGULATORY REFORM in Australia resulted in significant changes to the listed indications and Pharmaceutical Benefits Scheme (PBS) approvals process in 2019. A detailed timeline of the changes and the rationale behind them was laid out by Therapeutic Goods Administration (TGA) Chair Professor John Skerritt in a talk at the recent annual symposium. These changes also coincided with alterations to the PBS prescribing rules. Doctors, especially GPs, were partly aware of the TGA changes, but were largely caught unawares by the PBS changes, especially when their non-updated practice management software led to phone authority prescriptions being declined.

The impacts on both consumers and frontline health professionals have been very significant. Few specialist pain medicine physicians have not had patients who were well maintained on low or moderate doses of opioids as part of their management plan but who were suddenly confronted with a GP who wanted to unilaterally impose a forced taper or who simply abandoned prescribing.

FPM has been in regular liaison with Painaustralia, which has been overwhelmed with negative feedback about these changes and has been leading the response on behalf of consumers. It was predicted that anger from patients might lead to an increase in reporting to the Australian Health Practitioner Regulation Agency (AHPRA) of GPs or specialist pain medicine physicians who refuse to authorise increased or continuing doses of opioids. However, while this has happened, the number of complaints that we are aware of has been fewer than expected. We are awaiting information from AHPRA as to whether there has been a rise in reports of patient abandonment through regular prescribers abruptly ceasing medications.

Although they were mostly well-considered and supported by expert groups such as the faculty and the Australian Pain Society, these changes have caused such a backlash from consumers, GPs and our fellows that a few lessons seem apparent at this stage.

- There was very little lead-in time given to prepare. The up scheduling of codeine was flagged many months in advance and proceeded smoothly. The result was an almost seamless achievement of the policy goal of reducing codeine use while not impacting the management of patients who may need it. By contrast, the TGA reforms were pushed ahead for a pre-determined implementation date without the benefit of adequate time or attention being given to impact predictions from stakeholders. The PBS changes, which had significant practical effects, were very poorly flagged to GPs who then had to scramble to solve the problem without enough background to understand it.
- There was no meaningful practical support given to prescribers or pain services. While TGA funded a number of educational initiatives, no additional resources in the form of new Medicare item numbers, funding for pain clinics or addiction treatment centres, helplines or other decision support tools were provided. Existing pain services, congested at the best of times due to chronic under-resourcing, became caught up in a culture of long waiting times and service rationing.
- As a result of both the above factors, many GPs clearly began to feel that opioids were simply too much of a problem and they appear to have become much more reluctant to offer opioids, even when they may be appropriate for a period of time. Far too little consideration was given to consumers who had long been maintained on a stable dose of medication in the absence of any other effective therapy. This large group of "legacy" patients may still benefit significantly from a properly conducted, consensual dose reduction, but many of them have been forced onto a lower dose abruptly, with compromised quality of life, and, paradoxically, an increased likelihood of requiring a dose increase to maintain the same quality of analgesia. Not only is it unethical and seriously harmful to the patient to abruptly cease moderate or high-dose opioids without adequate support, due to severe erosion of quality of life and the risk of suicide, but also the health system itself is brought into disrepute. The TGA was made aware of the needs of this group in strenuous terms by the faculty in the short period we had to advocate and comment on the proposed changes.

"The impacts on both consumers and frontline health professionals have been very significant."

Recently published electronic Persistent Pain Outcomes Collaboration (ePOCC) data suggest that multidisciplinary pain services remain by far the most effective way to achieve the optimal outcome of both opioid dose reduction and improved quality of life.

As a faculty we will continue to maintain our position that regulatory changes to opioid prescribing are a very blunt tool, and need to be very carefully considered and implemented. Future regulatory reforms need to be thoroughly socialised with consumer and clinician groups and, critically, must be linked to dramatically increased funding and innovative models of care.

While the ePOCC data do show significant benefit from multidisciplinary pain services, a disturbing detail is the enormous dropout rate from such services. Planning is needed to avoid turning pain services into surrogate addiction services for drugs that we usually prescribe only sparingly. It will be a significant challenge to manage this surge in referrals for opioid reduction without turning these patients into "second-class pain citizens" who are being seen only to reduce their doses without engaging with the full range of available treatments on offer.

Properly funded services, that are comprehensive in scope, are the only meaningful public health response to this wicked problem. Really only one thing is clear, that more of the same inaction by governments in this respect will just result in more of the same poor outcomes for our patients.

Associate Professor Michael Vagg
Dean, Faculty of Pain Medicine

College response to regulatory changes in relation to opioids prescribing

The recent Therapeutic Goods Administration (TGA) changes to opioids prescribing (see www.tga.gov.au/hubs/prescription-opioids) prompted a review of FPM's statement on the use of opioid analgesics for chronic pain as well as college statements on slow-release opioids for acute pain and opioid-induced ventilatory impairment (OIVI).

PS01(PM) REVIEWED

The former title of *PM01 Recommendations regarding the use of Opioid Analgesics in patients with Chronic Non-Cancer Pain* became immediately untenable, as the document was, in fact, a guideline.

An urgent revision in content and tone was undertaken to articulate the college's stance on opioid use in this context. Consequently, *PM01* was transmuted into *PS01(PM) Statement regarding the use of opioid analgesics in patients with chronic non-cancer pain* (foreground paper) which is a formal position statement describing the current position of FPM regarding the prescription of opioids in chronic non-cancer pain, presented as a series of principles:

- General principles informing the management of patients with chronic non-cancer pain.
- Principles informing the prescription of opioids to patients with chronic non-cancer pain.
- Additional principles underpinning management of the patient already established on opioids (the "inherited" or "legacy" patient).
- Additional principles underpinning initiating a trial in an opioid-naive patient.
- Response to difficulty achieving or maintaining therapeutic goals in an opioid trial.

The document also offers the only interpretation of the "exceptional circumstances" promulgated but not defined by the TGA.

STATEMENTS ON SLOW-RELEASE OPIOIDS AND OIVI

The college statements on slow-release opioids for acute pain and opioid-induced ventilatory impairment (OIVI) are also being reviewed.

The two statements – *Position statement on the use of slow-release opioid preparations in the treatment of acute pain* and *Statement on principles for identifying and preventing opioid-induced ventilatory impairment (OIVI)* – will be incorporated into an updated *PS41 Guideline on acute pain management,* which is under review.

Professional document *PS45 Statement on patients' rights to pain management and associated responsibilities,* is also under review.

A bowtie analysis of infrastructure and system incidents

webAIRS
Anaesthetic Incident Reporting System from ANZTADC

IN THIS EDITION of the *Bulletin*, a bowtie analysis has been performed on the incidents involving infrastructure and system factors among the first 8000 incidents reported to webAIRS. This main category of incidents accounted for 4.8 per cent of the first 8000 reports in an initial interim analysis. For those readers not familiar with the bowtie diagram, the on demand session named "WebAIRS incident reporting – new concepts using incident analysis to improve safety and quality", released at the ANZCA Annual Scientific Meeting (ASM) in April 2021, will be available for a further 12 months via the ANZCA ASM virtual portal: asm.anzca.edu.au/virtual-delegate/. Please log in using your existing ANZCA ASM registration link or alternatively register using the portal before 31 July.

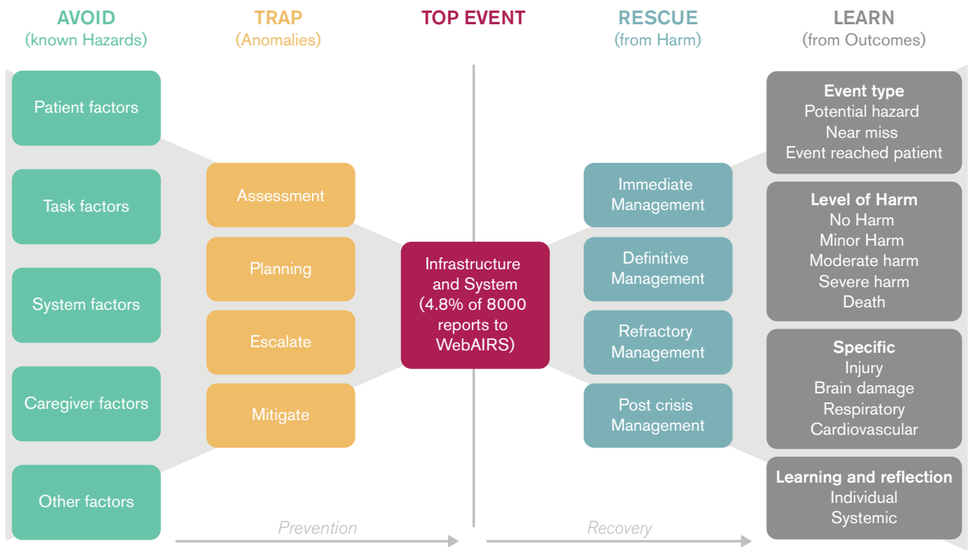
A comprehensive explanation is also available in the article "Unanticipated difficult airway events: A systematic analysis of the current evidence and mapping of the issues involved using a bowtie diagram" published in *Australasian Anaesthesia* in 2019[1].

The left side of a bowtie diagram is designed to prevent a critical incident, which is known as a top event. This process involves identifying hazards, which might lead to the critical incident category that is being analysed and methods to trap these hazards. The right side of the diagram deals with recovery from the event, which involves management methods to rescue from harm, and the final stage is to learn from the outcomes. The shape resembles a bowtie hence the name for the diagram.

The diagram shows an overview of the risk factors anticipated and methods to trap these potential hazards, summarised in a qualitative bowtie diagram. It is also possible to have quantitative diagrams with a single pathway from the hazards to the top event, but these are more difficult to construct in complex situations, such as anaesthesia. Using the diagram above as an overview, it is possible to expand each section with more detail. The detail can be as complex as required. There are five columns in this version of the diagram under the five headings avoid hazards, trap anomalies, rescue from harm, and learning from outcomes.

The hazards are split into five categories as shown in the green boxes. The results of the interim hazard analysis are shown below with the percentages rounded to one decimal place.

Infrastructure and System Bowtie Diagram



AVOID HAZARDS

Patient factors
- May affect patients of all ages, ASA PS, Sex and BMI.

Task factors
- Unfamiliar procedure/technique 3.6%

Caregiver factors
- Anaesthetist unwell 0.5%
- Communication 35.4%
- Distraction/fatigue/haste 6.5%
- Pressure to proceed 4.9%

System factors
- Environment
  - Unfamiliar 1.8%
  - Unsatisfactory 7.2%
- Equipment
  - Unavailable 6.7%
  - Unfamiliar 2.3%
  - Unsatisfactory 6.2%
- ICU/HDU bed (delay/unavailable) 6.6%
- Patient delay 3.6%
- Skilled assistance (delay/unavailable) 6.2%
- Ward bed delay (0.5%)

TRAP ANOMOLIES

Setting up barriers to prevent infrastructure and system problems typically takes a long time. For example, the Safe Surgery Checklist, which was an improvement to the existing checklist procedures, took several years to design, agree on a standard operating procedure (SOP), and implement in the participating countries, which included Australia and New Zealand[2]. In general, providing the right equipment and environment requires detailed planning, and ANZCA Professional Documents may assist. While the incidents reported to webAIRS might involve a wide range of errors, selected patients may require particularly complex equipment or facilities such as HDU and ICU.

Management of the listed caregiver factors might include efforts to improve workplace culture, to reduce working while distracted, fatigued[5], or unwell, or faced with inappropriate pressure to proceed. Working while unwell or coercive behaviours such as pressure to proceed might also contravene the Australian Workplace Health and Safety legislation[4]. Communication problems might be mitigated by improved use of the Safe Surgery Checklist and by targeting training and ongoing education, such as that provided by EMAC courses, or the NetworkZ program in New Zealand (www.networkz.ac.nz/). Prevention strategies may include greater emphasis on balancing the risk versus benefit to the patient when making decisions regarding the safety and wisdom of proceeding.

RESCUE FROM HARM

Management will depend on the stage at which the Top Event occurs. If the procedure has not begun, a risk versus benefit decision is still a possibility, ideally in consultation with the patient, particularly if the environment or equipment is not available or unsatisfactory. In situations where a caregiver is unwell, distracted, tired, hungry, or late, it might be possible to relieve that member of staff for a break or for the rest of the day. Undue haste should be avoided and balanced with the urgency of providing emergency care if required.

LEARNING FROM OUTCOMES

Immediate outcomes	Per cent
No effects	40%
Minor effects	26%
Case cancelled	8%
Prolonged length of stay	6%
Unplanned ICU/HDU admission	11%
Death	3%
Not specified	6%
Total	100%

Final outcomes	Per cent
Not affected by incident	64%
Temporary disability	21%
Permanent disability	2%
Death	6%
Not specified	7%
Total	100%

The immediate outcomes and the final outcomes are shown in the tables above. The majority of patients (54%) had some degree of harm or inconvenience in the immediate outcome of the episode of care. There were no immediate effects in 40% and the immediate outcome was not specified or not known in 6%.

It is concerning that infrastructure and system errors were associated with subsequent death in 3% of the reports and unplanned admission to ICU/HDU in 11% of the reports. Case cancellation (8%), prolonged length of stay (6%) or minor effects (26%) occurred in 40% of the reports. The final outcomes were also concerning with some degree of harm in 29% of reports, ranging from temporary disability in 21%, permanent disability in 2%, and death in 6%. The latter was a further 3% increase from the 3% observed in the immediate outcome.

Infrastructure, including staff, facilities, and environment were also frequently reported in a study of 12,606 reported incidents from the UK National Reporting and Learning System[5,6], with essentially similar contributing factors[7].

A full analysis is under way to determine the relationships between the outcomes and the various risk factors in the hazards section of the bowtie. This will allow a more detailed description of the analysis of each item in the hazards section and more detailed diagrams depicting each topic in more detail.

ANZTADC Case Report Writing Group

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

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We need you to tell us what you think about the future for ANZCA

THE COLLEGE FELLOWSHIP survey in 2021 will be emailed to all ANZCA and FPM fellows in mid-August. The survey development has been led by a working party of fellows including myself, Dr Bridget Effeney, Dr Chris Hayes, Dr Leesa Morton, and the college membership services team.

As in previous years the survey will be managed by an independent, qualified and professional agency, KPMG, who will facilitate distributing the online survey, send reminders and provide a detailed analysis back to the college. Importantly KPMG will retain the primary data and individual responses from the survey will remain confidential. After analysing responses from fellows, KPMG will de-identify responses from fellows and provide a report including descriptive analysis and high-level themes.

You will notice a distinct difference in the 2021 fellowship survey from previous surveys. The 2021 fellowship survey has one aim which is to gauge the thoughts and opinions of the fellowship on the future direction of the college. This vital information will help ANZCA Council develop the 2022-2027 ANZCA Strategic Plan. The survey does not focus on past experience nor is it a satisfaction survey. Most of the questions will ask about how much fellows value aspects of college activity.

Compared to the past, the 2021 survey will also have fewer questions and more opportunity for free text to allow detailed feedback. The survey can be completed in less than 10 minutes. Each fellow will receive an email from KPMG directly containing a survey link unique to them and the survey may be completed in one or multiple sessions on a laptop, tablet or smartphone. Please check your junk mail because some hospital firewalls may block the email from KPMG. If you do not receive an email with your survey by the end of August please contact the Membership Services team – membership@anzca.edu.au.

To reveal the areas that fellows place most importance on the future of the college, KPMG will undertake statistical analysis on the aggregate data, and some geographical and demographic cohorts. Free-text comments from fellows will be analysed for major themes to capture additional valuable detail and colour about primary rating questions, the survey, and the college.

I am proud to be involved with this important initiative and have, with the working group, developed a survey that I believe meets the standards expected by you in terms of rigour and best practice. It is only by your participation in the survey that the strategic direction of the college in the coming years will satisfy and meet your expectations.

Results of the 2021 Fellowship Survey will be reported back to fellowship via the *ANZCA Bulletin* and the college website before the end of 2021, and at the 2022 ASM. I encourage you all to proactively respond when you receive your online fellowship survey.

We want to know what you really think.

Professor David Story
ANZCA Councillor and Chair of Safety and Quality Committee

Mr Ross McLelland
Director, Co-Lead KPMG Customer Intelligence

KPMG uses secure, encrypted systems to manage fellows' details with this information only be used for the purpose of distributing the survey. At the conclusion of the survey the lists will be permanently removed from KPMG systems and all personally identifiable information will be removed from the survey database.

As a company partner of The Research Society, Australia's peak body for market research professionals, KPMG is bound by the Code of Professional Behaviour which is consistent with the Australian Privacy Principles in the Privacy Act 1988 (Cth) (Privacy Act).

As a further commitment to quality, KPMG is currently preparing to achieve AS ISO 20252:19 accreditation, the quality standard for market, opinion and social research.

beyond city limits

The wild and wonderful West Coast

When Dr Andrea Hages found an advertisement for a senior anaesthetist position at Grey Hospital on the West Coast of New Zealand, it seemed a world away from her northern Californian life. However, it was one she and her husband, both ex-US military, were ready to try. They packed up their three children in the middle of the first year of COVID-19 last year and headed to Greymouth in the South Island. What they are discovering is just one big West Coast adventure.

YOU MIGHT THINK a 40-bed brand new hospital with just three theatres doing mainly day surgery and endoscopy might be too quiet for this intrepid doctor who has been on emergency retrieval teams into parts of Africa and worked out of the biggest US base in Germany. Dr Hages, however, says it is surprisingly stimulating and rewarding.

What makes this a unique position is Greymouth's setting. With the Southern Alps on one side boasting the country's highest mountains, glaciers, mirror lakes and primeval rainforest, and the wild Tasman Sea on the other, it is remote. This means transporting anyone who is in need of high-level care across the mountains or through mountain passes to Christchurch Hospital. The West Coast is vulnerable to bad weather and it closes in fast. Anticipating that a patient may deteriorate and may need have to be moved sooner rather than later, means knowing your patients and their prognosis intimately.

"Doctors may think that this is not a challenging practice. However, one of the more challenging things about working here is knowing what you can safely do and what complications you might run into. At the back of your mind is, if there is bad weather or the retrieval team are on another job, you cannot always fly your patient out to Christchurch. So being a true perioperative physician and doing perioperative screening really is paramount in a setting like this." Dr Hages says that despite not doing the big heads and hearts [operations], in all cases, you really need to know your patients.

Te Nīkau (the new Grey Hospital) is transporting up to three patients to Christchurch daily by ambulance through the magnificent Arthur's Pass. The return journey brings coasters back following their treatment. Up to two or three times a week there are emergency transfers by fixed-wing or helicopter. At night, there is a dash 40 minutes down the road to Hokitika Airport to add to the computations. Greymouth Airport, directly opposite the hospital, is not equipped with lights for night landings of fixed wing aircraft.

The area of capture for this small hospital is from Haast down south to Karamea up north – more than 500 kilometres of windy road along the coastline. The population is just 32,000 spread widely along that route with many elderly people and a high proportion with co-morbidities.

Chief medical officer for the West Coast District Health Board (WCDHB) and clinical director for the anaesthesia department is ANZCA fellow Dr Graham Roper. He comes from Christchurch where he worked at the public hospital including six years as the clinical director. Dr Roper started working part-time in Greymouth eight years ago and made the move permanently just 18 months ago.

Dr Roper loves the coast. He loves the lifestyle but he loves his work as well. "It's the smaller team environment and the leadership opportunities. In such an environment, you are more likely to make a difference." Like Andrea, he says, it is the challenge.

Dr Andrea Hages in Grey Hospital.

Opposite: Emergency transfers by fixed-wing aircraft or helicopter occur on the West Coast two to three times a week.

Dr Hages with son Blake (3), daughter Victoria (10), husband Lee and son Colby (13); the Haast UNESCO World Heritage area.

"So being a true perioperative physician and doing perioperative screening really is paramount in a setting like this."

The deputy chair of the ANZCA New Zealand National Committee, and a cardiovascular specialist anaesthetist, Dr Roper has been pivotal in a couple of major emergencies at Te Nīkau just recently that are a good reminder of the isolation. The first was an unusual presentation of a toddler with epiglottitis, which thankfully was recognised early. She was put on to a ventilator overnight before being flown to Christchurch. Dr Hages has also dealt with an older child with a similar condition from the same local community. Then there was also a seemingly innocuous weed eater incident, which had the patient bleeding out on the table. A flicked piece of metal had damaged the lung of the patient. In all these cases, the presence of senior anaesthetists has been the difference of life and death.

So, call the caseload unchallenging if you like but you will get a wry smile from any anaesthetist who has worked on the wild and wonderful West Coast.

Adele Broadbent
Communications Manager NZ, ANZCA

"Team-focussed" training

SUMMER PIZZATO WAS taking a gap year after leaving Grey High School when she spotted an advertisement for a trainee anaesthetic technician (AT). Te Nīkau Hospital has just received accreditation to train ATs after many years' hiatus. For this 19-year-old, it was an opportunity of a lifetime. Ms Pizzato is halfway through training and loves her job. She does six months at Grey and six months at Christchurch where she gets to experience and learn from the bigger cases, but it is here on the coast that she is most at home. "It's more team focused and supportive. You know everyone. Christchurch has hundreds of nurses, surgeons and anaesthetists and it is not as personal. I love my team and my patients. It's a special place."

Anaesthetic technician Summer Pizzato and Dr Graham Roper.

Making the most of the wilderness

DR ANDREW WOODHEAD, formerly of St Vincent's in Melbourne, was coming to the end of a three-week locum on the West Coast at Te Nīkau Grey Hospital when the *Bulletin* visited. He loved it. "It's an excellent work-life balance. A brand new hospital with friendly welcoming staff who provide great care. It's a really enjoyable workplace." Dr Woodhead did not waste a minute of his stint, getting off shift and on his bike to explore the whole of the famous West Coast Wilderness Trail. This is a series of tracks carved by pioneering gold rush miners, together with extensive water races, logging tramways and short length railway lines. Dr Woodhead did parts of the 120-kilometre trail in all weathers over the time he was locuming. When he could not do one week down south, his colleague, Dr David Choi of Middlemore filled in. He also fell for the wild and wonderful West Coast exploring some of the many outdoor adventures it has to offer.

Dr Andrew Woodhead on the West Coast Wilderness Trail.

Dr David Choi also locumed and took advantage of the great outdoors.

One of the West Coast's drawcards, Fox Glacier, descends from the Southern Alps down into temperate rainforest just 300 metres above sea level.

COVID-19:

Up close and personal

ANZCA fellow Dr Julian Fuller from North Shore Hospital in Auckland writes about being infected with COVID-19 in South Africa. He reflects that the few weeks were among the deepest days of despair he had ever felt.

THE HUMAN MIND has an amazing ability to rapidly forget the bad times, and remember only the good times. Such is how I now feel, some months after returning to normality in Auckland. At the time I was in South Africa, the situation felt remarkably similar to what we have witnessed in India in recent weeks: utter despair, death everywhere, hospitals completely swamped, and healthcare systems overridden.

I lost a younger brother, had many flights home cancelled, contracted COVID-19, was refused permission to return into Managed Isolation and Quarantine (MIQ) in New Zealand. I faced spending three months locked in South Africa, and then watched the America's Cup races on my laptop, while isolating, recovering in my beachfront hotel. All very surreal at the time.

As I lay on my bed, feeling quite ill, in my "isolation hotel" in Durban, I would chat to my wife, Trish, by FaceTime several times a day, 12,000km away in Auckland. Reflecting now, it must have been so stressful for her, as she truly worried whether, at 69, I was ever going to get better, or not. Again, quite surreal.

I am now well back at work, fully recovered and fit, and fortunately suffering no long-COVID symptoms. I watched live on the water as Team NZ successfully defended the last races of the 36th America's Cup. I reflected on the experiences learnt while racing around the world on the Whitbread Race, with fellow crewmate, Grant Dalton who was now fronting the America's Cup campaign. The resilience and glass half-full attitude learnt then stood me in good stead as I faced possibly the biggest challenge of my life in South Africa.

As on long ocean passages, I have still not shaved since fleeing from South Africa in late January, just trimming now and then, so whiskers remain, as a visible reminder of hard times. However, it is true, just as with terrible weather at sea for days on end that, as the sun comes out, the mountainous seas flatten, and one soon forgets the bad times and focuses on the positive.

I wrote an account (see excerpt below), while I was in MIQ, when everything was still raw and real. Case numbers in South Africa have to be taken with a pinch of salt, as they found an easy way to keep them low simply by charging R850 ($A79) for a COVID-19 (PCR) test.

As we see the Trans-Tasman Bubble under threat with new outbreaks, and we crave a desire to return to 100 per cent normality, one tries to understand the large variation in expression of this disease, in fatality rates and infectivity.

I had undertaken a compassionate trip to Durban, to visit my 63-year-old brother, who was dying from cardiac and renal failure due to amyloidosis.

When I booked the flight on 9 November, COVID-19 infection rates in South Africa were relatively stable. There were roughly 1500 new cases a day, with 55 deaths. Nearly 5000 cases were in hospital, with 500 in ICU and 250 needing ventilation.

"As on long ocean passages, I have still not shaved since fleeing from South Africa in late January, just trimming now and then, so whiskers remain, as a visible reminder of hard times."

As I touched down, in Durban, on 19 December, daily cases had risen to 8500, with a further 8500 in hospital, more than 1000 in ICU, and 430 ventilated. The day that I became symptomatic, on 6 January 2021, the numbers were extremely grim, with 16,000 new daily cases, 13,400 hospital admissions, nearly 2000 in ICU and nearly 700 ventilated. By the time I flew out 15 days later, daily cases had just peaked at 20,000, with 17,000 admitted, 2500 in ICU and 1400 ventilated.

I guess it was almost inevitable that I would get the virus, although I took all the usual precautions, including masking up, hand sanitising, and distancing. I rarely "went out" apart from visiting my sick brother at his home every day.

Prior to becoming sick, I did end up having 10 wonderful, quality days with my brother, before he passed on 29 December 2020.

The undertakers described Durban to me as being like a "war zone", with death everywhere. So many dead and the mortuaries full, as were all the hospitals. All the crematoria were operating 24/7.

Talking with a former colleague anaesthetist, there just were no hospital beds left in Durban. Private hospitals had all stopped elective work, and were treating COVID-19 patients, in the wards (50 per cent of all South African COVID-19 hospital admissions in private) and in ICUs (90 per cent of all COVID-19 admissions in private). Makeshift ventilators were being used.

Durban was now so full of COVID-19, that were you to suffer a heart attack, or other medical emergency, you were on your own.

I do not regret doing what I did, of course. However, if I knew what I know today, there is some doubt in my mind as to whether I would have gone. I cannot, for the life of me, see any reason to leave New Zealand at present, excepting for compassionate reasons, and even then, one needs to seriously think about it, "eyes wide open".

Thanks to the Association of Salaried Medical Specialists (Dr Fuller is the former vice president) for allowing the *Bulletin* to use this excerpt from the original article that appeared in their magazine, *The Specialist*, in March 2021.

Above: ANZCA Global Development Committee member PNG anaesthetist Dr Arvin Karu at the Port Moresby General Hospital before the onset of the COVID-19 pandemic.

Pandemic challenges in PNG

AS COVID-19 sweeps through PNG, ANZCA Global Development Committee member Dr Arvin Karu explains how he and his colleagues are trying to cope.

AT THE HEIGHT of the second wave of COVID-19 infections in Papua New Guinea (PNG) in March this year Port Moresby General Hospital anaesthetist Dr Arvin Karu became aware of just how dire the situation had become.

As co-ordinator of the hospital's anaesthesia and ICU department, Dr Karu knew then that he and his colleagues – 10 senior medical officers (SMOs) and 12 registrars – were fighting a battle on several fronts.

Apart from a shortage of much needed ventilators for patients in their dedicated COVID ward there were not enough trained intensive care staff who knew how to operate the ventilators. And enforced absences of staff who had either tested positive for COVID-19 or who were sent home to isolate for 14 days made the staffing issues even more challenging.

"We had six patients on ventilators in a dedicated COVID ward of 201 patients and it was very busy," Dr Karu told the *Bulletin* from Port Moresby.

"Those two days in mid-March when we had six ventilated patients were hard because we didn't have enough nursing staff who knew how to manage patients on ventilators. It was very difficult to monitor the six patients and to watch them properly. We ran out of syringe pumps so that was challenging and we were dealing with two or three people at the same time but without the staff to look after them.

"From July 2020 to April this year we have had 202 patients admitted to isolation and of these 140 recovered and 62 died. Of the 34 patients we ventilated, about 85 per cent died with only about five recovering.

"From the first wave last year we didn't have enough ventilators. We only had four. Now we have 20 located throughout the hospital and in our COVID ward we have an eight-bed ICU."

As president of the Society of Anaesthetists of PNG (SAPNG) Dr Karu is in regular contact with government health department officials and other medical specialists as the country deals with the pandemic crisis. A flood of offers of ventilators, personal protective equipment and oxygen from countries including Australia and the US has helped PNG to manage the pandemic's second wave. The arrival of an AUSMAT team in mid-March provided drug and equipment supplies including infusion pumps, infusion lines and muscle relaxants.

But Dr Karu says the country needs to be prepared for a possible third wave. The SAPNG has been proactive and has organised a series of UNICEF-funded workshops of ventilator and basic ICU training for healthcare workers, anaesthetists and anaesthetic service officers (ASOs).

"With a population who speak more than 800 languages and mostly live in traditional villages the pandemic has severely tested the country's health services."

"When the extra ventilators arrived we received calls from doctors asking us how to use them so we decided to come up with a two to three day ventilator workshop. We have now done three of these and we have brought in health workers from different provinces and they have gone very well. We know we will need to offer more of these over the next few months," Dr Karu explained.

"Many staff from the anaesthetic and ICU departments contracted COVID. Nine of our staff were diagnosed as positive but all had mild symptoms. A couple of doctors with moderate symptoms were admitted to an isolation ward and a few registrars and resident doctors also had mild symptoms but recovered well.

"We have had about 15 COVID positive cases in the hospital's dedicated COVID theatre – from July last year through to May this year – but there were also some cases that we didn't know were positive until after their surgery."

Dr Karu is a member of ANZCA's Global Development Committee and his frontline experience has been crucial in giving the college a better understanding of the situation on the ground in PNG. The committee has been working to provide practical support such as online forums, developing educational resources and donating equipment and consumables. (In early May Dr Karu chaired a COVID-19 online support forum for anaesthetists and anaesthesia providers in PNG, with representatives from ANZCA, the Royal Australasian College of Surgeons and the Australian Society of Anaesthetists participating.)

In early April Dr Karu updated the Global Development Committee via Zoom from Port Moresby. He explained how the Port Moresby General Hospital's children's ward had been cleared of patients so it could be repurposed as a COVID ward. The children were moved into the adult wards and oxygen supplies were running low.

Nearly 200 staff at the hospital had tested positive for COVID-19 and there were projected staff deficiencies of 50-60 per cent which would make running the hospital almost impossible if those scenarios were realised. Dr Karu told the committee that coronavirus testing rates were extremely low and it had been predicted that between five to 10 per cent of the population (400,000-800,000 people) would contract the coronavirus. Most of PNG's 21 provinces were reporting several hundred cases and there were frequent requests for advice on oxygen therapy and ventilation from the provincial capitals which had much more limited resources than Port Moresby.

As of 8 June the country had officially recorded 16,300 cases and 164 deaths according to the Johns Hopkins coronavirus resource centre. However, these figures are believed to be much higher because the country's low rate of COVID-19 testing is masking the true infection rate in Port Moresby and the provinces where most of PNG's nine million people live.

With a population who speak more than 800 languages and mostly live in traditional villages the pandemic has severely tested the country's health services. While vaccination rates are slowly improving there is still widespread vaccine hesitancy in many parts of the country, largely fuelled by misinformation on social media.

As the second wave hit the country the government set up temporary COVID-19 hospitals in a Port Moresby sports stadium and an aquatic centre. A decline in cases meant that as of mid-June these were now longer being used to treat COVID patients and the aquatic centre has been converted to a COVID testing centre.

Dr Karu says while the rate of infections appears to have slowed with locals getting used to a "new normal" approach to living with the virus, the next few months will be crucial in helping to prevent a potential third wave. He is hoping the recent decline in COVID-19 hospital admissions will give his colleagues time to organise more training workshops for healthcare workers and anaesthetic service officers.

"The temporary hospitals have now closed but of course we are on standby just in case. Our COVID isolation ward is one third full at the moment and these are mild, moderate cases."

Carolyn Jones
Media Manager, ANZCA

Pacific boost for online anaesthesia learning

ANZCA's Global Development Committee makes a real difference to people living in Australia and New Zealand's nearest neighbours in the Asia-Pacific. As an educational college, teaching and vocational training is at the core of the committee's activities – fostering and developing a sustainable, local health workforce. The ongoing COVID-19 pandemic and the resulting travel restrictions have affected how we can provide ongoing educational support to our anaesthesia colleagues throughout the Pacific.

THE PACIFIC ONLINE Learning and Education (POLE) working group was established at the end of 2020 to continue our support and maintain our connection with our overseas colleagues. In addition to the college, membership of the group consists of representatives from:

- The Australian Society of Anaesthetists (ASA).
- The New Zealand Society of Anaesthetists.
- The Society for Paediatric Anaesthesia in New Zealand and Australia (SPANZA).
- The Society of Anaesthetists of Papua New Guinea.
- The University of Papua New Guinea
- Fiji National University College of Medicine.
- The Pacific Society of Anaesthetists.
- The Micronesia Society of Anaesthetists
- Timor-Leste (Hospital Nacional Dili).
- The Samoa Ministry of Health.
- An Australian junior consultant.

The first online meeting between all representatives was held in November 2020 with some of us meeting virtually for the first time. The first step was to undertake a needs assessment and develop an education plan for 2021. This plan included:

- Monthly Saturday morning education sessions for anaesthesia trainees and junior doctors.
- Monthly Saturday morning education sessions for anaesthetic scientific officers (in PNG) and other nurse anaesthetists.
- Four continuing medical education sessions for consultant anaesthetists spread over the year.
- A Pacific whole-day conference.

The Pacific representatives provided topic choices for these education sessions over December and January. The collaboration between all of our societies also helped to expand our network and opportunities.

In January, 25 anaesthesia trainees from around the Pacific attended a one-day medical viva preparation course. Dr Nilru Vitharana, the junior consultant representative in the POLE working group, is also the convenor of the course and with the support of the ASA was able to organise complimentary registration for these registrars. In the Pacific they are particularly reliant on their clinical skills when they may not have access to investigations that are routinely available in Australia and New Zealand, so the medical viva remains a core component of their exams. The Pacific trainees all enjoyed the day and welcomed the opportunity to join their Australian colleagues preparing for their exams.

Our first online education sessions started in February when Dr Anna Loughlan provided obstetric anaesthesia sessions on two consecutive Saturdays. A total of 58 participants from Papua New Guinea, Timor-Leste, Solomon Islands, Samoa and Fiji attended. Dr Loughlan has a specific interest in obstetric anaesthesia and has made many visits to low resource countries. Hence, she was the perfect candidate to kick off the POLE learning sessions.

In Papua New Guinea, anaesthetic scientific officers (ASOs) provide the majority of anaesthesia in the country. ASOs are mainly nurses who have received about a year of anaesthesia training before working primarily independently in provincial and rural areas of the country. POLE supported the yearly ASO education in March with online sessions covering topics in paediatric anaesthesia over one week. Also during March, other online education sessions continued with Dr Kim Fuller providing an update on paediatric anaesthesia for trainees and Dr Jess Lim covering basic and advanced life support for nurse anaesthetists and scientific officers. The popularity of the sessions continued to grow with participants joining from Micronesia, Tonga, and Tokelau in addition to those Pacific nations already mentioned.

In April, the focus of the training sessions was on pain management. Dr Roger Goucke donated his time over three consecutive Saturday mornings to facilitate education sessions for ASOs, trainees and the first consultant continuing medical education session. Dr Goucke is the co-founder of the Essential Pain Management course (with Dr Wayne Morriss), a program designed to address pain issues in low resource countries. Sessions in May covered regional anaesthesia for ASOs and junior doctors, presented by Dr Mark Trembath.

In addition to the online sessions, the POLE working group has organised other education events for anaesthesia and pain medicine professionals in the Pacific, such as facilitating attendance at the medical viva preparation course, as well as sponsoring 31 registrations for the ANZCA Annual Scientific Meeting (ASM) and, through the Society for Paediatric Anaesthesia in New Zealand and Australia (SPANZA), 24 registrations for the virtual component of their conference in October.

Feedback from the Pacific has been overwhelmingly positive. The regular meeting sessions are an opportunity to stay in contact, continue medical education and exchange experiences while further developing and strengthening the anaesthesia and pain medicine network in the Pacific. The sessions provide collaborative two-way learning, with facilitators learning from our Pacific colleagues, as they do from us. In a May talk on regional anaesthesia, participant Ms Martha Moufa, from Chuuk in the Federated States of Micronesia, talked about how they use spinals for open appendectomies with excellent anaesthesia. This was a delightful moment in which we learnt about how our colleagues in the Pacific use regional anaesthesia to provide safe anaesthesia care in a resource limited setting.

A project like this is only possible with the help of a team of enthusiastic colleagues who are donating their time to share their expertise. A huge thank you to everyone involved!

Special thanks go to Dr Nilru Vitharana and Dr Jessica Lim who facilitate the regular ASO and nurse anesthetists education sessions, to Dr Mark Trembath who is organising the regular trainee sessions and Dr Indu Kapoor and Dr Meg Walmsley for their ongoing support for the consultant continuing medical education sessions. Thanks also go to college staff for ongoing administration and technical support.

Dr Yasmin Endlich, FANZCA
Chair, POLE Working Group

How you can get involved

Feel free to share the timetable, including the Zoom link, with your colleagues and friends in the Pacific: www.anzca.edu.au/safety-advocacy/global-health/asia-pacific-resources

Colleagues who have anaesthesia experience in lower- and middle-income countries and who would like to get involved and share their knowledge are invited to contact the chair of the POLE working group, Dr Yasmin Endlich, at globaldevelopment@anzca.edu.au

FEEDBACK FROM THE PACIFIC

"It was a wonderful session, very interactive and curtailed to our needs. Very happy with the session, looking forward to more."

GOLIATH LEONARD (PNG)

"I think it's perfect!"

GOLIATH LEONARD (PNG)

"A timely topic for our team to learn more about, especially during Covid-19. Trying to encourage our trainees to do more regional limb blocks... hopefully will try harder blocks after the session."

DR MELANY WERROR (PNG)

"I personally feel these have been very useful and delivered in a manner very applicable to our settings. The feedback I received from the trainees has been similar."

DR SHERENE PRASAD (FIJI)

"Dr Goucke is good at teaching. I found his talking at the right pace, clear and easy to understand. He highlighted what needs to be known about pain."

DR PAULINE WAKE (PNG)

Tracking ANZCA's reconciliation journey

ANZCA's Indigenous Health Committee launched a college-wide Indigenous Health Strategy in 2018 following 12 months of development and consultation with Indigenous health organisations, internal committees, Indigenous members and other relevant stakeholders. As a binational college, ANZCA's Indigenous Health Strategy targets health inequity between Indigenous and non-Indigenous peoples in both Australia and Aotearoa New Zealand.

ADDRESSING HEALTH INEQUITY is at the core of the strategy along with the principles of Australia's commitment to Closing the Gap and Aotearoa New Zealand's Te Tiriti o Waitangi (Treaty of Waitangi). Since the launch of the strategy the college and the Indigenous Health Committee have worked to implement dozens of initiatives and actions across the four pillars of governance, partnerships, workforce and advocacy. Some of these include:

- A new te reo Māori name for the college – Te Whare Tohu o Te Hau Whakaora.
- Establishing a career and professional advice service for Indigenous medical students and prevocational doctors.
- Inviting an Aboriginal and/or Torres Strait Islander and Māori new fellow to attend the Emerging Leaders Conference each year.
- Support for Aboriginal, Torres Strait Islander and Māori trainees to attend regional trainee exam preparation courses.
- Relocation of cultural competency under the continuing professional development (CPD) program to the practice evaluation category (which has resulted in a fivefold increase in the number of participants including this activity as part of their CPD portfolio over the past 12 months).
- The launch of an Aboriginal and Torres Strait Islander Health Award and a Māori Health Award to recognise members who have made a significant and sustainable contribution to First Nations Peoples health.
- Amendments to the Indigenous Health Committee's terms of reference to allow for a larger and more inclusive membership.
- A guide for staff and members with information on acknowledging First Nations Peoples at official college meetings and events.

While we have made some small but important steps forward over the past four years, we know we still have a long way to go. In 2020 ANZCA Council approved the development of the college's first Reconciliation Action Plan which represents the next step in the college's reconciliation journey.

WHAT IS A RECONCILIATION ACTION PLAN OR RAP?

A RAP is a formal, strategic document that provides a framework for organisations to support national reconciliation. It provides a detailed list of initiatives the college will undertake to play our part in reconciliation with Australia's First Nations Peoples. Reconciliation action plans are submitted to, and must be approved by, Reconciliation Australia – a national, independent not-for-profit organisation leading the nation's reconciliation journey.

There are four different types of RAP that an organisation can develop: Reflect, Innovate, Stretch and Elevate. Each type of RAP is designed to suit an organisation at different stages of their reconciliation journey. Given ANZCA's work to date under our Indigenous Health Strategy action plan, the college will commence with an Innovate RAP.

An Innovate RAP outlines actions that work towards achieving our unique vision for reconciliation. Commitments within this RAP allow us to be aspirational and innovative in order to help gain a deeper understanding of our sphere of influence and establish the best approach to advance reconciliation. It is important to remember that developing a RAP is just one step in our reconciliation journey – implementation and continuous improvement are what committing to a reconciliation journey is all about. Reconciliation is an ambitious goal with no specific endpoint, rather it is a cycle of continuous learning and always aiming to improve.

WHY IS A RAP IMPORTANT?

The colonisation of Australia and Aotearoa New Zealand has had a devastating impact on the First Nations Peoples of both countries. The survival and flourishing of First Nations' knowledges and culture are testament to their excellence and resilience. Nevertheless, the cultural trauma caused by loss of lives, lands, languages, culture and freedoms, entrenched by government policies and interventions, and by racism, has left a growing and immeasurable amount of health and wellbeing issues.

Today, the health and wellbeing of Indigenous peoples in Australia and Aotearoa New Zealand is an urgent priority due to significant disparities across a wide range of measures. In Australia, Aboriginal and Torres Strait Islander people have a significantly shorter life expectancy than non-Indigenous Australians (median age at death 60.4 years compared with 81.9 years). Statistics on surgery, hospitalisation and waiting times also highlight significant differences in access to care for Aboriginal and Torres Strait Islander people.

Opportunities for First Nations peoples to pursue careers in health are increasing, however Indigenous health practitioners remain significantly under-represented in the specialist workforce. For example, about 3.3 per cent of the Australian population identifies as Aboriginal and Torres Strait Islander yet First Nations People comprise only 0.15 per cent of Australia's 71,700 medical specialists. At ANZCA, 0.4 per cent of our trainees and 0.2 per cent of our fellows identify as Aboriginal and/or Torres Strait Islander people (as at 31 December 2020). In Aotearoa, 4.4 per cent of college fellows and trainees identify as Māori (versus 14.9 per cent of the population).

There are many systemic barriers to entering the health workforce, including financial disadvantage, reduced access to secondary and tertiary education, lack of access to information about higher education and specialisation, and policies that focus on enrolment quotas rather than graduation outcomes. Overcoming these barriers, there is an ever-growing number of Aboriginal and Torres Strait Islander doctors and fellows who now provide First Nations' youth with culturally aligned role models – a necessary foundation for imagined futures in medicine and its specialties.

Aboriginal and Torres Strait Islander doctors face extra challenges in the workplace, such as racism and discrimination. An Australian Indigenous Doctors' Association survey found that 48 per cent of respondents had experienced bullying, racism and violence in their workplaces. A similar proportion of respondents also reported that colleagues had a negative reaction to their cultural identity, with misconceptions about perceived privileges and easier pathways into and through medicine for Indigenous Australians being the most commonly cited reaction. Indigenous medical practitioners may also face greater personal, social and cultural pressures than most of their peers, which can impact on day-to-day work and training requirements when needing to balance the often competing pressures surrounding cultural obligations and obligations to employers and work colleagues.

> "Today, the health and wellbeing of Indigenous peoples in Australia and Aotearoa New Zealand is an urgent priority due to significant disparities across a wide range of measures"

Reconciliation action plans are a powerful tool for advancing reconciliation in Australia. By developing a RAP, ANZCA is joining more than 1000 corporate, government and civil society organisations that have formally committed to reconciliation through the RAP framework since 2006. RAPs help to foster a community of shared value, goals and a common language when it comes to reconciliation.

As we develop the college's RAP throughout 2021 we will continue to share important developments and I urge you to consider ways to get involved and be a part of our reconciliation journey. Finally, to our cousins across Te Tai-o-Rehua (the Tasman), while the RAP is an Australian initiative the college is also exploring the development of a similar Te Tiriti o Waitangi implementation strategy to progress our work in Aotearoa.

ANZCA RAP Working Group

ANZCA RAP WORKING GROUP

- Dr Susie Lord, FFPMANZCA
- Dr Dash Newington, FANZCA
- Dr Angus McNally, trainee
- Dr Sharon MacGregor, FANZCA
- Dr Paul Mills, FANZCA
- Dr Matt Bryant, FFPMANZCA, FANZCA
- Mr Nigel Fidgeon, Chief Executive Officer
- Ms Ellen Webber, Learning and Innovation Manager
- Ms Kate Davis, Policy Officer
- Ms Laura Foley, Operations Manager, Knowledge Resources
- Ms Iesha Iselin, Queensland Committees and QARTS Coordinator
- Ms Kiri Rikihana, Executive Director New Zealand
- Ms Marayah Taylor, community representative

Safety shield invention a boon for patients with beards

A silicon device developed by FANZCA Dr Paul Scott to make it easier to bag-mask bearded patients has been awarded a $100,000 innovations grant by the Queensland government.

BAG-MASKING a patient with a beard has long been a challenge for anaesthetists who often resort to cling wrap, plastic dressings or a lubricating jelly to try and secure the seal.

For Brisbane fellow Dr Paul Scott developing a solution to the problem became such a priority that in September 2018 he sketched a prototype of a device on a cafe napkin and his SAM Safety Shield was born.

Since drafting that first sketch he has received a prestigious Australian Good Design Award and a $100,000 grant from the Queensland government's Advance Queensland Ignite Ideas fund which helps small-to-medium businesses to scale up market-ready, innovative products or services to national and global markets.

Dr Scott's silicon shield is now being used by a Queensland private hospital group and is under evaluation in the state's public health system. The device is now made in China but Dr Scott is hoping he can manufacture the device in Australia.

"The $100,000 grant will enable us to produce on a mass scale and create jobs and we're currently evaluating the possibility of producing the product here in Australia. It has been wholly Australian developed and designed and we would love to see it being manufactured in Australia," he explains.

When patients can't breathe anaesthetists apply bag valve mask ventilation (BMV) to push oxygen into the patient's lungs. BMV relies on a tight face seal and having a beard or a misshaped face can make that difficult.

"I had a couple of these patients on the same day and not long after I was at the Royal Brisbane and Women's Hospital and watched an anaesthetist trying to overcome the problem using small plastic dressings which is one of the proscribed techniques. It was time consuming, fiddly and ultimately ineffective and it has been a problem since anaesthetists started bag mask ventilating 70-80 years ago. It can be stressful for the anaesthetist and clinical staff, and dangerous for the patient," Dr Scott recalls.

His "aha" moment came later the next day: "I was at a cafe and I noticed there were all these hipsters there with beards and my prototype sketch developed from there."

Dr Scott applied for a patent and then started some basic trials with a dental dam before employing an industrial designer to build the first silicone prototype. After trialling 10 different prototypes produced in China the safety shield is now in market.

While the device was first developed to make it easier for anaesthetists and emergency responders working with bearded patients the onset of the COVID-19 pandemic early last year fuelled further interest in the device from hospitals and clinical staff concerned about aerosol generating procedures.

"When you're doing our job you can't avoid these risks. We can't stay away from the patient or socially distance and the patient can't wear a mask. So it became clear at that point that this device could help reduce aerosol airway secretions by improving the seal and capturing any aerosol secretions," Dr Scott explains

"Until COVID and this device everyone was happy to wear a mask but no one was thinking about what the patient actually emits. This is the first device that helps to protect against those emissions.

"While one option is to shave the patient's beard off many patients will refuse that either for aesthetic or religious reasons. I recently spoke to a patient who remembers 15 years ago that he was asked to shave off his beard that he had had for 40 years. To this day he is still angry that he was forced to shave it off."

In recognising the SAM Safety Shield with a Good Design Award accolade in the product design medical and scientific category for outstanding design and innovation the judges noted: "The protective aspect of the device is critical, particularly at the time of global pandemic."

The device has been registered with the Therapeutic Goods Administration in Australia and Dr Scott is working towards receiving approval from regulatory bodies in the US and Europe.

For more information visit www.scottairwaymanagement.com

Carolyn Jones
Media Manager, ANZCA

**Publication does not imply ANZCA endorsement of the above product over other similar devices.*

New “Wellbeing CPD education sessions” activity

WE HAVE APPROVED a new “Wellbeing CPD education sessions” activity for the Knowledge and skills category at one credit per hour, capped at 10 per year. The new activity acknowledges the importance of our members’ development in this area and ensures we maintain a sustainable workforce with healthy doctors who can provide the best in patient care. This need was heightened by the demands of the COVID-19 pandemic, requiring specific attention from our members and all healthcare personnel.

The activity is supported by a new CPD Handbook – Appendix 24 Guidelines for Wellbeing CPD education sessions. Full details are available on the college website.

INNOVATIVE CPD AT 2021 ANZCA ASM

Our first virtual annual scientific meeting (ASM) from 27 April – 4 May 2021 was a huge success and captured our innovative approach to professional development. With virtual Emergency response workshops for CICO, Cardiac Arrest and Acute Severe Behavioural Disturbance (ASBD), to a Practice evaluation Clinical audit on preoperative fasting, to our new Knowledge and skills activity Wellbeing CPD education sessions – our approach offered many opportunities for participants to participate in a diverse range of professional development – all while remaining virtual!

We recommend you check out the ASM highlights on the college website and continue to access the post-meeting recordings.

Importantly, CPD participants who attended the ASM now have their CPD credits auto-populated to their CPD portfolio, awaiting confirmation in your “pending folder”. All post-meeting content viewing will need to be manually updated to your CPD portfolio.

2021 COLLEGE CPD OPERATIONS

After careful consideration the ANZCA and FPM CPD Committee will proceed as per normal with its 2021 verification of CPD activities (audit) notifying those randomly selected in September. We recommend all participants to regularly update their CPD portfolio with completed activities and supporting documentation/evidence. Full details are available at www.anzca.edu.au/news/cpd-news/cpd-update.

2018-2020 CPD END OF TRIENNIUM RESULTS

Congratulations to all 1687 participants in the 2018-2020 CPD triennium for achieving 100 per cent completion, and for their dedication to updating their CPD portfolios. Professional development has never been more important, with the need to upskill to support your patients, yourselves and to deal with this highly infectious disease. This result shows the resilience, innovation and dedication you have to your professional development amidst a pandemic and its ongoing restrictions. Full details are available on the college website.

CPD FOR DHM PRACTITIONERS

The ANZCA and FPM CPD Program is open to all DHM practitioners. Those who do not hold a FANZCA or FFPMANZCA may choose to do the CPD program of their primary college or choose to join our program through our non-fellow pathway. There is no separate CPD program for DHM practitioners or additional DHM CPD requirements or verification (audit). In addition to the new CNS-OT emergency response activity, to support DHM practitioners completing CPD activities the college has:

- **Tailored Practice evaluation appendices**
  In June 2019, nine tailored CPD handbook appendices were made available to support DHM practitioners completing Practice evaluation activities. This includes forms and guidelines relating to the Patient experience survey, Multi-source Feedback (MsF) and Peer review of practice activities. These are available via the CPD handbook.
- **DHM specific clinical audit sample**
  A new DHM specific Clinical audit sample on Prevention of Middle Ear Barotrauma (MEBT) during compression for hyperbaric oxygen therapy (HBOT) was made available in September 2019. This Clinical audit sample includes a clinical audit guide, date collection form and summary of results form for participants to use for the Practice evaluation Clinical audit activity (valued at 20 credits). These are available for members through Networks.

NEW EMERGENCY RESPONSE ACTIVITY CNS-OT, DESIGNED FOR DHM PRACTITIONERS

A new Continuing Professional Development (CPD) emergency response activity for “Central nervous system oxygen toxicity (CNS-OT)” has been introduced from April 2021 designed specifically for diving and hyperbaric medicine (DHM) practitioners. This is the first DHM-specific emergency response activity, and has been developed by Dr Susannah Sherlock (FANZCA, ANZCA Dip Adv DHM, pictured) in liaison with the ANZCA and FPM CPD Committee and the Diving and Hyperbaric Medicine Sub-Committee (DHMSC).

Dr Susannah Sherlock

Dr Sherlock reflects “As many hyperbaric physicians are also anaesthetists, they participate in the ANZCA and FPM CPD program and split their learning between the two areas of interest. It made sense to formalise an emergency response which most units regularly practice to enable recognition. Hopefully colleagues may consider contributing other responses.”

There are no changes to annual or triennial CPD requirements, the CNS-OT inclusion is the eighth activity to the emergency response category. The inclusion of a DHM-specific emergency response activity provides the opportunity for all to participate in components of the CPD program relevant to their scope of practice.

The emergency response category has doubled in the past few years, with FPM specific activities Acute Serve Behavioural Disturbance (ASBD) introduced in 2019, and Cardiac Arrest – Special Pain Medicine Physicians (SPMP) introduced in 2020. With the seventh, COVID-19 airway management promptly introduced in April 2020 in response to the pandemic’s essential training. The ANZCA and FPM CPD Committee continue to evaluate and encourage the development of this category and members key learnings.

Diving hyperbaric chamber

ANZCA EDUCATORS PROGRAM
LEARNING TO TEACH

Calling future ANZCA educator facilitators

Looking for a new opportunity to get involved with college work?

The ANZCA Educators Sub-Committee are seeking new facilitators to deliver modules from the ANZCA Educators Program (AEP) across Australia and New Zealand.

The AEP consists of a series of teaching and feedback modules designed to help facilitate positive learning.

Share your passion and experience, network with peers and be a part of a rewarding and engaging teaching program while learning CPD credits.

Email **AEP@anzca.edu.au** for the selection criteria, terms of reference and to register.

NSW health district drives change to reduce healthcare waste

John Hunter Hospital Operating Theatre and Recovery Environmental Sustainability Committee, from left: Dr Robert Thomas, Dr Candice Peters, Dr Patrick Farrell, Dr Timothy Wong, Dr Gavin Sullivan, Mr Nick McGavin, Ms Vicki Sandy, Ms Amy Bernotas. Absent: Dr Stanley Chen, Ms Elissa Klinkenberg.

CLIMATE CHANGE IS the greatest global health threat of the 21st century[1]. It directly increases pressure on existing healthcare systems and undermines public health achievements. This is evident in the increased cardiovascular and respiratory admissions following catastrophic Australian bushfires[6,7,9]; and the redistribution and resurgence of infectious diseases like malaria[3,8].

Healthcare itself also fuels climate change with Australian hospital CO_2 emissions comprising 7 per cent of national emissions[4,5]. This is largely indirect, via upstream manufacturing and energy supply, although operating theatres additionally contribute solid waste and inhalational anaesthetics[5]. This inextricable link between environmental and human health demands urgent change towards sustainability.

The Hunter New England Local Health District (HNELHD) in NSW aims to become carbon and waste neutral by 2030, with anaesthetists acting as leaders of change and sustainability. Collaboration between anaesthetics and the infrastructure and planning department led to the formation of an Environmental Sustainability Committee to drive initiatives in theatres and perioperative areas. New Sustainability Project Manager Elissa Klinkenberg further enhances network-wide sustainability via advocacy for HNELHD sustainability representatives and facilitating communication between clinicians and executives.

Interdisciplinary collaboration enables a united transition towards sustainable healthcare. At John Hunter Hospital (JHH), collaboration between anaesthetists and perioperative staff established reliable recycling streams. For example, perioperative nurse Vicky Sandy contributes via a Kimguard recycling setup. Post-anaesthetic recovery unit (PARU) nurses Amy Bernotas and Nick McGavin assist in intravenous bag recycling and auditing soft plastic production. Copper wire recycling established by anaesthetics senior resident medical officer (SRMO) Dr Timothy Wong reduces waste, abates CO_2 emissions from new material production and raises funds for future sustainability projects.

Setbacks, however, are inevitable, with ongoing difficulty in contracting a company for soft plastic collection and recycling within the Hunter region. The anaesthesia department is raising funds for a baler machine to partially overcome this.

Pharmaceuticals and disposable equipment all affect the HNELHD's sustainability. They contribute to theatres being one of the highest carbon footprint areas in healthcare[2]. The direct involvement of anaesthetists in medication administration and handling of waste and equipment, provides an opportunity to examine theatre resource use and waste production.

> "Healthcare itself also fuels climate change with Australian hospital CO_2 emissions comprising 7 per cent of national emissions"

Modification of daily routines by anaesthetists can impact general waste output. Many HNELHD anaesthetists have committed to minimising use of environmentally damaging equipment. For example, replacing "blueys", used to collect removed supraglottic devices in PACU, with patients' disposable hats (with thanks to Dr Steve Bruce, staff specialist anaesthetist, and dissemination via Twitter). Or collecting uncontaminated soft plastic theatre waste by staff specialist anaesthetist Dr Candice Peters' team for disposal in REDcycle bins. These simple practices reduce landfill and abate CO_2 emission associated with new material production.

Inhalational anaesthetic agents contribute to climate change via atmospheric pollution[2]. Anaesthetists are encouraged to examine their individual practices and preference environmentally friendly techniques, like TIVA and regional techniques[5]. Staff specialist anaesthetist Dr Gavin Sullivan, for example, has stopped using desflurane due to its known high global warming potential and runs departmental education on its deleterious effects[2,5]. Consequently, all JHH desflurane canisters were relocated to satellite storage, effectively deterring desflurane use. Dr Michael Law, staff specialist anaesthetist has also long promoted a volatile sparing induction (VSI) technique which he will present at the Newcastle anaesthesia conference on 6-7 August 2021. Personal anaesthesia carbon footprints can be estimated via free tools, like the Yale Gassing Green and the Association of Anaesthetists Anaesthetic Gases Calculator[5].

In summary, anaesthetists are well positioned drivers of environmentally sustainable healthcare. Given the urgency of climate change and its close relationship with human health and healthcare, they have the responsibility to strive for sustainability, raise awareness and minimise the negative environmental impacts of healthcare.

Dr Timothy Wong
Dr Lara Beukes
Dr Candice Peters, FANZCA
Dr Gavin Sullivan, FANZCA
John Hunter Hospital, NSW

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Operation Clean-Up: Raising awareness in healthcare

For the second year running, TRA2SH (Trainee-led Research in Anaesthesia and Sustainability in Healthcare) hosted its annual Operation Clean-Up on 22 April. The four-bundle theme included “refuse desflurane, reduce bluey use, reuse drug trays, and recycle”.

From top: Alfred hospital, Melbourne, from left: Staff Specialist Dr Steven Gaff, ANUM/PACU nurse Naarah Lucantonio, and anaesthesia fellow Dr Stewart Brown; Ipswich Hospital, Queenlsand. Registrars Dr Paras Lovel, Dr Anirudh Bhardwaj, Dr Abraham Petrus, anaesthesia fellow Dr Rajesh Pachchigar and anaesthesia nurses Esther Sadler and Kelli Klassen.

AUSTRALIAN HEALTHCARE PRODUCES an overwhelming amount of waste, contributing 7 per cent of the country’s carbon footprint. This is compounded by increasing use of single use items and complex recycling programs which are dependent on waste companies. Infection control restrictions, time, space, and lack of knowledge are barriers that can be overcome by an organised effort to practice sustainably. Operating theatres produce 30 per cent of total hospital waste. Of this, 25 per cent is due to anaesthesia, 60 per cent of which is recyclable (*PS64: Statement on Environmental Sustainability in Anaesthesia and Pain Medicine Practice*).

Trainees tackled these challenges with the use of evidence-based information provided in TRA2SH’s resource packs. Trainees had the opportunity to take on a scholar role activity by collating data for procurement audits that were in line with this year’s theme (desflurane index audit, bluey audit, drug tray audit), in which data over a period of 12 months was entered into a centralised database. During this process staff received feedback and reflected on their current practices and were free to come up with solutions and implement a change that suited individual departments.

Educational posters, PowerPoint presentations, and journal articles were available for bulletin boards, departmental talks, and journal clubs. Many hosted an afternoon tea to engage the perioperative team, fostering an inclusive and interactive forum to start the conversation and trial creative ways to reduce, reuse, and recycle. Green Champions were also identified and Green Theatre Groups were helped implement change and monitor activity.

Many hospitals have an underdeveloped recycling program. Therefore, focusing efforts on reducing and reusing will mitigate the barriers of recycling. At Ipswich Hospital, Kimguard (sterile wrap) is one such item that can be repurposed for many tasks for which blueys are used including use as a table liner for the endoscopy trolley, placing on the operating table while applying surgical prep to a limb before surgery, rolling up and placing under the wrist for arterial line insertion, and for covering up laryngeal mask airways that are removed from patients in the post anaesthetic care unit.

At the same time, waste from bluey use is reduced. Reducing use is one of the most effective ways to decrease the environmental impact of items because it not only reduces landfill but also reduces the impact of manufacturing, sourcing, transporting, and processing raw materials. One can envisage these efforts spilling over into other clinical areas including the emergency department, the intensive care unit and medical/surgical wards.

Provisional fellowship trainees (PFTs) are required to have a portfolio which focuses on non-clinical aspects of training. A passion for the environment, a gap in sustainable practice in anaesthesia and the support from TRA2SH provides many PFTs the opportunity to value-add to the department and focus their energy on making key changes by educating and leading the registrar group to undertake audits or to produce educational material for submission to TRA2SH. More departments should be encouraged to provide a provisional fellowship year in environmental sustainability. This will also allow the momentum of sustainable practice to continue beyond Operation Clean-Up.

Since its inception in 2020, TRA2SH has grown to include more than 200 participants on its mailing list across Australia and New Zealand as well as a Twitter following of more than 400 and growing! TRA2SH also collaborates with the ANZCA environmental sustainability working group and presents at numerous scientific meetings including the ANZCA Annual Scientific Meeting.

Trainees are well positioned to share ideas and lead by example to make changes at a grassroots level. As the network expands, TRA2SH aims to remain trainee-led and collaborative to help achieve a common goal.

If you are interested in joining the TRA2SH team email tra2shgroup@gmail. For more information visit our website at www.tra2sh.org and follow us on Twitter @tra2sh1.

Many thanks to the 80 participants who signed up this year representing 34 hospitals in Australia and five each in New Zealand and the UK.

Dr Rajesh Pachchigar
Provisional fellow, Anaesthesia
Ipswich Hospital, Queensland

Kimguards are repurposed in the hospital as an alternative to blueys.

Research

The evolution of CTN

Professor Tomás Corcoran with the team of research co-ordinators at Royal Perth Hospital. From left: Ms Natalie Hird, Ms Yvonne Buller, Professor Tomás Corcoran, Ms Pauline Coutts, Ms Lucy Glazov and Ms Susan March.
Photo courtesy of RPH Medical Illustrations.

THE PUBLICATION OF The Perioperative ADministration of Dexamethasone and Infection (PADDI) trial results in the *New England Journal of Medicine* on 6 May builds on the brilliant track record of the ANZCA Clinical Trials Network as a world-leading clinical trials network to deliver trials that improve the evidence base in anaesthesia, perioperative and pain medicine. The results were announced at a worldwide webinar by chief principal investigator, Professor Tomás Corcoran, Director of Research in the Department of Anaesthesia and Pain Medicine, Royal Perth Hospital and Adjunct Clinical Professor in the Central Clinical School at Monash University.

The PADDI trial received $A4.6 million from the National Health and Medical Research Council (NHMRC) project grant, which was the highest value grant in that year of the scheme. The pilot study (PADDAG) was funded by the Royal Perth Hospital Research Foundation, with $A143,000 being provided to support that trial. The PADDI trial recruited 8880 patients from March 2016 to July 2019 from 55 hospitals across Australia, New Zealand, Hong Kong and South Africa. We thank all our PADDI trial committee members, site investigators, fellows, trainees, research co-ordinators and the thousands of patients who were involved in the trial. Their efforts ultimately improve safety and care in the perioperative setting. The PADDI trial has debunked myths about the use of the dexamethasone in the perioperative settings, especially in patients with diabetes.

Since PADDI started recruitment in 2016, CTN has experienced 50 per cent growth in new sites in Australia and New Zealand coming onboard our trials. We believe that PADDI was important in the evolution of CTN as the trial was relatively easy for hospitals to get a handle of clinical trial research for the first time. Contributory factors included the ease of delivery of the trial intervention (single 8mg bolus of dexamethasone intraoperatively), the user friendly clinical trial management system, the accessible patient population and the support by the CTN office and the PADDI project teams.

We invite you to be part of the next success story. We have 12 clinical trials under way that you can become involved in. Each of these trials will answer important questions in perioperative medicine over the next five years. We encourage you to get in contact with the CTN office to learn more about these trials and the support available to your site.

Contact Karen Goulding for further information – ctn@anzca.edu.au. For links to the PADDI webinar recording and publication and for more information on our clinical trials, visit www.anzca.edu.au/ctn or follow us on Twitter @PADDI_Trial.

No increased risk of surgical site infection with dexamethasone for surgical procedures:

The PADDI trial results

Professor Tomás Corcoran, PADDI chief principal investigator at Royal Perth Hospital, drawing up dexamethasone. Photo courtesy of RPH Medical Illustrations.

THE PADDI TRIAL was the first large randomised trial to evaluate the safety of dexamethasone in terms of its influence of surgical site infection and was the culmination of 10 years of investigation from concept development and preliminary research through to trial completion.

Dexamethasone is widely used by anaesthetists in the perioperative period, principally as an effective antiemetic to prevent postoperative nausea and vomiting (PONV), but there are a number of other indications for its perioperative use, including to improve post-operative analgesia, improve the quality of recovery and decrease facial swelling and sore throat in maxillofacial surgery and to reduce the risk of respiratory complications during cardiac surgery. Because it is a potent glucocorticosteroid, it has immunosuppressive and hyperglycaemia effects, and the investigators hypothesised that these actions may increase the risk of perioperative infections, particularly in patients with diabetes mellitus, who are already at increased risk of complications. This is an important health priority as in each year in Australia alone, there are at least 200,000 healthcare associated infections including surgical site infections that are diagnosed in hospital patients costing approximately $1 billion a year.

The PADDI trial was a pragmatic, multicentre, randomised, noninferiority trial conducted in 55 hospitals across four countries. A total of 8880 adult patients were enrolled and randomly assigned to 8mg dexamethasone or matched placebo shortly after the induction of anaesthesia and before incision, and randomisation was stratified according to diabetes status. The study population consisted of adult patients undergoing elective or expedited noncardiac, nonobstetric surgery with an expected operative duration of at least two hours' duration, an incision of at least five centimetres and a planned hospital stay of at least one night. The primary endpoint was the onset of surgical site infection within 30 days of surgery. Secondary outcomes included other infections such as deep and organ space infections at 90 days and quality of recovery on Day 1 and Day 20 as well as onset of chronic post-surgical pain, death on new onset of disability at six months.

The findings showed that 8.1 per cent of patients who received dexamethasone experienced a surgical site infection at 30 days after surgery, compared to 9.1 per cent in the placebo group. The p value for non-inferiority was highly statistically significant ($p<0.001$) and therefore the conclusion is that dexamethasone does not increase the risk of surgical site infection. This is particularly reassuring in patients with diabetes and in those with prosthetic material implanted as they are believed to be at a higher risk of infection. The trial also confirmed the antiemetic effectiveness of dexamethasone, but there did appear to be a small increase in the incidence of chronic postsurgical pain in those patients treated with dexamethasone (8.7% versus 7.1%), a finding which may be spurious and which is under further investigation. The authors have recommended that dexamethasone is safe to use as clinically indicated.

Professor Tomás Corcoran
Chief principal investigator, PADDI trial
Director of Research in the Department of Anaesthesia and Pain Medicine, Royal Perth Hospital
Adjunct Clinical Professor in the Central Clinical School at Monash University

For more information about the PADDI study trial visit www.nejm.org/doi/10.1056/NEJMoa2028982.

2021 ANZCA National Anaesthesia Day

- Mark Monday 18 October in your diaries.
- Nominate someone to organise your activities.
- Book your hospital foyer space.

The theme for this year is

“Anaesthesia and having a baby”

A new ANZCA patient information video will also be launched in time for #NAD21 so you can start thinking about your displays now. ANZCA National Anaesthesia Day is held each year to raise awareness of the crucial role anaesthetists play in healthcare. The aim of the 2021 theme is to help the community understand how anaesthetists keep women and their babies safe if they need an anaesthetic before, during or after the birth.

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

ANZCA will send posters and other material to hospitals in late September. Visit www.anzca.edu.au/NAD for more information or email communications@anzca.edu.au.

Recognising ANZCA Research Foundation donors

WHILE IMPORTANT TO regularly report the latest news on the important work in medical research and health equity the foundation supports, it is just as important to recognise those who make that work possible – our generous and committed donors.

We encourage readers to refer to the ANZCA website and recent foundation newsletter for exciting highlights of the work. More project outcomes will be reported in forthcoming issues of the *ANZCA Bulletin*, with several studies nearing completion and the grants programs recommencing this year with encouraging numbers of new applications.

In this issue, we take time to recognise and sincerely thank a selection of our most influential donors. Their passion for supporting continuous improvement in patient outcomes and equity through anaesthesia, pain and perioperative medicine, is a common theme, clearly evident among foundation donors at all levels of giving.

Mrs Ann Cole and family

Since 2014, Mrs Ann Cole, with the support of her daughters Rowena and Victoria, has provided full funding for a substantial and generous annual grant for medical research in pain medicine, with a focus on the alleviation of cancer-related pain, through the Russell Cole Memorial ANZCA Research Award. The award commemorates the career contributions of the late Dr Russell Cole, an innovator in the field including establishment of dedicated pain management departments within Victorian hospitals.

Dr Peter Lowe

Also since 2014, Dr Peter Lowe, a retired Melbourne anaesthestist, has provided annual grants aimed particularly at assisting young researchers in the process of establishing their research careers.

Initially establishing the annual ANZCA Melbourne Emerging Anaesthesia Award, Peter then added the ANZCA Melbourne Emerging Researcher Scholarship. Peter extended his initial five-year support commitment to ongoing provision of both grants, recognising their track record of recipients successfully delivering high-quality studies, establishing their careers and more recently completing PhD degrees in anaesthesia research.

Professor Barry Baker

Professor Barry Baker, a past ANZCA Dean of Education and current ANZCA Honorary Historian, made generous gifts in 2014 and 2015, the investment of which has become capable of funding two biennially alternating grants. The first, the ANZCA Provisional New Fellow Research Award, is provided every two years to an emerging investigator to assist during the difficult early stages of embarking on a career in research. The ANZCA Research Committee provides matching funding, allowing a grant equivalent to an ANZCA Novice Investigator Grant. In alternating years, the earnings provide the ANZCA Joan Sheales Staff Education Award.

Robin Smallwood Bequest

A visionary philanthropic gift from Mrs Rosalind Smallwood, utilising funds bequeathed by the late Dr Robin Smallwood, a past Dean of the Faculty of Anaesthetists at the Royal Australasian College of Surgeons, provides ANZCA’s Robin Smallwood Bequest, an annual grant for medical research led by an ANZCA or FPM fellow or trainee. This substantial bequest has made possible the completion of a diverse range of high-quality studies adding significant new knowledge in important sub-specialties within anaesthesia, pain and perioperative medicine.

Elaine Lilian Kluver Bequest

Another very generous bequest was left to the foundation by Dr Elaine Lillian Kluver, with a quantum that through the investment earnings produced has been able to also support the annual provision of a significant ANZCA Project Grant through the research committee.

Darcy Price ANZCA Regional Research Award

The foundation, Dr Michel Kluger and his colleagues at Auckland’s North Shore Hospital established this annual grant in 2019 to honour the memory of Dr Darcy Price, and his passion for education in regional anaesthesia. This new award is annually funded through the Waitemata District Health Board. The foundation is again honoured to be able to join the team at North Shore Hospital in honouring the memory and legacy of Dr Darcy Price.

Announcing the Skantha Vallipuram ANZCA Research Scholarship

As we honour the wonderful ongoing contributions of our donors, it is fitting and exciting to announce the new Skantha Vallipuram ANZCA Research Scholarship. The foundation is enormously grateful to Mrs Asoka Vallipuram, who has worked with us to establish this new scholarship to assist emerging investigators pursuing higher research degrees. The scholarship will be an ongoing annual award, with a grant of $A15,000, through the foundation and the ANZCA Research Committee.

Mrs Vallipuram has established the new scholarship in memory of her late husband, Dr Skantha Vallipuram (FANZCA, FFPMANZCA). Skantha was widely known and respected as a Melbourne-based pain medicine physician and anaesthetist, a long-time foundation Life Patron donor, and philanthropist with a deep passion for overseas aid.

The foundation is deeply honoured to play a part in the perpetual recognition of Dr Skantha Vallipuram, and his lifetime of dedicated contributions to patients and the specialties.

Gifts in wills

To leave a perpetual legacy in your will to support continuous improvement in science, evidence, practice, and global equity in anaesthesia, pain or perioperative medicine, please contact Rob Packer at the foundation.

Contact the ANZCA Research Foundation

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

For general queries, contact:

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Kayla Smith
ksmith@anzca.edu.au
Fundraising Administration Officer

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

FANZCA Dr Kara Allen prepares to host a virtual program session in one of the ASM studios at the Melbourne Convention and Exhibition Centre.

Reflecting on an extraordinary meeting

ASM SNAPSHOT

Delegates 2504 and counting!

Speakers and facilitators 260

Plenary sessions 7

Concurrent sessions 38

Workshops 75

E-posters 151

ENGAGE hubs in nine locations, around Australia, New Zealand, and Hong Kong

Number of virtual platform logins 19,632

Most watched session "Pandemic" plenary session

Two years ago, the Regional Organising Committee for the 2021 ASM decided the theme for the meeting should be "Leaps and Bounds", based on the Paul Kelly song about Melbourne in May. As it happened, it also turned out to be an appropriate theme song for running a meeting during a pandemic, something none of us expected we would ever have to do.

The switch to virtual happened in August last year, when Melbourne was in the grips of a long winter lockdown. The decision was not made easily but once it was made, the certainty was helpful – finally we could make plans. We engaged the excellent audiovisual team, Wallfly, pooled all our collective knowledge of virtual meetings and put our imaginations to work.

The result was an extraordinary virtual meeting with almost 2500 registered delegates and 75 online workshops. Fortunately Melbourne remained Covid-free long enough to allow ANZCA President Dr Vanessa Beavis to fly into Melbourne and for us to host many of the sessions from the Melbourne Convention Centre. The rooms were repurposed like small television studios with chairs and panels presenting to camera, often after watching pre-recorded content. It was a strange experience for everyone but it was great to see how willing everyone was to engage with this new format. For the first time we had a Welcome to Country and smoking ceremony by the Boon Wurrung people and we were fortunate that the convention centre allowed us to stage this inside the largely empty building. The smell of the eucalyptus lingered for days adding even more poignancy to those of us who were there each day, guiding people through the maze of technology.

In order to provide at least some in-person experience, and to enable our new fellows to graduate, we instituted a series of hubs around Australia and New Zealand for Super Saturday. Apart from the late withdrawal of Perth due to a brief lockdown, this was a really successful and emotional day. Many people took advantage of the hubs to meet with their colleagues and watch the online content during the day. And then in the evening, attendance increased even more for the College Ceremony. The College Ceremony proceeded as normal in Melbourne with the stage party and our wonderful guest orator, Professor Sharon Lewin, Director of the Doherty Institute. She had many interesting insights for our fellows and was quick to acknowledge the great contributions that anaesthetists have made during the current pandemic. The hubs were all visible on the large screen and it felt really surreal to see everyone waving and cheering as their cities were announced.

Scientific program

While presenting a daunting challenge, the decision to convert the meeting from in-person to virtual eight months before it was due to start presented some unique opportunities for the scientific program, convened by Dr Lachlan Miles, Associate Professor Lis Evered and Dr Tuong Phan. Normally, the attendance of an international speaker is associated with appropriate reimbursement of travel costs. However, due to the introduction of pre-recorded presentations and virtual attendance, costs were minimised and access to international speakers was increased. In addition to keynote speakers Professor Hugh Hemmings, Professor Cor Kalkman, Professor Alicia Dennis and Associate Professor Meghan Lane Fall, the scientific committee was able to secure Professor Donal Buggy, Dr Kariem El-Boghdadly, Professor Paul Wischmeyer, Dr Florian Falter and Associate Professor Laura Duggan.

ASM Convenor Associate Professor Chris Ball with Scientific Convenor Dr Lachlan Miles.

David Tournier a Boonwurrung Senior Cultural Officer and his daughter Tahlia Tournier.

ANZCA President Dr Vanessa Beavis in conversation with ASM Convenor Associate Professor Chris Ball at the STEMM breakfast.

Further innovations were built into the program upon recognising the altered attendance patterns associated with virtual conferences, and to consider "domestic" delegates attending from across multiple timezones, stretching from Perth in Western Australia to Gisborne in New Zealand. It was anticipated that delegates were less likely to forego income to attend a virtual meeting; consequently, evening sessions (branded "ASM@ Night") were introduced on normal business days to allow delegates attend both the meeting and work if they chose. Start times on weekends were delayed, allowing delegates to spend time with their families in the mornings should the timezone allow. The addition of pre-recorded sessions added further flexibility: No longer were delegates restricted to attend a single session where concurrent sessions were running. Rather delegates could move seamlessly between sessions, or alternatively, watch the recorded session later. These recorded sessions – totalling more than 95 hours of curated content – will be available to watch to those who registered before, during or after the meeting for the next 12 months.

Despite our confidence in the program (helped immeasurably by the constant and unwavering support of Kate Chappell and Fran Lalor from the ANZCA Events team), the experience of executing the program at the meeting itself was rather discombobulating, as the remote experience of the delegate was reflected on us as convenors. We did not have access to the immediate feedback that an in-person meeting affords, and the entire experience was a little like shouting into the void for eight days. Nevertheless, the echoes returned eventually, and the feedback submitted thus far suggests the scientific program has been generally well received by the fellowship. Given the circumstances under which it was established, the experience of the 2021 ANZCA ASM will hopefully never be repeated. However, we shall be interested to see which virtual elements of this extraordinary meeting can be incorporated into future ANZCA events.

There's still time to access ASM content

You can still catch up on more than 95 hours of onDemand content, whenever and wherever suits you until May 2022, just by registering for the ANZCA ASM by Saturday 31 July.

Visit www.asm.anzca.edu.au.

Workshops

The workshop program for the ASM needed to be completely reimagined following the decision to go fully "virtual". After the shared experience of several months of videoconferencing it was clear that the main challenge would be to ensure adequate engagement with the material in a workshop format, rather than just providing lectures with minimal interaction via a virtual platform. Early after the decision to go virtual was made the workshop convenors and Events staff worked closely with the facilitators of more than 70 workshops to confirm the learning objectives and interactivity of the sessions could be maintained in the "in-silica" delivery method. The use of polls, breakout rooms and practical "at-home" demonstrations was planned in detail. Online education sessions for the facilitators about the capabilities of the platform were run and a "resource portal" webpage was created with ideas, tips and tricks to improve the effectiveness of the learning methods chosen.

The Events staff contacted all of the workshop facilitators multiple times to troubleshoot any problems they may have had, or answer questions. Not all of the workshop facilitators were experts at the technology as well as being a skilled educator on their expert topic! As a result, some needed additional coaching as well as the "ANZCA host" available online for every workshop to troubleshoot any issues that arose.

ENGAGE hubs across Australia and New Zealand

The ENGAGE hubs were a great success and were held in nine locations around Australia, New Zealand and Hong Kong. Clockwise from top: Adelaide, Brisbane, Sydney, Canberra, Auckland, and Melbourne.

The College Ceremony stage party in Melbourne. ANZCA President Dr Vanessa Beavis welcomes the ENGAGE hubs around Australia and New Zealand to the ceremony.

Apart from engagement, the other substantial problem was to maintain the high quality of education for the workshops such that the stringent ANZCA continuing professional development (CPD) standards were met and were therefore eligible to attract CPD credits. The workshop convenors and Events team liaised closely with the CPD Committee to not only make sure that these standards were met but to develop new ways of delivering content that could be used in the future. Of particular significance were the emergency response activities. The new Acute Severe Behavioural Disturbance (ASBD) and the Can't Intubate, Can't Oxygenate (CICO) activities both have substantial practical components. Videos were created for the ASBD workshops with attendees pairing up with friends or family members at home to practice defensive manoeuvres. The "virtual CICO" workshops required even more preparation, with 3D printed laryngeal models and CICO rescue kits mailed to the participants several weeks before the sessions. Furthermore, a set up at the convention centre with overhead high definition cameras a full mixing desk and audiovisual technicians provided a television quality experience for more than 40 participants in the workshops run over the course of the day. Overall a total of more than 2700 workshop places were provided with nearly all sold out.

Each year the ASM Regional Organising Committee chooses a preferred charity to donate $10,000 in lieu of speaker gifts. We chose FareShare – born in Melbourne and the brainchild of a pastry chef, FareShare has grown to be Australia's largest charity kitchen with its healthy and delicious meals provided free of charge to soup vans, homeless shelters, women's refuges and community food banks.

It remains only for us to thank everyone involved in this extraordinary meeting. The rest of the Regional Organising Committee, the hard working and extremely professional Events team, Wallfly, and all the presenters, chairs and workshop coordinators. The ASM only happens every year because so many give so generously of their time and expertise. On this occasion people were also generous with their understanding – and we are really grateful. The content is still there – make sure you continue to watch it over the next 12 months and get the maximum benefit from this highly unusual meeting.

ANZCA New Fellow Councillor Dr Maryann Turner with the college mace that was gifted to the college by the Royal Australasian College of Surgeons at our first ASM in 1994.

Associate Professor Chris Ball
Convenor

Dr Lachlan Miles
Scientific Convenor

Associate Professor Stuart Marshall
Workshops Co-Convenor

FPM Symposium

On Friday 30 April we had our annual FPM symposium day held virtually for the first time. It was a great event, which saw our international invited speakers Professor Matthew Smuck and Professor Eva Kosek give us insight for how they treat back pain in the US and Sweden and we had an Australian perspective provided by Professor Flavia Ciccutini.

Other highlights included reframing the ideas about pain through adversity and better ways to enhance communication with First Nations Peoples and other marginalised patient groups. We had the latest updates in opioids and Therapeutic Goods Administration and Pharmaceutical Benefits Scheme changes, which invariably led to a discussion on cannabis and finally rounded out the day, with an overview of the third-party system and better ways to enhance collaboration between doctors and insurers, ultimately leading to better outcomes for our patients.

These recordings will be available for 12 months after the meeting, so if you missed out there's still a chance to watch and learn. Register before Saturday 31 July to gain access! Visit asm.anzca.edu.au.

A big thank you to all invited speakers, Deputy Convenor Dr Guy Buchanan and the Events team for putting on a memorable virtual meeting!

Dr Noam Winter
FPM Symposium Convenor

Turn to page 70 for photos and a wrap up of the symposium.

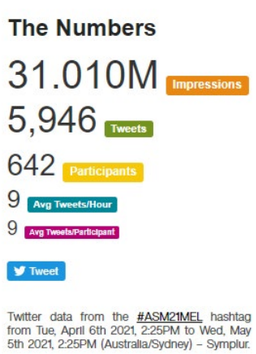
Raising our profile

Social media

Social media played a more important part than ever at this year's ASM, by providing places for you to connect, collaborate, and share an ASM experience even though we couldn't come together in person.

The conversation on Twitter didn't disappoint. 640 people posted almost 6000 tweets using the #ASM21MEL hashtag. This resulted in a tremendous 30 million impressions, smashing our previous record at KL's ASM by almost 10 million.

Although we've been on Instagram since October 2020, this was our first real opportunity to take it for a test drive. With limited live action at ASM Central, we had to get creative and crowdsource. We shared casual, behind-the-scenes interviews with the Melbourne Regional Organising Committee and workshop facilitators. These videos were a hit and received over 2000 views on our profile. We also did our inaugural Instagram livestream. We streamed the cleansing smoking ceremony, performed by representatives of the Boon Wurrung People before the Opening Plenary.



Twitter data from the #ASM21MEL hashtag from Tue, April 6th 2021, 2:25PM to Wed, May 5th 2021, 2:25PM (Australia/Sydney) – Symplur.

We livestreamed the Melbourne College Ceremony to Facebook which received over 1000 views and reached nearly 5000 people. As it was the first time new fellows weren't all presenting in the one place, we set up Zoom links for the families of those in the regions so they could catch a glimpse of their loved ones too. We received a lot of positive feedback that people were grateful for the chance to join in and watch the ceremony virtually.

Media coverage

ANZCA 2021 ASM and FPM Symposium presentations featured in the media.

Melbourne FANZCA Dr Meg Allen's research on opioid prescribing in hospitals was reported in a page 6 article in the *Herald Sun* on 3 May "Too many pills a problem". Dr Allen's presentation was featured in an ANZCA media release and the article reached 310,000 readers.

FPM guest speaker Associate Professor Flavia Cicuttini's presentation on back pain image screening and the ANZCA media release "Back pain imaging on rise despite calls to limit use" led to a news broadcast interview on Radio 2SM in Sydney on 30 April that was syndicated to several regional NSW radio stations.

Another guest speaker, Deakin University epidemiologist Professor Anna Peeters, was interviewed by the *Herald Sun* medical editor Grant McArthur for an article on 30 April "Call to ensure obesity fight stays a priority". Professor Peeters' presentation was the topic of an ANZCA media release and the article reached 310,000 readers.

Ground control to ANZCA ASM

At first glance it looks like a fancy computer set-up a serious gamer might use but encased in an area of about one metre square is the beating heart of the 2021 ANZCA Virtual Annual Scientific Meeting (ASM) in Melbourne. It has the technical capacity of an outside live broadcast (OB) van – similar to those you see lined up outside large sports events.

Here, at the Melbourne Convention and Exhibition Centre (MCEC), technician John McCartney is operating one of six of these custom-made one system constellation racks that are the engines driving the college's first virtual ASM.

Mr McCartney operates his rack inside the ASM's "mission control" – the room at the MCEC that serves as the command centre for delivering more than 95 hours of live and pre-recorded core meeting content across the scientific program including plenaries, SIG Time to Answer Thoughts (STAT) sessions, workshops, poster presentations and panel discussions. Mr McCartney is essentially performing the equivalent of multiple OB roles – he's a vision operator, a broadcast switcher and content manager all rolled into one.

Each ASM studio room at the MCEC has the same rack set-up with identical cabling, computer and mouse ensuring that the delivery of each streamed session complete with multi-channel Zoom rooms, is seamless. In one studio on the day the *Bulletin* shadowed the Wallfly team, Melbourne anaesthetist Dr Kara Allen was sitting in front of a green screen presenting a Virtual CRASH workshop. (The virtual course is designed to help participants revisit skills and knowledge in preparation for returning to work, including accreditation for ANZCA emergency response for cardiac arrest.)

Over eight days on site and eight months leading up to the event a team from Adelaide-based conference management specialists Wallfly and their technology partner Novatech developed and ran a bespoke virtual platform – including the world's first virtual CICO (Can't Intubate, Can't Oxygenate) workshop – that was delivered globally to 2500 delegates. More than 300 speakers, presenters, contributors and facilitators were involved with the program that also included 75 virtual workshops, plenaries (pre-records and live sessions) panel discussions, workshops and poster presentations.

Wallfy's managing director Dior Yarwood and chief technical officer Grant Whitehead worked with ANZCA's Events team from June 2020 on the new meeting plans. Most of the planning was carried out by the Melbourne-based ANZCA team from their homes as many of the city's offices were shuttered by COVID-19 until earlier this year.

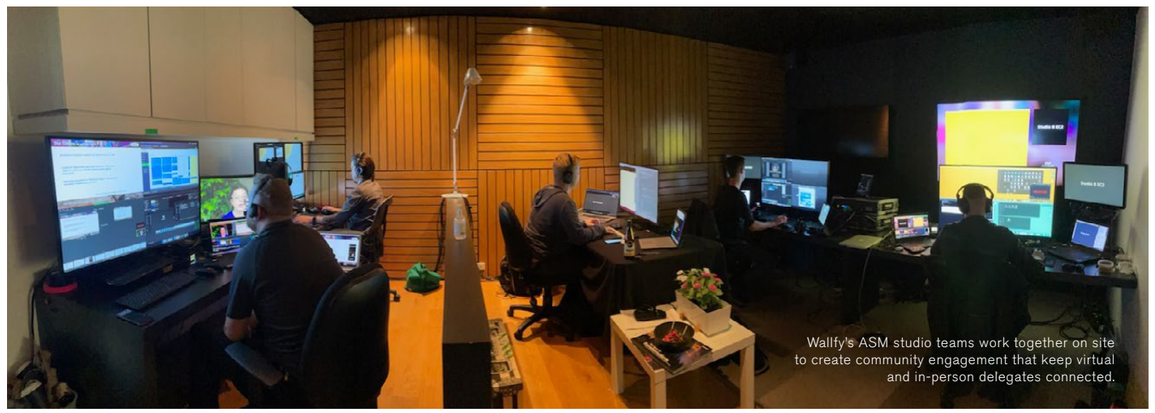
"It's really just like a military operation," Mr Yarwood told the *Bulletin*.

"Until you actually see how we pull everything together there's this perception that all we're doing is setting up Zoom meetings. Zoom is one of the tools we use but how you use it and the showcraft you apply to it is what makes the difference. It was a massive effort to set this up in eight months with the ANZCA Events team as the college hadn't done anything on this virtual scale before. It really was an intense level of systemisation so we had to rely on everyone playing their part."

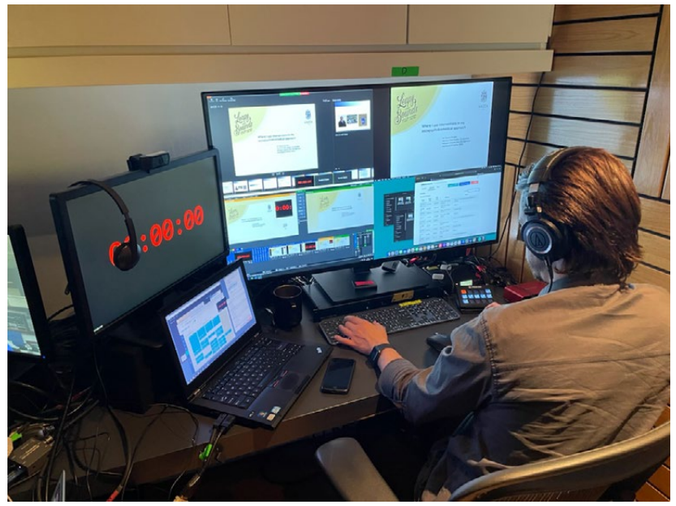
Mr Yarwood and colleague Andrew Ely have worked for ANZCA on several consecutive ASMs and Wallfly has been managing and running virtual events and live streams for the last decade.

"We understand the fabric of what makes a successful event so when we had the pivot to go online it was quite easy for us to transition," Mr Yarwood explained.

"Very quickly we found a solution to make it work. It's not just about the technology, it's about how you continue to create community engagement to keep your virtual and in-person delegates connected. Our gold standard is to make sure that whether you are sitting in the conference centre ballroom, one of the ASM hubs or at home or in your office that you are an equal part in the event.



Wallfy's ASM studio teams work together on site to create community engagement that keep virtual and in-person delegates connected.



One of the custom-made one system constellation racks which helps drive the college's first virtual ASM.

"We try to use technologies to strike a balance between the software and the human interface. It's easy enough for people to do it and they become familiar because there's a steep learning curve when you jump online and start doing these things. It's about finding the right software that's easy enough to learn for the broader audience but that also gives us all the technology and tricky bits we need to live stream.

"There's always a bit of a trade-off. It's not like a TV production where you can keep throwing lots of resources at it. We have to work within a budget and find the right formula to promote that engagement for the online community so that people don't feel like they're sitting in the cheap seats or the back seats and that's often what can happen in a virtual event. So we are really mindful of making sure everyone feels they are getting an equal part of the event."

One of the challenges in developing customised equipment such as the one system constellation racks was having to deal with global supply chain delivery delays caused by the coronavirus pandemic. The Wallfly and Novatech teams had to find computer equipment from a range of disparate sources and relied on the goodwill of their contacts in the UK and US to air freight essential equipment to Adelaide in time for the ASM pre-recording sessions.

Much of the success of the delivery of the ASM's virtual focus lay with the booking and pre-recording of dozens of sessions for the scientific program, the FPM Symposium and special interest group sessions by the Wallfly team at their Adelaide studios from 8-14 April. Technicians worked across two time zones from 7am to 4pm and then 6pm to 10pm to ensure that presenters in Australia, New Zealand, Canada, the US, the UK and Sweden could pre-record their sessions at their preferred local times. Hundreds of recordings were made and then edited using customised software. Each presenter was given access to an online briefing session which was then downloaded to a specially created resource hub "how to" website.

Once the ASM was under way the recordings were then matched to a program run-sheet for streaming.

"The technology can be quite overwhelming for some presenters and trainees," Mr Yarwood explained.

"But by doing the pre-records we were able to maintain a level of quality control which meant that on the actual day of their session or event they were able to connect, sit back and listen and watch and they could hear their presentation played back and then hear the others in the session. The pre-recording takes a lot of pressure off those speakers on the day if say, they're worrying about their camera not working. We had a few people who had problems connecting from home so we had time to manoeuvre during the pre-recording sessions. It gave us a lot more flexibility and we had a pretty good success rate."

Once on site at the MCEC the nine Wallfly and Novatech staff worked with five local technicians and MCEC staff across four studio rooms. Another four Wallfly staff in Adelaide and Brisbane worked as online live tech support crew from 7am-9pm each day.

The face-to-face interaction model of traditional ASMs was modified for 2021 in Melbourne. All virtual presenters had a dedicated ANZCA host for their sessions and a virtual "green room" was also available before the presenters or speakers were moved onto their virtual "stage".

"The presenters and speakers were constantly managed," Mr Yarwood said. "That's a significant part of the success of this virtual model. Often people are left to fend for themselves but that's not how the college or Wallfly approached it."

Back at the MCEC inside ASM's mission control centre Mr Yarwood and his team direct the proceedings through a series of computers and giant screens that not only stream real-time sessions but also display key graphics including a giant map of the world showing how many delegates are logged in at any one time across the globe.

During the opening plenary the global heat map revealed that more than 600 people were watching the live stream of the event. Interest in individual presentations, sessions and workshops was also captured in a series of bar graphs to make it easy to see at a glance how many delegates were watching.

While the Wallfly crew knew the on-demand content for the STAT sessions would be popular they had to move quickly to ensure the content was available as soon as possible even though registration gave delegates up to 12 months to view the content at their leisure. The demand was so strong that Wallfly's initial goal of having content online within 24 hours had to be stretched to 48 hours.

Mr Yarwood regards the 2021 Melbourne ASM as a watershed in terms of the hybrid model approach that could be the future of scientific meetings such as ANZCA's.

"COVID-19 has forced our hand five to 10 years forward in the space of just a few months. We and ANZCA have already been doing some virtual events on a much smaller scale and you might have had one or two keynotes in past ASMs that were virtual.

"Virtual events will never go back to what they were. In person events will return but there will always be a virtual expectation. People are no longer restricted by time. They can get online and consume all this great information at their own leisure. What Melbourne showed is there's no more bookends on an event any more.

"The whole virtual aspect means we now have a bigger audience, a global audience. We're not restricted by time or space. It's a natural progression but of course I can't wait for the face-to-face events to return."

Carolyn Jones
Media Manager, ANZCA

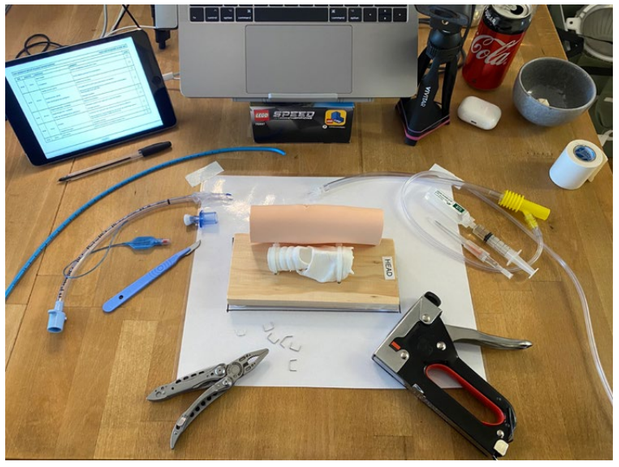
ASM hosts world-first virtual CICO workshop

Dr Luke O'Halloran and his anaesthesia team at Monash Health have spent the past few years finessing their face-to-face delivery of the bedrock CICO (Can't Intubate, Can't Oxygenate) continuing professional development (CPD) sessions for anaesthetists and critical care doctors.

So when planning began for the 2021 ANZCA Annual Scientific Meeting (ASM) back in 2019 and his CICO workshop was added to the program he expected that participants would most likely be bussed from the Melbourne Convention and Exhibition Centre (MCEC) to Monash Medical Centre in Clayton for several high fidelity simulation sessions (The sessions meet requirement for ANZCA's CPD.).

When COVID-19 forced the transformation of the 2021 Melbourne ASM into a mostly virtual meeting Dr O'Halloran and his team had to make a decision – could they deliver the CICO workshop to 60 participants across three 90 minute sessions as an online presentation, complete with real-time hands-on tasks and equipment?

"We were optimistic that this was something we could do even though the workshop had never been attempted virtually before," Dr O'Halloran, Deputy Director, Department of Anaesthesia and Perioperative Medicine at Monash Health, explained.



Preparing one of the 3D printed Cric (cricothyrotomy) CICO kits complete with with artificial "skin", cable ties and staple guns.

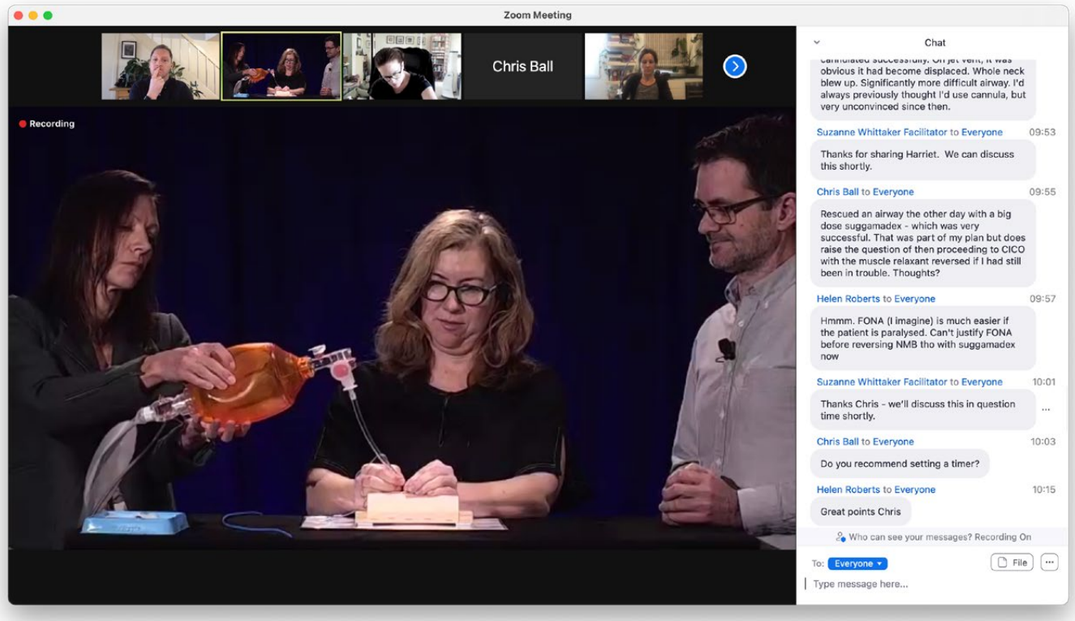
"Given this was a virtual workshop the big issue we needed to cover off quickly were the workshop resources. In our face-to-face workshop model the equipment is all there ready for the participants when they arrive on site and then they sit at a bench and are ready to go. For the virtual workshop we had to provide all the course materials to the participants at home so they could set everything up themselves and have everything ready. You can imagine the logistics involved as we had to ensure we had all the equipment ready for the mail-out well in advance of the workshop date."

Dr O'Halloran and his workshop facilitators worked with ANZCA Councillor Associate Professor Stu Marshall to build and prepare the CICO kits so they could be posted to all workshop participants in Australia, New Zealand and other countries by mid-March.

The clinical procedural equipment section of the CICO kits used by the Monash Health anaesthesia team were easily reproduced as these included cannulas, syringes, scalpels and oxygen delivery devices. The second part of the kit, the Cric (cricothyrotomy) Trainer that replicates the anatomy of a patient's neck, was more challenging as 60 of these had to be built from scratch using a 3D model template from Canada complete with artificial "skin", cable ties and staple guns.

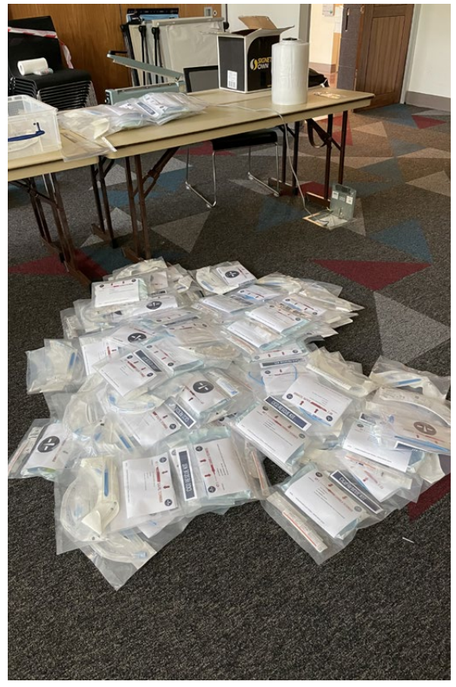
With the help of the ANZCA Events team the kits were mailed out to the workshop participants well ahead of the sessions to allow for postage delays. A week before the workshop the team from virtual conference company Wallfly organised a tech information session so all participants could check in and see if their camera and audio set-ups worked. The workshops require focused close-ups of each participant's hands so this preparation was crucial to ensure nothing was left to chance on the day.

On the day of the workshop Dr O'Halloran, as lead facilitator, was on site at an MCEC studio with two other facilitators. He started the presentation by demonstrating the drills and procedures that would be practised during each 90 minute session. Four home-based facilitators then led virtual breakout sessions so participants' skills and techniques could be monitored and feedback provided.



Above: A screenshot of one of the CICO workshop sessions complete with the CICO tools of trade.

Right: Pre-packaged kit equipment bagged ready to send to CICO workshop participants.



"We had a checklist of all the skills required of each participant and we made sure that all of them completed every task to our satisfaction. Also, the MCEC studio had multiple camera angles set up so we could get close-ups of our hands and the CICO procedures. The feedback from the participants was so positive. Many of them said they had never seen such high resolution presentations or close-ups – even in the face-to-face live sessions – so these were really useful for them," Dr O'Halloran said.

"It was crucial for us to have a clear view of what the participants were doing with their hands and also we had to make sure we could hear them. Preparation was critical and the expert audio visual support was essential. Everyone collaborated exceptionally, and the delivery of the course really did exceed our expectations."

Dr O'Halloran said the success of the virtual CICO workshop proved that ASM or CPD presentations need no longer be confined to just one traditional face-to-face model.

"It's pretty likely that a virtual approach will be part of our future CICO workshops. It might be that some participants can't attend face-to-face as they may be overseas or interstate but we know that we can still have a large group on site as well. We proved that it was possible to have either virtual, face-to-face or a combination of both."

Carolyn Jones
Media Manager, ANZCA

Awards, presentations and prizes

Prizes

Gilbert Brown Prize

2020
Dr Lachlan Miles for "Pharmacokinetic algorithm-driven versus fixed dose ratio dosing of protamine following cardiopulmonary bypass: the PRODOSE phase II randomised controlled trial".

2021
Dr Patrick Tan for "High flow humidified nasal oxygen (HFNO) versus face mask oxygen for preoxygenation of pregnant women – a prospective randomised controlled crossover study (HINOP2)".

ANZCA Trainee Academic Prize

2020
Dr Nathaniel Hiscock for "Regional anaesthesia and its association with Victorian inpatient arteriovenous fistula complication rates".

ANZCA Trainee Research Prize

2021
Dr Jason Denny for "Incidence of ketone elevation amongst patients with diabetes on day of surgery".

ANZCA Trainee Quality Improvement Prize

2021
Dr Joanna Yu for "Surgical day care unit (SDCU) fasting clock – an initiative to reduce prolonged preoperative fasting times in patients undergoing elective colorectal and bariatric surgery".

Open ePoster Prize

2021
Associate Professor Victoria Eley for "A comparison of the ClearSight™ finger cuff with invasive arterial pressure measurements in patients with Class III obesity: A Pilot Study".

Trainee ePoster Prize

2021
Dr James Cheng Jiang for "Postoperative recommencement advice for antithrombotic agents".

FPM Dean's Prize

2020
Dr Roopa Gawarikar for "Targeting two birds with one stone: Efficacy of Ketamine in pain and opioid reduction".

FPM Best Free Paper Award

2021
Dr Megan Allen for "Opioid stewardship assessment: a multicentre study of post discharge opioid use and handling in surgical patients".

Keynote presentations

ANZCA ASM Visitor Ellis Gillespie Lecture

Professor Hugh Hemmings, "Why anaesthesiologists should care about basic science".

Organising Committee Visitor Lecture

Associate Professor Meghan Lane-Fall, "A failure to communicate: Interpersonal interactions and detection of the deteriorating patient".

FPM ASM Visitor Michael Cousins Lecture

Professor Matthew Smuck, "Physical performance monitoring and the future of precision pain medicine".

ANZCA Australasian Visitor Mary Burnell Lecture

Professor Alicia Dennis, "Doctors, Disasters and Destiny".

Victorian Regional Visitor Lecture

Professor Cor Kalkman, "Wearable patient monitoring and the Nightingale Project".

FPM Regional Visitor Edward Shipton Lecture

Professor Eva Kosek, "Nociplastic pain – why should anaesthesiologists care?".

Robert Orton Medal

PROFESSOR MILTON L COHEN AM

2020 RECIPIENT

The Robert Orton Medal is awarded at the discretion of ANZCA Council, the sole criterion being distinguished service to anaesthesia, preoperative medicine and/or pain medicine.

Professor Milton Cohen AM graduated in medicine and surgery with first class honours from the University of Sydney in 1972, achieved fellowship of the Royal Australasian College of Physicians in 1978, specialising in rheumatology and Doctor of Medicine (Sydney) in 1985. His realisation that pain was the most daunting challenge for his patients and himself as a physician led him to join the St Vincent's Hospital (Sydney) pain clinic in 1988.

Milton has made significant and lasting contributions to the Faculty of Pain Medicine and ANZCA, and the discipline of pain medicine in Australia and internationally as a leader, clinician, teacher, researcher and mentor. He made major contributions to the recognition of pain medicine as a medical specialty in Australia in 2005 and as a scope of practice in New Zealand in 2012. Milton was appointed as a Member of the Order of Australia in the 2019 Australia Day Honours.

Milton was a foundation board member and third dean of the Faculty of Pain Medicine from 2004–06. He has served the faculty in many roles including as chair of the education committee that developed the foundation curriculum in 1998 establishing the faculty as a world leader in pain medicine. Milton has been the Director of Professional Affairs since 2010 and chair of the faculty's Learning and Development Committee. He remains active in many other organisations including the International Association for the Study of Pain, and as an adviser to federal and state governments. Milton has taught extensively, published more than 100 articles in peer reviewed journals and more than 30 book chapters and is a senior editor for the journal Pain Medicine. He is recognised for his incisive analysis and wise counsel.

Professor Milton Cohen is a worthy recipient of the Robert Orton Medal in recognition of his significant and lasting contributions to the Faculty of Pain Medicine, the college and pain medicine internationally.

Dr Meredith Craigie
FPM Immediate Past Dean

Dr Ray Hader Award for Pastoral Care

DR CHRISTOPHER J SPARKS

2020 RECIPIENT

The Dr Ray Hader Award for Pastoral Care promotes compassion and has a focus on the welfare of anaesthetists, other colleagues, patients and the community. The award was established by Dr Brandon Carp in memory of his friend Dr Ray Hader, a Victorian trainee who passed away in 1998 due to an accidental drug overdose.

Dr Christopher Sparks, FANZCA, is the recipient of 2020 Ray Hader Award based on his significant contribution to the pastoral care of trainees as a mentor as well as providing welfare and wellbeing support especially for the young trainees in the Pacific Island.

From top: Professor Milton L Cohen AM receiving the Robert Orton Medal at the College Ceremony; Dr Christopher J Sparks receiving the Dr Ray Hader Award for Pastoral Care at the College Ceremony.

Steuart Henderson Award

The Steuart Henderson Award is awarded to a fellow who has demonstrated excellence and provided outstanding contribution, scholarship, and mentorship to medical education in the field of anaesthesia and/or pain medicine.

DR ADAM H REHAK

2021 RECIPIENT

Dr Adam Rehak commenced his anaesthetic registrar training with Southern Health at Monash Medical Centre in 2002. During his training he also spent a year at Guys and St Thomas' Hospital in London. In 2006 Adam moved to Sydney for his provisional fellowship at Royal North Shore Hospital where he was given the simulation fellow portfolio.

From this time Adam has been strongly involved in clinical simulation and education. He has been a staff specialist at Sydney Clinical Skills and Simulation Centre (SCSSC) since obtaining his FANZCA in 2007 and the lead for the anaesthesia stream of courses. Adam was the centre's supervisor of EMAC from 2007-2018, and continues to instruct there as one of SCSSC's most experienced instructors. He has also played a significant role in the evolution of the EMAC curriculum as a co-author in the revision of both the airway and trauma modules.

Adam has also developed and run numerous other anaesthesia courses including a difficult airway course which focuses on human factors and decision-making in difficult airway management, a suite of emergency response unit courses, and a neuroanaesthesia course. The creation of new educational programs is an aspect of simulation and education that Adam finds particularly rewarding, and one that he continues to be heavily involved in.

Adam has also made a significant contribution in shaping our current understanding of best practice in airway management. He co-authored the 2014 ANZCA report Transition from supraglottic to infraglottic rescue in "can't intubate can't oxygenate" (CICO) scenario which subsequently formed the basis for the ANZCA professional document PS61-BP. He was a key member of the Safe Airway Society working group which published the widely endorsed statement on airway management and intubation in Covid-19 patients. He has also co-authored multiple publications in the British Journal of Anaesthesia and Anaesthesia which have largely been related to the role of human factors in promoting effective airway management.

Adam's engaging presentation manner combined with an expertise in human factors and airway management has led to regular invitations as a speaker and workshop convener at national and international conferences. This included his involvement in the 2019 World Airway Management conference in Amsterdam. He has been a member of the EMAC sub-committee since 2014, and is also a co-opted member of the ANZCA Airway SIG. Adam has previously been a member of the Education and Simulation SIG executives. Adam is also one of the founding members of the Safe Airway Society.

Despite his busy non-clinical and clinical schedule, Adam has always been generous with his time in providing support to colleagues. He is viewed in extremely high regard by both anaesthetic and non-anaesthetic colleagues and this is reflected in his guidance being regularly sought on challenging clinical cases as well as issues relating to human factors and communication. Adam has a reputation for treating people with honesty and integrity, and for his ability to offer insightful observations and pragmatic advice.

Adam is the type of anaesthetist you want there before the crisis, during the crisis and after the crisis. The respect he garners is not only related to his high level of technical skills and knowledge in education, debriefing, human factors and trauma management but also the humility and respect in his communication with others. He is an inspirational mentor and role model to trainees and consultants alike. It is for these reasons that Adam embodies the values of the Steuart Henderson Award.

Dr Gerri Khong

DR DAMIAN J CASTANELLI

2020 RECIPIENT

Have you ever wondered why the ANZCA training program uses workplace-based assessments (WBAs) to inform decisions about competence and progression?

In the not-so-distant past, trainees progressed through ANZCA training without any robust assessments of their competence, and their performance in the examinations was the primary measure of progress. That all changed with the introduction of the 2013 curriculum and greater emphasis on performance in the workplace, its assessment through WBAs, and a clearly articulated curriculum through learning outcomes. One of driving forces and leaders behind these developments has been, and continues to be, Dr Damian Castanelli.

Damian's achievements in medical education, training and influence are both exceptional and numerous. He has mentored and guided hundreds of Victorian trainees as a supervisor of training and as the education officer. He was a final examiner for 11 years, and a member of the Final Examination Sub-Committee. Damian was chair of the Education Development and Evaluation Committee until 2019, and continues to be a member of that committee and the Education Executive and Management Committee. He has contributed to many college educational offerings including the curriculum and the diploma in hyperbaric medicine.

Damian has been an inspirational mentor and provided support and guidance for new researchers and committee members. Perhaps most importantly, Damian's research, as well as his collaborations with other educational leaders, has informed and significantly influenced the development of the ANZCA training program and demonstrated that it is a world-class, robust program. He has been the recipient of multiple ANZCA research grants exploring aspects of the ANZCA training program. The findings from these projects have provided evidence in support of ANZCA training as well as shaping the development of new resources and the future directions of the program.

Damian welcomes diversity of ideas and innovative approaches, encourages participation, and recognises and promotes the skills and expertise of others. Damian's achievements make him a very worthy recipient of the 2020 Steuart Henderson Award.v

Dr Jennifer Woods

Faculty's advocacy crucial for bi-national approach

> "The biggest barrier to expanding high-quality multidisciplinary care into the subacute and community sector is the lack of Medicare item number support."

ONE OF THE privileges of my current position is to be able to take a high level, long-term look at the advocacy efforts of our faculty. From the early years after foundation, the focus of advocacy was making the case for pain medicine as a specialty, and ensuring that we were taken seriously and respected for the quality of our training and practice. Subsequently, the focus shifted to advocating for expanded numbers of training positions and ensuring that our supervisors of training were properly supported and accredited. The process of competing for awareness bandwidth and funding in the political and bureaucratic arenas also became much more important, and led to the creation of Painaustralia as an organisation which could focus on this exclusively.

The creation of the electronic persistent pain outcomes collaboration (ePPOC) as a binational outcomes data set has taken time to bear fruit, but the recent release of data from this large repository of outcomes would suggest that multidisciplinary pain management programs are highly effective at improving quality of life and reducing low-value medication use. As encouraging as these numbers are, the concerning part of them is the high number of referred patients to do not complete the whole episode of care. Units are constantly forced to ration resources and play to their strengths, when what is needed is more equitable access to comprehensive pain care that encompasses acute, subacute and community sectors as well as acute chronic and cancer pain.

In my experiences as a Training Unit Accreditation Committee reviewer, and also now with the frontline reports gained from the regional committees, it's clear that although our units are quite disparate in terms of their geography and physical and operational setups, they are all trying to solve the same set of problems. This set of problems can be briefly summarised as "How do you provide as many evidence-based skills and services as possible to wrap around an individual patient to give them the best opportunity to improve their quality of life and reduce pain where possible?" Operational barriers often limit the scope of what patients are offered, leading to many leaving the service with unmet needs.

Right now, in Australia the biggest barrier to expanding high-quality multidisciplinary care into the subacute and community sector is the lack of Medicare item number support. In the May federal budget, the implementation date of the pain management item number reforms was given as March 2022. These reforms are expected to save around $40m over the next three years. There was no further information given, and the faculty and Painaustralia will be collaborating to uncover more details about what this means. It is potentially an enormous missed opportunity to provide the structural means to improve access to effective care for community patients.

In New Zealand, the major barrier to equitable access to high-quality care is also structural. It is not mandated for district health boards to provide pain services, and consequently there is a concentration of expertise in large tertiary centres, and no plan for provision of regional or community level care anywhere else. The national committee of the faculty in New Zealand is collaborating with the health ministry on a project to address this with a model of care that is both equitable and high-quality. In the middle of this, we are also dealing with lack of funding support for our major South Island unit in Christchurch. If this unit is not adequately supported, it will leave a population of just over 1 million people without a level I training unit, and all of the clinical expertise that goes with it.

The advocacy we need right now has to be directed at holding on to the gains of the past 20 years in the face of changing priorities for our services and complacency on the part of funding authorities about the costs in both human and economic terms of poor pain care.

Associate Professor Michael Vagg
Dean, Faculty of Pain Medicine

Pain management health practitioner education strategy project update

The faculty-led, federally-funded project to develop a national pain management education strategy for Australian health practitioners is progressing well towards completion in December 2021. The strategy will utilise current evidence-based information to guide and promote pain management education for a broad range of Australian health practitioners, across the span of their career.

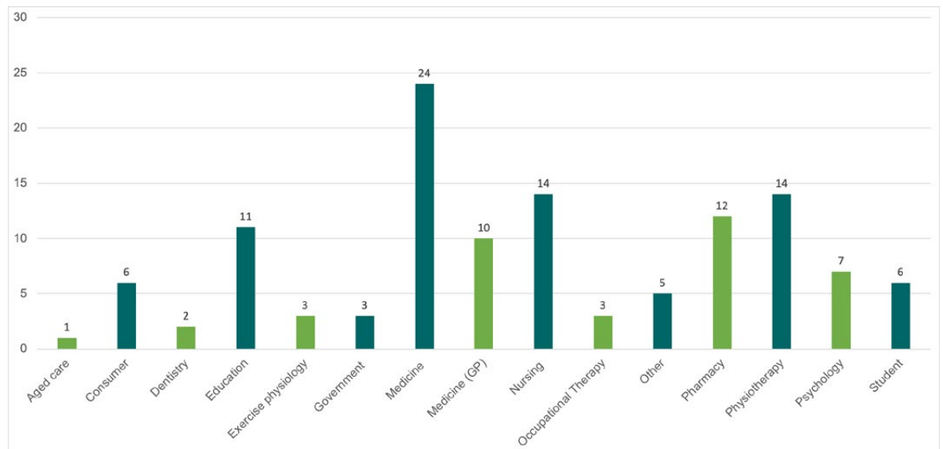
The Australian Department of Health awarded two further grants in 2020 for pain management education. The first, focusing on the development of pain management education and training programs and resources for health professionals, is being undertaken by a consortium led by the Pain Management Research Institute. The second project, led by Painaustralia, is consumer-facing and focuses on increasing the availability of evidence-based information about chronic pain for consumers. The faculty is engaged with representatives from both projects through our governance advisory group to ensure that the work is clearly aligned.

In the last *Bulletin* we reported on a successful roadshow comprising seven consultation workshops conducted face-to-face and via Zoom for stakeholders across Australia. The workshops were an excellent opportunity to engage with stakeholders from across the spectrum of pain care and health practitioner education. The 120 workshop participants represented a diverse range of sectors, including clinicians, educators, consumers and students, as shown below. During the sessions, participants worked in multi-disciplinary groups, brainstorming ideas to inform the strategy's values, principles, and goals, as well as implementation considerations and recommendations.

Feedback from workshop participants illustrated that people valued the opportunity to engage with the project and with a multi-disciplinary group. While participants recognised the challenges of creating a nationally consistent approach to pain management education, they felt positive about the passion and commitment of stakeholders across Australia who are willing to work together to make it happen.

The project team are currently in the process of validating and thematically analysing the workshop data. The analysed data, along with findings from the comprehensive literature review and environmental scan completed last year, will inform the strategy write-up process over the coming months. Ongoing input from a smaller, representative group of stakeholders will assist with data validation and implementation design. There will be an opportunity for stakeholders to provide input on the draft strategy more broadly when it is distributed for consultation later this year.

Stakeholder consultation workshop participant breakdown by discipline



Departing FPM Board members

ASSOCIATE PROFESSOR MEREDITH CRAIGIE retires from the board with few career achievements left to aspire to. Since being elected to the board in 2012, she has been a member of the Curriculum Development Working Group, chair of the Examinations Committee and Learning and Development Committee, vice-dean and in 2018 she became the 10th FPM Dean. She has represented the faculty with effective advocacy and relationship-building at all levels of government in both Australia and New Zealand. As dean, her major achievements were updating the board structure to be more reflective of current best practice, as well as collaborating with then-president Dr Rod Mitchell to build the relationship between the faculty and college to a position where we could join the ANZCA and FPM strategic plans into a single shared vision for the organisation. Her time as dean also saw FPM win two major federal government grants which ensured the provision of 10,000 Better Pain Management licenses to Australian health professionals and also led to the faculty leading the development of the National Health Practitioner Pain Education Strategy project. Meredith will continue as lead clinician for the project until its completion later this year, and she leaves the board with our immense gratitude and best wishes.

DR KYLIE HALL was elected as the new fellow board member in 2018, and took office in May that year. She has served for many years as an active service medical officer in the RAAF and has attained the rank of Wing Commander with several tours on active service. As a board member, she has brought the perspective of not just trainees and new fellows but also that of the Queensland fellowship as well as a perspective of caring for current and former serving members of the ADF. She provided open and frank opinions to the board, and was a valuable contributor to many challenging discussions. We look forward to further contributions from her as she continues her professional relationship with the faculty.

DR MELISSA VINEY has been a contributor to faculty affairs almost since its inception, having done her original training in pain medicine with Professor Michael Cousins at Royal North Shore Hospital. She was one of the earliest supervisors of training in Victoria, and has chaired the Training Unit Accreditation Committee as well as the Professional Affairs Committee and has been a member of the Examination Committee and Learning and Development Committee at various times. She formed a crucial part of the Curriculum Development Working Group which produced the 2015 curriculum document. This world-leading document for pain medicine has strongly informed the curricula of several other jurisdictions and was a major achievement for FPM. She was elected to the board in 2012 and has been a tireless contributor throughout her term. She will continue to serve the faculty on the Perioperative Medicine Steering Group, and as the Assessor. Her intellectual integrity and passion for maintaining educational standards will be missed, as will her sage advice and deep knowledge of the faculty.

The board has received the resignations of two members for personal reasons. We thank them both for their service and wish them well.

DR RENATA BAZINA joined the board in 2020 and is chair of the FPM New South Wales Regional Committee, a member of the Examination Committee and a contributor to the Procedures in Pain Medicine project.

DR GEOFFREY SPELDEWINDE was elected to the board in 2019 after previously having been the president of the Australian Pain Society. Dr Speldewinde has contributed to the Procedures in Pain Medicine project, been an examiner and supervised pain medicine trainees.

Meet our new board members

DR TIPU AAMIR is a specialist pain medicine physician and trained in psychiatry as well. He is senior lead clinician at The Auckland Regional Pain Services. He is the chair of the FPM New Zealand National Committee, a member of the Learning and Development Committee, an examiner, an accreditation reviewer and a previous supervisor of training. His interests include continuing the education of new specialists to ensure the vitality of our specialty and increasing awareness and recognition for this valuable field of medicine in the eyes of rest of medical profession and public. He has two children and enjoys outdoor pursuits which include cycling, tramping and kayaking.

DR GRETEL DAVIDSON graduated in medicine from the University of Sydney, and completed training in anaesthesia at the Prince of Wales Hospital in Sydney, with a fellowship at Children's Hospital Westmead. After several years as a consultant anaesthetist at both Sydney Children's Hospital and Children's Hospital Westmead, and completing postgraduate studies in pain management, the opportunity to complete formal training in pain medicine arose. She is currently working in both anaesthesia and pain medicine (acute and chronic) for children and adults, in public and private facilities. Her main clinical interest is chronic pain management in children, adolescents and young adults.

DR STEPHANIE OAK is a consultant psychiatrist and specialist pain medicine physician who is based in Newcastle, NSW. She studied medicine at the University of Newcastle, completed psychiatry training in 1998 and was elected to fellowship of the FPM in 2009 while working with the Hunter Integrated Pain Service. Since 2012 she has been actively involved with the Continuing Professional Development and Professional Standards committees of FPM and ANZCA, and designed the first emergency response module specifically targeting pain specialists in the ANZCA and FPM CPD program. Her clinical interests include pain management for people with co-morbid mental illness, improving service provision for those who live in rural and remote communities, and clinician health and wellbeing.

New members co-opted to board under new process

As part of the board reforms introduced last year, a formal process of co-option was used to replace retiring board members. The departures of Associate Professor Meredith Craigie and Dr Melissa Viney opened the option for the board to co-opt up to two replacements.

Under the new process, the faculty executive developed a skills and attributes matrix for the board to guide the choice of co-opted members. The aim of adding co-option to election in the new process was to ensure that the board was adequately representative of the fellowship, and also displayed a diversity of gender, regional representation, governance skills, faculty knowledge and cognitive styles. This is in keeping with research suggesting that leadership groups which are multiply diverse make better decisions and produce more effective strategic planning.

Once the results of the board election in February were known, the nominees who were not elected from that election were automatically considered for co-option. The board then considered the diversity matrix and invited a small number of fellows to nominate for co-option. This process was conducted with high regard for confidentiality and ensured that at the April board meeting there was an exceptional shortlist of five candidates for the two co-opted positions available. Following a secret ballot, the new board members chosen were Dr Tipu Aamir (NZ) and Dr Stephanie Oak (NSW). On behalf of the board I would like to congratulate our two new members, and thank all our nominees for providing a very high-quality field.

Dr Aamir and Dr Oak will join the incoming new fellow board member, Dr Gretel Davidson (NSW) for induction workshops ahead of the first full meeting of the new board in June. Early feedback from board members was positive about the process and further implementation of the reforms to board membership will continue for the next round of elections.

Associate Professor Michael Vagg
Dean, Faculty of Pain Medicine

Hitting the 10,000 target – high demand for faculty education modules

The faculty is pleased to report that it will reach its target of allocating 10,000 licences for the federally funded "safer opioid prescribing" online learning program well ahead of the 30 June deadline.

Sponsored through the Therapeutic Goods Administration (TGA) our six-module online learning package, derived from the Better Pain Management (BPM) program, is assisting healthcare professionals develop sustainable and effective pain management programs for appropriate and safe opioid therapy.

When it began in June last year, "Better Pain Prescribing: Clarity and confidence in opioid prescribing" was actively marketed across key health professional segments – with consistent messaging to drive awareness of this key initiative. Via direct email, paid advertising, social media, online/e-newsletters and print editorial content, BPM reached targeted medical and allied healthcare associations, general practitioners, pharmacists, universities, hospital groups and nursing professionals. The faculty also regularly promoted this course in key college e-newsletters.

The TGA has congratulated the faculty for not only producing an e-learning package that has remained consistent with their opioid regulatory opioid reform objectives, but also for our performance in successfully reaching and influencing agreed target prescriber audiences.

We are sincerely grateful to our fellowship for their professional networking efforts and "word-of-mouth" support, and our sincere thanks go to all those who have helped drive this educational program across their respective hospitals, clinics and university locations.

The TGA grant has provided development revenue for the faculty, enabling us to further position ourselves as a reliable and authoritative source of advice for health professionals, regulators and government. The faculty looks forward to continuing its engagement with key pain medicine groups, prescribers, allied health associations and educational institutions, to further extend the reach of the BPM education offer.

Key project facts and deliverables:

- Seventy per cent individual course completion across all Australian states.
- More than 60 per cent of course enrolments from prescribers and other key pain management influencers.
- Thirty-six per cent were general practitioners.
- Course inclusion within medical school pain management curriculums.
- New user page-views on BPM website tripled to 100,000 since project commencement.

WHAT'S NEW IN BETTER PAIN MANAGEMENT?

BPM learning product options have recently been extended to enable the creation of personalised study packages. Users can choose a selection of three or six learning modules from the BPM library and they can be bundled in a single discounted purchase.

Mid-year the faculty is commencing work on reviewing and revising a number of key BPM modules.

Expert Advisory Group starts work on chronic pain model of care

The Ministry of Health/Faculty of Pain Medicine Expert Advisory Group (EAG) had its first meeting in Wellington on 2 June setting the groundwork for a national model of care to cover chronic pain.

The group of 12 is made up of representatives from across the pain management spectrum. The group is investigating overseas models of care and designing a New Zealand-specific system that can be used across the country.

The timing fits in well with the new Health and Disability System reforms that come into place in July next year. This is when all the 20 district health boards are disbanded and Health New Zealand and the Māori Health Authority take up leadership of a national health system.

The FPM New Zealand National Committee (NZNC) chair Dr Tipu Aamir, deputy chair Dr Duncan Wood, vice FPM dean Dr Kieran Davis and committee member Dr Leinani Aiono-Le Tagaloa attended the meeting after the FPM NZNC to helped to set up the membership of the advisory group.

Dr Aamir says the two-hour meeting made more progress than expected with the hub and spoke framework (as outlined in FPM's Sapere Report on chronic pain) being seen as the best model to remedy what he says they all agreed is, "the current diabolical inequitable services that exist across the country."

The group, chaired by the Ministry of Health, will meet again in July to look specifically at how the system will work across primary, secondary and tertiary services.

National Strategic Action Plan for Pain Management launch

On 18 May FPM Dean Associate Professor Michael Vagg and FPM Executive Director Leone English travelled to Canberra to attend Painaustralia's annual general meeting (AGM) and the launch of the National Pain Services Directory at a Parliamentary Friends of Pain Management.

The Painaustralia AGM heralded a change in board leadership with Major General Duncan Lewis set to take over as chair of the board from Emeritus Professor Ian Chubb AC. The meeting also saw the approval of proposed constitutional changes which will mean that ANZCA and the faculty will cease to be "category A members", as this classification will no longer exist, and as of 1 July 2021 will become "members".

While this change signals another phase in the evolution of Painaustralia, and brings its board processes in line with current governance practice, it also means that ANZCA and the faculty no longer have guaranteed seats at the board table. For now, faculty fellows Dr Chris Hayes and Associate Professor Meredith Craigie will remain on the board as individual directors to serve their term of office. ANZCA and the faculty remain committed to working collaboratively with Painaustralia to promote the pain agenda at a federal and state level.

In a positive move at the Parliamentary Friends of Pain Management Group event that followed the AGM, Minister Greg Hunt formally launched the National Strategic Action Plan for Pain Management. The plan outlines eight key priority areas to help address the growing burden of chronic pain in Australia. Since its publication in 2019 the plan has gained national support and the minister reported that it has now been endorsed by all Australian jurisdictions.

In 2020 the government provided $2.5 million towards the early implementation of the plan with the Faculty of Pain Medicine receiving $500,000 to develop a national strategy for pain management education for Australian health practitioners. The project has now been under way for almost 12 months and is due to be completed at the end of this year.

As part of the $2.5 million two other priority areas were funded. Painaustralia was awarded $1 million to support consumer education and awareness and, at the Parliamentary Friends of Pain event, launched its improved National Pain Services Directory. The revamped directory is aimed at making it easier for pain sufferers, carers and health professionals to search for appropriate pain services by location. In addition, the University of Sydney – Pain Management Research Institute is leading a $1 million project to develop pain management education and Painaustralia.

It is hoped that this launch will add more weight to the push to have chronic pain recognised as a national health priority and assist the faculty as it continues to work with governments and fellows at a national and local level to grow and improve services for Australians living with pain.

The visit to Canberra was a great opportunity for the dean and I to catch up face-to-face with Painaustralia CEO Carol Bennett, local politicians, pain advocates and fellows, including Dr Chris Hayes, who made the trip down from Newcastle.

Leone English
Executive Director, FPM

NEW FELLOWS

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

- **Dr Chor-San Alfred Chan**, FANZCA, FFPMANZCA (Hong Kong).
- **Dr James Forbes**, FANZCA, FFPMANZCA (Qld)
- **Dr Lauren Kite**, FRANZCOG, FFPMANZCA (NSW).
- **Dr Karen Park**, FANZCA, FFPMANZCA (New Zealand).
- **Dr Nitin Yogesh**, M.Ch Neurosurgery, FFPMANZCA (Tasmania)

TRAINING UNIT ACCREDITATION

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

- Alfred Health, Victoria.
- Austin Health, Victoria.
- PainScience Joondalup, WA.
- Queen Mary Hospital, Hong Kong.

FPM Symposium

The FPM Symposium and annual scientific meeting (ASM) programs were a great success and a tribute to the hard work of the faculty's FPM Symposium Convenor, Dr Noam Winter. See page 55 for Dr Winter's wrap up of the event.

COLLEGE CEREMONY

The faculty would like to congratulate its new fellows who were presented at the College Ceremony on Saturday 1 May 2021.

New fellows presented at the College Ceremony Sydney hub.

BEST FREE PAPER AND DEAN'S PRIZE

The faculty would like to congratulate Dr Roopa Gawarikar and Dr Megan Allen on being awarded the 2020 FPM Dean's Prize and 2021 Best Free Paper Award.

Dr Roopa Gawarikar was awarded 2020 Dean's Prize for her paper, "Targeting two birds with one stone: Efficacy of ketamine in pain and opioid reduction".

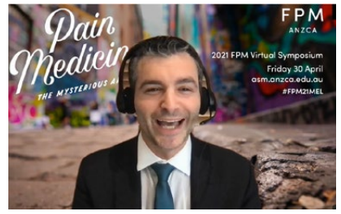
Dr Megan Allen was awarded the 2021 Best Free Paper for "Opioid stewardship assessment a multicentre study of post discharge opioid use and handling in surgical patients".

Dr Hannah Bennett wins the Barbara Walker Prize

THE BARBARA WALKER PRIZE

The 2021 Barbara Walker Prize was presented to Dr Hannah Bennett by Associate Professor Newman Harris at the Queensland remote hub at the ASM. Dr Bennett was awarded the prize for achieving the highest mark in the 2020 fellowship exam.

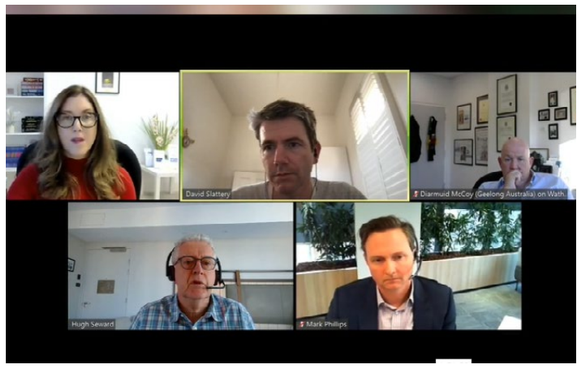
Faculty of Pain Medicine Dean Associate Professor Michael Vagg welcoming delegates to the symposium.



FPM Symposium Convenor Dr Noam Winter.

FPM Regional Visitor Professor Eva Kosek, Sweden, presenting "Updates in pain modulation".

FPM ASM Visitor Professor Matthew Smuck, US, presenting the "US: Low back pain outcomes".



Panel discussion "Bridge over chaos: Navigating the third party system".

Self matters

This edition's column is by Dr Joanna Sinclair, anaesthetist at Counties Manukau Health, Wellbeing SIG executive member, and chair of the Long Lives Healthy Workplaces Toolkit Implementation Committee. One of the biggest challenges we face is creating effective and sustainable changes within our hospitals.

As you will read, Jo has tackled this by developing relationships outside her department, particularly through executive sponsorship for her new hospital-wide wellbeing role. I'm sure that many wellbeing advocates and others will find her insights both inspirational and instructive.

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

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

EVERY WORKPLACE HAS a responsibility to protect the mental health and wellbeing of its workers and reduce risks associated with mental ill-health. The global pandemic has thrown a spotlight on some of the unique stressors healthcare workers face. Despite ample evidence of the benefits of investing in workforce wellbeing, we had not made it part of "business as usual" in healthcare. When the pandemic arrived, we scrambled to put support structures in place as we recognised the added stress our healthcare systems were facing.

The Long Lives, Healthy Workplaces (LLHW) toolkit, recently relaunched with new resources to assist implementation[1], is designed to support anaesthetists and departments to operationalise an evidence-based framework for a workplace wellbeing program that would be business as usual. Through the LLHW implementation group I met some amazing mentors who advanced my understanding that true systems changes require executive level buy-in.

Unfortunately, many departmental wellbeing advocates still struggle to get support for wellbeing initiatives in their workplaces.

My own journey in wellbeing advocacy arose from similar frustrations. Using the Well-Being Index, a simple tool to identify doctors in distress which has undergone rigorous multi-step validation[2], I surveyed senior medical officers (SMOs) at my hospital and found really high distress levels. I presented these results with the evidence on the cost of not attending to staff wellbeing, to our chief medical officer (CMO), human resources (HR) director and chief executive officer. I proposed a new role, SMO wellbeing officer, with full-time equivalent (FTE) attached, to work on wellbeing issues and keep them on the executive leadership team and board agendas. The HR director and CMO became my executive sponsors and after 18 months the new role was established. I am now our hospital lead for the Health Roundtable Workforce Wellbeing Improvement Group[3], Schwartz Rounds4, and a Stress First Aid (Peer Support) program which is in development. I work with colleagues from nursing, allied health and psychological medicine on these projects.

I also work closely with our organisational development and HR teams. I have observed that staff working in these areas have both an in-depth understanding of the organisation's obligations to their employees' wellbeing at work and a genuine desire to look after our staff. Most have experience predominantly outside of healthcare and so do not fully understand the unique features and stressors of working on the frontlines of healthcare. They are very worried about things like fatigue and burnout, but unpacking these issues without some context from frontline staff is a challenge. On the other side, doctors and nurses are often suspicious of HR and have little interest in bridging that gap. The HR staff I work with are grateful to have a doctor's voice at the table when planning workplace initiatives for staff.

I do not believe the "organisation" is the only problem though. Medicine also needs cultural change and that needs to come from those in practice. We have problems with gender bias, racism, incivility, bullying and a hierarchical system that still encourages and rewards self-sacrifice. Added to this, doctors are typically not great at self-compassion. If we ignore compassion for ourselves, in the end that erodes our compassion for others – our colleagues and our patients. There is overwhelming evidence5 that this will cost our health system dearly, through poor patient compliance with treatment plans, increased medical errors, high staff turnover or reduced FTE, increased sick leave and so on. Unfortunately, reversing this requires more effort than many of us think we can currently give.

Individuals, leaders and organisations share a mutual interest and responsibility for creating an optimal work environment and addressing high rates of burnout and job dissatisfaction in our medical workforce. In 2020, Dr Tait Shanafelt and Dr Stephen Swensen, two of the world's foremost authorities on burnout in healthcare, published a blueprint for creating the ideal workplace[6]. They propose eight ideal work elements for organisational resilience (Figure 1).

The Pandemic Kindness Movement in Australia[7] presents a model for organising health worker support based on Maslow's hierarchy of needs (Figure 2) and emphasises that attending to basic physiological needs, and physical and psychological safety, will allow healthcare workers to feel secure and supported enough at work to achieve job satisfaction and enable them to provide the best care for our patients. Organisations might begin this work by finding those small things that are easiest to change and make a difference, as well as having two-way conversations about things like managing resource constraints to increase transparency and co-creation of solutions.

Getting executive buy-in in my organisation has taken time but has ultimately been a richly rewarding process which has allowed me to achieve more than I previously thought possible.

Dr Joanna Sinclair, FANZCA
Joanna.Sinclair@middlemore.co.nz
@josinclanz

Figure 1: Ideal work elements

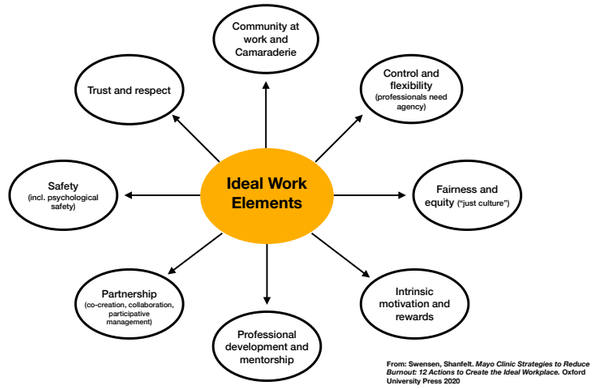
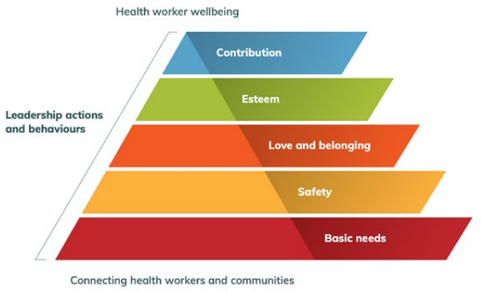


Figure 2: Pyramid of needs



ANZCA'S DOCTORS' HEALTH AND WELLBEING RESOURCES

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

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

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

Emergency contacts

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

References:

1. Long Lives Healthy Workplaces Toolkit and resources – www.asa.org.au/llhw - recently relaunched at the ANZCA ASM with a new suite of resources to assist implementation.
2. https://www.mywellbeingindex.org/product/validation accessed 31 May 2021
3. https://www.healthroundtable.org/Join-Us/Improvement-Groups/Workforce-Wellbeing accessed 07 June 2021
4. https://www.theschwartzcenter.org/programs/schwartz-rounds/ accessed 07 June 2021
5. Trzeciak S, Mazzarelli A. Compassionomics: The Revolutionary Scientific Evidence That Caring Makes a Difference. Studer Group; May 2019.
6. Swenson S, Shanafelt T. Mayo Clinic Strategies to Reduce Burnout: 12 Actions to Create the Ideal Workplace. Oxford University Press; 28 Feb 2020.
7. The Pandemic Kindness Movement. At https://aci.health.nsw.gov.au/covid-19/kindness accessed 31 May 2021

What's new in the library?

NEW RESEARCH CONSULTATION SERVICE

ANZCA Knowledge Resources has begun a pilot for a new Research Consultation Service until the end of 2021, which aims to develop and deliver research services to fellows, trainees, college staff and other key college stakeholders.

A key goal of the research consultation service is to facilitate the translation of research-based evidence about anaesthesia, pain medicine and perioperative medicine into policy and practice.

The research librarian will be involved in:

- Conducting literature searches (and producing evidence summaries), as well as advising on the literature review process.
- Responding directly to queries related to the conduct of research, as well as helping to guide emerging investigators through the research lifecycle and full utilisation of the Research Support Toolkit.
- Teaching academic literacy skills through activities like online webinars and participation in key workshops.
- Collaborating with the Safety and Advocacy unit in the creation and review of professional documents.

The new research librarian is Kathryn Rough, who is available on Tuesdays and Fridays.

Research-related literature searches should be submitted using the Request a Literature Search form on the library website (and selecting Purpose = Research). Kathryn can be contacted directly via email: krough@anzca.edu.au.

Contact the library:

+61 3 9093 4967

library@anzca.edu.au

anzca.edu.au/resources/library

LATEST TRIALS

ANZCA library has recently begun two trials:

- Covidence is a web-based tool that improves healthcare evidence synthesis by improving the efficiency and experience of creating and maintaining Systematic Reviews. The Covidence trial ends 30 June 2021.
- AccessEmergency Medicine is a comprehensive online resource covering the fundamentals of emergency medicine. Includes leading medical e-books like Tintinalli's *Emergency Medicine*, multimedia, interactive self-assessment Q&As, an integrated drugs database and patient education. The Access EM trial ends 20 July 2021.

Google "ANZCA library trials" to access further information and provide feedback.

NEW MEDICINAL CANNABIS LIBRARY GUIDE

The library recently launched a new medicinal cannabis library guide. The guide has been designed for anaesthetists and pain specialists seeking more information on how medicinal cannabis impacts anaesthesia, perioperative medicine, and pain management. The guide brings together a wide variety of resources, including *PM10: Statement on "medicinal cannabis" with particular reference to its use in the management of patients with chronic non-cancer pain* and therapeutic guidelines. Other resources include relevant articles from clinical journals, articles from the *ANZCA Bulletin*, podcasts, e-books, and links to legislation and policy regarding prescribing and using medicinal cannabis.

Google "ANZCA library cannabis" to access the guide.

Note: The guide is not intended to endorse or support the use of medicinal cannabis, but provide medical professionals with an introduction to the topic.

KEEPING CURRENT USING READ BY QXMD

Read by QxMD is a mobile app for tablets and smart phones that allows you to create a custom profile that alerts you to – and summarises – newly published content based on your selection of favourite journals, favourite topics, followed collections and specific keyword matches.

It is easy to set-up, employs an alerts-based approach to notifications, and displays content in the style of a personalised digital journal with full PDF access.

You have the choice of receiving your notifications as either an email or SMS-style alert, and can connect through to the ANZCA full-text (where available) or submit an ILL request (where not available).

Google "ANZCA apps" to access our apps guide for further details, including full set-up instructions.

Recommendation: This app is ideal for tracking newly published content and for bookmarking articles for CPD purposes.

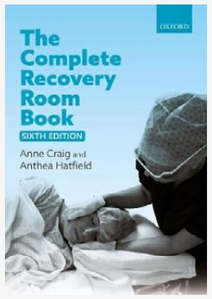
AIRR | ANZCA Institutional Research Repository

Recent contributions to AIRR – airr.anzca.edu.au.

- Merry A, Wahr J. Medication Safety during anesthesia and the perioperative period. Cambridge, United Kingdom: Cambridge University Press, 2021.
- Corcoran TB, Myles PS, Forbes AB, et al. The perioperative administration of dexamethasone and infection (PADDI) trial protocol: rationale and design of a pragmatic multicentre non-inferiority study. BMJ Open. 2019;9(9):e030402.
- van Rysewyk S, Galbraith M, Quintner J, Cohen M. Do we mean to ignore meaning in pain?. Pain Med. 2021;22(5):1021-1023.
- Lim DZ, Newby JM, Gardner T, et al. Evaluating real-world adherence and effectiveness of the "Reboot Online" program for the management of chronic pain in routine care [prepub ahead of print, 2021 Mar 17]. Pain Med. 2021.

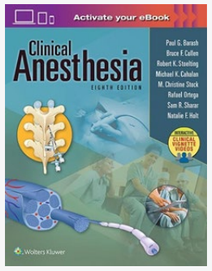
New books for loan

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



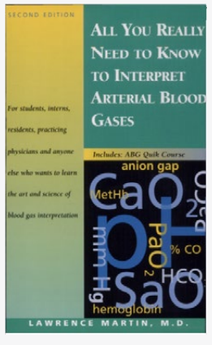
The complete recovery room book, 6e

Craig A, Hatfield A. Oxford: Oxford University Press, 2020.



Clinical anesthesia, 8e

Barash, PG. Philadelphia, PA: Wolters Kluwer, 2017.

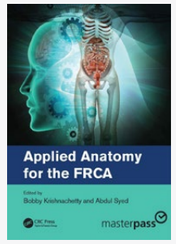


All you really need to know to interpret arterial blood gases, 2e.

Martin, L. Philadelphia: Lippincott Williams & Wilkins, 1999.

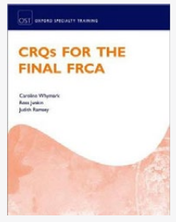
NEW EXAM BOOKS

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



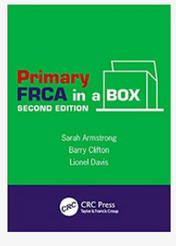
Applied anatomy for the FRCA

Krishnachetty B, Syed A, Scott H, eds. Boca Raton, FL: CRC Press, 2021.



CRQs for the final FRCA

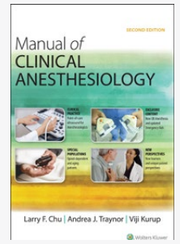
Whymark C, Junkin R, Ramsey J. Oxford, UK: Oxford University Press, 2021.



Primary FRCA in a box, 2e

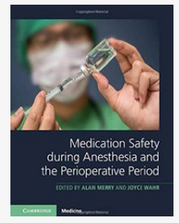
Armstrong S, Clifton B, Davis L. Boca Raton, USA: CRC Press, 2018.

NEW EBOOKS



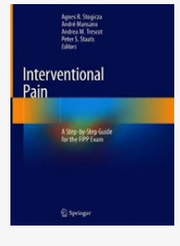
Manual of clinical anesthesiology, 2e

Chu LF, ed. Philadelphia, US: Lippincott Williams & Wilkins, 2021.



Medication safety during anesthesia and the perioperative period

Merry A, Wahr J. Cambridge, UK: Cambridge University Press, 2021.



Interventional pain: a step-by-step guide to the FIPP exam

Stogicza AR, Mansano A, Trescot AM, Staats PS, eds. Cham, Switzerland: Springer, 2020.

2020 ANZCA trainee survey results

THE FOURTH ANZCA Trainee Survey confirms a high level of trainee satisfaction with the anaesthesia training program while identifying some areas for improvement. Not surprisingly, working conditions in 2020 and the need to delay examinations during the COVID-19 pandemic impacted trainee wellbeing, which was demonstrated in the survey results.

During the survey period the coronavirus pandemic significantly impacted Australia and New Zealand, with varying levels of lockdown and border restrictions across different regions. There were significant effects on trainees, both in their training through ANZCA, and also in the general wellbeing of trainees and their families.

The 2020 online survey was conducted from 12 October to 8 November 2020 and invited 1591 trainees to participate by asking trainees to comment on the preceding 12 months of training. The survey attracted 662 responses (42 per cent) and trainees were asked about the impact that COVID-19 has had on their wellbeing, their training, and their exams.

In the hospital environment, trainees experienced redeployment to other hospital units, difficulty accessing training lists, inability to access leave, a heightened requirement for personal protective equipment (PPE), and the risk of encountering COVID-19 patients.

In the training program, trainees were affected by access to specialised study units and in-person teaching, significantly delayed examinations, and delayed progression through the training program.

Due to the negative impacts of the COVID-19 pandemic, there are some elements of the survey in which declines, or increases have occurred year on year. These may not be a reflection of the ANZCA training program year on year, but are rather a reflection of measures implemented as consequences of the pandemic.

Some of the changes driven by COVID-19 have resulted in positive impacts on trainees, for example, access to more accessible digital learning. However, many of the trainees said they would have preferred more regular communication about the disruptions to the exam process caused by COVID-19.

IMPACT OF COVID-19

- The majority of trainees have been impacted by COVID-19, particularly through delayed examinations. Of those who intended to sit exams in 2020 the majority (95 per cent) felt COVID-19 had impacted their ability to prepare for exams, and one quarter (25 per cent) have had to delay their exams due to COVID-19.
- One in two trainees (54 per cent) planned to sit exams in 2020.1 or 2020.2, and of those, only one quarter (25 per cent agree/strongly agree) decided to delay their exams due to COVID-19.
- Changes to exam plans (61 per cent) had the greatest impact on their wellbeing, followed by life impacts such as cancellation of travel plans (58 per cent) and worrying about family members (52 per cent).
- Overall, trainees felt that they were adequately trained in the use of PPE (88 per cent agree/strongly agree) and had adequate access to PPE (86 per cent agree/strongly agree). However, two thirds of trainees believe that COVID-19 has impacted their volume of practice (68 per cent agree/strongly agree), and one half that COVID-19 has impacted their training time (51 per cent agree/strongly agree).

FLEXIBLE WORKING AND TRAINING OPTIONS

Two thirds of trainees (60 per cent) say they believe having access to flexible/part-time training options is important, and of these, one in five (19 per cent) had tried to access these options.

Of those trainees who tried to access flexible working, 86 per cent were successful, agreeing that their hospital departments were supportive.

Among the trainees who had not tried to access flexible or part-time options, the increased length of training time, or being unsure what impact this would have on their training, were identified as barriers.

BULLYING, DISCRIMINATION OR SEXUAL HARASSMENT (BDSH)

The optional BDSH section of the survey was completed by 578 trainees, a response rate of 87 per cent, down slightly from 2018 and 2017. Trainees were asked whether they had been personally subjected to any BDSH in the workplace in the past 12 months.

Workplace bullying

The number of trainees who had witnessed bullying is trending downwards, with 40 per cent saying they had witnessed bullying (44 per cent in 2018, 47 per cent in 2017, 54 per cent in 2016).

Two thirds of trainees felt adequately supported to deal with bullying, discrimination or sexual harassment, but fewer had received formal education in these areas.

One third of trainees reported they have received formal education and training in identifying, managing or preventing workplace bullying, discrimination or sexual harassment.

Workplace discrimination

Claimed experiences of workplace discrimination have significantly increased since 2018, with significantly more trainees reporting they have experienced discrimination in the workplace compared to 2018 (15 per cent up from 11 per cent). The overall increase in experiencing discrimination among trainees has been driven particularly by South Australia and the Northern Territory where the proportion of trainees personally experiencing discrimination has increased to 26 per cent – the highest of all regions.

Similar to 2018 and results on workplace bullying, trainees were far more likely to know how to report or seek help regarding discrimination in their hospital department (84 per cent) and hospital (58 per cent), than through their college(s) (44 per cent) or outside bodies (30%).

Workplace sexual harassment

In line with 2017 and 2018, those reporting experiencing and witnessing workplace sexual harassment are low, with very few trainees reported having experienced (3 per cent) or witnessed (7 per cent) workplace sexual harassment and no significant differences between hospital locations.

Consistent with 2018, two thirds (67 per cent) of trainees feel prepared and supported to deal with sexual harassment in the workplace. However, the number of trainees who reported having received formal training on identifying, managing or preventing it has slightly decreased this year from 30 per cent in 2018 to 27 per cent, with all hospital locations experiencing a slight decrease.

ANZCA TRAINING PROGRAM

The majority of trainees (79 per cent agree/strongly agree) were overall satisfied with the ANZCA trainee program.

Trainees are significantly more satisfied in 2020 with:

- The volume of practice targets (89 per cent agree/strongly agree).
- The overall useability of the training portfolio system (85% agree/strongly agree).

HOSPITAL TRAINING ENVIRONMENT

Trainees were asked to identify the most recent hospitals at which they had worked and were given the opportunity of identifying up to three. A series of questions were then asked of trainees with reference to each of the hospitals identified. While satisfaction is overall relatively strong across most key elements of the hospital training environment there are some areas where satisfaction is lower than in 2018. This is likely related to the delayed examinations trainees experienced driven by limitations caused by COVID-19.

Over 90 per cent of respondents agreed with the following:

- The supervisor of training had been supportive in helping to meet training goals (94 per cent agree/strongly agree).
- They had been able to take leave when required (92 per cent agree/strongly agree).
- The consultants in the department had been fair in their assessment of performance (97 per cent agree/strongly agree).

However, a notable number of respondents agree disagreed or strongly disagreed that they:

- Had access to a functioning mentoring program (19 per cent).
- Had a balanced roster (for example, hours, overtime) (15 per cent).
- Had adequate time for clinical duties out of the operating theatre (17 per cent).

RURAL, PROVINCIAL AND REMOTE WORK

Nearly three in four trainees have lived in a regional or rural area, with almost one in two (44 per cent) having trained for 12 months or more in these areas. While only 31 per cent plan to work in a regional or remote area following training, 70 per cent would consider working in these areas in future.

SOCIAL MEDIA

While the most common forms of social media used by trainees are Facebook and Twitter, trainees reported that they preferred to receive information from ANZCA either from email updates (86 per cent extremely/somewhat valuable) or the Training E-Newsletter (74% extremely/somewhat valuable).

INDIGENOUS IDENTIFICATION

In line with previous years, a similar level of 3 per cent of trainees identify as Indigenous. Of these, the most common identification was Māori, with the highest proportion in New Zealand.

WHAT HAPPENS NOW?

The ANZCA Trainee Committee thanks all trainees for taking the time to share feedback on their training experience.

Despite the challenges posed by the COVID-19 pandemic, ANZCA training sites are to be congratulated on maintaining the positive trend of survey results in relation to trainee satisfaction with their workplace experience. The survey has also identified areas within the training experience where there may be room for improvement.

The survey was managed by an external consultant and a suite of reports has been prepared for ANZCA to disseminate results to key stakeholders, including ANZCA training sites. Training sites have received de-identified results of the survey relevant to that site. Results have also been shared with ANZCA executive committees and committees that support trainees and the training program.

The Education and Research unit will be co-ordinating an action plan in consultation with the ANZCA Trainee Committee and relevant education committees from the results of both the 2020 ANZCA Trainee Survey and the 2020 Medical Board of Australia Medical Training Survey. When the analysis is complete and themes and issues fully identified, the results will be widely shared.

Thank you to all of the trainees who participated in the survey. It is important that your voice is heard by the college and your feedback will be used to continue to improve our world-class training program.

Dr Katherine Gough
Co-Chair, ANZCA Trainee Committee (2020)
Chair, 2020 ANZCA Trainee Survey Working Group

Dr Nicole Muir
Co-Chair, ANZCA Trainee Committee (2020)

Successful candidates

Primary fellowship examination

2021.1 Exam

One hundred seventy-two candidates successfully completed the primary fellowship examination:

AUSTRALIA

Australian Capital Territory

Manil Lakshan Abeygunasekara
James Marcus Mccredie Dando
Liam Daniel Gleeson
Darcy Mark Mcfarland
Dharan William Sukumar
Edward Charles White

New South Wales

Dani Martin Bachmann
Harrison Ray Bell
Bradley Robert Bridge
Vanessa Shwen Yuen Chen
Sjorjina Nichole Crowther
Andrew Do
Kieran Raleigh Easter
Byron John Economos
Simon William Graham Ellis
Catherine Rose Epstein
Anri Forrest
Rory Giles Gillingham
Alexander Henry Goswell
Mark Roland Grivas
Anna Amelia Hines
Christopher James Hudson
Jaeni Huynh
Dushyant Iyer
Matthew Mackenzie James
Emily Rose Kettle
Ho-Kyung Kim
Kasia Kulinski
Rebecca Frances Landers
Priya Maheshwari
Michelle Wing Yan Miu
Stephanie Joseph Naim
Li Ching Ooi
Justin William Payne
Daniel Joseph Pearce
Brian Pereira
Benjamin David Pons
Daniel Thomas Robertson
Saipriyadharshan Ruthirakumar
Andrew James Simpson
Gene Stokel Slockee
Kelly Teneile Stallard
Katie Ann Sullivan
Lucy Cameron Sutherland
Laura Simone Thomas
David Tian
Hannah Tracey Watson
Rosie Ann Watters
Oscar Yuan Ti Wen
Julian Robert Nicholas Wicks
Daniel Zardawi
Kylie Jun Ting Zhong

Queensland

Stephen Brian Alvarado
Neeban Balayasoderan
Janjovenjit Bassi
Margaret Anne Blanco
Andrew Brendon Michael Bond
Matthew Ralph Bright
Alyce Jance Burgess
Samuel Joseph Cook
Ellen Kathryn Coonan
Gareth Edward Evans
Mustansir Farooq
Zenan Michael Franks
Matthew Thomas Greber
Megan Wendy Elaine Grigg
Gert Benjamin Van Heerden
Susanna Rose Hoffmann
William Johnson
Simon Ali-Akba Robert Baker Jones
Gabriela Diana Kelly
Maggie Tess Keys
Lamont Tsochang Chongwi Lee
Amy Chien-Ho Lin
Chloe Louise McKenna
Nathan Paul Murray
Kathryn Noakes
Norman Rodger Petersen
Jerry Jiajun Qian
Louise Marie Rafter
Kate Ralfe
Alexander Ramsay Lyndhurst Robinson
Ben Steve Steiger
Anna-Marie Georgette Tanios
Kevin James Twomey
Emma Jennifer Walker
Siqi Wang
Laltaksh Wangoo
Michelle Dahlia Wartski
Raphael Weidenfeld
Rachael Maree Weir

South Australia

William John Emmerton
Damian Joseph Graham Johnson
Arvind Jothin
Alexander David Kimpton
Courtney Ellen Lloyd
Angela Alex Mathew
Luke Aiden Proctor
Christopher James Stanton
Vimal Sekhar
James Paul Turnbull

Tasmania

Lisa Christina Allen
Bing Hui Chang

Victoria

Kieran Peter Bates
Patrick Lloyd Beall
Alexandra Amy Bolger
Macushla Clare Byrne
Madeline Grace Corke
Patryck Julian Lloyd-Donald
Stefanie Fabris
Dominique Marie Grant
Leonie Madeline Harold
Robert Joffe
Hamish Westcott Lanyon
Natalie Lok Hunn Law
Simon Paul Leckenby
Efstratios Maglogiannis
Maria Fernanda Perez Miranda
Thomas Patrick Mullaney
Braden Lee Preston
Carolina Radwan
Callum James Robinson
Emily Jane Robson
Keiran James Rowan
Ashleigh Joan Sellar
Tarun Sharma
Jin Sern Toh
Loran Varlie Towell
Juan Camilo Sandoval Vesga
Kasun Shaminda Wickramarachchi
Marcus Jia-Sheng Yip

WA

Erin Anne Chevis
Katherine Anne Collins
Michael James Connelly
Rohit Daswani Daswani
Louise Elizabeth Dawson
Sharon Eow
Aileen Therese Fenelon
Si Ying Lim
Jingjing Luo
David Andrew Robertson
Kieran Patrick Robinson
Ilan Sean Silberstein
Natalie Sarah Elizabeth Smith
Nicholas Thomas Ward
Jacob Daniel Woodward

NEW ZEALAND

Kirsty Luisa Pantua Ammundsen
Aliya Arslanova
Thomas Matthew Barr
Alexander Edward Bewick
Joseph William Collinson
Andrew Neil Curtis
Jenna Elizabeth Donaldson
Jan Duleba
Keith Donald Green
Richard John Hanlon
Matthew James Barraclough Hill
Archie Cameron Hughes
Saoirse Rachel Kelly
Dayle Andrew Keown
Suhyun Kim
Jiyeon Kwon
Caroline Weiling Law
Rohan John Lynham
Jonathon Neil MacColl
Jessica Murphy
Jonathan Richard Paulin
Persis Anne Hepzibah Samuel
Rebecca Grace Stewart
Aidan Ian Norman Ward
Katherine Joan Wauchop
Annie Gia-Mun Yau

RENTON PRIZE

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

Natalie Sarah Elizabeth Smith, WA

MERIT CERTIFICATE

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

Neeban Balayasoderan	**Qld**
Louise Marie Rafter	**Qld**
Kieran Patrick Robinson	**WA**
Joseph William Collinson	**NZ**

ANZCA PRIMARY EXAMINERS

Clockwise from left: Primary Exam examiners in New Zealand, Victoria and New South Wales

ANZCA Final Examination

2020.2 Exam

Seventy-six candidates successfully completed the final fellowship examination:

AUSTRALIA

Australian Capital Territory

Cameron Douglass Maxwell
Kathryn Louise Mence
Nerida Anne Robinson

New South Wales

Benjamin James Bartlett
Mark Chemali
Tejas Chikkerur
Laura Joan Dansey
Anne-Marie Winfield Dempster
Faith Fenella James Dyer
Ronald Kam Fai Fung
Mary Kathleen Grealish
Sophie Shuang Liang
Eugene Joseph McKernan
Tessa Alexandra Nall
Sarvpreet Pala
Yvonne Strohmeier
Claire Ellen Strong
Benjamin Daniel Tassie
Victoria May Ward

Queensland

Keith Addy
Michael Gregory Brown
Thiruvashrin Chetty
Joshua C Chew
Yevgen Demidenok
Martha Ghaly
Alexandra Ellen Hickey
Anoop Jain
Faisal Khan
Jacqueline Maree Laws
Joyce Hilda Leung
Chi-Hang Leung
Louven Bing Menzies
Mark John Moll
Romitha Vidushan Ranasinghe
Kellie Maree Rozdarz
Dione Elizabeth Stuart
Siji Thomas Thalekal
Allister David Erskine Ware

South Australia

Dana Louise Bolt
James Andrew Briggs
Shaun Peter Campbell
Kedar Santosh Joshi
Mitchell Keith Petersen-Tym
Brianna Alysia White

Tasmania

Charles Paul Noonan

Victoria

James William Charles Ballantyne
Katherine Amelia Carroll
Maryam Khalil Cassim
Joanne Linzi Court
Harsh Deep Dubey
Rohan Hardikar
Sarah Ling-Yi Hong
Angus Edward Patrick Thomson

Western Australia

Nicholas Anthony Enzor
Laura Jane Hamilton
Jonathan Richard Hills
Aria Bradford Lokon
Gabrielle Eve Sicari

NEW ZEALAND

Charles Robert Wiremu Allen
Oliver Greg Ball
Matthew James Beard
Jonathan Paul Bennett
Kate Elizabeth Campbell
Trent George Cutts
Emma Elizabeth Foster
Michelle Ann Gatter
Qiao He
Amiria Isabelle Taylor Howie
Zeyin Li
Matthew Jeremy Lowe
Keryn Dale McLeay
Shuh Fen Moy
Ching Wern Ong
Marta Danuta Seretny
Michael Thomas Wadsworth
Michael Craig Waterhouse

SIMG examination

Two candidates successfully completed the specialist international medical graduate examination:

Ilkka Sakari Salmenkaita, SA
Falk-Hendrik Droste, WA

CECIL GRAY PRIZE

No candidates were awarded the Cecil Gray Prize for the 2020.2 final examination.

MERIT CERTIFICATES

Merit certificates were awarded to:

Trent George Cutts, NZ

Michael Craig Waterhouse, NZ

2021.1 Exam

One hundred and sixty candidates successfully completed the final fellowship examination:

AUSTRALIA

Australian Capital Territory

Annelise Kerr
Kurtis Tadeusz Zapasnik

New South Wales

Patrick Marie Francois Bazin
Maximilian Geoffrey D'Bras Benness
Daniel Francis Broderick
Gregory John Dale
Christopher John Dawson
Jason Paul Denmeade
Cameron James Dunn
Timothy Loi Duong
Stephanie Leanne Giandzi
Andrew John Gilmore
Neha Gosavi
Andrew John Inglis
Melissa Ann Inglott
Andrea Kasthuri Jeyendra
Polwatte Karunathilake
Gaston Leroy Kohar
Jessica Ida Elizabeth Lack
Yan Tong Lai
Jaroslaw Jerzy Latanik
Sara Letafat
Natalie Marion Lukas
Angus Stuart-Charles McNally
Briana Loloma Miller
Melissa Anne Oliver
Timothy Francis O'Loughlin
Myfanwy Sarah Avis Painter
Parita Patel
Lauren Paton
Daphne Subarna Premnath
Bridget Marjorie Prior
Emma Elise Privett
Braden Robert Lowry Rivers
David Michael Mark Saunders
Nicholas Edward Stewart
Simon Tiew Fong Ting
Simone Rebecca Young
Weiting Lisa Zhao

Northern Territory

Kobi Lee Haworth
Matthew Nikola Pavicic
Daniel James Stone

Queensland

Adam Frank Bartlett
Ruth Miriam Blank
Kristopher Michael Blucher
Rosalyn Clare Boyd
Grant James Breadsell
David Michael Briggs
David John Burgess
Michael John Busser
David Emanuel Coe
William Brett Curtis
Zahra Maryam Farzadi
Elliot David Field
Charles Greet
Jatinder Paul Grewal
Jonathan George Guirguis
Rebecca Susan Haenke
Maxim John Hatton
Jane Caroline Leadbeater
Alyce Jane McKenzie
Brendan Anthony Mitchell
Rachel Ilse Preisenberger
Stephanie Ann Samuelraj
Jacqueline Anne Seebold
Yi Ching Siah
Justin Nicholas Swierczek
Victoria Man Ying Tsang
Mark Alexander Wynne
Kewei Xu

South Australia

Dustin Che De Jonge
Thomas Paul Goddard
Christopher James Harry
Thomas David Maycock
Alicia May Paterson
Charlotte Naomi Wade
Richard Jonathan Wood

Tasmania

James Alexander Correy
David John Hargreaves
Brigit Ann Ikin
Alistair James Park

Victoria

Sarah Louise Allen
Benjamin David Allnutt
James Lachlan Bainbridge
Emily Ruth Balmaks
Caroline Mary Bate
Ben James Blackman
Daniel Brooks Reid
Elaine Rea Chilcott
Lillian Sarah Coventry
Thomas David Darling
Rick Jonathon Davis
Oliver Thomas Gouldthorpe
Thomas Ian Grosser-Kennedy
Yu-Feng Frank Hsiao
Nicole Jacqueline Hunt
Shaun Michael Hutchinson
Grigor Indjeian
Luxmana Sean Jeganathan
Namrata Devi Jhummon-Mahadnac
Ezra William Keebaugh
Matthew John Kilpin
Jana Alexandra Lau
Kent Edward Lavery
Annabel Li Ming Lim
Jonathan Lin
Ainsley Christina Lorych
Joshua Reid Lun
Tom Luo
Tess Alexandra Maplestone
Amelia Rose Marshallsea
Clare Mary McCann
Adam Daniel Morrow
Reubban Shivaprian Muthusamy
Benson James Nardino
Tim Nguyen
Nicole Paterson
Sandeep Singh Rakhra
Cameron Nathaniel Rush
Di Shan
Lauren Michelle Smith
Michelle Nicole Stewart
Dominik Aleksander Teisseyre
Hon-Ming Tung
Lauren Kate Walton
Timothy John Williams
Nicholas Casimir Zichy Woinarski
Christine Wu

WA

David Brooke
Angus Campbell Johnston
Natalie Carole Thurston
Frederick James Achille Torlot
Dorian Martin Wenzel

NEW ZEALAND

Rachel Patrice Bell
Thomas Benjamin Brown
Frances Helen Campbell
Devin John De Groot
Mikaela Louise Garland
Louis Edgar Wilkinson Glass
Patrick Alan James Griffin
Elizabeth Rachel Hall
Andrew David Ham
Renee Clair Hope
Maureen Josie Indoe
Narendran Jayaraman
Rebecca Margaret Johansen
Toby Francis Kane
Max Malte Martensson
Walston Reginald Martis
Anna Jan Mearns
Natalie Hazel Paterson
Anna Julia Pozaroszczyk
Kayleigh Anne Price
Kate Ellen Rea
Jennifer Ross
Sam Whitley Schriek
Atsuko Tarapore
Saana Ann Rosie Taylor
Amy Shan-Mei Tseng
Grace Qing Zhang

SIMG examination

Seven candidates successfully completed the specialist international medical graduate examination:

Mathias Stefan Legrand, SA
Kamal Kishore, Tasmania
Bhuwan Sareen, Tasmania
Neha Raheja, Victoria
Rajesh Kumar Cheria Parambathu, WA
Manisha Desai, WA
Kiran Bharath Venkatesulu, WA

CECIL GRAY PRIZE

No candidates were awarded the Cecil Gray Prize for the 2021.1 final examination.

MERIT CERTIFICATES

Merit certificates were awarded to:

Devin John De Groot, NZ

Walston Reginald Martis, NZ

Michael John Busser, Queensland

Kiran Bharath Venkatesulu, WA

Foundations of clinical anaesthesia course for WA trainees

RIACCT course participants at Fiona Stanley Hospital

THE FIRST THREE-DAY Readiness for the Initial Assessment of Anaesthetic Competencies Training (RIACCT) course was held recently for WA trainees. The course aims to provide a solid foundation for introductory trainees' (ITs) clinical practice. Adapted for the ANZCA curriculum and WA's training needs, the RIAACT course is based upon the well-established RIACT course run for the UK's Oxford Deanery trainees.

RATIONALE

Introductory trainees begin training with varying levels of experience. With no centralised, clinical education on the IT syllabus plus an "intimidation factor" created around the primary examination, ITs focus much of their early enthusiasm and effort on exam preparation rather than developing clinically safe anaesthetic practice. RIAACT shifts this focus back to the theatre and contributes towards the primary purpose of the IAAC – to ensure ITs can "safely work beyond Level 1 supervision for suitable cases".

COURSE STRUCTURE

The objectives of RIAACT are:

- To provide a structured overview of core topics for ITs to "pin" their daily experiences on.
- To provide a safe environment to encourage open discussion and facilitate applying new skills, knowledge and experience to clinical situations in both case-based discussions and simulation scenarios.

Held over three days in the first three months of introductory training, each day escalates in complexity. Following a set of short lectures, trainees rotate through sets of three concurrently running sessions with four to five trainees per group. We used a combination of learning techniques including hands-on skills stations, immersive simulation and interactive tutorials to promote active learning and reflection.

MOVING FORWARD

The course ran well with very positive feedback from both faculty and trainees and we are hugely grateful for the ongoing time and effort given by the faculty at all of our hospitals. Special thanks go to Dr Archana Shrivathsa in her role as medical lead and running the Fiona Stanley Hospital component and to Dr Tania Rogerson and Dr Ryan Juniper for running the Sir Charles Gairdner and Royal Perth Hospital components.

RIAACT will continue to run every six months in WA. As expected, a few minor aspects can be improved over subsequent courses, however no changes to course structure, content or methods are needed.

We are happy to share our resources and experience with anyone who is interested in extending the RIAACT course to their area so please contact us if you require more information.

Dr Michael Robbins,
Advanced Anaesthesia Trainee, Fiona Stanley Hospital
RIACCT Co-ordinator
Michael.robbins@health.wa.gov.au

Dr Archana Shrivathsa, FANZCA
Medical Lead, Fiona Stanley Hospital
Archana.shrivathsa@health.wa.gov.au

A coffee break with a difference

Two Melbourne anaesthetists have created a podcast that is aimed at trainees preparing for their ANZCA primary exam.

ANAESTHESIA COFFEE BREAK was developed by Dr Lahiru Amaratunge and Dr Stanley Tay, both consultant anaesthetists from Western Health and honorary lecturers at the University of Melbourne. The podcast centres on the ANZCA primary exam and explores the important basic science concepts as well as tips and tricks to passing the exam.

The podcast launched in November 2020 and episodes include short answer question and multiple choice question tips, the effect of morbid obesity on the washout of volatile anaesthetics, and practice viva simulations with primary exam candidates.

Dr Amaratunge and Dr Tay describe themselves as passionate educators who are "part of the evolutionary changes in education, using digital technology to support trainee-centred constructivist learning."

"We recognised early during the pandemic last year that online learning and social interaction through video conferencing apps had rapidly become the substitute for traditional face-to-face classes and study groups. We wanted to support this method of learning and after seeing the success of the Deep Breaths podcast by Dr Katherine Steele and Dr Kate McCrossin for the final exam, starting a podcast for the primary exam seemed like the natural thing to do," says Dr Tay.

Dr Amaratunge who already runs a Viva Boot Camp for final exam candidates as well as a YouTube channel (ABCs of Anaesthesia), was excited at the opportunity to share his knowledge and experience in assisting trainees to pass the exam.

"The ANZCA primary exam is one of the most difficult exams in the medical system. For most of us it is our first specialty exam and the first exam that requires us to memorise a vast and potentially overwhelming quantity of information," said Dr Amaratunge.

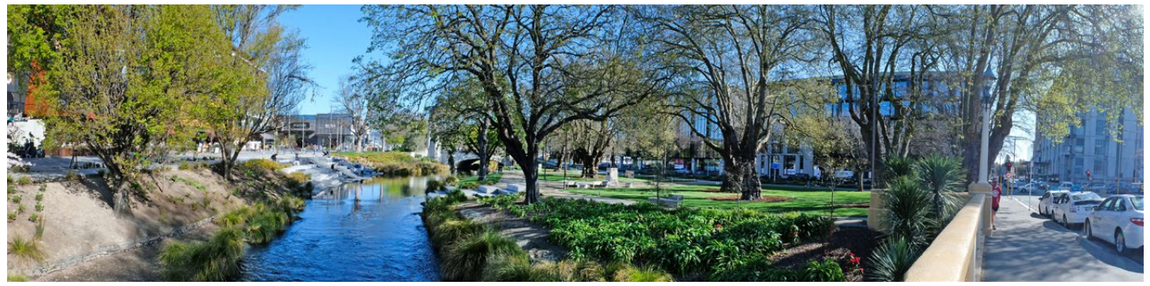
"Our aims for this podcast are to cover the core components of the syllabus, discuss exam techniques and interview interesting guests such as examiners and anaesthetists who have excelled in this exam. We want trainees to pass this exam on their first attempt and to do this, we want to rapidly enhance their learning curve, avoid crucial learning errors and unproductive study patterns and most importantly be motivated, productive and efficient in their study."

The podcast is available on all platforms including iTunes, Spotify, Google and Amazon.

With more than 15,000 downloads and a global audience, Dr Amaratunge and Dr Tay believe the content they are producing is making a difference, allowing trainees to learn when it suits them.

"We have a lot to be thankful for, and we are grateful for the support of our listeners, because to know that we are making a positive difference means the absolute world to us," reflects Dr Tay.

Search for "Anaesthesia Coffee Break" on all major podcast sites. We invite those who share the same passion and vision as us to contribute to our podcast by contacting us at lahiruandstan@gmail.com.



Make Christchurch your destination:

Aotearoa NZASM this October

#NZASM21

ŌTAUTAHI CHRISTCHURCH IS a revitalised city in the heart of New Zealand's South Island. Over more than a decade, Christchurch has suffered from unexpected and devastating events. However, the city is back and more vibrant than ever. This October, the city is hosting an anaesthesia conference that you do not want to miss.

The theme of the Aotearoa New Zealand Anaesthesia Scientific Meeting (ANZASM) is Whakaora (To Heal): Our patients, Ourselves, Our City, Our Planet. The theme is profoundly meaningful for Christchurch.

Healing has been big on the agenda here.

At this whanau (family)-friendly conference from 27-30 October, Whakaora guides everything the organising committee are doing and everything you will experience.

"Whakaora – to heal is not just a theme," says organiser Dr Ross Scott-Weekly, "it underpins every decision and plan we have made for this conference. There is a sense of healing that is happening for the people of Ōtautahi after a tumultuous decade. Hosting an exciting, innovative conference is part of that healing."

One of the keynote speakers, Professor Carol Peden is well known for her role co-ordinating the National Emergency Lapartomy Audit (NELA) in the UK. Earlier this year, her team published the first consensus guidelines for optimal care of these patients using an Enhanced Recovery After Surgery (ERAS) approach. ERAS protocols reduce length of stay, complications and costs for a large number of elective surgical procedures. A similar, structured approach appears to improve outcomes, including mortality, for patients undergoing high-risk emergency general surgery. Dr Peden is also the chair of the American Society of Anesthesiologists Perioperative Brain Heath Initiative.

Another keynote is Professor Daniel Sessler from Ohio who founded and directs the Outcomes Research Consortium. The consortium is the world's largest clinical anaesthesia research group, and publishes a full paper every three days. Dr Sessler is an editor for Anesthesiology and serves as a director for the Foundation for Anesthesia Education and Res-earch (FAER).

Speakers aside, the three-day ANZASM also boasts some excellent workshops including a trauma simulation held at the Christchurch Adventure Park. People can also sign up for Te Reo Māori classes or waka paddling on the beautiful Avon River that meanders through the newly rebuilt city.

Dr Ben van der Griend, convenor of the 2021 ANZASM in Christchurch says this conference will be one you will always remember. "We are very fortunate and excited to be able to host this conference. We are hoping that many of you will come to Christchurch to take the opportunity to reconnect face-to-face with the broader anaesthetic community. With the trans-Tasman travel bubble established, we may even get to welcome some of our colleagues from across the ditch."

Early bird registrations are open, closing on 26 September (https://www.nzanaesthesia.com/register). Paper or poster submissions are welcome from all delegates attending the meeting. There are three ANZCA and New Zealand Society of Anaestheisa (NZSA) prizes on offer.

Tamariki attending the ASM?

Back by popular demand, on-site childcare facilities will be available for all "junior delegates" who will be accompanying you on your trip to Christchurch, but may find the scientific content of the plenary sessions a little beyond their current attention span. If your pēpi needs to be with you, you are of course welcome to bring them to all of the sessions.

Christchurch Hyperbaric Medicine unit certified for training

From left: Dr Greg van der Hulst, FRNZCGP, FDRHMNZ, DipAdvDHM (ANZCA), Clinical Director, Christchurch Hyperbaric Medicine Unit and Dr Kenneth Lo, FACEM, Hyperbaric Fellow, Christchurch Hyperbaric Medicine Unit.

TE WHARE HAU o Te Hau Ora (the Christchurch Hyperbaric Medicine Unit) recently received approval for advanced training in Diving and Hyperbaric Medicine (DHM) from ANZCA's DHM subcommittee.

The Canterbury unit is one of only two in New Zealand, which, alongside the Slark Hyperbaric Medicine Unit at Waitemata District Health Board, provide hyperbaric oxygen therapy services for both acute and elective conditions for all of New Zealand. Christchurch now joins the five Australian Hyperbaric Units accredited for training by ANZCA.

The subspecialty of Diving and Hyperbaric Medicine (DHM) has two main areas. These are diving medicine, which is primarily involved in the prevention and treatment of diving-related injury, and hyperbaric medicine, the treatment of specific medical conditions with hyperbaric oxygen.

DHM in the South Island of New Zealand began in Christchurch in 1973 with a trial of hyperbaric oxygen (HBOT) to enhance radiotherapy for patients with head and neck cancers. It was also used to treat acute problems such as decompression sickness, gas gangrene and carbon monoxide poisoning.

In the late 1970s, the local diving community raised the money for a dual-lock chamber, which they donated to the North Canterbury Hospital Board. The chamber operated at the Princess Margaret Hospital for 15 years. In 1995, the chamber and associated plant moved to Christchurch Hospital, allowing better access to core services such as radiology and intensive care. In 2000, permanent staff were appointed and a new rectangular, walk-in chamber replaced the old one. This achieved the goal, set back in the early 1980s, to establish the Christchurch unit as a comprehensive hospital-based hyperbaric facility.

Over the years, permanent medical, nursing and technical staff were recruited intermittently, but there has been no recognised training positions in DHM for medical, nursing or technical trainees in New Zealand. Without the ability to train the next generation of diving and hyperbaric physicians, technicians and nurses, small-subspecialised areas like this tend to lurch from one staffing crisis to the next.

ANZCA's Diving and Hyperbaric (DHM) Sub-Committee put significant time and effort into developing the Diploma of Advanced Diving and Hyperbaric Medicine that became available in its current form in 2017. While this post-specialisation qualification for medical practitioners does not lead to specialist registration in DHM, it is the only one of its kind in Australasia. The Christchurch Hyperbaric Medicine Unit is also in the final stages of developing a training position for a hyperbaric technician.

The current hyperbaric fellow in Christchurch is Dr Kenneth Lo, FACEM. The Christchurch Emergency Medicine Department recently developed subspecialisation fellowship positions, one of which is in DHM. Fellows are appointed for two years with a 75 per cent/25 per cent split between emergency medicine and DHM. The benefits of having a fellow join the Hyperbaric Unit team are already apparent with a sharing of knowledge from different primary subspecialty backgrounds bringing an injection of enthusiasm and new ideas for research.

Dr Greg van der Hulst, FRNZCGP, FDRHMNZ, DipAdvDHM (ANZCA)

Australian Capital Territory

ART OF ANAESTHESIA

The 2021 Art of Anaesthesia CME will be held on September 11 and 12 at the Hotel Realm, Barton ACT. The theme of the meeting is "The Occasional Anaesthetist" and the focus for much of the lectures will be refreshers in the main anaesthesia disciplines. We have an exciting line up of speakers on offer this year including Dr Joanne Irons (RPA, Sydney), Professor Bernhard Riedel (Peter Mac, Melbourne), Associate Professor Forbes McGain (Western Health, Melbourne), Dr Peter Hebbard (Northeast Health, Wangaratta), and plenty of our best local speakers. On Sunday morning, delegates will also be able to register to participate in ALS and CICO emergency response workshops. We have timed the meeting to coincide with the Floriade flower festival, Australia's largest celebration of spring which showcases one million flowers in bloom throughout Commonwealth Park. Why not bring the family, stay for the weekend and enjoy a unique experience in the nation's capital. Registration is now open so jump on the college website and secure your place now!

New South Wales

INTRODUCTION TO ANAESTHESIA

The ANZCA NSW Regional Committee are pleased to announce that the introduction to anaesthesia course will held on Saturday 13 November 2021. The venue will be confirmed soon.

The course is specifically aimed at basic trainees in their first year of training or doctors about to take up training positions in 2022. The course covers many topics, from how to deal with clinical errors, to what to expect in anaesthesia training and how to look after your own welfare, all delivered in a short and informal format. The session has been such a success in previous years that many departments have made it compulsory for new trainees. Look for the flyers soon to be sent to anaesthesia departments. The course is free. Register your interest by emailing nswcourses@anzca.edu.au before Friday 5 November 2021.

Dr Rebecca Lewis
Convenor

Dr Natalie Kent
Convenor

PRIMARY EXAM REFRESHER COURSE

This is a full-time revision course, run on a lecture/interactive tutorial basis and is most suitable for candidates presenting for their primary examination in the first part of 2022.

- Monday 29 November – Friday 3 December 2021
- Northside Conference Centre, Corner Oxley Street and Pole Lane, Crows Nest NSW 2065
- $A660

Applications close on Monday 15 November 2021, if not already filled. The number of participants for the course will be limited. Preference will be given to those candidates who will be sitting the primary examination in the first part of 2022. Late applications will be considered only if vacancies exist. For further information please email nswcourses@anzca.edu.au or phone +61 2 9966 9085.

FINAL EXAM REFRESHER

The course is a fulltime revision course, run on a lecture/interactive tutorial basis and is open to candidates presenting for their final fellowship examination in 2022.

- Monday 6 December – Friday 10 December 2021
- Northside Conference Centre, Corner Oxley Street and Pole Lane, Crows Nest NSW 2065
- $A825

Applications close on Monday 22 November 2021, if not already filled. The number of participants for the course will be limited. Preference will be given to those candidates who will be sitting for their final fellowship examination in the first part of 2022. Late applications will be considered only if vacancies exist. For further information please email nswcourses@anzca.edu.au or phone +61 2 9966 9085.

UPCOMING MEETINGS

NSW Spring Meeting Leura – 20 and 21 November 2021

NSW Anatomy Workshop – 27 November 2021

Queensland

2021 ANZCA ASM – BRISBANE ENGAGE HUB AND COLLEGE CEREMONY

The ANZCA annual scientific meeting (ASM) came to Brisbane on Saturday 1 May as part of this year's virtual ENGAGE hubs "Super Saturday". Delegates had the opportunity to come together and network at the Pullman King George Square, with morning and afternoon sessions being broadcast on the big screen. In the evening the hub transformed into the College Ceremony. Congratulations to the 39 new fellows of the college, and the three new fellows of the Faculty of Pain Medicine who were presented in Brisbane. Well done also to Dr Hannah Bennett who was awarded the Barbara Walker Prize for achieving the highest mark in the 2020 pain medicine fellowship exam. The evening concluded with light refreshments, and a chance for family, friends and colleagues to celebrate this tremendous achievement.

Many thanks to Dr Sean McManus, Dr Christopher Stonell, and Dr Paul Lee-Archer for hosting the ENGAGE hub, and also to Dr Sean McManus, Associate Professor Newman Harris, and past president Dr Genevieve Goulding for presenting at the College Ceremony.

PRIMARY EXAM REFRESHER COURSE

The primary exam refresher course was held from 31 May to 4 June at the Souths Leagues Club, West End, attended by 34 trainees. This week-long interactive course was designed to help candidates prepare for the primary exam in August, and included practise short answer questions. Special thanks to course convenor Dr Bronwyn Thomas, and to all presenters for contributing their time and expertise to this course.

Above: Course convenor Dr Bronwyn Thomas presenting to Queensland trainees.

Left, from top: College ceremony; Associate Professor Newman Harris presenting The Barbara Walker Prize to Dr Hannah Bennett.

Photo credits: Scene to Believe

South Australia and Northern Territory

BIENNIAL NORTHERN TERRITORY ACE CONFERENCE

The 2021 NT Anaesthesia Continuing Education Conference "Clever Clever in the Never Never – Improving perioperative outcomes" was held at the Darwin Convention Centre on 5 June 2021. Delegates took the opportunity for a sunny winter break and to gather face to face to examine the themes of perioperative optimisation and improving perioperative outcomes.

Keynote speaker Professor Guy Ludbook presented "The hidden pandemic" discussing current and emerging initiatives in the field of early postoperative care and strategies to improve outcomes and value in healthcare. Professor Ludbrook also spoke on "Back to the future" outlining the processes of developing therapeutic goods, some perspectives of what it takes to develop these and how clinicians and jurisdictions consider new drugs and devices when planning their care delivery.

During the afternoon, delegates had the opportunity to choose from two emergency response workshops – Advanced Life Support and Can't Intubate, Can't Oxygenate. Dr Allan Cyna also presented a workshop "Wizard ways with words – the hitchhiker's guide to hypnotic communication in anaesthesia" which provided a "how to" guide to therapeutic communication for anaesthetists when the usual strategies aren't working. Challenges addressed included severe needle phobia, communicating calm to the extremely anxious, soothing words in acute and chronic pain management and adjunctive communication techniques in paediatric burns and obstetric anaesthesia.

Delegates and partners enjoyed some Top End hospitality at the end of the day at the alfresco conference dinner, watching the glorious sunset overlooking the Arafura Sea.

The CME Committee would like to thank conference convenors Dr Ruth Barbour and Dr Sandy Smirk, FANZCA speakers and workshop facilitators for their efforts in putting together such a successful conference.

From top: Dr Guy Ludbrook, Dr Sandy Smirk, Dr Ruth Barbour, Dr Allan Cyna and Dr Richard Walsh; NT ACE Conference Dinner – Dr Jacob Koshy, Dr Bernadette Wilks and Dr Yena Hwanga; Delegates participating in ALS workshop.

COLLEGE CEREMONY

The SA/NT College Ceremony held at the Adelaide Intercontinental Hotel was a memorable and enjoyable evening. Immediate past president Dr Rod Mitchell and immediate past FPM dean Dr Meredith Craigie, councillor Dr Scott Ma and ANZCA staff were delighted to congratulate and celebrate the Renton Prize Winner Dr Andrew Burch and the 16 new fellows, including Cecil Gray Prize winner Dr Craig Morrison.

It was a wonderful opportunity to meet proud and beaming partners and family members, some of whom had travelled from interstate and from New Zealand, and a unique occasion to rejoice with the new fellows in achieving the rewards of the many years of hard work and commitment.

From top: ASM presenting fellows; Immediate past FPM dean Associate Professor Meredith Craigie, Immediate past president Dr Rodney Mitchell, Dr Elena Vowels, Dr Nicole Diakomichalis and Dr Darryl Jones.

Tasmania

COLLEGE CEREMONY

COVID-19 continues to bring unprecented times with the College Ceremony held simultaneously around the country (except for WA due to a last-minute outbreak). The ceremony in Hobart was held on Saturday 1 May at The Hobart Function and Conference Centre on Elizabeth Pier. This provided a sparkling waterfront outlook for the three new fellows presenting: Dr Nathaniel Jackson, Dr Nicola Delany and Dr Shirin Jamshidi with Dr Lia Freestone, Chair, Tasmanian Regional Committee hosting the event.

Dr Nicola Delaney was thrilled that her parents in Christchurch were able to watch the ceremony live from Melbourne as well as the ceremony in Hobart. The event was a special occasion for our new fellows and a wonderful opportunity to celebrate together with family and colleagues.

TASMANIAN REGIONAL COMMITTEE (TRC)

The committee last met on 29 April 2021 via Zoom, which has become the standard method for meeting. For the first time in three years, the Tasmanian ASA Committee of Management also held their meeting on the same night. Both committees plan ACE meetings together and share the CME officer and welfare officer positions. Dr Lia Freestone, Chair of the Tasmanian Regional Committee outlined that as both committees have a strong history of working collaboratively together, holding the meetings on the same night, five times a year makes a lot of sense and ensures continued close collaboration.

The TRC has had quite a few recent changes with Dr Andrew Messmer stepping down as safety and quality officer which he has undertaken since 2013. Dr Pravin Dahal has recently taken over this role. Dr Joanne Samuel has stepped down from the CME role and has been replaced by Dr Sam Walker. Dr Margo Peart is no longer working at the North West Regional Hospital and is currently working at the Royal Hobart Hospital. Although ANZCA councillor Associate Professor Deborah Wilson provides strong representation for north west Tasmania, the TRC is seeking a north west representative and I welcome anyone from the north west who would like to join. Strong regional representation is a priority for the TRC to ensure equitable and accessible representation throughout Tasmania.

On behalf of members of the Tasmanian Regional Committee I thanked those leaving the committee for their valuable support and contribution. I also thanked new members joining the committee for their time and support and outlined how important it is, especially in smaller regions to have dedicated passionate members to contribute to the work of the committee.

Dr Lia Freestone
Chair, Tasmanian Regional Committee

WINTER MEETING IS COMING UP

Check out the Tasmanian Winter Meeting that is coming up on Saturday 21 August 2021 at Barnbougle. This will be the third time the meeting has been held there and has proven to be a popular destination. The theme "Links to the future" explores topics and examines challenges that the future holds in relation to pediatrics, the environment and sustainability, both on a personal and professional level.

This is being held in a stunning location in north east Tasmania, where you will have the opportunity to relax with colleagues, enjoy the sunset over the Bass Strait and either golf or explore the local award winning wineries nearby on the Sunday.

Check the 2021 Tasmanian Winter Meeting webpage on the college website for details and registrations. If the meeting is full, please e-mail tas@anzca.edu.au to add your name to the waiting list. With changeable restrictions, you may be able to come.

TASMANIAN ASM

After the success of this year's meeting, planning for the Tasmanian ASM 2022 is well under way. Convenors Dr Jana Vitesnikova and Dr Stephanie Cruice are planning another dynamic meeting on "Making connections" that will run the weekend of 26-27 February 2022. Mark it in your calendars with registrations expected to open November 2021.

Dr Sam Walker
CME Officer, Tasmanian Regional Committee

TRAINEE COMMITTEE

The Tasmanian Trainee Committee would like to congratulate candidates Dr Lisa Allan and Dr Bing Chan in the most recent primary exam. The 100 per cent success rate continues Tasmania's strong academic performance over recent years and reflects well on both trainees and the profession. In the final exam, all candidates have achieved an invitation to the viva and we wish those sitting all the best. The new medical viva format has been well received by candidates and it's pleasing to see the adaptation that departments have shown in preparing practice exams for those sitting. Exam preparation in general continues to impress in Tasmania, with organised viva practice sessions being successfully run for both examinations – thank you to all those involved.

The committee was pleased to see the interest shown in the TRA2SH environmental stall hosted at the Launceston General Hospital in April and hope to run similar events around the state in the future.

Dr Dylan Siejka,
Deputy Chair, Tasmanian Trainee Committee.

FPM UPDATE

Tasmanian anaesthetists should be aware that there are plans to transition from the current Tasmanian Real Time Prescription Monitoring System (RTPM) DORA, to a national system. The new system is due to be rolled out later this year.

FPM is leading a project to develop a pain management education strategy for Australian health practitioners, funded by the Department of Health's Public Health and Chronic Disease Program. Tasmania was well represented in a recent stakeholder consultation forum and some representatives will continue their representation into the future.

March saw the annual state-wide Acute Pain Day being held for anaesthesia registrars in the north and north west of the state.

Dr Nina Loughman,
FPM representative, Tasmanian Regional Committee

Victoria

RECENT COURSES AND EVENTS

A series of evening sessions were hosted for our trainees to attend viva practice nights over 12 nights in April and May. One was held onsite at Western Health and others were held online via Zoom. The breakout room function was used to run sets of viva practice over the duration, typically with two-to-three candidates to one examiner in each room and groups would rotate to have a different examiner each set. Each set would give a trainee a chance to have a go at a viva while others observed. Thanks to all the hospitals and staff that contributed to these nights.

We were thrilled to be able to hold our first face-to-face course at the college after COVID lockdowns and restrictions. The Primary Refresher Course was held in May and we had a hybrid set up where trainees were able to come onsite and/or join online via Zoom to watch the presentations. Unfortunately Covid-19 restrictions resulted in the last few days of the course being fully online. Over the two weeks there were 28 presentations that were tailored to assist with preparation for the primary exam. Each one was recorded giving trainees the option to continually review in the lead up to their exams. Many thanks to the trainees that joined, and special thanks to all the presenters, the viva examiners and convenor Dr Adam Skinner for their time and commitment to this course.

The Victorian Anaesthetic Training Committee held an information evening meeting at the college on Monday 24 May. Presentations were given on the selection process and from each of the four rotations (Eastern, Monash, North Western and Regional) that form our rotation scheme to give an overview of their hospitals and facilities they can offer. More than 140 attended either face-to-face or online via Zoom. Many thanks to the committee chair Dr Tarin Ward, the presenters, rotation supervisors and supervisors of training that contributed to the evening.

A supervisors of training meeting was held in early June. The group was welcomed by our education officer team – Dr Alex Henry, Dr Tim McIver and Dr Deas Brouwer. The program included two educators workshops "Feedback to enhance learning" and "Planning effective teaching and learning", updates from the Education unit and competencies based medical education project group, a talk on "Helping the previously unsuccessful candidate to re-sit the (final) exam" by Dr Craig Noonan and an opportunity to ask the DPA questions with Dr Maggie Wong. The next meeting is scheduled for Tuesday 9 November. It will be another full day meeting with two educator workshops modules and the plan to hold a dinner in the evening (should restrictions permit!).

UPCOMING COURSES AND EVENTS

Melbourne Winter Anaesthetic Meeting

Plans are progressing for this year's meeting to be held on the last weekend in August: Saturday 28 August (an online scientific meeting during the day, followed by a face-to-face dinner in the evening at the Sofitel Melbourne on Collins) and Sunday 29 August (Emergency Response Workshops to be held face-to-face) at the Sofitel. Further details to come. Save the date in your calendars!

Victorian Registrars' Scientific Meeting

The Victorian Regional Committee invites you to join us on Friday 12 November from 1 to 6pm. Once again we are offering a prize for best presentation on the day in each of the following two categories – scientific research project or audit. To participate please send in an abstract of 250 words in either category, and/or you can register to attend to support your colleagues online.

Exam prep course dates

- Final Refresher Course (Monday 19 to Friday 23 July)
- Final Anatomy Course (Monday 26 July)
- Primary viva practice nights (Monday 6, Wednesday 8, Monday 13, and Wednesday 15 September)
- Final viva practice nights (Monday 4, Wednesday 6, Monday 11, Wednesday 13 October)
- Primary Refresher Course (Monday 15 to Friday 26 November)

We plan to offer our refresher courses face-to-face at the college with the option to also dial in for those that are unable to come in person. Should lockdowns/restrictions prevent us holding face-to-face we will move to a full online delivery. Please contact us should you have any queries and/or to express interest in attending either of our courses/events by emailing vic@anzca.edu.au or phone +61 3 8517 5313.

Attention trainees!

You can contact the members of Victorian Trainee Committee confidentially! If you have any queries or concerns that you would like to discuss with a member of the Victorian Trainee Committee you are welcome to contact them direct via their private email: vicanaestheticregistrars@gmail.com.

Western Australia

PPE IN THE OPERATING THEATRE

2020 was the year of the rat and it was also the year that COVID gnawed a hole in our comfortable approach to PPE in the operating theatre. Like the rest of the anaesthesia community, early on we saw the slowly moving tsunami of destruction moving towards Australia. Colleagues around the world getting sick, unable to protect themselves due to the world-wide shortage of N95 masks and adequate PPE. At Sir Charles Gairdner Hospital, we took a slightly novel approach, researching viable re-usable N95 options. We landed on the Australian-made Clean Space Halo PAPR and haven't looked back.

These PAPR units potentially provided essentially an uninterruptible, high level (99.9 per cent) protection to wearers. We quickly moved to secure units in the department and set about getting them accredited for use in the hospital. This involved a number of departments including OSH, infection control and CSSD. Eventually a guideline was developed and signed-off on. This has paved the way for a roll-out of these devices in other departments and WA hospitals.

In addition, we had to learn and train staff in the correct donning and doffing technique. There is a steeper learning curve to using this device than with most N95 masks but the benefits (comfort for use when worn for long periods, high level of protection, re-usable) certainly made it worthwhile.

The health department has now purchased additional units and these are being made available to other hospitals around the state. We are proud of our foresight in securing these devices and despite the work required in developing an approved guideline, can see the future benefit in providing high-grade protection of staff.

Dr David Kingsbury, Dr Scott Sargant, Dr Bridget Hogan, Dr Cat Goddard and Dr Tania Rogerson
Sir Charles Gairdner Hospital

HALO donning; HALO trolley

Final Examination Trainees in Quarantine

WA ACE CONFERENCES

The WA ACE Country Conference 2021 "All the small things" will be held from 29-31 October at the Pullman Resort in Bunker Bay and is convened by Dr Chris Gibson and Dr Paddy Cowie from the Perth Children's Hospital with the WA office.

Dr Benjamin Hallett will be speaking on TIVA for kids, Dr Priya Thalayasingam will present on scared kids and anxious parents and Dr Chris Gibson, Dr Marlene Johnson and Dr Ian Forsyth will present an airway case-based discussion. Jon Mould will provide a paediatric advanced life support workshop and Dr Tom Flett will provide an airway workshop.

The social calendar includes a welcome dinner at the Pullman Resort and an evening at Bunkers Beach House. A mini-conference for children will be held on the Saturday afternoon with more details to come!

FINAL EXAMS

Trainees from the 20.2 and 21.1 sitting sat their final examinations at the Perth Convention Centre from 26-29 May. It was an immense week for all involved and would not have been possible without the tireless efforts from the examiners and the WA office. Congratulations to all of the trainees!

FINAL EXAM PREPARATION COURSE

The Final Exam Preparation Course is well under way. If you are a trainee studying for your final exam and would like some further tutoring please visit the ANZCA Calendar for the WA Final Exam Preparation Course registration page.

Joint SIG success

For the first time the Airway Management, Obstetric Anaesthesia and Perioperative Medicine Special Interest Groups held a one-day virtual meeting on Thursday 29 April. The meeting included well known international speakers Professor Monty Mythen (UK), Professor Ramani Moonesinghe (UK), Associate Professor David Healy (USA), Associate Professor Lisa Lefftert (USA), Dr Louise O'Brien (USA) and Dr Imran Ahmad (UK) and plenty of outstanding local speakers. With more than 370 registrations the meeting was a great success and we look forward to working together in the future.

Clockwise from top left: Dr Ainslie Murdoch, Dr Yasmin Endlich, Associate Professor Victoria Eley, Dr Linda Beckmann, Dr Chris Futter and Dr Libby McLellan.

We're excited to announce these upcoming events

For further information on the meetings, please contact events@anzca.edu.au.

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Significant Reduction in Post-surgical Mortality

33% 30 Days

29% 90 Days

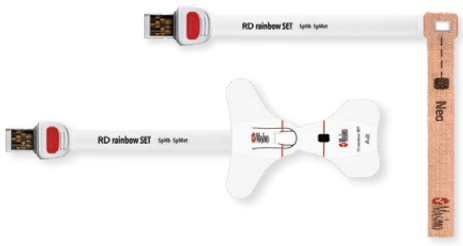
STUDY TIMELINE

2013 **Retrospective Control** (n = 9,285)
No GDT algorithm or Masimo technology implemented

2014 **Prospective Control** (n = 5,856)
No GDT algorithm or Masimo technology implemented

2014 **Prospective Experimental** (n = 3,575)
GDT algorithm with Masimo technology implemented
> Post-surgical mortality was 33% lower at 30 days and 29% lower at 90 days

2015 **Post-Study Observational**
GDT algorithm implemented without Masimo technology
> Mortality rates rebounded to pre-study levels



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[1] Cros et al. *J Clin Monit Comput.* Aug 2019:1-9.

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